



Health Reform Update – Week of October 24, 2016

CONGRESS

AHIP fights Republican efforts to block ACA risk corridor payments to insurers

The president of America's Health Insurance Plans denounced efforts last week by Republican lawmakers to prevent the Centers for Medicare and Medicaid Services (CMS) from settling lawsuits related to risk corridors payments under the Affordable Care Act (ACA).

Senator Marco Rubio (R-FL) led successful efforts to prevent CMS from transferring funds from other accounts whenever there was a shortfall in the revenue collected by an insurer assessment that is intended to compensate insurers for exceptional costly claims. Democrats agreed to include this prohibition in the 2015 and 2016 spending bills in an effort to break legislative stalemates that threatened to shut down the government (see Update for Week of December 15, 2014) and it is currently part of health appropriations bills for the coming year (S.1695 and H.R. 3020).

The prohibition has caused CMS to be unable to pay insurers no more than 12.6 percent of the \$2.87 billion in risk corridors payments that they were scheduled to receive for 2014, forcing the agency to divert all 2015 funding to cover those obligations (see Update for Week of September 12th). This deficit has already been directly responsible for the liquidation of 16 of the 23 Consumer Owned and Operated Plans (CO-OPs) created with ACA start-up loans, as well as indirectly led to the decision by several major insurers to leave most or all of their ACA Marketplaces for 2017 (see Update for Week of August 15th). As a result, at least four of the surviving CO-OPs (including Evergreen Health of Maryland and Health Republic of New Jersey) and eight other insurers are suing CMS to recover their 2014 costs (see Update for Week of August 15th).

CMS officials hinted last month they are willing to use a legal "Judgement Fund" maintained by the Department of Justice to negotiate settlements to the lawsuits that would provide the insurers with at least some of the risk corridor funds they were due under the ACA. The move immediately drew protests from Republican lawmakers who insist that it is a poorly-disguised effort "to subvert Congressional intent to [prevent insurers from receiving] government handouts in excess of incoming funds under the Act's risk corridors program."

House Republicans sought this week to file an *amicus* or "friend of the court" brief as part of the Health Republic lawsuit filed in the U.S. Court of Federal Claims. Meanwhile, Senate Republicans including Rubio and John Barasso (R-WY) plan on attaching prohibitions to the upcoming federal spending bills that would specifically prevent such settlements.

Former CMS Administrator and AHIP President Marilyn Tavenner criticized that move, stating that the largest association of health insurers would be against "any work that tried to interfere with the Judgment Fund and the process that's underway." She argued that Congress has no authority to intervene in such an "administrative issue" and that AHIP would "work with members of Congress to make sure that there's not action taken in this area."

FEDERAL AGENCIES

Less competition leads to dramatic premium spikes for some ACA Marketplaces



The withdrawal of major insurers is having a dramatic impact on benchmark premiums for several federally-facilitated Marketplaces (FFM), according to data released this week by the Department of Health and Human Services (HHS).

The benchmark plan is the second-lowest cost silver tier plan and by far the most popular choice among Marketplace consumers since it is tied to the premium and cost-sharing subsidies under the Affordable Care Act (ACA). Benchmark premiums for the 38 states defaulting to the federal web portal (www.healthcare.gov) will increase by an average of 25 percent for 2017 or more than three times the 7.5 percent average last year (which was only two percent in 2015).

As with prior years, average increases vary widely by state, largely depending on the number of insurers participating in each FFM. For example, average benchmark premiums for a 27 year old will spike by 116 percent in Arizona (the highest of any state) and by more than 50 percent in states like Alabama, Kansas, Nebraska, Oklahoma, and Tennessee. By contrast, the average benchmark premium for a 27 year old will actually fall by two percent in Indiana and increase slightly by two percent in Arkansas, New Hampshire and Ohio. (Michigan and New Jersey will see premiums increase by less than seven percent on average).

