HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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IN FOCUS

NEW YORK HEALTH INSURANCE MARKETPLACE: PLANS AND PREMIUMS

As the open enrollment period in the marketplaces kicks off this week, HMA is preparing detailed analyses of qualified health plan (QHP) participation and premium rates by region and metal tier in all 50 states and the District of Columbia. As a demonstration of this effort, this week our *In Focus* section reviews the New York State health insurance marketplace, known as NY State of Health. NY State of Health features 16 health insurance carriers, offering qualified health plans in at least one of eight regions. For more information, please contact us at: HMAweeklyroundup@healthmanagement.com

NY State of Health Overview

New York is one of 17 states operating a state-based marketplace and the state selected the Oxford EPO plan as the benchmark health plan for the marketplace. New York's marketplace features 17 insurers, four of which have previously operated purely as Medicaid plans in New York. Four QHPs have previously operated purely as commercial plans, while seven QHPs have operated both Medicaid and commercial plans in New York. Additionally, NY State of Health features one Consumer Oriented and Operated Plan (Co-Op), the newly-created Health Republic Insurance plan. Nonprofit organizations were awarded low-interest loans from the federal government to create CO-OP health plans with the goal of creating low-cost health insurance options in as many state marketplaces as possible.

The table below details QHP participation by region and identifies those plans that are the lowest and second lowest priced Silver tier plans in each region, as well as QHPs offering Bronze Tier products priced below the second lowest priced Silver.

An overview of QHP monthly premium rates indicate that:

- Health Republic Insurance (Co-Op) is the lowest priced Silver in 6 regions and second lowest in 1 region

- Fidelis Care is the lowest priced Silver in 1 region and second lowest in 5 regions.
- MetroPlus is the lowest priced Silver in 1 region; however, it is the highly populous New York City region

For more information, please see the NY State of Health website.

Qualified Health Plan Participation by Region

Health Plan	Plan Type	# Regions Participating	# Lowest Silver	# 2nd Lowest Silver	# Bronze Lower
Health Republic Insurance	*CO-OP*	8/8	6	1	8
Fidelis Care	*Medicaid*	8/8	1	5	8
MVP Health Plan	*Comm./Medicaid*	7/8		1	5
Excellus	*Comm./Medicaid*	6/8			1
American Progress	*Commercial*	6/8			1
Empire BCBS	*Commercial*	5/8			1
Capital District PHP	*Comm./Medicaid*	4/8			
HIP of Greater NY	*Comm./Medicaid*	3/8		1	3
Affinity Health Plan	*Medicaid*	3/8			2
Aetna Life [WITHDREW]	*Commercial*	3/8			
United Healthcare	*Comm./Medicaid*	3/8			
HealthNow New York	*Comm./Medicaid*	3/8			
North Shore LIJ	*Commercial*	2/8			2
Oscar Health Insurance Co.	*Commercial*	2/8			2
Healthfirst New York	*Medicaid*	2/8			2
MetroPlus Health Plan	*Medicaid*	1/8	1		1
Independent Health	*Comm./Medicaid*	1/8			

Significance of the Second-Lowest Priced Silver Plan in Each Region: Premium Assistance and Subsidies Overview

Premium assistance tax credit amounts for the population below 400% FPL will be based on an individual's or a family's income and linked to the second-lowest priced Silver tier plan in their region. The lowest and second-lowest priced Silver plans may therefore receive a significant portion of enrollment. Marketplace-based subsidies take two forms:

Premium Assistance Tax Credits offset monthly premiums for qualified health plans. Tax credits are based on income and the second-lowest priced Silver plan in the region. Premium assistance eligibility is limited to those with incomes between 138%--400% FPL in states that expand Medicaid and between 100%--400% FPL in those states that do not expand Medicaid.

Cost-Sharing Subsidies will be available to the same population eligible for premium assistance tax credits, and will offset out-of-pocket expenses such as copays and deductibles. Cost-sharing subsidy limits vary based on income. However, an individual or family must be enrolled in a Silver plan in order to be eligible for cost-sharing subsidies.

NY State of Health – QHP Monthly Premium Rates by Region

In the tables on the following pages, we present regional rates for the individual market, as well as effective rates after the premium assistance tax credit based on 200% FPL. These post-tax credit monthly costs are estimates based on 2013 income levels and should be viewed as estimated approximate premium assistance levels for the marketplace in 2014. Tax credits are not available for the purchase of Catastrophic/Minimum tiered plans.

New York's health insurance marketplace is unique, in that the state requires products be priced according to a pure community rating methodology, meaning that premium rates cannot vary based on age, gender, or health status. As a result, the premiums quoted in the tables below represent the prices available to all purchasers. In other states, the rates may vary based on the age and/or smoking status of the purchaser.

In the following tables, premium rates highlighted in **green** are priced below the second-lowest priced Silver plan in this region; rates highlighted in **red** are priced above the second-lowest priced Silver plan in this region; the rate highlighted in **yellow** is the second-lowest priced Silver plan. Premium costs after tax credits are shaded according to their relative cost, where **dark green** is the lowest and **dark red** is the highest priced plan offerings.

New York City Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	New York City Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
MetroPlus Health Plan	*Medicaid*	$334	**$359**	$396	$443	$69	$93	$130	$177
HIP of Greater NY	*Comm./Medicaid*	$334	$387	$462	$556	$68	$121	$196	$290
Fidelis Care	*Medicaid*	$308	$390	$478	$577	$42	$124	$212	$311
Health Republic Insurance	*CO-OP*	$312	$395	$446	$523	$46	$129	$180	$257
North Shore LIJ	*Commercial*	$330	$420	$487	$568	$64	$154	$221	$302
Affinity Health Plan	*Medicaid*	$379	$442	$510	$601	$113	$176	$244	$335
Oscar Health Insurance Co.	*Commercial*	$362	$446	$518	$603	$96	$180	$252	$337
Healthfirst New York	*Medicaid*	$384	$450	$526	$623	$118	$184	$260	$357
Empire BCBS	*Commercial*	$406	$468	$553	$650	$141	$202	$287	$384
MVP Health Plan	*Comm./Medicaid*	$472	$611	$734	$864	$206	$345	$468	$598
Aetna Life [WITHDREW]	*Commercial*	$513	$597	$688	$799	$247	$332	$422	$533
United Healthcare	*Comm./Medicaid*	$548	$636	$749	$914	$282	$370	$483	$648
Excellus	*Comm./Medicaid*								
American Progress	*Commercial*								
Independent Health	*Comm./Medicaid*								
HealthNow New York	*Comm./Medicaid*								
Capital District PHP	*Comm./Medicaid*								

