EXECUTIVE SUMMARY OF THE

HEALTH INSURANCE REFORM COMMISSION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
JANUARY 2016

HEALTH INSURANCE REFORM COMMISSION

EXECUTIVE SUMMARY OF 2015 INTERIM ACTIVITY AND WORK

January 2016

I. BACKGROUND

Chapter 53 (§ 30-339 et seq.) of Title 30 of the Code of Virginia charges the Health Insurance Reform Commission (HIRC) with:

- Monitoring the work of appropriate federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (the Act), including amendments thereto and regulations promulgated thereunder;
- Assessing the implications of the Act's implementation on residents of the Commonwealth, businesses operating within the Commonwealth, and the general fund of the Commonwealth;
- Considering the development of a comprehensive strategy for implementing health reform in Virginia;
- Recommending health benefits required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth, including any benefits that are not required to be provided by the terms of the Act;
- Assessing proposed mandated benefits and providers and recommending whether, on the basis of such assessments, mandated benefits and providers be providers under health care plans offered through a health benefit exchange, outside a health benefit exchange, neither, or both;
- Conducting other studies of mandated benefits and provider issues as requested by the General Assembly; and
- Developing such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

The HIRC is chaired by Delegate Kathy Byron. Senator Frank Wagner serves as the HIRC's vice-chairman. The other members of the HIRC are Delegates Thomas Rust, Lee Ware, and Eileen Filler-Corn and Senators John Watkins, Jeffrey McWaters, and Rosalyn Dance. Commissioner of Insurance Jacqueline Cunningham and Commissioner of Health and Human Resources William Hazel serve as ex officio non-voting members.

This executive summary of the interim activity and work of the HIRC is submitted pursuant to § 30-345 of the Code of Virginia.

II. ISSUES ADDRESSED

1. Implementation of House Bill 2026

The HIRC was established in 2013 as the successor to the former Special Advisory Commission on Mandated Health Insurance Benefits (SAC). Staffing for the SAC was provided by the

Bureau of Insurance (BOI) of the State Corporation Commission (SCC) and the Joint Legislative Audit and Review Commission (JLARC). The same staffing responsibilities were in effect during the HIRC's first two years. With the enactment of House Bill 2026 by the 2015 Session, the Division of Legislative Services began staffing the HIRC on July 1, 2015.

In addition to changing the HIRC's staff, House Bill 2026, patroned by Delegate Byron, revised the procedure for the HIRC's review of legislative measures proposing to create a mandated health insurance benefit or provider. As amended, § 30-343 establishes a two-step review process. Under the first step, the HIRC requests that the BOI prepare an analysis of the extent to which the proposed mandate is currently available under qualified health plans and advise the HIRC as to whether, on the basis of that analysis, the Exchange would likely determine, in accordance with applicable federal rules, that the proposed mandate exceeds the scope of the essential health benefits. On the basis of the results of the step one assessment, the HIRC may direct BOI and JLARC to jointly assess the social and financial impact and the medical efficacy of the proposed mandate. The step two assessment shall include an estimate of the effects of enactment of the proposed mandate on the costs of health coverage in the Commonwealth, including any estimated additional costs that the Commonwealth may be responsible for pursuant to § 1311(d)(3)(B) of the Act. Section 1311(d)(3)(B) of the Act requires a state to make payments to an individual enrolled in a qualified health plan offered in the state, or on behalf of such an individual directly to the qualified health plan in which such individual is enrolled, to defray the cost of any benefits that are in addition to the essential health benefits specified under § 1302 of the Act.

At its meeting on July 15, 2015, the HIRC adopted a proposed procedure for implementing the two-step process outlined in House Bill 2026. Under the procedure, the HIRC will request BOI to conduct a step one assessment of appropriate proposals. The step one assessment will address (i) the extent to which coverage in the proposed mandate is currently available under qualified health plans (QHPs) on the Exchange; (ii) whether the Exchange, according to federal rules, would likely determine that the proposed mandate exceeds the scope of essential health benefits (EHBs) prescribed by the Act; and (iii) whether the proposed mandate would likely lead to increased state costs. Using the step one assessment, the HIRC will determine whether further assessment of the proposed mandate is warranted. If it determines further assessment is warranted, the HIRC will request JLARC and the BOI to conduct a step two assessment, which will consist of two separate but coordinated reports. JLARC's assessment will address background on proposed coverage and medical condition, medical efficacy and effectiveness of proposed coverage, current availability and utilization of treatment, current financial impact on individuals without coverage for treatment, and the proposed mandate's consistency with the purpose of health insurance and impact on public health. The BOI's assessment will address the expected impact on utilization of services and providers, the expected impact on premium costs and administrative cost of insurers, the expected additional cost to the state as required by § 1311(d)(3)(B) of the Act, and the expected impact on the total cost of health care in the Commonwealth generally. After reviewing the two reports, the HIRC will recommend its support of or opposition to the proposed mandate.