A Kaiser Family Foundation study found a similar disparity among average benchmark premiums in major cities. They range from an increase of 145 percent for a 40 year old non-smoker in Phoenix (to \$507 from \$207) and 71 percent in Birmingham (from \$288 to \$492) to a decrease of four percent in Indianapolis (from \$298 to \$286) and two percent in Cleveland (from \$234 to \$229). Two of Florida's largest counties (Broward and Palm Beach) will see only a four percent average increase.

Premiums increases are somewhat less in state-based Marketplaces (SBMs) with available data, bringing the overall average rate hike down to 22 percent when they are included. However, wide variation also exists among SBMs with the 59 percent average increase in Minnesota causing state lawmakers to consider expanding the eligibility for premium subsidies (see below).

Despite the dramatic increase in some states, HHS insists that the average 2017 premium of \$5,538 is actually in line with 2009 projections from the Congressional Budget Office of a weighted average of \$5,586. Agency officials stressed that because ACA subsidies will increase along with premiums, more than two-thirds of FFM consumers will still be able to purchase coverage for less than \$75 per month while 77 percent can find coverage under \$100 per month (more than 85 percent of FFM consumers receive ACA subsidies).

The HHS report also points out that several of the states experiencing the highest rate increases (such as Arizona, Hawaii, Illinois, Kansas, Minnesota, and Pennsylvania) had 2016 premiums that were "well below" the national average and "especially far below" premiums for comparable employer-sponsored coverage. A Kaiser Family Foundation survey also released this week found that premiums for employer coverage are increasing by only three percent on average next year, which is dramatically lower than pre-ACA spikes of 20 percent in 2011 and 58 percent in 2006.)

HHS blames the premium spikes on the expiration of the ACA's temporary reinsurance program, which compensated insurers with exceptionally costly claims for the first three years after ACA implementation. Congressional Republicans successfully cut funding for this program under a deficit reduction agreement that the President signed in 2014 to avoid a federal government shutdown (see above).

The agreement's ban on HHS shifting funding from other sources to cover deficits in the reinsurance program has led some of nation's largest insurers to withdraw from the Marketplaces for 2017, citing substantial financial losses and the lack of competition in many states has predictably forced premiums substantially higher. For example, the rate of insurer withdrawals is more than five times the rate of new Marketplace entrants (89 to 16), meaning that 20 percent of FFM consumers will have only



one insurer from which to choose a health plan option. Overall, FFM consumers will be able to choose from an average of only 30 plan options, compared to 47 in 2016.

An earlier analysis from Avalere Health further showed that the weighted average number of carriers available per county next year is only 2.9 or nearly half the 5.7 average in 2015 and 5.3 for this year. FFM consumers in five entire states (Alabama, Alaska, Oklahoma, South Carolina, and Wyoming) will have only one insurer from which to choose. However, competition will remain robust in states like Wisconsin (whose 15 Marketplace insurers lead all states) and Michigan (see Update for Week of October 10th).

An unrelated survey also released this week by Health Pocket shows that Marketplace deductibles are likewise increasing substantially for 2017. The average deductible for bronze tier plans, will rise six percent to \$6,092 with a 15 percent jump for silver plans (to \$3,572).

HHS predicts Marketplace enrollment will climb by 1.1 million for 2017

The Department of Health and Human Services (HHS) predicted this week that roughly 13.8 million consumers will sign-up for coverage through Affordable Care Act (ACA) Marketplaces during the fourth open enrollment period that starts November 1st.

The modest target is only 1.1 million higher than the total for 2016 (a nine percent increase) and reflects the challenges that the Marketplaces are expected to face as fewer insurers lead to higher premiums (see Update for Week of October 10th). In addition, the pool of uninsured consumers has shrunk to a historic low (see Update for Week of September 12th). HHS is also basing estimates this year on average paid enrollment throughout the year instead of an end-of-year enrollment goal to more accurately account for the typical attrition of consumers that fail to pay their first monthly premium.

