YEAR-END REPORT - 2022

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Introduction

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The Centers for Medicare & Medicaid Services (CMS) released enrollment data in January for the federal health insurance exchange. Approximately 13.8 million Americans signed up or were automatically re-enrolled in 2022 individual market health insurance coverage through health insurance exchanges.

The United States Department of Health and Human Services (HHS) office of the Assistant Secretary for Planning and Evaluation (ASPE) released a report showing that the rate of uninsured people in the United States decreased after the implementation of the American Rescue Plan (ARP) and outreach efforts.

The Biden-Harris Administration announced that 14.5 million people had signed up for health insurance coverage through the ACA Marketplaces during the open enrollment period (OEP) ending on January 15, 2022.

Delaware announced a record high increase in enrollment in health insurance plans through the Delaware Health Insurance Marketplace during the latest open enrollment period.

The Oregon Health Authority (OHA) announced that a record number of people in the state had health coverage in 2021, 95.4%, an increase from 94% in 2019.

New Jersey Governor Phil Murphy announced that a record number of people had enrolled in health insurance plans through the state's Affordable Care Act individual health insurance marketplace.

Friday Health Plans tripled its enrollment in plans available through the Affordable Care Act marketplaces during the last open enrollment period.

In the State of the Union Address, President Biden outlined a plan to increase coverage of mental health care that included requiring more coverage of telehealth services.

The Department of Justice, together with Attorneys General in Minnesota and New York, filed a civil lawsuit to stop UnitedHealth Group Incorporated (United) from acquiring Change Healthcare Inc. (Change).

People with lower incomes will now be eligible for a new Special Enrollment Period (SEP) for health insurance plans available through the Affordable Care Act (ACA) state and federal Marketplaces.

President Biden and Vice President Harris have proposed a fix to the so-called ‘Family Glitch” that prevents some families from accessing affordable health insurance coverage through the Affordable Care Act Marketplace.

According to a recent report from the Urban Institute, the average cost of a health insurance premium for a plan available through the Affordable Care Act exchanges decreased for the third straight year.

The Connecticut state auditor performed an audit of the state's health insurance exchange, revealing that 44 data breaches over the last 3.5 years had not been fully reported.

The White House released a Fact Sheet outlining the changes to the rules affecting the Affordable Care Act Marketplaces.

The federal government indicated to Georgia that it had suspended approval of the state's plan to create a state-run marketplace rather than continue to use the Affordable Care Act's federal health insurance exchange.

Connecticut's health insurance exchange opened a special enrollment period for low-income families that will remain open throughout 2022.

Washington state has submitted a waiver to the federal government requesting permission to allow undocumented immigrants to participate in the state's health insurance marketplace.

The American Hospital Association (AHA) praised the Internal Revenue Service for proposing to change the calculation of affordability for employer-sponsored coverage when determining eligibility for the health insurance marketplace.

The Centers for Medicare and Medicaid Services (CMS) issued a new proposed rule on the funding methodology for the Basic Health Program (BHP) for 2023. The change would incorporate a new Section 1332 waiver factor relative to Minnesota's state-based reinsurance program.

The U.S. Department of Health & Human Services and the U.S. Department of the Treasury (collectively, the Departments) recently approved Colorado's application to amend its State Innovation Waiver under the Affordable Care Act (ACA).

New York insurers requested significant rate increases for small group plans covering companies with 100 employees or less and for consumers who are not part of a group plan.

The Michigan Department of Insurance and Financial Services (DIFS) released proposed rate filings showing that Michigan residents will have over 300 health plans to choose from during the upcoming open enrollment.

A recent study by the Kaiser Family Foundation showed that insurers offering plans through the federal health insurance exchange marketplace denied almost one out of every five claims, or 18% of claims, for in-network health care services in 2020.

The cost of premiums for health insurance plans available through California's health insurance exchange is set to increase an average of 6% next year, according to officials from Covered California.

The U.S. Department of Health and Human Services (HHS) and the Departments of Labor and of the Treasury issued guidance to clarify protections for birth control coverage under the Affordable Care Act (ACA).

The enacting of the American Rescue Plan (ARP) and the Inflation Reduction Act (IRA) is expected to affect the affordability component of the ACA for the Employer Mandate.

President Biden signed the Inflation Reduction Act into law which includes a continuation of the enhanced subsidies for health insurance plans purchased through the ACA marketplaces.

A recent survey showed that employers are facing challenges with the cost of group health insurance coverage for employees.

Pennsylvania Governor Tom Wolf announced the upcoming Open Enrollment Period for Pennie, the state's health insurance marketplace.

Bright Health announced that it would no longer offer individual and family plan products through its Bright HealthCare segment, effectively exiting the Affordable Care Act Marketplace.

U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra issued a statement on the final rule addressing the ‘family glitch” in the Affordable Care Act marketplace plans.

Researchers at the Kaiser Family Foundation indicated that Marketplace enrollment is at a record high and enrollment in off-Marketplace plans has been decreasing.

The Biden-Harris Administration announced that consumers will be able to preview health care coverage options through the federal health insurance marketplace prior to the start of the open enrollment period.

Several changes are expected for health insurance as the 2023 Affordable Care Act (ACA) Open Enrollment period continues. Open Enrollment began November 1 and will last until January 15. Some states with state-based marketplaces will have longer open enrollment periods.

CMS Releases Enrollment Numbers for Federal Marketplace

The Centers for Medicare & Medicaid Services (CMS) released enrollment data in January for the federal health insurance exchange. Approximately 13.8 million Americans signed up or were automatically re-enrolled in 2022 individual market health insurance coverage through health insurance exchanges.

The open enrollment period began on November 1.

9.7 million plan selections were made in the 33 states that use the federal healthcare exchange, HealthCare.gov by December 14, 2021, the deadline for coverage beginning January 1.

An additional 4.1 million enrollments in the 17 states and the District of Columbia that use state-based marketplaces (SBMs) were made through December 25, 2021. Half of the SBMs allowed this deadline for coverage beginning January 1.

Two million consumers (approximately 15% of enrollees) are new to the Marketplaces for 2022. Returning consumers numbered 11.8 million. They had active coverage in 2021 and made a new plan selection or were automatically re-enrolled in their current plans.

Thirty-three states use the federal platform for health insurance enrollment for the 2022 coverage year. Three states, Kentucky, Maine, and New Mexico, transitioned to state-based platforms for 2022. The states using the federal platform are Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

The states running their own enrollment platforms include California, Colorado, Connecticut, the District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

The cumulative plan selections include the total number of people submitting an application and selecting a plan, minus cancellation occurring after November 1, 2021. Consumers who were automatically re-enrolled in their current plan or another similar plan are also counted.

New consumers are those who did not have 2021 Marketplace coverage through December 31, 2021 and made a plan selection for 2022.

Returning consumers are renewing consumers if they had 2021 Marketplace coverage through December 31, 2021 and either actively selected the same or a new plan for 2022 or who were automatically re-enrolled in coverage, either the same plan or a suggested alternate plan. [FN2]

California Sues Health Care “Sharing Ministry'

California Attorney General Rob Bonta announced that the state was suing The Aliera Companies (Aliera) and the Moses family, founders of Sharity Ministries, Inc. (formerly Trinity Healthshare, Inc., a nonprofit corporation that held itself out as a health care sharing ministry (HCSM).

The state alleges that Aliera, a for-profit corporation, created, operated, and sold unauthorized health plans and health insurance through Sharity/Trinity. Thousands of California residents and other consumers paid millions of dollars in monthly premiums to the companies for the plans.

Rather than paying for the healthcare costs of consumers, the company denied claims and kept almost 84% of the money consumers paid.

According to Attorney General Bonta, the company left ‘many crushed by the burden of impossible medical debt.”

'Aliera preyed on consumers who, in many cases, thought their monthly payments were being used to help others who shared their faith and religious beliefs. Instead, Aliera and the Moses family funneled its members' payments into their own pockets,” said Attorney General Bonta. ‘When members suffered medical emergencies, their problems were compounded by Aliera claiming it had no obligation to pay medical costs. Aliera's sham business is unlawful and our lawsuit seeks to ensure they are held to account to pay the price for the Californians they lured in and cheated.”

'These allegations provide a chilling reminder of the dark days of health insurance, when some companies took advantage of people by offering Swiss-cheese coverage that was full of holes, when benefits were routinely rejected and people were left with enormous medical bills,” said Peter V. Lee, executive director of Covered California. ‘The good news is that Californians do not need to put themselves and their families at risk because Covered California's open enrollment period is underway right now, and thanks to the American Rescue Plan, comprehensive coverage has never been more affordable.”

Attorney General Bonta issued a consumer alert last year to warn California residents about illegitimate HCSMs.

HCSMs are exempt from many of the coverage mandates under the Affordable Care Act (ACA). Prior to the ACA, HCSMs permitted people sharing religious beliefs to pool money to assist each other to pay for medical costs.