Long Island Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Long Island Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Fidelis Care	*Medicaid*	$285	**$360**	$441	$533	$11	**$86**	$167	$259
Health Republic Insurance	*CO-OP*	$312	$395	$446	$523	$38	**$121**	$172	$249
North Shore LIJ	*Commercial*	$330	$420	$487	$568	$56	$146	$214	$294
Empire BCBS	*Commercial*	$374	$431	$509	$599	$100	$157	$235	$325
HIP of Greater NY	*Comm./Medicaid*	$380	$439	$525	$631	$106	$166	$251	$358
Oscar Health Insurance Co.	*Commercial*	$362	$446	$518	$603	$88	$172	$244	$329
Healthfirst New York	*Medicaid*	$384	$450	$526	$623	$110	$176	$252	$349
Affinity Health Plan	*Medicaid*	$387	$451	$521	$614	$113	$178	$247	$341
Aetna Life [WITHDREW]	*Commercial*	$513	$597	$688	$799	$240	$324	$415	$525
United Healthcare	*Comm./Medicaid*	$548	$636	$749	$914	$274	$362	$475	$640
MetroPlus Health Plan	*Medicaid*								
MVP Health Plan	*Comm./Medicaid*								
Excellus	*Comm./Medicaid*								
American Progress	*Commercial*								
Independent Health	*Comm./Medicaid*								
HealthNow New York	*Comm./Medicaid*								
Capital District PHP	*Comm./Medicaid*								

Albany Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Albany Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$237	**$300**	$339	$397	$15	**$78**	$117	$176
Fidelis Care	*Medicaid*	$270	**$342**	$419	$506	$49	**$121**	$198	$285
MVP Health Plan	*Comm./Medicaid*	$297	$384	$461	$543	$75	$162	$240	$322
Empire BCBS	*Commercial*	$378	$436	$515	$605	$157	$215	$294	$384
Capital District PHP	*Comm./Medicaid*	$402	$478	$564	$644	$181	$257	$343	$423
Excellus	*Comm./Medicaid*	$377	$487	$565	$654	$156	$266	$343	$433
American Progress	*Commercial*	$395	$490	$564	$633	$174	$269	$343	$411
HealthNow New York	*Comm./Medicaid*	$435	$525	$639	$738	$214	$303	$418	$517
MetroPlus Health Plan	*Medicaid*								
HIP of Greater NY	*Comm./Medicaid*								
North Shore LIJ	*Commercial*								
Affinity Health Plan	*Medicaid*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Aetna Life [WITHDREW]	*Commercial*								
United Healthcare	*Comm./Medicaid*								
Independent Health	*Comm./Medicaid*								

Buffalo Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Buffalo Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$222	**$280**	$317	$372	$4	**$63**	$100	$155
Fidelis Care	*Medicaid*	$267	**$338**	$414	$500	$50	**$121**	$197	$283
MVP Health Plan	*Comm./Medicaid*	$270	$349	$419	$493	$52	$131	$202	$276
HealthNow New York	*Comm./Medicaid*	$340	$406	$494	$568	$123	$189	$277	$351
American Progress	*Commercial*	$350	$434	$499	$560	$132	$216	$282	$342
Independent Health	*Comm./Medicaid*	$396	$471	$538	$619	$178	$253	$321	$402
Excellus	*Comm./Medicaid*	$367	$473	$549	$635	$149	$256	$331	$418
MetroPlus Health Plan	*Medicaid*								
HIP of Greater NY	*Comm./Medicaid*								
North Shore LIJ	*Commercial*								
Affinity Health Plan	*Medicaid*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Empire BCBS	*Commercial*								
Aetna Life [WITHDREW]	*Commercial*								
United Healthcare	*Comm./Medicaid*								
Capital District PHP	*Comm./Medicaid*								

Mid-Hudson Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Mid Hudson Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$266	**$337**	$380	$446	$42	**$112**	$156	$222
Fidelis Care	*Medicaid*	$273	**$345**	$422	$510	$48	**$121**	$198	$286
HIP of Greater NY	*Comm./Medicaid*	$334	$387	$462	$556	$110	$163	$238	$331
Affinity Health Plan	*Medicaid*	$369	$431	$497	$587	$145	$207	$273	$362
MVP Health Plan	*Comm./Medicaid*	$363	$470	$564	$665	$139	$246	$340	$440
Excellus	*Comm./Medicaid*	$377	$487	$565	$654	$153	$263	$341	$430
Empire BCBS	*Commercial*	$446	$514	$607	$714	$222	$290	$383	$490
Aetna Life [WITHDREW]	*Commercial*	$457	$531	$613	$711	$232	$307	$389	$487
Capital District PHP	*Comm./Medicaid*	$454	$539	$636	$727	$229	$315	$412	$502
American Progress	*Commercial*	$446	$553	$637	$714	$222	$329	$413	$490
United Healthcare	*Comm./Medicaid*	$548	$636	$749	$914	$324	$411	$525	$690
MetroPlus Health Plan	*Medicaid*								
North Shore LIJ	*Commercial*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Independent Health	*Comm./Medicaid*								
HealthNow New York	*Comm./Medicaid*								

Rochester Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Rochester Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$218	**$276**	$312	$366	$2	**$60**	$96	$150
MVP Health Plan	*Comm./Medicaid*	$260	$337	$405	$476	$44	**$121**	$189	$260
Fidelis Care	*Medicaid*	$268	$339	$415	$502	$52	$123	$199	$286
Excellus	*Comm./Medicaid*	$292	$376	$436	$505	$76	$161	$220	$289
American Progress	*Commercial*	$366	$455	$523	$586	$150	$239	$307	$371
MetroPlus Health Plan	*Medicaid*								
HIP of Greater NY	*Comm./Medicaid*								
North Shore LIJ	*Commercial*								
Affinity Health Plan	*Medicaid*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Empire BCBS	*Commercial*								
Aetna Life [WITHDREW]	*Commercial*								
United Healthcare	*Comm./Medicaid*								
Independent Health	*Comm./Medicaid*								
HealthNow New York	*Comm./Medicaid*								
Capital District PHP	*Comm./Medicaid*								

Syracuse Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Syracuse Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$230	**$291**	$329	$386	$9	**$71**	$108	$165
Fidelis Care	*Medicaid*	$270	$341	$418	$505	$49	**$121**	$197	$284
MVP Health Plan	*Comm./Medicaid*	$339	$439	$527	$620	$118	$218	$306	$400
Excellus	*Comm./Medicaid*	$355	$458	$531	$614	$134	$237	$310	$394
American Progress	*Commercial*	$372	$461	$531	$592	$151	$241	$310	$372
Capital District PHP	*Comm./Medicaid*	$449	$533	$629	$718	$228	$313	$408	$497
MetroPlus Health Plan	*Medicaid*								
HIP of Greater NY	*Comm./Medicaid*								
North Shore LIJ	*Commercial*								
Affinity Health Plan	*Medicaid*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Empire BCBS	*Commercial*								
Aetna Life [WITHDREW]	*Commercial*								
United Healthcare	*Comm./Medicaid*								
Independent Health	*Comm./Medicaid*								
HealthNow New York	*Comm./Medicaid*								