An earlier analysis from Standard and Poor's predicted even weaker Marketplace enrollment for 2017, suggesting that sign-ups were not likely to be more than four percent higher than 2016 and could actually decline by as much as eight percent (see Update for Week of September 12th).

HHS figures also differ from higher Congressional Budget Office (CBO) projections, which predict that 15 million people on average will enroll in the Marketplace during 2017. HHS notes that CBO estimates assume that some enrollees will shift from employer to Marketplace coverage although HHS insists that "the evidence to date suggests that no such shifting has occurred."

According to HHS, roughly 10.4 million consumers effectuated Marketplace coverage on average for the first half of 2016 (meaning they were enrolled and paid premiums.) Another 650,000 were enrolled in the Basic Health Plan option that New York and Minnesota elected to pursue for those earning from 138-200 percent of the federal poverty level (see Update for Week of October 10th).

Approximately 84 percent of those with effectuated Marketplace coverage are receiving ACA premium tax credits while another 56 percent are benefiting from the law's cost-sharing reductions.

Among federally-facilitated Marketplace consumers, only 113,000 enrollees had their coverage terminated during the second quarter of 2016 due to "unresolved citizenship or immigration status data." Another 425,000 had their premium or cost-sharing subsidies adjusted due to "income data matching issues." This represents a 63 and 42 percent respective decrease from the same quarter in 2015.

Increase in Social Security benefits likely to cause Part B premium spike for some enrollees

The Social Security Administration (SSA) announced this week that benefits will increase by a 0.3 percent cost-of-living adjustment (COLA) for 2017 (or roughly \$4 per month).



The amount is greater than the 0.2 percent COLA anticipated by the Medicare trustees and is high enough to trigger a so-called “hold harmless” provision that cause up to 30 percent of Medicare Part B premiums to see a spike in premiums for next year.

Roughly 70 percent of Part B enrollees have their premiums automatically deducted from their Social Security benefits and do not have to pay premium increases in years that premiums rise by more than the annual Social Security COLA. However, the other 30 percent (many of whom are dually-eligible for Medicare and Medicaid) are left to pay both their share of the premium increase, plus the share of the other 70 percent. In many cases, state Medicaid programs would shoulder much of this increase as they are obligated to pay Part B premium for dual-eligibles.

Ranking Senate Finance Committee member Ron Wyden (D-OR) pledged that his committee would consider several options to avert the Part B premium spike, just as they used a bipartisan budget bill to mitigate a 52 percent spike in Part B premiums last year for a similar group of Part B enrollees (see Update for Weeks of October 5 and 12, 2015). That legislation would likewise have protected enrollees from premium spikes this year, but only if the COLA remained at zero, as it did for 2016.

Congress could act to extend that protection for 2017. However, the feasibility of any bipartisan agreement during the lame-duck session could depend largely on the outcome of the Presidential and Congressional elections in November.

Medicare Part D premiums to rise nine percent in 2017

A new analysis released this week by the Kaiser Family Foundation (KFF) predicts that premiums for stand-alone prescription drug plans (PDPs) under Medicare Part D are likely to increase by an average of nine percent for 2017, while average deductibles will increase by another seven percent.

However, premium increases will vary greater across all plans, with seven regions of the country seeing an average increase of not more than six percent while average premiums will jump by 18-20 percent in states like Arizona and California. Part D enrollees in New Mexico will experience the lowest average premium (\$31.27) while the highest belongs to New Jersey (\$50.95).

Among plan types, the Humana Walmart Rx plan will offer the lowest average premiums (\$16.81), while AARP Medicare Rx Preferred has the highest average (\$71.66).

Nearly all PDPs will continue to have five cost-sharing tiers, but cost-sharing for particular products will vary widely by plan. Likewise, nearly all PDPs will charge coinsurance for specialty and non-preferred drugs, while one-third have no cost-sharing for preferred generics.