After the implementation of the ACA, some companies began to take advantage of the HCSM exemption, using this structure to market HCSMs as cheaper health insurance coverage. HCSMs are exempt from the ACA requirement that plans cover essential health benefits such as birth control, prescriptions, preexisting conditions, and mental health care.

According to California, Aliera has never fallen within the legal definition of an HCSM. One requirement mandates that HCSMs must have been IRS 501(c)(3) nonprofits in existence since December 31, 1999. [FN3]

Enrollment Tops 14 Million at Close of Open Enrollment

The Biden-Harris Administration announced that 14.5 million people had signed up for health insurance coverage through the ACA Marketplaces during the open enrollment period (OEP) ending on January 15, 2022.

Enrollment was higher than in any previous years.

5.8 million people enrolled in health insurance plans who were new to the health insurance ACA Marketplace.

The Centers for Medicare and Medicaid Services (CMS) credited American Rescue Plan for the record enrollment. The new federal law decreased health care costs for most people enrolling in Marketplace plans. The cost of an average premium available through the Marketplace decreased by 23%.

The Biden-Harris Administration made a commitment to decreasing costs of health insurance for working families and for reaching people through outreach regarding health insurance enrollment.

'The numbers say it all: We are delivering on our commitment to make health care a right for Americans and to ensure it is accessible and affordable," said Health and Human Services Secretary Xavier Becerra. 'We are proud to have completed the Biden-Harris Administration's inaugural Open Enrollment with a record-breaking 14.5 million Americans who now have high-quality, low-cost health coverage, thanks to President Biden's American Rescue Plan and our unprecedented outreach efforts. We will continue to deliver for the American people and work to ensure no one is left behind in getting access to the care they deserve."

Secretary Becerra continued, 'For people in states and the District of Columbia where enrollment remains open, there is still time to get covered. Don't wait. Sign up today for high-quality, low-cost health coverage."

Many of the State-based Marketplaces also ended open enrollment on January 15 , 2022, along with the 33 states using the federal health insurance platform, HealthCare.gov.

Enrollment closes on January 31, 2022 the District of Columbia and five states (California, Kentucky, New Jersey, New York, and Rhode Island).

The District of Columbia, Colorado, Maryland, and New York have created COVID SEPs that allow uninsured consumers to sign up for coverage past the initial OEP end dates.

10.3 million of the 14.5 million enrollees live in the 33 states using HealthCare.gov. 4.2 million people live in the 17 states and the District of Columbia, which have their own state-based Marketplaces.

Three million people who were not previously enrolled in coverage gained coverage in the United States, representing a seventeen percent increase compared to enrollment at the end of the 2021 OEP.

Thirty-two percent of people accessing health insurance through HealthCare.gov, 3.2 million consumers, were able to choose plans that cost $10 or less per month due to the additional subsidies provided through the American Rescue Plan.

'We are proud that this Open Enrollment Period and President Biden's American Rescue Plan enabled a historic 14.5 million people to sign up for quality and affordable health care coverage," said Centers for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure. 'Investing in financial assistance and outreach allows more people to have access to the care that they need." [FN4]

American Rescue Plan Outreach Efforts Decreased Uninsured Rate

The United States Department of Health and Human Services (HHS) office of the Assistant Secretary for Planning and Evaluation (ASPE) released a report showing that the rate of uninsured people in the United States decreased after the implementation of the American Rescue Plan (ARP) and outreach efforts.

Researchers found that the uninsured rate throughout the United States was 8.9% during the third quarter of 2021 from July through September. During the last quarter of 2020, that rate was 10.3%.

The rate represents an increase of approximately 4.6 million people with health insurance coverage.

Children and working age adults gained coverage. The largest coverage gains occurred in people with incomes under 200% of the federal poverty line.

A family of four earning about $56,000 per year is considered under 200% of the federal poverty level. A single person earning $27,000 per year falls into that category.

According to the Centers for Medicare & Medicaid Services (CMS), 'During the 2022 OEP, the Biden-Harris Administration worked tirelessly to ensure health equity by increasing outreach to communities that have historically been uninsured or underinsured. Through CMS, HHS revamped the Champions for Coverage program and quadrupled the number of Navigators to 1,500 certified Navigators ready to help consumers enroll, and held over 1,800 outreach and education events at accessible areas—such as local libraries, vaccination clinics, food drives, county fairs, and job fairs."

CMS pointed to the success of the Biden-Harris Administration's first OEP as evidence that the Administration is committed to making health care affordable and accessible for consumers. The Administration hopes to build on the momentum of the 2021 Special Enrollment Period (SEP).

Since the beginning of the Biden-Harris Administration, 5.8 million people have gained health insurance coverage, due in large part to the increased health insurance tax subsidies under the ARP.

2.8 million people gained health insurance coverage during the 2021 SEP and 3 million gained coverage during the 2022 OEP. [FN5]

Oregon Plans for Transition to Marketplace for Some Medicaid Enrollees

The Oregon Health Authority (OHA) announced that a record number of people in the state had health coverage in 2021, 95.4%, an increase from 94% in 2019.

The biannual Oregon Health Insurance Survey data revealed that 2021 was the first year since the expansion of the ACA that insurance coverage had increased significantly in Oregon. Researchers credited the federal pandemic rule changes to Medicaid for the increase.

Under temporary rules implemented during the COVID-19 public health emergency, people enrolled in Medicaid kept their coverage. The largest gains in coverage were among people with low incomes.

People reporting that they were covered under Medicaid increased from 25% in 2019 to 29% in 2021. However, employer-based insurance coverage continued along the previous trend of decreasing. Medicare coverage and private health insurance coverage stayed the same.

Researchers pointed to the near elimination of ‘churn” in the people enrolled in Medicaid, which is people returning to Medicaid coverage after less than a year. The high churn population was 34% of new enrollees in September 2019. Due to the continuous enrollment policies implemented during the Public Health Emergency (PHE), the high churn enrollment was only 8%.

About 9,000 people per month in Oregon both before and after the PHE entered Medicaid who had never had Medicaid coverage.

'We know that keeping people enrolled in health insurance ? whether it is a public program or their job-based coverage ? is key to lowering our rate of uninsurance so people can access critical health care services,” said Jeremy Vandehey, Director of Health Policy and Analytics at OHA. ‘Specifically, this two-year period shows that people cycling on-and-off insurance means they eventually lose coverage. Therefore, its deeply important to break those cycles and keep people continuously enrolled. For low income families, we know that incomes fluctuate, but access to the health care should not.”

In addition, Oregon reduced disparities in health coverage due to health inequalities and structural racism. The uninsured rate for Black/ African American individuals decreased from 8.2% to 5% from 2019 to 2021. Uninsured rates in Hispanic/Latinx and American Indian/ Alaska Native communities decreased slightly.

'With our goal of ending health inequities by 2030, OHA is committed to enacting policies that continue our progress,” added Vandehey. ‘One key area we look to sustain this improvement is through our upcoming Medicaid waiver, where we are asking the federal government's permission to implement policies like continuous Medicaid enrollment for children until their sixth birthday, and two-year continuous enrollment for people age 6 and up. We now have proof that such policies will make a significant difference for Oregon families ? particularly those harmed by historic and contemporary racism.”

OHA is shifting its focus to transitioning people currently enrolled in Medicaid to marketplace coverage if they will no longer be eligible for Medicaid after the PHE moratorium on disenrollment ends.

'OHA's goal is to ensure that at the end of the Public Health Emergency, we work systematically to keep people covered,” said Vandehey. ‘For those who are no longer eligible for OHP, we will be working to make sure they access a Marketplace plan or connect to other programs. This handoff is critical, as the data show, because we cannot lose people as they exit Medicaid. If we do, much of this hard-won coverage gain will be lost.”

The transition plan involves:

-Implementing a robust outreach and communication plan to let Medicaid members know what to expect and encourage them to update their contact information so that their coverage can be renewed.

-Creating ongoing coordination between Medicaid and the Marketplace to ensure that members who lose Medicaid coverage are supported in their transition to a private plan.

-Maximizing the existing automated renewal process to reduce the burden on members. If coverage cannot be automatically renewed, members receive a pre-populated renewal notice that they must sign and return.

-Engaging community partners to help connect people leaving OHP to other sources of health coverage, such as through a job. [FN6]

Delaware Health Insurance Marketplace Enrollment Reaches All-Time High

Delaware announced a record high increase in enrollment in health insurance plans through the Delaware Health Insurance Marketplace during the latest open enrollment period.

The stated credited strong public demand for coverage during the COVID-19 pandemic, enhanced federal subsidies, and Delaware's reinsurance program keeping the cost of monthly premiums relatively steady for the record enrollment.

Enrollment increased 26.8% over the open enrollment total for 2021.

The state's latest open enrollment period began on Nov. 1, 2021, and ended Jan. 15, 2022. A total of 32,113 Delawareans enrolled for health insurance on HealthCare.gov. Enrollments were 25,320 during the prior open enrollment period.