Utica Region – Monthly Premium Rates and Tax Credit Impact

Health Plan	Plan Type	Utica Region				Premium After Tax Credit (at 200% FPL)			
		BRONZE	SILVER	GOLD	PLATINUM	BRONZE	SILVER	GOLD	PLATINUM
Health Republic Insurance	*CO-OP*	$224	**$283**	$320	$376	$7	**$67**	$104	$159
Fidelis Care	*Medicaid*	$267	$337	$413	$499	$50	**$121**	$196	$282
American Progress	*Commercial*	$328	$407	$469	$525	$112	$191	$252	$309
MVP Health Plan	*Comm./Medicaid*	$318	$411	$494	$582	$101	$194	$277	$365
Excellus	*Comm./Medicaid*	$377	$487	$565	$654	$161	$271	$348	$437
Capital District PHP	*Comm./Medicaid*	$431	$512	$604	$690	$215	$296	$387	$473
HealthNow New York	*Comm./Medicaid*	$455	$549	$669	$773	$238	$332	$452	$556
Empire BCBS	*Commercial*	$602	$694	$819	$964	$386	$478	$603	$747
MetroPlus Health Plan	*Medicaid*								
HIP of Greater NY	*Comm./Medicaid*								
North Shore LIJ	*Commercial*								
Affinity Health Plan	*Medicaid*								
Oscar Health Insurance Co.	*Commercial*								
Healthfirst New York	*Medicaid*								
Aetna Life [WITHDREW]	*Commercial*								
United Healthcare	*Comm./Medicaid*								
Independent Health	*Comm./Medicaid*								

HMA MEDICAID ROUNDUP

Alaska

HMA Roundup

Private Insurance Broker Fills Niche for Health Enrollment. Following Governor Parnell's Administration's decision to opt for a Federally Facilitated Exchange in Alaska, Northrim Bank took the initiative with its Enroll Alaska affiliate to build a website, establish retail locations around the state, and educate and enroll uninsured Alaskans, which HHS estimates at 139,000. COO Tyann Boling believes that the mission of the company is to educate and inform how the ACA works and enroll the uninsured in plans. In contrast to Navigators, which are prevented from recommending plans, Enroll Alaska's agents are not barred from doing so, or from selling health plans outside the exchange.

Arkansas

HMA Roundup

CMS Approves Arkansas' "Private Option" Waiver. On September 27, CMS approved Arkansas' Section 1115 waiver that uses Medicaid expansion funds for premium assistance in health plans available on the state's exchange. The waiver should apply to some 225,000 Arkansans. Eligible beneficiaries will choose from silver tier plans without a monthly premium, although co-pays and deductibles will apply to individuals whose income exceeds the federal poverty level. Over time, Arkansas will require cost-sharing for people who have income above 50 percent of the poverty level.

California

HMA Roundup

Californians Remain Unclear on Healthcare Options. A Kaiser Family Foundation survey, conducted in August, reveals that nearly half of respondents newly eligible for Medi-Cal are unaware that they will be able to enroll for 2014. Nearly three-quarters of people eligible for tax credits for exchange plans are either unaware or mistaken about their ability to qualify for benefits. About 70 percent of uninsured Californians eligible for coverage benefits are unclear on how the ACA will affect them.

Los Angeles Sues to Prevent the Establishment of a Redundant Health Department. On September 30, 2013, the city of Los Angeles filed a suit to prevent a ballot measure that would mandate the creation of the city's own health department, separate from that of the county. AIDS Healthcare Foundation President Michael Weinstein has criticized the county's health department, citing more responsive and effective health departments in the cities of Long Beach and Pasadena. The city of Los Angeles argues that the proposed ballot initiative would violate state laws and encroach on the city's administrative functions. LA County has filed its own lawsuit to halt the initiative before it makes it on the ballot.

Denti-Cal Adult Benefits to Be Reinstated in May 2014. In July 2009, California eliminated most adult dental services under the Medi-Cal dental program (Denti-Cal), resulting in three million beneficiaries losing their dental benefits. However, the recent state budget partially reinstated Denti-Cal benefits effective May 2014. Unfortunately, automatic 10 percent provider cuts retroactive to 2011 will make it difficult to find dentists that accept Denti-Cal. Given the low rates, many private dentists refuse Denti-Cal patients. The California Medical Association reports that 56 percent of Medi-Cal patients have difficulty finding a doctor.

Colorado

HMA Roundup—Joan Henneberry

Colorado Receives CMS Grant for Rate Review. Colorado Division of Insurance received a second grant from CMS for rate review in the amount of $3.55 million. The first grant in 2010 was for $1 million. The money also can be used for consumer education about insurance issues. State insurance division leaders didn't immediately give their plans for uses of the funding. In a press release, CMS administrator Marilyn Tavenner said that the $67.6 million awarded to 21 states are designed to require insurers seeking rate increases of 10 percent or more to rationalize the increases. The grants intend to help states reduce rates and save consumers money.

Connect for Health Notes that Tax Credit Calculations Will Initially Be Manual. Connect for Health Colorado announced that starting October 1 consumers will be able to do most of the enrollment process online. But near the end of the process, those who are eligible for a tax credit will be prompted to call a number to speak with a customer service representative, who will enter information for that person manually. That workaround will last for about four weeks so that more testing can be done to make sure it works before consumers do it online themselves. Several other states announced recently that some of the on-line functionality, including interfaces with Medicaid, will not be ready for several more weeks.

Fiscal Management Request for Information. The Department of Health Care Policy and Financing is issuing a Request for Information (RFI) from vendors that can provide information with regard to the re-procurement of Fiscal Management Services (FMS) for the Department's Consumer Directed Attendant Support Services (CDASS). The Department seeks responses to identify potential changes to its FMS contract for CDASS delivery by November 8, 2013.

District of Columbia

HMA Roundup

DC Exchange Will Not Determine Medicaid Eligibility. On September 25, 2013, the District of Columbia announced that D.C. Health Link—the state's health exchange—will not be determine Medicaid eligibility or tax credits, although it would open on-time on October 1, 2013. People seeking Medicaid coverage will work with 200 trained personnel who will assist in completing an off-line application. Tax credit calculations will be e-mailed to those eligible in early November, offering ample time to enroll in a plan by December 15, 2013.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Releases MMA Notices of Intent to Protest. As of September 26, 2013, the Agency for Health Care Administration (AHCA) received notices of the intent to protest the Managed Medical Assistance (MMA) awards from twelve carriers. From September 26, the parties have 10 days to formally submit a protest and post a protest bond. Below, is a summary of the parties filing a notice of an intent to protest:

Statewide Medicaid Managed Care (SMMC)
SMMC Managed Medical Assistance(MMA) ITN
Notice of Intent to Protest

		Region											
	Plan Name	1	2	3	4	5	6	7	8	9	10	11	TOTAL
	Standard Plans												
1	Amerigroup Florida, Inc.							X	X	X	X	X	5
2	Coventry Health Care of Florida, Inc.	X	X	X	X	X	X	X	X	X	X	X	11
3	Molina Healthcare of Florida	X			X	X	X	X		X	X	X	8
4	Simply Healthcare Plans, Inc.					X						X	2
5	UnitedHealthcare of Florida, Inc.	X	X	X		X	X	X	X	X			8
6	Wellcare/Staywell of Florida, Inc.				X					X	X		3
7	Care Access, LLC - PSN											X	1
8	First Coast Advantage, LLC - PSN			X									1
9	Integral Health Plan, Inc. - PSN	X											1
10	Prestige Health Choice - PSN								X				1
11	Salubris, LLC - PSN									X			1
12	South Florida Community Care Network (SFCCN) - PSN										X		1
	Total Standard Plans	4	2	3	3	4	3	4	4	6	5	5	43