2. House Bill 1339: Information on Plans Offered through Exchange

House Bill 1339 was introduced by Delegate Lee Ware in the 2015 Session and tabled in the House Commerce and Labor Committee at the request of the patron. The bill would require health carriers that offer health benefit plans through an exchange to provide to the operator of

the exchange's website certain information about those plans, to be posted on the exchange's website. The bill also directs the SCC to make reasonable efforts to ensure that the information provided to the website operator is made available to persons who access the website.

The SCC has no authority over the placement of information on the federal exchange website. Most of the information required by the bill to be provided is available for plans offered on the federal exchange. The disclosure of information addressed by the bill is not a mandate for coverage of a benefit, and therefore the procedure under § 30-343 is inapplicable.

At the HIRC's July 15, 2015, meeting, it was reported that interested parties have been meeting independently to discuss concerns with the bill. At the December 1, 2015, meeting, interested parties reported that the matters of disagreement had been resolved. Anne Leigh Kerr, representing the Pharmaceutical Research and Manufacturers of America, advised the HIRC that changes in the federal Marketplace portal have addressed some concerns regarding the types of information that are made available to persons shopping for health insurance through the Exchange. Stakeholders have developed information sheets and checklists of options that are being distributed to potential purchasers using the Exchange. Doug Gray, representing the Virginia Association of Health Plans, concurred that the matter has been resolved to his organization's satisfaction. Delegate Ware stated his appreciation for the involvement of all parties in developing a process that will provide greater transparency. Based on these representations, the HIRC took no formal action on House Bill 1339.

3. House Bill 2156: Coverage for Hearing Aids

House Bill 2156, introduced by Delegate Rob Krupicka, would have required coverage for hearing aids and related professional services in individual and group health insurance policies when prescribed or provided by a licensed audiologist. Previous studies of proposals to mandate coverage for the cost of hearing aids resulted in recommendations against enactment. The fiscal impact statement for HB 2156 notes that the bill's expected state fiscal impact is $3.49 million.

At its July 15, 2015, meeting, the HIRC adopted Senator Watkins's suggestion that the BOI be asked to conduct a step one assessment of the measure. Jim Young of the BOI presented the step one assessment of House Bill 2156 at the December 1, 2015, meeting. The step one assessment concludes that the proposed mandate will exceed the scope of Virginia's essential health benefits. As a result, the coverage proposed in House Bill 2156 would most likely lead to increased costs to Virginia.

Upon receipt of the step one assessment, the HIRC unanimously voted not to request a step two assessment of House Bill 2156. This decision completes the HIRC's review of the issue.

4. Senate Bill 1277: Coverage for Prescription Contraceptives

Senate Bill 1277, introduced by Senator George Barker, would have required all health insurance policies, individual or group accident and sickness subscription contracts, and health care plans offered by a health maintenance organization issued or renewed on or after July 1, 2015, to include coverage for any prescribed drug, device, or product approved by the U.S. Food and Drug Administration (FDA) for use as a contraceptive. The bill was passed by in Senate Commerce and Labor on a vote of 11-3.

Currently, Code § 38.2-3407.5:1 provides that coverage for prescription contraceptive drug or device is a "mandated offer," under which insurers are required to offer and make the coverage available as an option.

Under the Act, coverage for contraceptives appears to be both an essential health benefit and a preventive service. Under § 1302 of the Act, preventive and wellness services and prescription drugs are 10 categories of EHBs. Self-insured group health plans, large group health plans, and grandfathered health plans are not required to offer EHBs.

Section 2713 of the Public Health Services Act, as added by the Act, requires private health plans (except for grandfathered plans) to provide coverage for four categories of preventive services, without cost-sharing on patients receiving these services. One of the categories is preventive services for women. The Act authorized the Health Resources and Services Administration to make additional coverage requirements for women. Pursuant to this authorization, coverage is required for all FDA-approved contraceptives and related services.