'We are pleased that an increasing number of Delawareans decided to buy coverage through Delaware's Health Insurance Marketplace,” Governor John Carney said. ‘Being able to provide access to high-quality, affordable health care is one of the

cornerstones of the Affordable Care Act. We are grateful to the Biden administration and the Congressional Delegation for providing enhanced federal subsidies on the marketplace plans to help improve access to health insurance for Delawareans.“ [FN7]

Health Plan Triples Its ACA Enrollment

Friday Health Plans tripled its enrollment in plans available through the Affordable Care Act marketplaces during the last open enrollment period.

The company, based in Denver, was created to simplify health insurance in the individual and family market. It increased membership by over 300%.

The company expanded its 2022 offerings to 185 counties across seven states. It signed up over 300,000 members in its Affordable Care Act (ACA)-compliant health plans.

'With a record enrollment for individual and family health insurance, more people are finding value in Friday's plans that are built around their wants and needs,” said Sal Gentile, CEO, Friday Health Plans. ‘People want the lower prices and meaningful benefits that we offer, such as free doctor visits— in person and virtually—free generic drugs, and free mental health counseling. We look forward to expanding into more states and counties very soon.”

The largest increase in Friday's existing markets was in Texas, where the company represented over 20% of the marketplace enrollments in areas including Houston, Dallas/Fort Worth and the Rio Grande Valley.

The company increased its market share to 17% of ACA enrollments in Nevada and nine percent in Colorado. It expanded offerings to Georgia, North Carolina and Oklahoma and added more counties in Colorado and Texas.

According to Friday, ‘This past open enrollment period saw a record 14 million people sign up for health insurance under the ACA. Growth has been fueled by policies that increased premium subsidies, with many people qualifying for lower cost or no-cost health plans. The COVID-19 pandemic has also driven people into different careers that do not offer employee-sponsored health plans.”

Benefits for many of Friday Health Plans' offerings include unlimited $0 primary care visits, $0 mental health counseling, and free or low-cost generic drugs.

The company stated that it ‘takes the complexity out of choosing and using health insurance due to its singular focus on serving people who buy their own health plans.”

It defined itself as follows, ‘Friday Health Plans is purpose-built specifically for people and small businesses who buy their own health insurance. The company focuses on overall simplicity to offer affordable health plans with benefits that help members stay healthy and cover them if they get sick or hurt. Operational efficiency, top-notch customer service, and smart technology are core to Friday's consumer-centric approach. Headquartered in Denver, insurance plans and services are state-based subsidiaries of Friday Health Plans Management Company, Inc.“ [FN8]

New Jersey Sees All-Time High Enrollment in ACA Plans

New Jersey Governor Phil Murphy announced that a record number of people had enrolled in health insurance plans through the state's Affordable Care Act individual health insurance marketplace.

The increased enrollment largely occurred during the open enrollment period. New Jersey residents were free to enroll in in ACA health plans available through the marketplace from Nov. 1 to Jan. 31.

The increased enrollment represented a 20% increase from last year.

The state credited increased state and federal financial aid with the increase in enrollment. Financial subsidies were increased in response to the economic impact of the COVID-19 pandemic.

Part of the increased financial aid included the federal requirement in the 2021 American Rescue Plan that the cost of health insurance for an individual or family purchasing a plan through the ACA marketplace could not exceed 8.5% of their yearly individual or family income.

This rule is effective regardless of an individual or family's income level.

New Jersey also assisted its residents by increasing the size of subsidies for people earning up to $77,280 and $159,000 for a family of four.

These subsidies are available only to people who purchase individual health insurance plans through the state or federal marketplaces. People who get health insurance through their employment do not qualify for the subsidies.

The New Jersey Department of Banking and Insurance indicated that certain lower-income people qualify for plans through the marketplace with low monthly premiums. Some people qualify for insurance coverage through the New Jersey health insurance marketplace at no monthly cost.

All of these subsidies are available because of the federal Affordable Care Act, which set up the marketplaces. Republican legislators have challenged the law several times in front of the Supreme Court.

President Joe Biden has expanded the law through the 2021 American Rescue Plan. Democrats aim to make some of these changes permanent and expand the law further. President Biden is moving toward a goal of access to health insurance coverage for all Americans.

In addition to significantly increasing federal subsidies for the individual and family marketplace plans, the American Rescue Plan also incentivized states that have not yet expanded Medicaid to expand the program. [FN9]

Justice Department Sues to Block Health Insurance Acquisition

The Department of Justice, together with Attorneys General in Minnesota and New York, filed a civil lawsuit to stop UnitedHealth Group Incorporated (United) from acquiring Change Healthcare Inc. (Change).

The complaint was filed in the U.S. District Court for the District of Columbia.

The DOJ alleged that the proposed $13 billion transaction would harm competition in commercial health insurance markets. It would also be detrimental to the technology market that processes health insurance claims, leading to higher costs for health care consumers.

'Quality health insurance should be accessible to all Americans," said Attorney General Merrick B. Garland. 'If America's largest health insurer is permitted to acquire a major rival for critical health care claims technologies, it will undermine competition for health insurance and stifle innovation in the employer health insurance markets. The Justice Department is committed to challenging anticompetitive mergers, particularly those at the intersection of health care and data."

'The proposed transaction threatens an inflection point in the health care industry by giving United control of a critical data highway through which about half of all Americans' health insurance claims pass each year," said Principal Deputy Assistant Attorney General Doha Mekki of the Justice Department's Antitrust Division. 'Unless the deal is blocked, United stands to see and potentially use its health insurance rivals' competitively sensitive information for its own business purposes and control these competitors' access to innovations in vital health care technology. The department's lawsuit makes clear that we will not hesitate to challenge transactions that harm competition by placing so much control of data and innovation in the hands of a single firm."

The DOJ alleged in the complaint that the proposed acquisition would allow United to access a vast amount of sensitive information from its rival health insurers, leading to unfair competition. United is a massive company that owns the largest health insurers in the United States.

If the acquisition were allowed, it would place United at an unfair advantage by allowing it access to its rivals' information. It would harm competition in the health insurance markets, leading to higher prices for consumers.

The proposed acquisition would also eliminate United's only major rival for first-pass claims editing technology. This product is necessary to efficiently process health insurance claims. It saves health insurers billions of dollars per year.

The move would all United to take a monopoly share in the market.

The acquisition would also eliminate a firm that the DOJ calls 'independent and innovative," Change, the provider of vital software and services to many participants in the health care industry, including the major competitors to United.

According to the DOJ, 'Indeed, Change markets itself as a valuable partner for insurers, working closely with them to innovate and problem-solve. United's acquisition of this neutral player would allow United to tilt the playing field in its favor, harming current competition and allowing United to control and distort the course of innovation in this industry for the foreseeable future. " [FN10]

Plan to Increase Mental Health Coverage Includes Telehealth

In the State of the Union Address, President Biden outlined a plan to increase coverage of mental health care that included requiring more coverage of telehealth services.

According to a statement from the White House, 'Our country faces an unprecedented mental health crisis among people of all ages. Two out of five adults report symptoms of anxiety or depression. And, Black and Brown communities are disproportionately undertreated ? even as their burden of mental illness has continued to rise. Even before the pandemic, rates of depression and anxiety were inching higher. But the grief, trauma, and physical isolation of the last two years have driven Americans to a breaking point."

The new mental health strategy aims to 'strengthen system capacity, connect more Americans to care, and create a continuum of support ?transforming our health and social services infrastructure to address mental health holistically and equitably."

A severe shortage of behavioral health providers is a significant issue. Over one-third of Americans live in areas that are Mental Health Professional Shortage Areas, or fewer mental health providers than needed for the population.

The Biden Administration has a goal of dramatically expanding the supply, diversity, and cultural competency of the mental health and substance use disorder workforce.

The crisis response infrastructure also needs to be improved to connect people needing mental health care to the necessary services. Toward that aim, the Biden Administration will have a goal of connecting Americans to mental health care.

Currently, less than half of Americans with mental health conditions receive treatment. Costs often prevent people from accessing care.

The Biden Administration indicated, ‘We must fight to ensure that every American can access mental health and substance use disorder care through their insurance coverage, while integrating mental health services and supports into a variety of other settings, online and in the community.”

The Administration is focused on expanding and strengthening parity and integrating mental health and substance use treatment into primary care settings.

The Administration also plans to expand access to tele- and virtual mental health care options, stating ‘These tele-mental health services have proven both safe and effective, while reducing barriers to care. To maintain continuity of access, the Administration will work with Congress to ensure coverage of tele-behavioral health across health plans, and support appropriate delivery of telemedicine across state lines.“ [FN11]

Biden Proposes Fix to ACA “Family Glitch'

President Biden and Vice President Harris have proposed a fix to the so-called ‘Family Glitch” that prevents some families from accessing affordable health insurance coverage through the Affordable Care Act Marketplace.

According to the Biden-Harris Administration, the proposal will strengthen the ACA and save hundreds of thousands of families hundreds of dollars a month.