Contract Awards Standard Plans	2	2	3	3	4	7	3	3	3	3	6	39
HMO	**1**	**1**	**2**	**2**	**3**	**4**	**2**	**2**	**2**	**2**	**5**	26
PSN	**1**	**1**	**1**	**1**	**1**	**3**	**1**	**1**	**1**	**1**	**1**	13

Statutory Max Awards (at least 1 PSN)	**2**	**2**	**5**	**5**	**4**	**7**	**6**	**4**	**4**	**4**	**10**	53
HMO	**1**	**1**	**4**	**4**	**3**	**6**	**5**	**3**	**3**	**3**	**9**	42
PSN	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	11

Difference Max Awards and Actual Awards	0	0	2	2	0	0	3	1	1	1	4	14
HMO	0	0	2	2	0	2	3	1	1	1	4	16
PSN	0	0	0	0	0	(2)	0	0	0	0	0	(2)

Note: Regions 1, 2, 5 and 6 have been awarded the statutory maximum; therefore the Agency cannot move forward in negotiating contracts in these regions until all protests have been resolved. Region 6 was the only region in which more than 1 PSN was awarded (this was due to bonuses awarded to 2 PSNs).

Office of Insurance Regulation Releases Premium Impact Notices. On September 27, 2013, the Office of Insurance Regulation released "Federal Health Care Reform Consumer Premium Impact Notices", as required by Senate Bill 1842, which passed during the 2013 Legislative Session. These notices, filed by 27 health insurers and HMOs offering plans on the state's exchange, show the impact of the ACA on health insurance plan costs in Florida by comparing new plan premiums to those of the insurer's most popular plan available prior to ACA implementation.

Department of Corrections Commends Privatization Efforts. On September 25, 2013, officials from the Department of Corrections said that the privatization of healthcare services in prisons was proceeding smoothly, with most former state employees transitioning to the private companies running the clinics. Wexford and Corizon have already assumed operations in all four DOC regions. Wexford has completed its transition from state operations on its $48 million annual contract, while Corizon had completed the transition for 27 of the 40 institutions covered in its $230 million annual contract.

HCA Wins Hospital Board Support for Citrus Memorial Hospital Takeover. On Monday, September 30, 2013, HCA won the support of both key boards at Citrus Memorial Hospital in a bid to operate the public hospital. Citrus Hospital Board approved of HCA with a 4-0 vote, followed by a 7-1 favorable vote by the Citrus Memorial Hospital Foundation Board. Tampa General Hospital had been vying with HCA to win control of the hospital. The boards split between a lease agreement or an outright sale to HCA, so the boards will continue talks about what transaction type to pursue.

Sheldon to Return to Florida from Federal Role. On September 26, 2013, HHS Sec. Kathleen Sebelius announced that George Sheldon**,** Acting Assistant Secretary for Children and Families, would be leaving his post effective October 18, 2013. Sheldon had formerly served as Secretary of Florida's Department of Children and Families and as Florida's Deputy Attorney General. There is speculation about a potential bid to challenge Attorney General Pam Bondi in 2014.

Tallahassee Federal Judge Rejects Medical Malpractice Reform Legislation. On September 25, US District Judge Robert Hinkle rejected the Florida Legislature's 2013 medical liability reform package for attempting to circumvent federal HIPAA privacy requirements. The Florida Medical Association believes an appeal is likely.

Few Navigators Have been Licensed. In the wake of controversies surrounding the potential threats to privacy from navigators, the Florida Department of Financial Services revealed last week that just 57 of the 150 navigators had applied for requisite state licenses, with 11 having been approved.

Legislators Likely to Pay More for Health Insurance. Last week, the AP reported that House Speaker Will Weatherford will require legislators to pay health insurance premiums consistent with state workers. Senators were subjected to this change this past year.

AHCA to Host Meetings on Extending 1115 Managed Medical Assistance Waiver. Given the expiration of the state's 1115 Managed Medical Assistance (MMA) waiver on July 1, 2014, the Agency for Health Care Administration will host public meetings to gather input on the extension of this waiver through June 30, 2017. The waiver would implement statewide managed care delivery while continuing the Low Income Pool (LIP) program.

Georgia

HMA Roundup – Mark Trail

Georgia Premium Varies More than Any Other State. This week, Kaiser Health News identified Georgia as the state with the most premium variation in the nation. Due to differences in plan competition, provider availability, and incidence of chronic diseases, rural southwest Georgia had premiums for silver tier plans that doubled those of silver tier plans in the other three regions of the state, including metro Atlanta.

RFP for ABD Population Set for Mid-October. According to the Department of Community Health, the request for proposal for a vendor to provide case management and intensive case management services to Georgia's Aged, Blind, and Disabled (ABD) population is on track for a mid-October release

Idaho

HMA Roundup

Idaho Behavioral Health Plan Transitions to Optum. Last month, Optum assumed management of the outpatient community-based behavioral health services for the Idaho Behavioral Health Plan and its 245,000 members. Individual network providers must have independent clinical licensure (ICL) and network provider agency employees who lack an independent license will be required to work under the supervision of an independently licensed clinician. Optum has promised to help providers in their efforts to obtain the required credentials and join the provider network. Starting on November 1, 2013, members will be required to use network providers.

Altius Drops Out of Idaho's Exchange. On September 25, 2013, Altius Health Plans, a subsidiary of Aetna, dropped out of Idaho's health exchange. As a result, Idaho lost its only for-profit carrier and its 15 policies originally slated for the marketplace. Altius will still offer plans outside the exchange and would evaluate potentially offering plans on the exchange in 2015. The remaining four carriers offering individual plans are Blue Cross of Idaho, BridgeSpan Health Company, PacificSource Health Plans, and SelectHealth of Utah.

Indiana

HMA Roundup—Cathy Rudd

Indiana's Exchange Disconnected from Medicaid. While Indiana's Federally Facilitated Exchange was open for business on October 1, 2013, the system was disconnected from the state's Medicaid program, requiring many Hoosiers to fill out more than one application to determine what plans they may be eligible for in 2014. State officials are pointing potential applicants to www.in.gov/healthcarereform, which will link them to the appropriate web sites and applications. The state claims that it has done its part of the work for integrating the two systems and they should be linked later this year.

Iowa

HMA Roundup

Iowa Still Awaiting CMS Approval of its Waiver. On September 26, 2013, Gov. Terry Branstad said that Iowa has not received CMS approval for its Medicaid expansion waiver due to concerns about the premiums built into the plan. The Iowa Health and Wellness Plan projects to cover as many as 150,000 residents of the state, but assumes small premiums will be charged to serve as economic incentives for beneficiaries to meet health goals. Some of the projected beneficiaries of the plan are currently on a state plan that will expire by year-end.