Code § 38.2-3442 has required since 2011 that health carriers provide coverage, without cost-sharing, with respect to women, for evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. This section does not apply to grandfathered plans.

The interplay between these sections of the Act and the Code raises questions regarding the bill's effect. As drafted, it appears to extend to grandfathered plans the requirement that coverage be provided for prescription contraceptives.

At its July 15, 2015, meeting, the HIRC adopted Senator Watkins's suggestion that the BOI be asked to conduct a step one assessment of the measure. At the December 1, 2015, meeting, Jim Young of the BOI presented the step one assessment of Senate Bill 1277. He observed that Act-compliant policies are required to cover at least one form of contraception in each of the 18 categories of approved contraceptive methods. While not every prescription contraceptive is covered, each method category must cover at least one prescription contraceptive at no cost.

The BOI's assessment interprets Senate Bill 1277 as expanding the Commonwealth's existing requirement for contraceptive coverage to apply to grandfathered plans in any case where the grandfathered plan includes coverage for prescription drugs on an outpatient basis. Such coverage would be required, or automatically included with the renewal of the grandfathered plan. Coverage under a grandfathered plan is defined as coverage provided by a health carrier to (i) a small employer on March 23, 2010, or (ii) an individual who was enrolled on March 23, 2010, including any extension of coverage to an individual who becomes a dependent of a grandfathered enrollee after March 23, 2010, for as long as such plan maintains that status in accordance with federal law.

The assessment did not specifically state whether Senate Bill 1277 would have ensured that all FDA-approved birth control methods (rather than one contraceptive in each category) be covered. Advocates for the bill were reported as stating during the 2015 Session that the purpose of the bill was limited to ensuring that all FDA-approved birth control methods (rather than one contraceptive in each category) were covered under Virginia's Code. The BOI's assessment notes that if coverage were required for all, rather than one, of the prescription contraceptives in each of the 18 categories of approved contraceptive methods, such a change would not require the Commonwealth to pay the cost of the additional benefit under § 1311(d)(3)(B) of the Act because the preamble to the final federal rule on EHBs in 78 FR 12845 states that QHPs are permitted to go beyond the number of drugs in the benchmark plan without exceeding EHB requirements. The assessment concludes that since grandfathered plans are not QHPs and are not

required to provide EHBs, a specific determination concerning how the Exchange would view the proposed mandate is unnecessary.

It is unclear whether Senate Bill 1277 would require coverage for prescription contraceptives without the Act's exceptions for health plans sponsored by certain exempt religious employers or nonprofit religious organizations that certify they have religious objections to contraceptive coverage. The assessment does not address the fact that Senate Bill 1277 amends Virginia Code § 38.2-3407.5:11, which pertains to coverage provided for such contraceptives in a health benefit plan, but not § 38.2-3442, which limits cost-sharing requirements for preventive care. As a result, it is not clear that grandfathered plans required by the bill to provide such coverage would be required to provide the benefit without cost sharing requirements.

The step one assessment concludes that because Senate Bill 1277 concerns non-QHP grandfathered plans, an additional cost to Virginia for this mandate is highly unlikely, and that even if grandfathered plans were considered QHPs, Senate Bill 1277 adds additional drugs to those that are already required under EHB, and therefore it is unlikely there would be additional cost to Virginia for this mandate.

As part of its assessment, the BOI conducted a survey to determine the number of grandfathered plans that may be affected if Senate Bill 1277 were enacted. Nineteen health carriers representing more than 98 percent of the health insurance marketplace responded to the survey. Ten carriers had no grandfathered plans. The nine carriers reporting in-force grandfathered plans reported a total of 1,484 grandfathered plans covering 59,403 policyholders. With the exception of two individual plans and one large group plan, the carriers reported that all their grandfathered plans include coverage for prescription contraceptives. The BOI estimated that about 300 individuals were in the large group plan without coverage for prescription contraceptives.

Upon receipt of the information contained in the step one assessment, the HIRC, with Delegate Filler-Corn objecting, decided not to request that the BOI and JLARC conduct a step two assessment of Senate Bill 1277. This decision completes the HIRC's review of the issue.