The ACA allows people to access health insurance coverage, and federal tax subsidies if they are eligible, through the ACA Marketplace, but only if they do not have access to affordable health insurance coverage through their employers. Currently, the affordability of employer-sponsored health insurance only contemplates the cost of health insurance for the employed individual, not the cost of a family plan through that individual's employer.

However, even if the plan for family coverage through the employer is expensive, family members cannot qualify for coverage on the ACA Marketplace and the federal tax subsidies that lower the cost of coverage.

According to the White House, ‘For family members of an employee offered health coverage through an employer, the cost of that family coverage can sometimes be very expensive and make health insurance out of reach. The ‘family glitch” affects about 5 million people and has made it impossible for many families to use the premium tax credit to purchase an affordable, high-quality Marketplace plan.”

The new proposed rule from the Treasury Department and the Internal Revenue Service would eliminate the ‘family glitch.”

The proposed rule would allow family members of workers who can access affordable individual coverage from their employers but unaffordable employer-sponsored family coverage to qualify for premium tax credits to purchase health insurance plans from the ACA Marketplace.

Estimates show that 200,000 uninsured people would gain coverage if the rule were implemented. Almost 1 million Americans would benefit from more affordable health insurance coverage. Many families would save hundreds of dollars a month off the cost of their current coverage.

The White House indicated, ‘This proposed rule would amount to the most significant administrative action to improve implementation of the ACA since its enactment.”

The White House noted, ‘The Biden-Harris Administration continues to deliver on that promise. Thanks to the landmark American Rescue Plan, ACA premiums are at an all-time low, while enrollment is at an all-time high. Four out of five Americans can find quality coverage for under $10 a month, and families are saving an average of $2,400 on their annual premiums—$200 in savings every month back to families. The Administration has lowered costs and increased enrollment to a record high of 14.5 million Americans—including nearly 6 million who newly gained coverage. With the addition of Missouri and Oklahoma, two states that expanded Medicaid last year, nearly 19 million low-income Americans are enrolled in the ACA's Medicaid expansion coverage, adding up to a record nearly 80 million children, pregnant women, seniors, people with disabilities, and other low-income Americans covered by Medicaid.“ [FN12]

Maine Governor Janet Mills released a statement in support of the Biden Administration's proposal to fix the ‘family glitch” in the ACA. She estimated that the proposal would allow 200,000 uninsured Americans, including 34,000 residents of Maine, to access health insurance coverage.

'This proposed fix would extend affordable health coverage to an estimated 34,000 people in Maine ? a welcome development as we continue our work to expand access to health care in Maine,” said Governor Janet Mills. ‘Having health insurance saves lives, keeps people healthy, reduces costs to families, and keeps people working and contributing to our economy. This fix is good for the health of Maine people and the health of our economy.“ [FN13]

New Health Insurance Special Enrollment Period for Low-Income People

People with lower incomes will now be eligible for a new Special Enrollment Period (SEP) for health insurance plans available through the Affordable Care Act (ACA) state and federal Marketplaces.

People who earn at or below 150% of the Federal Poverty Level (FPL) will be eligible for the new SEP.

Currently, the Federal Poverty Level (FPL) is set at about $19,000 for an individual, $26,000 for a family of two, $32,000 for a family of three, and $39,000 for a family of four. The Federal Poverty Level amount changes based on family size, increasing for larger families with more dependents.

People eligible for the new SEP will be able to enroll in a Marketplace plan at any time during the year. Eligible people who already have health insurance coverage will be able to take advantage of the SEP to change their existing policy or switch to a new plan. However, mid-year changes could result in in different monthly premiums.

Also, people switching mid-year from an existing policy will be subject to a reset of annual deductible amounts and out of pocket limits.

To meet the criteria for the SEP, individuals must be eligible for an APTC (advanced premium tax credit aka subsidy) and must have an estimated annual household income at or below 150% FPL.

People who have access to affordable employer-sponsored health insurance coverage and people who are eligible for Medicaid coverage are not eligible for the SEP. [FN14]

CT Insurance Exchange Data Breaches Unreported

The Connecticut state auditor performed an audit of the state's health insurance exchange, revealing that 44 data breaches over the last 3.5 years had not been fully reported.

The auditor also reported that the exchange has not taken sufficient steps to protect sensitive data.

The Connecticut Health Insurance Exchange serves as a health insurance marketplace for state residents purchasing private health insurance plans or enrolling in Medicaid coverage. It was established under the Affordable Care Act.

Access Health did report the data breaches to the Department of Health and Human Services. Reporting of data breaches is required under HIPAA. It also notified the Connecticut attorney general. However, the breaches were not reported to the state auditor or the comptroller.

State law requires the Connecticut Health Insurance Exchange to notify the Auditors of Public Accounts and the State Comptroller of exchange data breaches when they are discovered.

Most of the data breaches were small. Thirty-four of the breaches involved a Hampton, VA-based contractor, Faneuil Inc., a call center operator for Access Health CT. The errors were mostly administration errors and password reset errors affecting single individuals or people in the same household.

Forty-nine individuals were affected in the 34 data breaches.

Ten of the data breaches stemmed from five additional contractors. The largest breach resulted from a phishing attack. The information of 1,100 individuals was involved in the attack.

The auditors found that Access Health had failed to report the breaches. They also found that Access Health had failed to take necessary steps with client data to protect it. Auditors pointed to the 34 data breaches from a single contractor as a failure to adequately address and fix the problem.

State and federal laws require controls in data handling to ensure confidentiality, integrity, and security of health data.

'Our audit identified internal control deficiencies, instances of noncompliance with laws, regulations, and policies, and a need for improvement in practices and procedures that warrant the attention of management," the auditors indicated.

The auditors found issues with the procurement policy for vendors. It did not include specific criteria for awarding sole-source contracts.

According to Access Health CT, the breaches had been reported. However, it claimed that it was not aware of the requirement to report the breaches to the state auditor and comptroller.

Access Health CT concurred with the auditors' recommendations. It indicated that third-party vendors were helping to implement a new risk management framework. It agreed to provide comprehensive visibility and oversight of compliance with the state and federal laws relating to data security.

The program also indicated that it was changing internal purchasing policies and procedures and its contract procurement policy as result of the incidents. [FN15]

Report: Marketplace Premiums Decreased

According to a recent report from the Urban Institute, the average cost of a health insurance premium for a plan available through the Affordable Care Act exchanges decreased for the third straight year.

The cost decreased an average of 1.8% in 2022.

Researchers found that more insurers offered plans through the exchanges in states expanding Medicaid and in states with state-run exchanges. Enhanced federal subsidies under the American Rescue Plan led to record enrollment of 14.5 million in 2022.

Researchers considered data from the average benchmark premium, the second-cheapest silver tier plan. This plan is linked to eligibility for premium tax subsidies.

The cost of premiums decreased by 1.8%. In 2021, the decline was 1.7%. In 2020, premiums cost an average of 3.2% less than the prior year.

'In contrast, premiums for employer-sponsored increased by 3.9% in 2020 and 3.6% in 2021," the researchers noted.

The cost of benchmark premiums varied significantly by state. Researchers indicated that 11 states had benchmark premiums above $500 per month for 40-year-old nonsmokers. Six states had premiums that cost less than $365 per month.

Costs varied based on which insurers participated in the rating region. Costlier plans were associated with Blue Cross Blue Shield, national or regional insurers and provider-sponsored payers.

Medicaid insurers in the rating region were associated with lower costs of benchmark plan premiums.

'The number of competing insurers was important; the presence of one insurer meant premiums would be $189.50 per month higher, on average, relative to a market with five or more insurers," researchers indicated.

Premium costs were less in Medicaid expansion states, states with reinsurance policies and states running their own marketplaces rather than relying on the federal health insurance exchange. [FN16]

Federal Government Suspends Georgia's Plan for State-Run Health Insurance Marketplace

The federal government indicated to Georgia that it had suspended approval of the state's plan to create a state-run marketplace rather than continue to use the Affordable Care Act's federal health insurance exchange.

Governor Brian Kemp announced the plan in 2020 as part of a healthcare overhaul. The plan was scheduled for implementation in 2023.

The Trump administration approved the state's plan. The Biden administration had suspended parts of the original approval prior to the latest suspension of the overall plan approval.

Governor Kemp's original plan included an expansion of Medicaid eligibility with the addition a work requirement. The Biden administration previously suspended approval for that aspect of the plan.

Georgia initiated legal action over the Biden administration's choice to suspend approval of the Medicaid work requirement.

The Centers for Medicare & Medicaid Services (CMS) indicated in a letter to Georgia that

Acumen, a research company hired by the federal government, reported that the healthcare overhaul plan would actually lead to a decrease in enrollment in health insurance coverage for Georgia residents.

The predicted decrease in insured Georgia residents was 4.4-8.4% in 2023. It would continue to decrease 8.4% every year from 2024 to 2027.