Kansas

HMA Roundup

KanCare Managed Care to Handle Developmentally Disabled on January 1. On September 26, 2013, officials at the Kansas Department for Disability and Aging Services advised Medicaid providers to submit contracts to the KanCare managed care companies to ease the transition of the developmentally disabled on January 1, 2014. Earlier this year, nearly all other Medicaid enrollees were placed in KanCare plans in pursuit of better coordination of care and cost savings. DD advocates have often argued that non-medical services—such as job placement or daytime activities—for the DD population rarely align with the medical services of managed care plans.

Louisiana

HMA Roundup

Jindal Administration Trying to Delay CNSI Lawsuit. On September 26, 2013, the Jindal Administration argued that CNSI's suit challenging its dismissal as Louisiana's MMIS vendor was invalid because the vendor did not use the state appeals courts first. The Attorney General's office appears intent on pursuing a grand jury investigation into alleged improprieties in the contract award.

Michigan

HMA Roundup—Esther Reagan

Dental Coverage Now Applies to Half of Medicaid Eligible Kids in Michigan. On October 1, 2013, 64,000 kids in Ingham, Ottawa, and Washtenaw counties were added to the Healthy Kids Dental program. The program is available to nearly 500,000 enrollees in 78 of the state's 83 counties, but remains unavailable to another 500,000 poor kids in Wayne, Oakland, Macomb, Kent, and Kalamazoo counties.

Missouri

HMA Roundup

Missouri Expansion Options Explored by House Committee. On September 26, 2013, a House interim committee on Medicaid transformation explored options to improve Medicaid without necessarily spending more on the program. The five hour meeting discussed extracting efficiencies to cover more people, without requiring tax increases. There are seven more scheduled meetings for the

committee to hone in on a plan to transform or expand Medicaid, in advance of a projected 2014 vote.

BJC Healthcare to Be a Part of Coventry's Network. On September 27, 2013, Coventry Health Care Missouri and BJC Healthcare—the state's largest hospital network—announced that Coventry would include BJC in its provider network for five of its ten plans offered on the state's exchange. The news comes on the heels of an Anthem Blue Cross and Blue Shield decision to exclude BJC from its network.

Nebraska

HMA Roundup

Nebraska's Medicaid and Exchange Will Not Link Until November. Last week, Nebraska's Medicaid Director was informed by the Federal Government that the Federally Facilitated Marketplace would not be available to provide account transfer services to the state's Medicaid eligibility system until sometime in November. Rather than transferring the applications of Medicaid eligible to Nebraska, the Federal Government will hold them until the transfer function is available.

New Hampshire

HMA Roundup

Medicaid Managed Care Enrolls 11,000 to Date. In the two weeks since open enrollment began, New Hampshire state officials say that 11,000 people have signed up for Medicaid managed care. The enrollment period will last through late November to sign up for one of three managed care plans starting in December. The Department of Health and Human Services notes that there are another 100,000 beneficiaries who still have to make their plan choices. Otherwise, they will be subject to auto enrollment. A series of forums will be held to assist beneficiaries in the process: Thursday, October 15 in Portsmouth, October 17 in Keene, October 18 in Manchester and October 22 in Littleton.

New York

HMA Roundup—Denise Soffel

Excellus may Withdraw from Medicaid Managed Care. The Department of Health announced the possible withdrawal of Excellus Blue Cross/Blue Shield from the Medicaid managed care program. Excellus operates the highly regarded Monroe Plan, and has been a significant presence in the Medicaid market in the western part of the state. Monroe Plan for Medical Care is a health care services organization that has been meeting the needs of low income and government sponsored populations in upstate New York for over 40 years. Excellus currently operates a Medicaid managed care plan in 22 counties with a total of 220,000 members. Excellus' decision was reportedly due to substantial financial losses that have resulted since long-term care services were carved into the Medicaid managed care benefit.

The potential withdrawal of Excellus would create significant disruption in parts of the state. The Monroe Plan is the only Medicaid managed care plan in 2 counties (Steuben and Yates). They are one of two plans in an additional 8 counties. The

terms and conditions of the Partnership Plan, New York's 1115 Medicaid waiver, do not allow for a mandatory program where there is no choice of plan (with an exception for rural counties), and the mandatory program will be in jeopardy should Excellus withdraw. The Department of Health stated that they are in discussions with Excellus and are hoping to find a way to retain the company. They are also talking to other plans to encourage them to move into the region served by Excellus to insure continued operation of a mandatory program.

Other New York Medicaid Managed Care Plan News. United Healthcare Plan of New York has expanded operations in Fulton County in September, and will begin operating in six additional counties as of October 1, including Albany, Chautauqua, Chemung, Essex, Niagara and St. Lawrence. United's enrollment has grown by 12 percent over the last 12 years; they are now the fifth largest plan, with 342,000 members. Separately, HealthNow has withdrawn from Gennessee and Niagara counties effective October 1, 2013.

Zucker to Join Health Department as First Deputy Commissioner of Health. Last month, Dr. Howard Zucker was named First Deputy Commissioner of Health within the New York State Department of Health. Dr. Zucker is a professor of Clinical Anesthesiology at Albert Einstein College of Medicine of Yeshiva University and pediatric cardiac anesthesiologist at Montefiore Medical Center in the Bronx. Dr. Zucker will focus on, among other things, the department's preparedness and response initiatives in natural disasters and emergencies. Dr. Zucker will be based in New York City and will lead DOH efforts on issues that affect the city, including closely working with the New York City Department of Health and other health-related entities.

DOH Proposes Antitrust Exemptions for Provider Collaborations and Mergers. Last week, New York's Department of Health proposed that provider collaborations and mergers be exempt from federal and state antitrust enforcement, consistent with 2011 state legislation. The regulations would have the DOH monitor and supervise collaborative provider arrangements, reviewing the benefits and costs of the agreements in evaluating the issuance of a certificate of public advantage (COPA).

NYC Delays Plan to Solicit Bids for Health Plans. On September 30, 2013, a Manhattan court judge issued a preliminary injunction preventing the Bloomberg Administration from soliciting health insurance bids for municipal workers. Previously, in August, a group of unions sued the city to stop the process, which was widely viewed as a first step toward greater cost-sharing with workers, in an effort to save up to $400 million annually.

Mount Sinai, Continuum Merger Closes; Moody's Downgrades Outlook. On September 30, Mount Sinai Medical Center and Continuum Health Partners completed their merger. The new entity, named Mount Sinai Health System, includes seven hospital campuses, 3,571 licensed beds, 177,000 annual inpatient admissions, 2.6 million annual outpatient visits, and nearly 35,000 employees. In addition, the system will encompass the Icahn School of Medicine and a slew of outpatient facilities. Moody's Investors Service changed its rating of Mount Sinai Hospital's outlook from "stable" to "negative" for $392 million of outstanding rated bonds. Moody's points to the additional debt, pension obligations, and weaker financial performance of Continuum, which could lead to deterioration in Mt. Sinai's financial position.

North Carolina

HMA Roundup

WakeMed CEO Steps Down. On September 25, 2013, WakeMed Health & Hospitals President and Chief Executive Bill Atkinson stepped down based on disagreements about the future direction of the hospital. WakeMed has experienced financial difficulties following the loss of volumes from a cardiology practice that shifted its business to a competitor hospital group, Rex Healthcare.