5. Senate Bill 760: Medicare Supplement Policies

The bill as introduced by Senator Edwards would have required insurers issuing Medicare supplement policies in the Commonwealth to make certain Medicare Supplement Plans available to any Medicare enrollee under age 65 who is eligible for Medicare due to disability or end-stage renal disease. It also would have provided that a Medicare supplement policy issued to such an individual may not exclude benefits based on a preexisting condition in certain circumstances. The Senate Committee on Commerce and Labor adopted amendments to the bill that (i) eliminated application to individuals eligible for Medicare due to end-stage renal disease; (ii) amended the language regarding an insurer's obligation to make plans available on a guaranteed issue basis; and (iii) removed certain limits in the introduced version on a carrier's ability to develop premium rates for eligible individuals. The substitute version was reported to the Senate floor, where it was recommitted to committee after the crossover deadline for committee action.

Conditioning the ability of insurers to offer Medicare Supplement policies to individuals age 65 or older upon their also offering such policies to Medicare-eligible persons under age 65 is not a mandate for coverage of a benefit, and therefore the two-step assessment procedure under § 30-343 is inapplicable.

At its July 15, 2015, meeting, the HIRC asked the BOI to ask those insurers offering Medicare Supplement policies in Virginia to persons age 65 or older what the effect would be on their willingness to continue offering such policies and being involved in the market if legislation were enacted that required them to also offer Medicare Supplement policies to eligible persons under age 65.

At the HIRC's September 8, 2015, meeting, Jim Young of the BOI presented the results of a survey of the 32 issuers of Medicare supplement policies in Virginia. The survey asked how these insurers would react if the provisions of Senate Bill 760 were enacted. Most of the 30 insurers that responded to the survey indicated that the enactment of the provisions of Senate Bill 760 would have an effect on their current Medicare supplement market. Effects cited by insurers included increased costs to develop and file new products. However, seven respondents said there would be no impact, and no respondent reported that the enactment of such a measure would result in its leaving the marketplace.

The survey responses indicated that insurers would offer plans to disabled, Medicare-eligible individuals under age 65 at a premium differential that ranged from one and a half times greater to five times greater than the premium for the company's current Medicare supplement plan. The HIRC concluded that the BOI survey addressed the questions regarding Senate Bill 760 that prompted the bill's referral to the HIRC for review. After providing a copy of the survey results to Senator John Edwards, no further action on this issue was taken.

6. Senate Bill 1394: Cap on Cost Sharing for Specialty Tier Drugs

Senate Bill 1394, introduced by Senator Dance in the 2015 Session, would have imposed a limit on coinsurance or copayments of $100 per month for up to a 30-day supply of a specialty tier drug, regardless of whether a deductible has been satisfied. The bill also would have prohibited insurers from placing all drugs in a given class of drugs on the highest cost tier, and it would have created a process for exceptions to the formulary. It appears that such a process for exceptions currently exists under Code § 38.2-3407.9:01.

The Joint Commission on Health Care (JCHC) conducted a two-year study (2012-2013) of the impact of cost-sharing, coinsurance, and specialty tier pricing on access to prescription medications for chronic health disorders, per HJR 579 (2011), which was patroned by Delegate John O’Bannon. One issue pertaining to specialty tier drug pricing that was duplicative of the efforts of the JCHC relates to § 1557 of the Act. This section prohibits discrimination on the basis of health and disability. In February 2015 the federal Centers for Medicare and Medicaid Services (CMS) issued a rule that prohibits plans placing "most or all drugs that treat a specific condition on the highest cost tiers" and charging more for single-tablet regimens than for treatments that require patients to take multiple pills. CMS commented that "[h]aving a specialty tier is not on its face discriminatory; however, placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the issuer pays for the drug may often be discriminatory in application when looking at the totality of the circumstances, and therefore prohibited. When CMS or the State requests a justification for such a practice, issuers should be able to identify an appropriate non-discriminatory reason that supports their benefit design, including their formulary design." To avoid duplicating the work of the JCHC, the HIRC will ask that interested parties focus on the issue of the applicability of the antidiscrimination provisions of § 1557 of the Act.

Limiting the cost-sharing liability of covered persons for specialty tier drugs is not a mandate for coverage of a benefit, and therefore the assessment procedure under § 30-343 is inapplicable.

The HIRC agreed to receive additional information at a hearing on this issue at a future meeting, including a report on the work of the JCHC on the issue of specialty tier drugs.