Federal law allows state waivers for some provisions of the Affordable Care Act to change healthcare policies. However, these changes must 'provide coverage to a comparable number of residents' and be 'at least as comprehensive and affordable as coverage provided without the waiver.'

CMS indicated that Georgia's plan to overhaul its healthcare system would not fulfill the requirements for a state waiver.

At the time he announced the new plan, Governor Kemp asserted that it would increase the number of healthcare consumers in Georgia by 33,000. And that the plan was an 'innovative approach to improving choice in the healthcare marketplace and lowering premium costs.'

CMS granted Georgia a 90-day response period in which the state can either 'respond with a written challenge' or 'submit a corrective action plan.' [FN17]

White House Releases Fact Sheet on Changes to Marketplace Rules

The White House released a Fact Sheet outlining the changes to the rules affecting the Affordable Care Act Marketplaces.

The Department of Health and Human Services (HHS) published a Notice of Benefit and Payment Parameters for 2023 Final Rule. The Centers for Medicare & Medicaid Services (CMS) made changes to standards for insurers and Marketplaces. Additional changes apply to agents, brokers, web-brokers, and issuers assisting consumers with enrollment through Marketplaces that use the federal platform.

According to the White House, 'Overall, the final rule seeks to strengthen the coverage offered by qualified health plans (QHPs) on the federal Marketplace. These policies will also ensure consumers can more easily find the right form of quality, affordable coverage for their circumstances."

Insurers offering plans through the Federally-facilitated Marketplace (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs) will be required to offer standardized plan options at every product network type, at every metal level, and throughout every service area. Changes will be effective for plans starting in 2023.

CMS will also regulate how these standardized plan options are displayed on HealthCare.gov, by web-brokers, and insurers using direct enrollment. Entities can request deviations from the rules as long as the display provides a similar level of clarity for consumers.

CMS will conduct network adequacy reviews in all states except states with standards as stringent as the federal standard that perform their own reviews. Reviews will encompass quantitative network adequacy standards based on time and distance standards. In PY 2024, reviews will include compliance with appointment wait time standards.

The rule finalizes changes to the Actuarial Value (AV) de minimis ranges various percentage points for all individual and small group market plans subject to the AV requirements.

The White House noted, 'The narrowing of the de minimis ranges of individual market silver QHPs will influence the generosity of the Second Lowest Cost Silver Plan (SLCSP), the benchmark plan used to determine an individual's Payments of the Premium Tax Credit (PTC). As a result, subsidized enrollees will likely receive increased premium tax credits."

Changes are also aimed at advancing health equity. CMS has refined its Essential Health Benefits (EHB) Nondiscrimination Policy for Health Plan Designs to ensure that they are based on clinical evidence.

The rule will scale back pre-enrollment Special Enrollment Period (SEP) verification to include only the SEP for loss of minimum essential coverage.

Additionally, it will update Quality Improvement Strategy (QIS) Standards to require insurers to address health and healthcare disparities. [FN18]

Washington Requests Waiver to Allow Undocumented Immigrants to Join Health Insurance Marketplace

Washington state has submitted a waiver to the federal government requesting permission to allow undocumented immigrants to participate in the state's health insurance marketplace.

The state called it 'an effort to expand health coverage options to all residents."

The submission is a Section 1332 Waiver Application. If approved, it will allow Washington residents regardless of immigration status to enroll in health and dental coverage through the state marketplace, Washington Healthplanfinder.

Coverage will be available beginning in 2024 for people newly eligible through the waiver, if granted.

'Since the introduction of the Affordable Care Act we have been charting a course toward providing health insurance coverage for all Washingtonians," Gov. Jay Inslee said. 'This waiver comes at an important time in our health care journey and its approval would strengthen our ability to provide equitable access for historically marginalized and uninsured populations."

The Washington State Legislature directed the Washington Health Benefit Exchange (Exchange) in 2021 to study possible coverage pathways for Washington residents who do not currently qualify for health insurance coverage through the state or federal governments. The legislature authorized the move to submit the federal marketplace waiver application.

If the federal government approves the waiver, it will also make eligible individuals and families able to qualify for Cascade Care Savings. This new state premium assistance program will begin this fall for plans effective in 2023.

'There are many in our state who have never had a chance to buy health insurance," said CEO Pam MacEwan. 'This waiver gives those individuals a chance to secure meaningful health coverage for themselves and loved ones. Additionally, this opportunity aligns with other initiatives, including Cascade Care and premium sponsorship programs, to further state efforts to strengthen the individual health insurance market and lower the rate of the uninsured."

During the state public comment period to obtain feedback on the Section 1332 Waiver Application, the state received overwhelming support for the decision. 134 organizations representing local and national health insurance carriers; provider associations; community health clinics; consumer and immigrant advocacy organizations; state and local elected officials; and 365 individuals commented.

The state decided to seek the waiver 'to ensure that comprehensive coverage and more affordable choices are available to uninsured Washington residents."

Over 105,000 Washington state resident cannot access health insurance due to federal restrictions related to their immigration status. This number represents nearly a quarter of the state's total uninsured population.

The number of uninsured people, 'adversely impacts individual health outcomes and finances, the health care sector (increasing bad debt and uncompensated care), and Washington's economy. The waiver will enable individuals to purchase health and dental coverage through Washington Healthplanfinder and leverage state-funded affordability programs that help lower premium costs for all individual market consumers."

The U.S. Department of Health and Human Services and the Department of the Treasury must approve Section 1332 Waivers. Factors used to grant approval include whether the waiver meets designated federal guardrails, and whether the coverage offered under the waiver is comprehensive, affordable, results in coverage gains, and does not increase the federal deficit. [FN19]

Connecticut Exchange Opens Special Enrollment Period for Low-Income People

Connecticut's health insurance exchange opened a special enrollment period for low-income families that will remain open throughout 2022.

Residents are eligible for the open enrollment period who earn at or below 150% of the federal poverty level. Household incomes that qualify: $26,130 for a family of two, $39,750 for a family of four or $46,560 for a household of five (Access Health CT will utilize last year's FPL calculations).

Plans that are free or no-cost through Access Health CT are subsidized by the federal government under the American Rescue Plan Act.

'This new Special Enrollment Period is all about creating access for Connecticut residents with lower income to get the health insurance coverage they need at an affordable price," James Michel, CEO of Access Health, said. 'And it is another way we are working to accomplish our mission of increasing the number of insured residents and reducing health disparities."

He indicated that if the federal subsidies are extended beyond 2022, the special enrollment period could also be extended.

People enrolling during the special enrollment period will receive coverage beginning the first of the month following their enrollment date.

A special enrollment period for Access Health CT is simultaneously running for people eligible for the Covered Connecticut program. Under that program, the state covers part of health insurance premiums for eligible individuals. [FN20]

CMS Issues New Proposed Rule for Funding Basic Health Program

The Centers for Medicare and Medicaid Services (CMS) issued a new proposed rule on the funding methodology for the Basic Health Program (BHP) for 2023. The change would incorporate a new Section 1332 waiver factor relative to Minnesota's state-based reinsurance program.

The change would increase payments to the state from $470 million to $603 million next year.

The new rule would also end the requirement to issue annual payment notices for the BHP. The methodology would stay in place unless changed through the rulemaking process. CMS would recalculate payments for the 2019 year to correct a calculation error.

That change would increase payments for New York and Minnesota by $224 million.

The rule does not address extending the enhanced subsidies through the health insurance marketplace that were increased temporarily under the American Rescue Plan Act (ARPA). The enhanced subsidies are currently set to expire.

The only two states with a BHP established are New York and Minnesota. More states, including Kentucky, Oregon, and West Virginia have expressed interest in creating a BHP. States can benefit from BHP's due to limited coverage losses for low-income people transitioning away from Medicaid at the end of the federal public health emergency.

The Affordable Care Act (ACA) allowed the BHP under Section 1331. States may offer alternatives to marketplace coverage for some individuals without insurance coverage who make between 133 and 200 percent of the federal poverty level (FPL). The BHP option gives people more affordable coverage and minimizes churning when transitioning between Medicaid and private health insurance.

CMS funds the BHP by making payments equal to 95 percent of the amount eligible BHP enrollees would have received in premium subsidies and cost sharing reductions if they were enrolled in qualified plans through the health insurance exchange. There is no codified formula for the payment calculations. CMS must publish the next year's proposed BHP payment methodology in the fall. The agency finalizes the payment methodology each spring.

Payments made by the federal government to states to fund BHP cover anticipated costs. States receive deposits into their BHP trust funds quarterly. They then contract with private health insurance companies to make BHP plans available to eligible resident low-income consumers.

States later submit data regarding the actual enrollment of eligible individuals into the BHP.

Minnesota has a BHP as well as a Section 1332 waiver for a state-based reinsurance program. Having both programs has created some disputes over how much federal pass-through funding the state is owed under its Section 1332 waiver. Minnesota officials contend that the state is due more funding and request a reconsideration of the methodology for calculating payments.