New Medicaid Director Chosen. On September 27, 2013, North Carolina Health and Human Services Secretary Aldona Wos named Sandy Terrell to head the state's Medicaid agency, replacing the outgoing Carol Steckel effective October 12, 2013. Terrell is a registered nurse who has worked in the Medicaid division since 2010.

Pennsylvania

HMA Roundup – Matt Roan

PA-DPW Engages Stakeholders on Healthy PA. Last week, Department of Public Welfare (DPW) Secretary Bev MacKereth presented details of the Healthy PA plan to the Medical Assistance Advisory Committee (MAAC) and announced that the MAAC will be the primary venue for communicating with stakeholders on the planned changes to the Medicaid program (including a potential expansion involving premium assistance). DPW is working on an 1115 waiver application, and has begun a series of discussions with CMS about components of the plan. DPW is working on revising adult Medicaid benefit packages to two plan options which closely mirror employer sponsored benefits and adhere to the federal essential health benefits guidelines. DPW envisions a high risk benefit package for enrollees with more serious health needs, and a low risk package for healthier enrollees. Healthy PA calls for modest monthly premiums on a sliding scale of income beginning at 50% of FPL. Secretary MacKereth expects that CMS will allow premiums above 100% FPL, although Federal regulations allow premiums for income above 150% of FPL. The proposed work search requirement and wellness elements would result in reduced premiums. The "private option" element allows enrollees eligible under the ACA Medicaid expansion to purchase coverage on the Health Insurance Marketplace. There are questions as to whether DPW or the Department of Insurance would oversee the program, given the DOI's regulation of Qualified Health Plans on the marketplace. DPW is expected to further detail proposed benefit packages and the 1115 waiver application to the MAAC in the coming months.

PA-DPW Planning for Shift of Lives from CHIP to Medicaid. DPW Secretary Bev MacKereth reported to the Medical Assistance Advisory Committee that the state is working with CMS to establish timing for the move of certain low income children from the CHIP program to Medicaid. The ACA requires children with family incomes under 133% of FPL to move into the state's Medicaid program effective January 1, 2014, but the Corbett Administration has been opposed to this change. Secretary Sebelius has clarified in a letter to Governor Corbett that this change is part of the law which cannot be waived by her agency, Sebelius has offered to work with the state to phase in the transition in order to minimize disruption.

Timing of Healthy PA Remains Unclear Following CMS Meeting. PA officials were optimistic after a recent round of discussions with the federal government on Governor Corbett's proposed Healthy PA plan. While discussions have progressed there is still no sense of the timing of when an agreement may be reached or when program changes might be implemented. Observers expect it to take several months for the state to develop its request for an 1115 waiver which will be submitted to CMS who may take several more months to review and approve the request. Other considerations that may impact the timeline are the ability of current Medicaid managed care plans to become certified to offer plans on the Health Insurance Marketplace, and the ability of the state to update its data systems to accommodate the proposed program changes.

Highmark Moves to Discontinue Plans that Do Not Comply with ACA Standards. Highmark has sent notices to approximately 13,000 enrollees in eastern PA that their health plans are being discontinued as they do not comply with the standards outlined in the ACA. Enrollees are being encouraged to sign up for new plans through the Health Insurance Marketplace. The plans on the Marketplace will offer more generous benefits, but it is yet to be determined whether they will be more expensive than the plans that are being discontinued.

Puerto Rico

HMA Roundup – Joan Montanez

Puerto Rico Health Care Reform Update. On Monday, September 30 Puerto Rico's Governor Alejandro Garcia Padilla announced his administration's proposal for using $925 million in federal funds earmarked in the Affordable Care Act (ACA) for one of two purposes:

- Offering premium subsidies in a health insurance marketplace (exchange), or
- Expanding the territory's Medicaid program.

There are three parts to the Governor's proposal.

PART 1. At present, approximately 200,000 out of the nearly 1.7 million beneficiaries of the *Government Health Insurance Plan (GHIP)*, the government-run medical assistance program which incorporates Medicaid and CHIP federal funds, are in what is known locally as the "commonwealth" population. In Puerto Rico the GHIP is known informally as *Mi Salud* (My Health, in Spanish). This population has access to all of the GHIP's benefits but with higher cost-sharing. The costs of covering benefits for this population have been borne **in full** by the Commonwealth government.

The Governor has proposed raising the income eligibility threshold for the GHIP's "federal" population –the population for which federal Medicaid and CHIP funds, matched with commonwealth funds, are used to cover services. As a result, approximately 76,000 GHIP members in the "commonwealth" population will become members of the "federal" population. A portion of the $925 million will be used as FFP for this population. Since their cost-sharing must conform to either Medicaid or CHIP requirements, the out-of-pocket expenses for these GHIP members will decrease. Perhaps most significantly, the administration expects that the commonwealth will save approximately $61 million in 2014 as a result of this policy change and membership transition.

This change can be effected with an amendment to the territory's Medicaid State Plan.

PART 2. Using the savings in commonwealth funds from the change described in part 1, in combination with a portion of the $925 million, the Governor proposed an actual expansion of the "federal" population within the GHIP which would result in net growth in GHIP membership. Based on analysis of census data, the administration has estimated that approximately 74,000 residents who at present do not qualify for the GHIP would qualify for the plan based on the aforementioned change in the income eligibility threshold.

PART 3. The remaining savings in commonwealth funds derived from the use of the $925 million as described above will be directed to offering premium subsidies in a new program. The program would be targeted at approximately 75,000 individuals with annual family income between $10,000 and $25,000. During his presentation the Governor referred to this program as a "basic health plan".

Details of this plan are still sketchy, but based on the Governor's presentation we can infer the following:

- 100% of the premium would be subsidized for at least some of the individuals who qualify for this plan,
- The plan would cover benefits consistent with the ACA's "essential health benefits", and
- There will be some as-yet unspecified cost-sharing.

PART 1 and PART 2 of the Governor's proposal would go into effect on January 1, 2014 when the Commonwealth can first access the $925 million. PART 3 of the proposal would not go into effect until (at the earliest) January 1, 2015.

This proposal does not alter the benefit design or the administration of the GHIP in any way.

South Carolina

HMA Roundup

South Carolina Launches Healthy Outcomes. In an effort to reduce ER visits by the uninsured, South Carolina's hospitals have launched Healthy Outcomes, in conjunction with the state's Medicaid agency. Each hospital has been assigned a number of uninsured patients to target, 8,500 in total, who are frequent users of emergency rooms. The outreach effort will emphasize access to primary care services to avoid ER visits. The range of patients assigned per hospital depends on the size and geography of the facility.

Tuomey Healthcare Fined $276.8 Million for Referral Violations. On October 1, 2013, US District Judge Margaret Seymour ordered Tuomey Healthcare System to pay $276.8 million in fines for flouting the Stark requirements on patient referrals. The 242 bed hospital has fought a whistleblower since 2005 over the allegations, but has been unsuccessful in its litigation. for violating laws that bar hospitals from paying doctors to refer Medicare patients for treatments. The fine is more than the hospital's annual revenues.