Michele Chesser, Senior Health Policy Analyst with the JCHC, presented an overview of specialty tier pricing of prescription medications at the HIRC's September 8, 2015, meeting. Ms. Chesser also summarized the policy options considered and the recommendation reached by the JCHC in the course of its study.

Julie Blauvelt of the BOI gave the HIRC a detailed report on the BOI's use of tools provided by the federal Centers for Medicare & Medicaid Services (CMS) for use in the BOI's review of qualified health plans. The CMS tools are designed to help regulators identify potentially discriminatory benefit designs, including designs related to specialty tier prescription drugs. Ms. Blauvelt noted that, in addition to the provisions of the Act and its regulations, § 38.2-508 of the Code of Virginia prohibits unfair discrimination in any of the terms and conditions of a health insurance policy. She advised that while unfair discrimination is prohibited, placing drugs in tiers and managing cost-sharing can be permissible means of designing a plan to encourage efficient utilization of a covered benefit. The federal market review tools made available by CMS are useful in helping the BOI identify cost-share outliers. A federal nondiscrimination review tool includes formulas used to determine outliers for specialty prescription medications. When such outliers are identified during the plan review process, the plan's carrier is asked either to change the plan or to explain why the proposed plan is not discriminatory.

Kelly Fitzpatrick of Fair Copay VA Coalition reported on actions in other states regarding potentially discriminatory benefit designs. She identified Montana, California, Illinois, and Florida as states that have taken action to address benefit designs that were found to be discriminatory.

At the December 1, 2015, meeting, staff provided the members with a summary of presentations received at prior meetings on this matter. Staff also distributed copies of a report released in September 2014 by the Pennsylvania Legislative Budget and Finance Committee on the effect of prescription drug specialty tiers on access and patient care. The report may be found at http://lbfc.legis.state.pa.us/Resources/Documents/Reports/494.pdf (the Pennsylvania Report). This comprehensive report complements the JCHC's two-year study of Cost Sharing and Specialty Tier Pricing by providing updated data on drug costs and activities in other states.

The affordability of prescription drugs remains a serious issue to the many residents of the Commonwealth. Prescription drug cost is also a major concern to health insurers, to the individuals and businesses that purchase insurance products, and to the Commonwealth’s budget. Coinsurance obligations requiring a patient to pay 32 percent of the cost of a specialty tier drug, which may exceed several thousands of dollars per month, can devastate a patient's financial condition. Arguments against imposing a cap on cost-sharing for specialty tier drugs include (i) the JCHC's decision not to support limits on an enrollee's out-of-pocket costs for prescription drugs on a specialty tier, (ii) the fact that the effects of legislation enacted in 2014 that requires health insurers to provide policyholders with at least 30 days' prior written notice of a modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements have not been measured, and (iii) the implementation of federal

interpretations of the Act in 2015 that expand the limits on out-of-pocket cost sharing for all essential benefits to separately administered prescription drugs.

The HIRC unanimously recommended at its meeting on December 1, 2015, that no action be taken on Senate Bill 1394.

7. House Joint Resolution 630: Abuse Deterrent Formulations for Opioid Medications

House Joint Resolution 630 was introduced in the 2015 Session of the General Assembly by Delegate Byron. The resolution, which passed both houses unanimously, directed the HIRC to study mandating health insurance coverage for abuse deterrent formulations (ADF) for opioid medications. ADF opioids are opioid drugs that are formulated in such a way that deters misuse and abuse, including making it difficult to snort or inject the drug for a more intense "high." In conducting its study, the HIRC was directed to examine the issues of access by citizens of the Commonwealth to effective pain management medications and the need to require the adoption of ADF technologies for pain medicines in order to assist in the Commonwealth's continuing efforts to eliminate substance and prescription drug abuse. The HIRC was required to complete meetings by November 30, 2015, and to submit an executive summary of its findings and recommendations by the first day of the 2016 Regular Session.

The HIRC received testimony from interested persons at its July 15, 2015, meeting. At the December 1, 2015, meeting, staff summarized some of the testimony previously received, including the conclusion of the BOI that because there is no specific requirement for coverage for this type of medication, imposing such a requirement could result in a cost to the Commonwealth. Members were also reminded of testimony by the Virginia Association of Health Plans that "next-generation" ADF opioids have not yet been approved by the FDA.

According to the BOI, there is no specific requirement for this coverage for this type of medication, and imposing such a requirement could result in a cost to the Commonwealth. The Governor’s Task Force on prescription Drug and Heroin Abuse has not examined this issue.