The proposed methodology for BHP plan year 2023 would be largely the same as in 2022. The only change is a new proposed Section 1332 waiver factor. It would account for the interaction between the BHP and Section 1332 waiver. The BHP would transition some people who would otherwise be eligible for PTCs out of the exchange. A Section 1332 waiver usually reduces the cost of benchmark plan premiums.

A Section 1332 waiver typically reduces benchmark plan premiums. At the same time, it reduces the PTCs available for eligible enrollees because it lowers the cost of the benchmark plans. If a state has both a BHP and a Section 1332 waiver, it reduces federal BHP funding. Funding amounts are based on the PTCs and CSRs that eligible enrollees would otherwise have received.

In Minnesota, the state did in fact receive less funding due to running both programs. The Trump administration authorized the reinsurance waiver but authorized it to only receive the amount saved through reduced subsidies. State officials have asked for a reconsideration of the funding amount.

The amount of the reduction in BHP payments between 2018 2022 in Minnesota is estimated at $359 million.

CMS responded in June 2021 to the request. It indicated that federal officials are reviewing the request. They will propose 'potential approaches" to address the interaction of the two programs. [FN21]

AHA Comments on Proposed Fix to "Family Glitch'

The American Hospital Association (AHA) praised the Internal Revenue Service for proposing to change the calculation of affordability for employer-sponsored coverage when determining eligibility for the health insurance marketplace.

The affordability of coverage affects whether a family qualifies for federal subsidies to help cover the cost of health insurance premiums.

'The AHA has long advocated for a fix to the current methodology for assessing affordability of employer coverage for family members, often referred to as the "family glitch,' which is estimated to affect about 5 million individuals," AHA wrote. 'We commend the IRS on proposing to revise this regulation and improve access to health insurance coverage for millions of American families. — While outside of the scope of this regulation, we urge the Administration to address in the future two critical issues that undermine the comprehensiveness of coverage: substandard coverage and unaffordable and confusing cost-sharing structures." [FN22]

NY Insurers Request Rate Increases

New York insurers requested significant rate increases for small group plans covering companies with 100 employees or less and for consumers who are not part of a group plan.

Requested rate increases are as high as 46% for small group plans and 35% for consumers purchasing individual plans.

Over 1.1 million New York residents obtain insurance through small group or individual plans.

Large employers in the state will mostly remain unaffected by the rate changes since they are self-funded. They cover the cost of employees' medical claims without purchasing group plans from health insurers.

The increases have not yet been approved. Comments are open until August for individuals and companies affected by the changes.

Average rate request increases were 18.7% for individual plans. Average requested increases for small group plans were 16.5%.

Insurers claim that the increases are necessary to cover the increasing costs of medicine and treatments.

The largest insurer in Central New York, Excellus, requested increases for small group plans of 6.3% to 18.1%. The company is seeking rate increases of 8.3% to 20.1% for its individual plans.

MVP Health Plans requested increases of 14.2% to 33.8% for its individual plans. Fidelis is seeking rate increases as high as 34% for individual plans.

Another company, Fidelis, wants to increase rates as much as 34% for individual plans available to New Yorkers.

All the rate changes affect people who obtain health insurance plans through those insurers on the Affordable Care Act health insurance exchange.

The cost of a premium for Excellus' standard platinum plan for individuals purchasing the plan through the state's exchange would increase from approximately $1,059 to $1,210. The increase requested is over 14%.

Twelve percent of people with Excellus insurance coverage are enrolled in individual or small group plans in Upstate New York, or about 181,000 people.

The rate increases will first require approval from the New York State Department of Financial Services. The agency has significantly reduced the requested rate increases from insurers for the last four years.

The decision on the current rate requests is expected in August. The new rates will take effect on Jan 1. [FN23]

CMS Approves Colorado Innovation Waiver

The U.S. Department of Health & Human Services and the U.S. Department of the Treasury (collectively, the Departments) recently approved Colorado's application to amend its State Innovation Waiver under the Affordable Care Act (ACA).

The change will allow the state to implement the Colorado Option, an innovative model for health insurance aimed at promoting competition and health equity. It includes:

standardized benefit plans; required premium reduction targets; regulatory and programmatic mechanisms as a backstop to ensure providers, hospitals, and issuers meet those targets; and state subsidies to lower out-of-pocket costs for individuals and families enrolling in coverage through the state's Exchange and for those not currently eligible for federal subsidies under the ACA.

The change will also allow the state to continue its state-based reinsurance waiver program through 2027.

The waiver will allow for plan-level rating variations for the Colorado Option in the individual and small group markets. The change will affect plan years 2023 through 2027.

The Colorado Option is offered through the state's Health Insurance Marketplace, Connect for Health Colorado. It is a state-based standard health benefit plan aimed at making health care more affordable, comprehensive, equitable, and accessible.

The legislation creates a set of premium reduction targets and improves regulatory and program mechanisms to ensure that healthcare providers meet the targets.

The amended waiver will likely significantly reduce the cost of premium tax credits for the federal government.

Under the waiver amendment, the state will receive a portion of the savings in the form of pass-through funding to support the state's reinsurance program and state-based subsidies for out-of-pocket costs for eligible Coloradans.

Some residents will be eligible for enhanced subsidies for purchasing health insurance plans through the state-based marketplace. Residents who are not eligible for PTC might be eligible for state subsidies.

The amendment will extend the section 1332 individual market reinsurance waiver program through 2027. It will not make other changes to the approved reinsurance program. [FN24]

Marketplace Insurers Denied 1 of 5 Claims

A recent study by the Kaiser Family Foundation showed that insurers offering plans through the federal health insurance exchange marketplace denied almost one out of every five claims, or 18% of claims, for in-network health care services in 2020.

Researchers indicated that the reason behind the high rate of denials was unclear from the publicly available data. Also, the ultimate consequences for consumers are difficult to determine.

Under the Affordable Care Act, insurers must report data regarding claims denials and appeals. These rules are in place to encourage transparency about health insurance plans available through the ACA marketplace for consumers.

Researchers looked at data released by the Centers for Medicare and Medicaid Services on more than 230 million claims submitted to 144 insurers selling marketplace coverage in 2020. The data was the most recent available.

Researchers found that there was a large variation among insurers. Average denial rates ranged from 1% of claims to 80% of claims.

In Florida, the average denial rate was 15%. The three insurers with the largest market share of enrollees had denial rates of 10.5% (Florida BCBS), 11.1% (Health Options), and 27.9% (Celtic Insurance).

While the CMS data includes some information about why in-network claims are denied, most (72%) fall into a broad category of ‘all other reasons.”

This category may include administrative or paperwork errors and other issues.

Some claims were denied for a specific reason, including lack of prior authorization or referral (10%), an excluded service (16%) or lack of medical necessity (2%).

For claims denied for reasons of medical necessity, approximately 1 in 5 involved behavioral health services.

Only some consumers appealed in-network claims that were denied in 2020. Fewer than 61,000 appeals were made in 2020. That was around one-tenth of one percent of denials. After appeals, insurers upheld 63% of the denials. Consumers rarely filed the next level of appeal, an external appeal.

Researchers made the analysis, along with data files of the insurer and state-specific information, available online. [FN25]

Michigan Residents to Have More Options for Health Insurance

The Michigan Department of Insurance and Financial Services (DIFS) released proposed rate filings showing that Michigan residents will have over 300 health plans to choose from during the upcoming open enrollment.

'Health care continues to be at the forefront of public policy discussions, both in Michigan and nationwide, and it is critical that Michiganders have access to the affordable, high quality health insurance they need for themselves and their families,' said DIFS Director Anita Fox. ‘Consumers who will need to buy a health plan during open enrollment this year will have all-new plan options, so it is important that they take advantage of these new choices by shopping around and choosing the plan that works best for their needs and budget.’

Open enrollment for health insurance plans beginning in 2023 will open November 1 and run through December 15, 2022.

Consumers will be able to choose from among 233 health plans on the Marketplace, an increase of 59 since last year. Including plans available off-Marketplace, 308 total plans will be offered, an increase of 52 plans.

The following insurers offer plans to Michigan residents individually:

Alliance Health and Life Insurance Company (off-Marketplace)

Blue Care Network of Michigan

Blue Cross Blue Shield of Michigan Mutual Insurance Company

Health Alliance Plan (off-Marketplace)

McLaren Health Plan Community

Meridian Health Plan of Michigan, Inc.

Molina Healthcare of Michigan, Inc.

Oscar Insurance Company

Physicians Health Plan

Priority Health

United Healthcare Community Plan

U.S. Health and Life Insurance Company

DIFS is the regulatory agency of the insurance industry in the state. It reviews all proposed plans and rates with respect to compliance with state and federal laws.

The proposed rates for 2023 have not yet been approved. The agency will further review them prior to approval. Requested rate changes range from a decrease of 2.8% to an increase of 12.9%.

The average proposed rates are an increase of 6.2%.