Part D enrollees can choose from an average of 22 PDPs in each region—the fewest since the Part D program was created in 2003.

Public comments overwhelmingly support third-party premium assistance from non-profits

The Marketplace Access Project (MAP) founded by PSI announced this week that more than 85 percent of 829 commenters urged the Centers for Medicare and Medicaid Services not to give insurers the discretion to refuse premium assistance from non-profit charitable programs.

Several insurers including Aetna have partly blamed non-profit premium assistance for skewing their risk pool towards costlier subscribers, leading to higher than expected losses that caused them to exit the Marketplaces for next year (see Update for Week of August 15th). In response, CMS had issued a Request for Information (RFI) on August 23rd asking for input on whether third-party premium assistance from provider-affiliated groups were actually diverting enrollees eligible for Medicare or Medicaid into higher-paying private plans under the Affordable Care Act (ACA) Marketplaces, as insurers



have alleged. The vast majority of public comments refuted these concerns, emphasized the importance of maintaining this critical lifeline for consumers with chronic or life-threatening conditions, and pointed out that bona-fide independent charities like PSI provide assistance based upon financial need.

A 2014 interim final rule from CMS required that Marketplace insurers accept third-party assistance from federal and state health care programs, after several insurers attempted to discriminate against HIV/AIDS patients by refusing to accept premium assistance from the Ryan White HIV/AIDS Program (see Update for Week of June 2, 2014). However, the regulation did not extend that requirement to non-profit assistance and insurers in at least 38 states are currently engaged in similar discrimination against costlier patients by refusing to accept premium payments made by charities on their behalf (see Update for Week of June 20th).

More than 130 bipartisan cosponsors have signed onto Congressional legislation (H.R. 3742) that would fix the interim final rule by requiring Marketplace insurers to also accept non-profit premium assistance and South Carolina is among the states where corrective legislation is expected to soon be considered (see Update for Week of June 20th). CMS had previously expressed a willingness to consider such a revision, but refused to do so as part of their most recent proposed Marketplace standards for 2018 (see Update for Week of September 12th).

STATES

Seven insurers face new discrimination complaints over HIV drug coverage

The Center for Health Law and Policy Innovation at the Harvard Law School has filed new complaints with the Office of Civil Rights (OCR) for the U.S. Department of Health and Human Services (HHS) alleging that seven insurers in eight states are discriminating against HIV/AIDS patients by making drugs for their condition prohibitively costly or inaccessible.

The complaints target Humana plans in six states (Alabama, Georgia, Illinois, Louisiana, Tennessee and Texas) and CIGNA plans in three of those states (Georgia, Tennessee and Texas). Other insurers that were cited include Highmark, Independence Blue Cross, and Blue Shield, and University of Pittsburgh Medical Center Health Plan (all from Pennsylvania). Community Health Choice in Texas and Anthem Blue Cross and Blue Shield of Wisconsin are also included.

The Center collaborated with local AIDs groups to review hundreds of silver-tier plans offered in Affordable Care Act (ACA) Marketplaces and determine whether their formularies and cost-sharing designs would allow access to six treatment regimens that are the current standard of care for HIV. One of the most egregious examples of discrimination found by the center is occurring in Illinois, where Humana placed 16 of 24 of the most commonly-prescribed HIV drugs in the highest cost-sharing tier, which requires subscribers to pay half of the drug cost. With monthly costs for different HIV drug regimens ranging from \$377 to \$684, enrollees in the Illinois Humana plans would have to pay 8-14 percent of their average monthly income for their drugs, according to the complaint.

The Illinois Insurance Commissioner previously found in 2014 that the practice of moving most or all HIV/AIDS drugs into the highest cost-sharing tier violated the ACA's anti-discrimination provision (see Update for Week of June 2, 2014). The AIDS Institute and National Health Law Program filed discrimination complaints with HHS against four Florida insurers engaged in similar practices, which were ultimately ended by the Florida Office of Insurance Regulation seeking to enforce that state's law prohibiting discrimination against HIV/AIDS patients (see Update for Week of March 23, 2015).