Delegate Byron noted that this is an issue of serious concern that needs continued monitoring. She noted her intent to introduce a resolution to continue the study pursuant to House Joint Resolution 630 for another year.

The members of the HIRC unanimously recommended that the study be extended for a second year.

8. The PACE Act (H.R. 1624): Amendment to the Act's Definition of Small Employer

In October 2015, President Obama signed into law H.R. 1624, the Protecting Affordable Coverage for Employees (PACE) Act. The PACE Act amends the Act and the Public Health Service Act to maintain the existing definitions whereby an employer with 51 to 100 employees is a "large employer" and an employer with 50 or fewer employees is a "small employer" for purposes of health insurance markets. However, the PACE Act specifically gives states the option to treat a small employer as one that employed not more than 100 employees in the preceding year.

Under the Act as originally enacted in 2010, effective January 1, 2016, the threshold between what constitutes a large employer and a small employer would change from 50 employees to 100 employees, so that the status of an employer with between 50 and 100 employees would switch on January 1, 2016, from a small employer to a large employer. By maintaining the status of

midsize employers as small employers, Congress has shielded employers with between 50 and 100 employees from being subject to several provisions of the Act that apply to small, but not large, employers. In addition, the American Academy of Actuaries predicted that increasing the size of small groups would likely raise premiums for the midsize groups and might also raise premiums for small groups.

To utilize the option provided by the PACE Act to maintain the one-to 50-employee definition of a small employer, the General Assembly would need to amend relevant sections of the Code. It was suggested that legislation with an emergency clause be enacted in the 2016 Session to remove the Code provisions added in 2013 that changed the definition of a small employer.

The HIRC unanimously recommended that the 2016 Session of the General Assembly enact such corrective legislation.

9. Other Issues

Other items on which the HIRC was briefed during its three meetings in the 2015 interim include:

- The Supreme Court's decision in King v. Burwell issued on June 25, 2015, in which a six-member majority upheld the Internal Revenue Service's interpretation of a provision of the Act in a manner that extended tax-credit subsidies to coverage purchased through the federal exchange.
- The selection process for Virginia's benchmark plan. States are allowed to select an essential health benefits benchmark plan for use in plan years 2014-2016 from one of the three largest small group plans, one of three largest state employee health plans, one of the three largest federal employee health plan options, or the largest non-Medicaid health maintenance organization. The federal Center for Consumer Information & Insurance Oversight (CCIIO) announced a June 1, 2015, deadline for states to select an EHB benchmark for small employer and individual coverage available in 2017. By letter dated May 27, 2015, Governor McAuliffe advised CMS of the selection of the Anthem Direct Access PPO plan that will serve as the reference plan for Virginia. Coverage for pediatric dental benefits is required to be supplemented and the FAMIS Smiles for Children program was selected to be the supplemental plan.
- The effects of the Act on employers. John M. Peterson, Esq., of Kaufman & Canoles in Norfolk provided the HIRC with examples of the concerns of businesses in Virginia as a result of implementation of several provisions of the Act, including accurately calculating and reporting the number of employees; preparing and filing new tax forms, including Form 1095-C; and posting a workplace notice regarding health coverage and the Marketplace. Among the pitfalls employers face as the Act is phased in are the prohibited practices of (i) reimbursing employees for an individual policy's premiums, (ii) providing employees age 65 or older with incentives to decline the employer's coverage and select Medicare, and (iii) giving all employees regardless of age an equal dollar amount health plan premium payment, which, when older workers pay a greater amount for coverage, has been found to violate the federal Age Discrimination in Employment Act.
- Final Rules on Notice of Benefit and Payment Parameters for 2016. Staff provided the HIRC with an overview of 16 provisions in the final rules issued by the federal Department of Health and Human Services (HHS) on the Notice of Benefit and Payment Parameters for 2016. The HIRC's attention was directed to provisions addressing

coverage for habilitative services and devices, benefits discrimination, prescription drug coverage, rate reviews, cost-sharing limits, and the determination that health plans offered by large employers must provide substantial coverage of both inpatient hospital services and physician services in order to be found to be providing minimum value. Commissioner Cunningham told the HIRC that nothing in the final rules for 2016 necessitates the enactment of legislation in the upcoming General Assembly session. Current state law requires that health plans sold in the individual and small group markets provide essential health benefits, so changes in the elements of such benefits would automatically be incorporated into Virginia's requirements for such plans. The BOI has already reviewed plans for 2016, and those approved plans are considered to comply with the requirements for 2016.