The fluctuation cost of health insurance throughout the United States is due to factors including:

An increased demand for health care, as procedures that were postponed or cancelled during the pandemic are rescheduled.

Inflationary and supply chain pressures that affect the cost of medical supplies and prescription drugs. [FN26]

HHS Issues Guidance on Birth Control Access

The U.S. Department of Health and Human Services (HHS) and the Departments of Labor and of the Treasury issued guidance to clarify protections for birth control coverage under the Affordable Care Act (ACA).

The ACA requires most private health plans to provide birth control and family planning counseling at no additional cost to the beneficiary.

The guidance was released soon after HHS increased its work to support family planning services, such as access to emergency contraceptives. Data for 2020 from a recent HHS report revealed that 58 million women benefited from the ACA's preventive services and birth control coverage. This coverage has saved billions of dollars in out-of-pocket spending on contraceptives since the passage of the ACA.

The guidance was issued to remind plans and insurers that the ACA requires coverage of contraceptives and to emphasize the Departments' commitment to enforcing that requirement.

According to HHS, ‘Today's announcement is part of a comprehensive effort by the Biden-Harris Administration to protect women's access to reproductive health care, while reproductive rights are under assault in many states across the country.”

'Under the ACA, you have the right to free birth control — no matter what state you live in,” said HHS Secretary Xavier Becerra. ‘With abortion care under attack, it is critical that we ensure birth control is accessible nationwide, and that employers and insurers follow the law and provide coverage for it with no additional cost. Family planning, one of the greatest public health achievements of the 20th century, is key to better health outcomes. We will do all we can at HHS to protect family planning and all other forms of reproductive health care, including abortion care, because it is essential health care.”

'Today's guidance makes clear that the law requires group health plans and health insurance issuers to provide contraceptive coverage — including emergency contraception — at no cost to participants,” said Labor Secretary Marty Walsh. ‘We have heard troubling reports that plans and issuers are not following the law. We expect them to remove impermissible barriers and ensure individuals have access to the contraceptive coverage they need. If plans and issuers are not complying with the law, we will take enforcement action to ensure that participants receive this coverage, again with no cost sharing.”

'To the American people, including those who are concerned that their access to care is at risk, I say this: we stand firmly with you, and the Centers for Medicare & Medicaid Services (CMS) will do everything we can to ensure that you have access to the full range of reproductive health care you need,” said CMS Administrator Chiquita Brooks-LaSure. ‘Today, we are taking another important step by reminding employer-sponsored health plans and health insurance issuers of their obligations to provide the full range of contraceptive care to their enrollees.”

Under the ACA, coverage of women's preventive services, including no-cost birth control and contraceptive counseling is required for all individuals and covered dependents with reproductive capacity.

HHS Secretary Xavier Becerra, Labor Secretary Marty Walsh, and Treasury Secretary Janet L. Yellen recently sent a letter to health insurers and employer health plan organizations about the requirement to cover contraceptives. The Departments convened a meeting with issuers, directing the industry to commit to meeting their obligations to provide coverage for contraceptive services at no cost. [FN27]

Insurance Rates to Increase in CA

The cost of premiums for health insurance plans available through California's health insurance exchange is set to increase an average of 6% next year, according to officials from Covered California.

The increase is the largest in the state since 2019. During the last three years, the increase in premiums averaged less than 2%.

Imperial, Inyo and Mono counties will see rate increases of 11.7%. Average rates will not change in Fresno, Kings, and Madera counties.

An individual's federal tax subsidy usually increases with the cost of premiums, so people who qualify for subsidies may see less of an increase. People who do not qualify for the subsidies will face the full cost of increases of their monthly premiums.

'Premiums are a capturing of what health care costs are, how they vary across geographies and communities, how health care costs are growing over time, which we know in this country are already too high and rising," said Jessica Altman, executive director of Covered California.

Altman pointed out that the California rate increases are less than increases in other states. According to a Kaiser Family Foundation analysis, a 10% average premium increase was proposed by 72 insurers in 13 other states.

Altman blamed the increases on people resuming physician visits that they postponed during the early part of the COVID-19 pandemic. She also pointed to inflation.

One percent of the increase is attributed to the loss of enhanced subsidies available under the American Rescue Plan through the federal government. They are set to expire at the end of the year without action from Congress. However, there is a good possibility that the United States Senate has reached an agreement to pass a budget resolution that will continue the enhanced subsidies for three years.

The American Rescue Plan provided California with an additional $3 billion for the two years of enhanced subsidies available through Covered California, the state's health insurance marketplace.

The enhanced subsidies reduced costs for some people who already qualified for subsidies and allowed more people with middle-incomes to become eligible for premium subsidies. [FN28]

Inflation Reduction Act Continues Enhanced Subsidies for ACA Marketplace Plans

President Biden signed the Inflation Reduction Act into law which includes a continuation of the enhanced subsidies for health insurance plans purchased through the ACA marketplaces.

The enhanced subsidies will continue for three years under the new law. People with lower incomes will continue to receive the increased subsidies, lowering their premiums for health insurance available through the ACA marketplaces.

In addition, people earning more than the previous hard cut-off for premium subsidies will continue to qualify for subsidies lowering the cost of their premiums to a maximum of 8.5% of income.

According to CMS Administrator Chiquita Brooks-LaSure: 'The historic Inflation Reduction Act builds on the Biden-Harris Administration's efforts to meaningfully lower health care costs for people across the country. Millions of people with Medicare coverage will benefit from lower drug prices, a $35 monthly co-pay cap for insulin, a limit on out-of-pocket expenses in Medicare Part D, and reduced costs under Medicare's new ability to negotiate drug prices in the years ahead. In addition, the enhanced tax credits for the Affordable Care Act Marketplaces will continue for three years to help people afford their premiums and connect to coverage during the upcoming 10th Open Enrollment Period. CMS will be working with people covered by our programs, health industry stakeholders, states, and more as we work to make the law a reality for people across the country."

CMS Deputy Administrator and Director of the Center for Medicare Dr. Meena Seshamani indicated, 'The Center for Medicare is ready to implement the historic provisions within the Inflation Reduction Act. We're working closely with the HHS Secretary and the CMS Administrator to hit the timelines outlined in the law. The Inflation Reduction Act's historic reforms will provide financial relief to the millions of seniors and people with disabilities who are struggling to afford the life-saving drugs they need and deserve. Expanded access and improved benefits including a $35 monthly insulin co-pay cap, a limit on out-of-pocket expenses in Medicare Part D, free vaccines and reduced costs under Medicare's new ability to negotiate drug prices will ensure Medicare is more affordable and equitable both now and for future generations."

CMS Deputy Administrator and Director of the Center for Consumer Innovation and Insurance Oversight (CCIIO) Dr. Ellen Montz noted, 'The passage of the Inflation Reduction Act means millions across the country will continue to see substantial savings, ensuring

critical access to insurance coverage and allowing consumers to keep more money in their pockets. Under the leadership of the HHS Secretary and the CMS Administrator, CCIIO is excited to make these savings available to the American people during the upcoming Open Enrollment period starting November 1, 2022.“ [FN29]

Federal Laws Affect ACA Employer Affordability Component

The enacting of the American Rescue Plan (ARP) and the Inflation Reduction Act (IRA) is expected to affect the affordability component of the ACA for the Employer Mandate.

When ACA reporting was first required for employers in 2015, the affordability component was created by indexing the standard of 9.5%.

With the passage of the ARP and the IRA, the Aca affordability percentage has dropped to a historic low 9.12% for the 2023 tax year.

In 2022, the ACA affordability percentage was 9.61%.

Beginning in 2023, employers will need to contribute more toward their employees' health insurance premiums to make up the difference.

The index has fallen largely due to the healthcare changes made under the ARP. Subsequent changes under the IRA are expected to also affect the ACA affordability percentage.

The ARP created the enhanced Premium Tax Credits (PTCs), providing premium assistance for people with incomes at and above 400% of the Federal Poverty Level (FPL) for the first time. They became eligible to purchase health insurance from the state and federal ACA exchanges for a maximum of 8.5% of their household income.

Also, individuals earning less than 150% of FPL received increased subsidies under the ARP, becoming able to purchase health insurance for as little as $0 monthly premiums.

The enhanced PTCs led to a significant increase in access to health insurance throughout the United States. The current uninsurance rate nationwide is the lowest ever at 8%.

The maximum of 8.5% of income applies only to households eligible to purchase health insurance plans through the ACA exchanges. The ACA affordability threshold of 8.5% maximum does not apply to employer-provided health insurance plans.

However, the IRS significantly lowered ACA affordability for 2023, seemingly adjusting it to align with the 8.5% individual cap 18 months after the ARP passed. A possible reason for this decrease is that the PTCs under the ARP curbed the rate of premium cost increases, leading to a lower employer affordability threshold.

According to IRS review documents, affordability percentages are indexed based on premium growth rates as related to income growth rates. Also, the IRS has indicated that the affordability threshold set for the ACA marketplaces should be consistent with employer affordability percentages.