HHS has yet to act on the specific complaints, despite acknowledging in federal regulations that the practice of "placing most or all of the drugs that treat a specific condition in the highest cost tiers are examples of 'potentially discriminatory practices'" and directing state officials certifying qualified health



plans for the federally-facilitated Marketplace to evaluate whether insurer benefit designs were discriminatory (see Update for Week of February 23, 2015). However, OCR has thus far only agreed to define discriminatory plan design on a “case-by-case basis” (see Update for Week of September 28, 2015).

A study completed earlier this year by Avalere Health concluded that the attention brought by the initial complaints have resulted in improved Marketplace coverage for HIV/AIDS and other high-cost conditions. It reviewed five classes of drugs that HIV/AIDS, cancer, and multiple sclerosis and found that fewer silver plans for 2016 placed all the drugs in the class in the top tier with the highest cost sharing or charged patients more than 40 percent of the cost for each drug in the class (see Update for Week of April 18th).

Arizona

Average premiums spike by up to 75 percent after mass exodus of Marketplace insurers

Final approved premiums released last week by the Department of Insurance show that the only two remaining insurers in the Affordable Care Act (ACA) Marketplace for Arizona will be allowed to increase premiums by up to an average of nearly 75 percent for 2017.

Four insurers were expected to remain in the Marketplace as recently as last summer (see Update for Week of August 15th). However, CIGNA and HealthNet have now elected only to offer individual market coverage outside of the Marketplace next year, leaving Blue Cross and Blue Shield (BCBS) and Centene to serve Marketplace consumers. However, these two insurers will compete directly only in Pima County (Tucson area), resulting in dramatic premium spikes in the remaining counties where they are currently the lone option.

BCBS was granted permission to increase rates up by a 51 percent average while Centene will boost premiums even higher (by nearly a 75 percent average). Marketplace consumers in the state’s largest county of Maricopa (Phoenix area) will only be able to enroll in Centene coverage after BCBS elected make Maricopa the only county it will not serve (see Update for Week of September 12th).

According to Department officials, premiums for a 40-year-old single Maricopa County resident who does not use tobacco would be charged an average pre-subsidy rate of \$475 per month for silver-tier coverage. A 40-year-old couple with two children would pay \$1,422 per month for a comparable family plan.

The Arizona Marketplace had been considered among the robust in the nation with 11 participating carriers as recently as 2015. As result of the broad competition, it had among the lowest average premiums at only \$324 per month in 2016 (far below the \$396 average among the 38 states that used the federal portal). Only Utah had a lower average pre-subsidy premium (see Update for Week of September 12th).

The dramatic premium increases will also extend to non-Marketplace coverage, ranging from a 33 percent average hike for CIGNA all the way up to 160 percent for Phoenix Health Plans.

California

Physician group sues to block new law on surprise medical bills

The Association of American Physicians and Surgeons filed a federal lawsuit late last week in an effort to block California’s new law protecting consumers from “surprise” medical bills.

The A.B. 72 legislation signed last month by Governor Jerry Brown (D) will not go into effect until next July (see Update for Week of October 10th). It requires insurers to reimburse out-of-network providers contracted with in-network facilities at only 125 percent of the rate Medicare pays or the



insurer's average contracted rate (whichever is greater). Previously, consumers were getting hit with surprise out-of-network charges from contracted providers at in-network facilities, which were dramatically higher than the out-of-pocket expenses they were obligated to pay for remaining in-network.

The physician advocacy group argued that the law “basically empowers private insurance companies to set prices for physicians and other caregivers who are not even in their network....[giving them] the power of government.” Their lawsuit claims that it violates the federal and state constitutions by denying physicians due process and “just compensation for their labor.” It also insists that the resultant withdrawal of physicians from certain markets will disparately impact minority communities, thereby violating constitutional equal protection clauses.