- BOI's recommendations for qualified health plans (QHPs) for 2016. Julie Blauvelt of the BOI reported that of the 12 carriers for which QHP applications were received and recommended for the individual Exchange for 2016, three are new carriers. One of the new carriers will offer plans in the small business (SHOP) exchange, and two of the new carriers will offer plans in the individual market. The total number of plans offered by carriers active on the Exchange will be 211, of which 124 are individual plans and 87 are small group plans. In addition, six multistate plans will be offered.
- Ms. Blauvelt also reported that the CCIIO advised that neither House Bill 1747 of the 2015 Session, which required mental health benefits parity, or House Bill 1940 of the 2015 Session, which amended the age provisions of the mandate for coverage of certain autism treatments in large group policies, would trigger state liability under § 1311(d) of the Act for the incremental costs of the benefits provided.
- David Shea, Health Actuary in the BOI's Life and Health Division, provided the HIRC with updates on rate increases for 2016 health plans. Mr. Shea provided a summary revealing, for each insurer, the number of plans offered in the individual and small group markets, both on the Exchange and off the Exchange, as well as each company's percentage of changes in the 2016 rates compared to its 2015 rates. In the small group market, the median of the change in rates between plans offered by companies in 2015 and 2016 ranged from a high of a 9.9 percent increase to a low of a 13.1 percent decrease. Corresponding figures for plans offered in the individual market ranged from a high of a 22.3 percent increase to a low of a 3.3 percent decrease.
- The Federal Reinsurance Program was reviewed by Mr. Shea at the HIRC's December 1, 2015, meeting. The Program provides certain health carriers in the individual market, both inside and outside the Exchange, with reinsurance during a three-year transitional period. All insurers, including third-party administrators, are required to contribute assessments. The funds collected through the assessment are available to make payments to those Virginia health insurers who covered high-cost claims. Approximately $130.5 million was paid on behalf of Virginia's insured for 2014. To be eligible for a reinsurance payment for a claim in 2014, a claim would exceed the attachment point of $45,000, and the reinsurance payment would be for 100 percent of the claim up to a cap of $250,000. Over the three years the transitional program is in effect, the attachment point increases from $45,000 to $90,000, and the coinsurance rate decreases from 100 percent to 50 percent. The cap on reinsurance payments stays at $250,000 over the 2014-2016 period. Over this period, the contribution rate per enrollee declines from $63 in 2014, $44 in 2015, and $27 in 2016.

- The amount of Exchange user fees paid in connection with Virginia policies purchased through the Exchange. Mr. Shea reported that data on the amount of 2014 Virginia user fees could not be obtained through the federal Secretary of Health and Human Services (HHS). HHS collects a user fee from health carriers that participate in the Exchange in order to fund its operations. The fee has been set at 3.5 percent of the monthly premium charged by the health carrier. While acknowledging the limits of his methodology, Mr. Gray of the Virginia Association of Health Plans offered that, based on a rate of 3.5 percent of premiums on policies sold through the Exchange, approximately 385,000 Virginians purchasing coverage via the Exchange, and an average premium of $4,000 per policy, for 2015 the total assessment could be in the area of $55 million. However, based on enrollment reports that approximately 82 percent of Exchange enrollees received federal subsidies, for 2015 over $45 million of that assessment was likely paid by the federal government. Based on these estimates, Mr. Shea observed that about 18 percent of the Exchange user fees would have been paid by Virginians.
- The Act's penalties for nonexempt individuals who fail to obtain coverage for 2016. Mr. Shea reported that the penalty will be the greater of $695 or 2.5 percent of household income. For comparison, the individual mandate penalty started in 2014 at the greater of $95 or one percent of household income. The penalty for 2015 is the greater of $325 or two percent of household income. For years after 2016, the dollar amounts are indexed to reflect cost-of-living adjustments.

III. CONCLUSION

The HIRC appreciates the valuable service provided by three of its members - Delegate Rust, Senator Watkins, and Senator McWaters - who opted not to return for the 2016 Session of the General Assembly.

Materials provided by speakers at the HIRC's meetings in 2015 may be found on the HIRC's website at http://dls.virginia.gov/commissions/hir.htm?x=mtg.