Tennessee

HMA Roundup

Haslam Confirms Medicaid Expansion Decision Has No Deadline. Last week, in the midst of extensive layoffs throughout the hospital industry, Gov. Bill Haslam told reporters that a decision on expanding Medicaid has no deadline. Haslam has requested CMS approval of a waiver to allow expansion funds to pay for private insurance premiums, with beneficiary co-payments and outcomes-based payment systems.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

Baylor and Scott & White Complete Merger. On September 30, 2013 Baylor Health Care System and Scott & White Healthcare completed their merger, resulting in the state's largest not-for-profit system boasting $6 billion in revenues and $8 billion in assets. Baylor Scott & White has 43 hospitals, more than 500 patient care locations, some 6,000 affiliated physicians, and 34,000 employees.

Sebelius Reminds Texas of the Heavy Price of Refusing Medicaid Expansion. In a recent visit to Texas, HHS Sec. Kathleen Sebelius reminded the state that it was walking away from $79 billion in Federal funds over the next decade by refusing to expand Medicaid. Texas leads the nation with 33% of its residents uninsured.

National

HMA Roundup

Technical Glitches Mark Exchange Launches, Largely Due to High Volumes. On October 1, 2013, with the opening of health exchanges nationwide, many consumers ran into technical difficulties largely associated with the surge in online activity. The New York State of Health website was overrun with more than 2 million hits in the first 90 minutes and more than 10 million hits in the first nine hours of operations. CMS noted more than 8,000 hits per second on the federally facilitated exchanges in the first few hours of operation. The CBO estimates that seven million people will sign up for individual coverage in plans offered on the exchanges in 2014, with another two million people expected to enroll in plans offered on small-business exchanges. System crashes and unavailability were often cited as problems on the first day, while others noted inaccurate eligibility determinations. However, the open enrollment period goes through March 31, 2014, so many observers are not overly concerned by initial snafus. Convention wisdom points to November and December as the time when consumers are most likely to enroll since coverage will not be effective until January 1, at the earliest.

CMS Delays Scrutiny of Short Inpatient Stays. Following a letter from more than 100 members of Congress to postpone the "two midnight" observation rule, CMS pushed back by 90 days the effective date of the observation rule, originally slated for October 1, 2013. The agency specified that Medicare administrative contractors (MACs) and recovery auditors (RACs) are not to review claims encompassing two midnights after admission to evaluate medical necessity for an inpatient stay. MACs and RACs are not to review critical access hospital claims for 90 days. The use of observation care has grown, in recent years, with critics citing it as a way for

hospitals to avoid readmission penalties and to shift costs to patients who were, technically, never classified as an inpatient admission.

Legislation Proposes Two-Year Delay in Implementing DSH Payment Cuts. On September 26, 2013, Sen. Roger Wicker (R-MS) introduced a Senate companion bill (S. 1555) to the DSH Reduction Relief Act (H.R. 1920), which had been introduced by Rep. John Lewis (D-GA). The companion bill would delay by two years the nearly $18 billion in reductions to Medicare and Medicaid Disproportionate Share Hospital programs through 2020, as specified by the Affordable Care Act. The American Hospital Association supports the legislation to ensure that hospitals serving large volumes of uninsured patients can continue delivering necessary care to their communities.

Drug Compounding Legislation Gains Bipartisan Support. On September 28, 2013, the House passed the Drug Quality and Security Act (HR 3204), which aims to ensure quality and safety measures as part of the drug compounding and supply chain processes. The bill orders the creation of a uniform framework and system that will track drugs from manufacturing through distribution. Traditional compounding pharmacies would be regulated by state boards of pharmacy. Bipartisan support for legislation raises hope for passage before the end of the year.

HHS Contingency Plan Could Furlough More than Half of Its Employees. A contingency plan offered by the Department of Health and Human Services indicates that more than half of its 78,000 employees would be subject to furloughs. The Centers for Medicare and Medicaid Services (CMS) would continue implementing many Affordable Care Act (ACA) activities. The Medicare program was not likely to face disruptions and states would continue to receive Medicaid and CHIP funding, uninterrupted. However, CMS was likely to suspend fraud and abuse "strike force team operations" as a result of the partial government shutdown. Some HHS employees would be exempt from furloughs since their jobs are funded through mandatory, carryover or user fee funds. Staff responsible for the "safety of human life" would likewise be exempt, including most of the Indian Health Service and the National Institutes of Health's (NIH) Clinic Center. However, the NIH would not admit new patients unless deemed medically necessary. CDC would have to suspend outbreak detection and seasonal influenza program activities. The FDA would have to stop some routine inspections and certain compliance and enforcement activities.

States Blocking Navigators, According to Study. Health Care for America Now released a study that indicates thirteen states—accounting for 17 million uninsured—have passed laws or implemented regulations that block navigators from helping guide the uninsured through the enrollment process. Among the provisions that inhibit navigators are residency rules, background checks, additional certification exams, and fingerprinting. Congressional Republicans argue that criminal background checks are important to protect individuals against identity theft and fraud, given the sensitivity of personal information collected. The states are Arkansas, Florida, Georgia, Iowa, Illinois, Indiana, Maine, Missouri, Montana, Ohio, Tennessee, Texas and Wisconsin.

HHS Releases Premium Information on Plans in Federally Facilitated Exchanges. On September 27, 2013, HHS released a report on premiums in the 36 exchanges that the Federal Government will operate or run in partnership with the

states. According to the report, premiums will average about 16 percent lower than originally projected, although the comparisons are not made to premiums in the market today due to the differences in essential health benefits required in 2014 and beyond. Nearly 95 percent of the population under 65 in the 36 states profiled lives in areas that offer a choice of two or more insurance plans. The average individual monthly premium nationwide for bronze plans is $249 and the average for second cheapest silver plans is $328, not considering subsidies.

HHS Delays SHOP Online Enrollment. On September 26, 2013, HHS announced that online enrollment through the small business health option program (SHOP) will be delayed until November. Employers will have access to plan options and may manually enroll by mail or fax as of October 1 and the coverage date will still begin January 1, 2014.

INDUSTRY NEWS

Molina Healthcare Named QHP Issuer in Nine Health Insurance Marketplaces. Molina announced that it will offer exchange-based health plans in nine states including Florida, Ohio, Texas, Utah, Wisconsin, New Mexico, Michigan, California and Washington.

WellCare to Acquire Healthfirst New Jersey Assets. On September 30, 2013, WellCare Health Plans announced an agreement to purchase certain assets of Healthfirst Health Plan of New Jersey, representing the ninth state for WellCare's Medicaid managed care services. Recently, WellCare received New Jersey state permission to offer Medicaid managed care plans in Essex, Hudson, Middlesex, Passaic and Union counties starting December 1, 2013, although CMS still has to give final approval.

WellCare Completes Transition of United's South Carolina Medicaid Business. As of October 1, 2013, WellCare Health Plans completed the transition of the former UnitedHealthcare South Carolina Medicaid program to WellCare of South Carolina. Former UnitedHealthcare Community Plan members have been auto-enrolled in the WellCare plan and have received a new ID card and member kit.