Illinois

Most Marketplace plans will see substantial premium increases for 2017

The Department of Insurance announced this week that final Marketplace premiums for 2017 will increase by an average of 55 percent for the lowest-cost gold tier plans, 45 percent for the lowest-cost silver tier plans, and 44 percent for the lowest-cost bronze tier plans.

The loss of four carriers in Get Covered Illinois is largely to blame for the increase, as only five will offer individual coverage when the open enrollment period opens on November 1st. Only an average of 1-3 carriers will be available per county and subscribers will have only 10-39 plan options from which to choose unless they live in Cook County (Chicago area), where 40 plan options will be available.

Despite the most plan options, Chicago consumers seek “benchmark” coverage will face an average premium increase of 48 percent (to \$291 before subsidies for a 27-year old or \$1,078 for a family of four). That is largely a result of the number of plan options being cut from 71 to 40.

Michigan

Marketplace premiums to jump by nearly 17 percent average

Premiums for individual health plans sold in the Affordable Care Act (ACA) Marketplace for Michigan will jump 16.7 percent next year according to Department of Insurance.

State regulators only slightly modified the premiums from the 17.2 percent average increase sought by the ten carriers that will participate in the Marketplace for 2017. Only Aetna and Alliance Health did not receive their full proposed increase, while Humana received all of the 39.2 percent average hike that it requested.

Unlike states like Arizona that have seen mass defections of major Marketplace insurers (see above), only a handful of mostly smaller plans have exited the Michigan Marketplace for 2017 (see Update for Week of August 22nd).

Minnesota

Democrats float plan to expand subsidies for Marketplace consumers

Democratic legislators released a proposal this week to use the state's \$313 million surplus to expand premium subsidies for Marketplace consumers facing 50-67 percent premium spikes.

Minnesota's 59 percent average increase leads all state-based Marketplaces and trails only three of the federally-facilitated Marketplaces (see above). Although Minnesota initially had the lowest Marketplace premiums (see Update for Week of September 29, 2014), the increase means that a family of four will now pay roughly \$1,396 per month for benchmark coverage, or 28 percent more than the \$1,090 average across 44 states, according to federal data released this week (see above).



According to the Department of Commerce, the dramatic spikes are largely due to the expiration of the temporary reinsurance program under the Affordable Care Act (ACA), noting that premiums would have been 45 percent lower for next year if not for the top 1.79 percent of individual consumers who had claims expenses exceeding \$100,000 (see Update for Week of October 10th). Governor Mark Dayton (D) has urged Congress to extend the reinsurance program, insisting that the ACA is “no longer affordable to increasing numbers of people.” However, House Speaker Paul Ryan (R-WI) and other Congressional Republicans flatly rejected such a proposal this week, stating that problems with the ACA are “beyond repair” and “cannot be fixed.”

Under the ACA, premium tax credits are available only to those earning from 100-400 percent of the federal poverty level. The plan advanced by Democratic legislators in Minnesota would use the state surplus to expand provide similar state subsidies to individuals earning above 400 percent of FPL (about \$47,000 per year) in an effort to cap premiums for those Marketplace consumers at no more than ten percent of income. The concept had previously been supported by Governor Dayton.

The leading House Democrat Paul Thissen stressed that such assistance would not require a federal waiver and could be implemented next year with the approval of Republican lawmakers that currently control the House. However, House Speaker Kurt Daudt (R) refused to endorse the plan this week, stating only that Republicans were committed to finding their own solution to “quickly [find] ways to reduce costs and address the health care crisis Democrats created.”

Pennsylvania

Average Marketplace premiums to increase by nearly 33 percent

The Department of Insurance announced this week that premiums for individual plans sold in the Affordable Care Act (ACA) Marketplace will increase next year by average of 32.5 percent.

In several instances, the Department actually gave insurers a higher 2017 premium than they requested in a stated effort to keep carriers from leaving the Marketplace. For example, dominant insurer Highmark received a whopping 55 percent increase for one of their Marketplace offerings and a 45 percent increase for another. Both were seven percent higher than the insurer sought. UPMC Health Plan also received similar rate upgrades.

Insurance Commissioner Teresa Miller (D) informed stakeholders that the higher premiums were needed to ensure statewide coverage, noting that the Department “faced the real possibility that people in a number of counties in Pennsylvania would have no health plans being offered through the exchange.” Currently, residents in 16 counties will have only one Marketplace insurer from which to choose when open enrollment starts on November 1st.

The commissioner also insisted that many Marketplace plans have been “underpriced” as Pennsylvania previously had some of the lowest premiums in the nation thanks to ample competition (ten insurers will continue to participate in the Marketplace next year). She insisted that the upgrades were a “one-time correction to previous underpricing” and the premiums in “future years [will not increase] significantly above standard increases in medical costs.”

Highmark has committed only to remaining in the Marketplace, but not offering plans in every county, insisting that it lost more than \$800 million in Marketplace business for 2014. The Department has filed an *amicus* brief in support of Highmark’s federal lawsuit seeking to collect more than \$220 million in risk corridor payments that it was due under the ACA to compensate for exceptionally costly claims (see Update for Week of June 20th).

However, the commissioner notes that unlike Highmark, UPMC Health Plan did not price their plans based on the assumption that it would receive these risk corridor payments and consequently it has not incurred substantial losses.



Vermont

State becomes first to create all-payer accountable care organization

The Green Mountain Care Board formally approved an all-payer accountable care organization (ACO) model for Vermont, making it the first state in the nation to do so.

Governor Peter Shumlin (D) had already secured federal approval for the voluntary model, which will cover Medicare, Medicaid, and commercial insurers, requiring those who participate to pay similar rates for all services. Once implemented, health care providers would be paid a flat fee per patient. They can keep any savings from spending less than that amount, but must incur any losses for going over the capitated rate.

Under the five-year Section 1115 demonstration waiver granted by the Obama Administration, Vermont must limit annual cost growth for major payers to no more than 3.5 percent per capita, while Medicare spending growth must stay 0.1-0.2 percentage points below national spending growth. The state will receive \$9.5 million in federal start-up funding for the model.

The Governor projects that 36 percent of insured residents will be covered through the ACO by next year and 70 percent by 2022 making it far more ambitious than the only other all-payer system enacted in Maryland, which sets all per capital rate caps only for hospitals.

The ACO model was intended to replace Vermont's previously-approved federal waiver to move all residents into a single payer system by 2017. Higher than projected costs forced Governor Shumlin to abandon single-payer two years ago (see Update for Weeks of October 20 and 27, 2014).

Washington

Competition keeps Marketplace premium increases well-below national average

Insurance Commissioner Mike Kreidler (D) announced this week that consumers in the Washington Healthplanfinder will likely face double-digit premium increases for 2017.

While the overall average increase of 13.6 percent is more than three times the 4.2 percent rate hike that the Healthplanfinder allowed for 2016 (see Update for Week of August 17 and 24, 2015), it is far less than the 25 percent average for "benchmark" coverage across all of the Affordable Care Act (ACA) Marketplaces (see above). Furthermore, the commissioner stressed that premiums for the most popular silver tier coverage (including second lowest-cost silver plans or "benchmark" coverage) will climb by only eight percent next year.

The reason Washington has been able to moderate rate hikes is because the level of insurer competition has remained constant. Despite the losses of UnitedHealth Care and Moda, the Healthplanfinder will have the same number of 2016 insurers (nine) when the open enrollment period starts on November 1st.

As with his counterpart in Pennsylvania (see above), Kreidler insisted that the sizeable increases are a "one-year adjustment" resulting from the expiration of ACA reinsurance and risk corridor payments and that rate hikes will "level off" as insurers have more data next year upon which to set premiums.