Evolent Health Secures $100 Million Series B Financing. On September 30, 2013, Evolent Health announced that it had received $100 million in Series B financing, from The Advisory Board Company, UPMC Health Plan and TPG Growth. The company plans to build out its population health and risk management platform, as well as expand its network of health systems. Evolent currently works with health systems to establish value-based care and streamline clinical and financial systems to deliver lower costs and better outcomes.

naviHealth and Cigna-HealthSpring Manage Post-Acute Care to 100,000 Members. On September 30, 2013, Cigna-HealthSpring and naviHealth announced a collaborative arrangement to manage post-acute care services for 100,000 Cigna-HealthSpring members in the Mid-Atlantic and Pennsylvania markets. The partnership will leverage naviHealth's decision support technology and field-based care managers to assess Cigna-HealthSpring members in the hospital regarding options for post-acute care and rehabilitation, as well as update care plans and monitor progress for members in skilled nursing facilities.

EngagePoint Connecting Federal and State Systems in Maryland and Minnesota. With headlines emphasizing the complexities and snafus associated with connecting state and federal eligibility and enrollment systems, EngagePoint is working with Maryland and Minnesota on their state-run exchanges to limit the glitches. The company acts as the systems integrator for MAXIMUS in Minnesota and Noridian in Maryland, handling bill processing and payments for the "front-end" Connecture portals offered to individuals.

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Wisconsin MLTC (Select Regions)	Contract awards	10,000
October, 2013	Tennessee	RFP Released	1,200,000
November 1, 2013	Rhode Island MLTC	Implementation	22,700
November 1, 2013	Florida LTC (Regions 2,10)	Implementation	11,935
November 1, 2013	Hawaii	Proposals Due	292,000
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 30, 2013	Delaware	RFP Released	200,000
"Early 2014"	North Carolina	RFP released	TBD
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
January 1, 2014	Illinois Duals	Implementation	136,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Wisconsin MLTC (Select Regions)	Implementation	10,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 6, 2014	Hawaii	Contract Awards	292,000
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,538
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Implementation	456,000
April 1, 2014	Ohio Duals	Implementation	115,000
April 1, 2014	Idaho Duals	Implementation	17,700
May 1, 2014	Washington Duals	Implementation	48,500
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	South Carolina Duals	Implementation	68,000
July 1, 2014	New York Duals	Implementation	178,000
July 1, 2014	Michigan Duals	Implementation	70,000
September 1, 2014	Vermont Duals	Implementation	22,000
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000
January 1, 2015	Hawaii	Implementation	292,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

Below is a summary table of the progression of states toward implementing dual eligible integration demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model					
California	Capitated	456,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup
Colorado	MFFS	62,982					11/1/2013	
Connecticut	MFFS	57,569					TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model					
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	1/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714					TBD	
Idaho	Capitated	22,548	June 2013	TBD	August 2013		4/1/2014	Blue Cross of Idaho
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	8/22/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	TBD		7/1/2014	
Missouri	MFFS‡	6,380					10/1/2012	
Minnesota		93,165	Not pursuing Financial Alignment Model					
New Mexico		40,000	Not pursuing Financial Alignment Model					
New York	Capitated	178,000				8/26/2013	7/1/2014	
North Carolina	MFFS	222,151					TBD	
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	12/11/2012	4/1/2014	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258					TBD	
Oregon		68,000	Not pursuing Financial Alignment Model					
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013		11/1/2013*	Neighborhood Health Plan of RI
South Carolina	Capitated	68,000	Summer 2013	TBD	TBD		7/1/2014	
Tennessee		136,000	Not pursuing Financial Alignment Model					
Texas	Capitated	214,402					1/1/2014	
Virginia	Capitated	78,596	X	5/15/2013	6/27/2013	5/21/2013	1/1/2014	Humana; VA Premier; WellPoint/Amerigroup
Vermont	Capitated	22,000	10/1/2013	TBD	TBD		9/1/2014	
Washington	MMFS Capitated	115,000	X X	5/15/2013	6/6/2013	MFFS Only	MFFS: 7/1; 10/1/2013 Capitated: 5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model				
Totals	**14 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***7***		

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Welcomes…

Nancy Jaeckels, Principal – Chicago, Illinois

Prior to relocating to Chicago, Nancy comes to us most recently from the Institute for Clinical Systems Improvement in Bloomington, MN where she worked since 1998. Her most recent role with ICSI was as the Vice President and Chief Consultant for ICSI Professional Partnerships. Some of Nancy's accomplishments in this position included the start-up and operation of a consulting/grant arm for this non-profit organization of which she successfully built a team of consultants, a pipeline of clients, and led the writing of two major grants that were ultimately funded. Some of the client services she provided included health care home structure, collaborative care models for depression, integrating behavioral health into primary care, and training hundreds of care managers in medical home demonstration projects. Nancy oversaw the operations aspects of the two funded grants that ICSI received – Agency for Health Research and Quality ($3M) and CMS/CMMI ($18M). She has also served as the Director of Care Improvement and Manager of Education and Knowledge Management for ICSI.

Prior to joining ICSI, Nancy worked for the Glencoe Area Health Care Center as the Director of Quality Safety, Park Nicollet Health System as the Coordinator of Guideline Measurement and Implementation, and provided patient care services for Family Physicians of Northfield. She serves as the Co-Chair for the MN Department of Health and Human Services Health Care Home Payment Methodology State Steering Committee, is a Member of the Mental Health Research Network (MHRN), and served two terms as President of the MN Chapter for Health Care Quality Professionals (MHQP).

Nancy received her Bachelor of Applied Science Degree from Kaplan University where she majored in Psychology. She is also a Certified Professional in Health Care Quality (CPHQ) through the National Association of Health Care Quality (NAHQ), is certified in Change Management through Implementation Management Associates, and is a Certified Manager of Quality/Organizational Excellence through the American Society for Quality.

"State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform."

Sharon Silow-Carroll, Author
JoAnn Lamphere, Author

In September 2013, the Commonwealth Fund released a report authored by Sharon Silow-Carroll and JoAnn Lamphere of Health Management Associates that reviewed the new models of care delivery and payment in states participating in the State Innovation Models (SIM) Initiative. (Link to Report)

"Managed Care Environment and its Impact on PAC/LTC"
Sponsored by: American Health Care Association (AHCA)

Greg Nersessian, Presenter
October 8, 2013
Phoenix, Arizona

"Health Behind Bars: What Obamacare Means for Courts, Prison, Jails, and the Justice-Involved (And How to Report the Story)"
Center on Media, Crime, and Justice

Donna Strugar-Fritsch, Panelist
October 21-22, 2013
New York, New York

"Health Insurance Exchanges"
American Institute of CPAs Healthcare Industry Conference

Barbara Markham Smith, Presenter
November 15, 2013
New Orleans, Louisiana

"Where Payor Meets Provider: Managing in a World of Managed Care"
HCap Conference sponsored by: Lincoln Healthcare Group

Greg Nersessian, Panelist
December 5, 2013
Washington, DC