Now that the IRA has continued the enhanced subsidies for another three years, the employer affordability percentage is expected to fall closer in line with the ACA marketplace affordability threshold. [FN30]

PA Governor Announces Open Enrollment

Pennsylvania Governor Tom Wolf announced the upcoming Open Enrollment Period for Pennie, the state's health insurance marketplace.

The online marketplace offers Pennsylvania residents an opportunity to enroll in health insurance coverage and obtain financial assistance to reduce the cost of their monthly premiums. The health insurance marketplace, created under the Affordable Care Act (ACA) is aimed at facilitating access to health insurance coverage by educating people and assisting them with enrollment.

'Pennie is making health care more affordable than ever here in Pennsylvania and I urge anyone who is seeking affordable health care coverage to visit pennie.com today to start weighing their options, and to hopefully take advantage of the quality health care and services available,” said. Gov. Wolf. ‘Having quality health insurance is a fundamental right all Pennsylvanians deserve. My administration has made exploring these benefits more readily accessible, right from your own home ? you can calculate potential savings, check out coverage options, and enroll in the best plan for you, your family and your budget.”

The open enrollment period in Pennsylvania will begin on November 1. Coverage for those plans will begin January 1, 2023.

Eligibility for enrollment is always open for someone experiencing a qualifying life event. Qualifying events include moving to a new part of Pennsylvania or losing coverage from another source.

When the Public Health Emergency ends, Medicaid redeterminations will also trigger qualifying life events if beneficiaries lose coverage.

New improvements for the upcoming open enrollment through Pennie include improvements to the marketplace shopping experience. The marketplace will have additional plan details and search features.

'The Wolf Administration has remained dedicated to the health, well-being and financial security of all Pennsylvanians and has taken various paths to educate consumers about the importance of health insurance before, during and after COVID-19," said Pennsylvania Insurance Commissioner Mike Humphreys. 'Governor Wolf and I know Pennsylvanians want and deserve equal access to health coverage, including increased options within the individual market."

According to the Governor's office, 'Governor Wolf, Commissioner Humphreys and Pennie strongly recommend Pennsylvanians shop around for the best plan to fit their individual, family, and financial needs, even if they are currently enrolled in a health insurance plan through Pennie. A change in rates can potentially result in a decrease in subsidies, so consumers are encouraged to shop around and compare plans."

Health and dental coverage will be available during the Open Enrollment Period from November 1, 2022 through January 15, 2023. [FN31]

Employers Challenged with Cost of Health Insurance

A recent survey showed that employers are facing challenges with the cost of group health insurance coverage for employees.

The survey was conducted by eHealth. Data also revealed that employers are seeking a new way to provide access to health insurance for employees.

Researchers polled 1,300 people in September 2022 about private health insurance. Respondents included over 1,000 members of the general population and over 250 owners and managers of small to mid-sized businesses.

The survey focused on problems with employer-sponsored health insurance coverage for employees.

Results showed that both employers and employees are seeking changes to the typical model of employer-sponsored health insurance plans.

Fifty-one percent of employers indicated that they are finding the costs of group plans challenging. Sixty percent of employers noted that monthly costs were the largest challenge to offering health insurance benefits to employees.

About 87% of employers want another option for insuring employees in addition to a group plan. However, 64% of employers were unaware of individual coverage health reimbursement arrangement (ICHRA) plans. These plans allow employers to reimburse employees tax-free for medical expenses including monthly premiums and out-of-pocket costs.

The survey revealed that 49% of employees had one to two plan options from their employers. Fifty-eight percent of employees indicated that their employer-sponsored plan options did not meet their needs for health services.

Seventy-four percent of employees indicated that they would prefer greater choice of plans available in their area rather than the limited choices offered by employers.

'Our survey suggests that many employers are unsatisfied with the standard group health insurance model ? and many employees feel the same way,' eHealth CEO Fran Soistman said in a statement. 'I would especially encourage smaller businesses that just can't afford group health insurance to consider alternatives like ICHRA to control costs and give employees more personalized coverage options.'

Healthcare costs are expected to increase 6.5% to over $13,800 per employee in 2023. [FN32]

HHS Announces Action to Address "Family Glitch' in ACA Plans

U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra issued a statement on the final rule addressing the 'family glitch" in the Affordable Care Act marketplace plans.

According to HHS, the Biden-Harris Administration's final rule aims to strengthen the implementation of the ACA. Fixing the family glitch will assist approximately 1 million Americans by helping them access health insurance coverage more affordably.

Becerra noted, 'Protecting and strengthening implementation of the Affordable Care Act is key to increasing access to quality, affordable health care. Today's action resolves a flaw in prior ACA regulations to bring more affordable coverage to about one million Americans. Our goal is simple: leave no one behind and give everyone the peace of mind that comes with health insurance.

'Under President Biden's leadership, our nation's uninsured rate is at an all-time low and Affordable Care Act enrollment is at an all-time high. This is not by accident. We are meeting people where they are to tell them about their health care options through unprecedented outreach efforts. And through landmark legislation like the American Rescue Plan and the Inflation Reduction Act, we have offered the lowest ACA premiums rates in history. Our work to expand coverage and lower health care costs for American families never stops.

'Whether you're part of a family previously affected by this glitch, or an individual buying insurance on the marketplace, the Biden-Harris Administration is committed to ensuring you have the access to health care you deserve." [FN33]

The so-called family glitch prevented people from accessing affordable health insurance through the ACA health insurance marketplaces. Under the ACA, individuals can only purchase health insurance plans through the ACA marketplaces if their employers do not offer them 'affordable" health insurance.

Federal tax credits to lower the cost of health insurance premiums are available only through the ACA marketplace.

Up to this recent rule change, regulations defined ‘affordable” employer-based health insurance only as the insurance plan offered to cover the employee, not the employee's entire family. Family members were not eligible to obtain health insurance through the ACA marketplace even if the employer-based plan was more expensive.

According to the White House, ‘For family members of an employee offered health coverage through an employer, the cost of that family coverage can sometimes be very expensive and make health insurance out of reach. The ‘family glitch” affects about 5 million people and has made it impossible for many families to use the premium tax credit to purchase an affordable, high-quality Marketplace plan.”

The rule change will allow family members of workers who are offered affordable self-only coverage along with unaffordable family coverage to qualify for individual plans through the ACA marketplace. They will be able to access federal tax subsidies to help with the cost of insurance premiums.

The Treasury Department estimated that 200,000 uninsured people will gain coverage under this rule and nearly 1 million Americans will be able to access cheaper health insurance plans.

The White House called the rule ‘the most significant administrative action to improve implementation of the ACA since its enactment.“ [FN34]

Bright Health Exits ACA Marketplace

Bright Health announced that it would no longer offer individual and family plan products through its Bright HealthCare segment, effectively exiting the Affordable Care Act Marketplace.

The company will also no longer offer Medicare Advantage plans except in California and Florida.

The changes are due to recent losses as the company seeks profitability. Six months ago, the company announced that it would exit six states beginning in 2023. The changes are expected to cut revenue by over half. However, company said it expects to reach profitability on an adjusted EBITDA basis in 2023.

Bright is completely stopping the sale of individual and group health insurance plans through the Affordable Care Act marketplaces as it shifts focus to care delivery and provider enablement business NeueHealth and Medicare Advantage plans in states with a better performance record.

Bright's business, Bright HealthCare, manages commercial and Medicare products. It has not been performing well financially.

Bright stated that the changes would lead to a ‘faster path to profitability” in a press release. The changes will reduce the need for capital and lower operating expenses as the size of the business is reduced.

Bright announced it is leaving the following states where it offered individual and family health plans:

Alabama, Arizona, Colorado, Florida, Georgia, Nebraska, North Carolina, Texas, and Tennessee. [FN35]

Biden-Harris Administration Launches Preview of Open Enrollment

The Biden-Harris Administration announced that consumers will be able to preview health care coverage options through the federal health insurance marketplace prior to the start of the open enrollment period.

Consumers can visit HealthCare.gov to access detailed information about 2023 health insurance plans and prices offered in their area. Open Enrollment will begin November 1, 2022.

The White House called the 2023 Open Enrollment period ‘the most competitive Marketplace in history.”

The national uninsured rate has fallen to a historical low during the Biden-Harris Administration. More Americans than ever before are accessing health insurance coverage through the Marketplace.

'Under President Biden's leadership, the Marketplace is stronger than ever,” said HHS Secretary Xavier Becerra. ‘We are delivering what Americans deserve: high-quality health care at affordable cost. We have been tireless in our efforts to increase competition, drive down costs, and connect people to coverage. We urge everyone to visit HealthCare.gov and find an affordable health plan that best meets their needs.”

'All families have the right to quality, affordable health care coverage. During this Open Enrollment period, consumers will have access to a variety of quality plan options at an affordable price. We encourage consumers to visit HealthCare.gov and their state-based Marketplaces to preview plans and premiums now so that they're ready to make selections when Open Enrollment begins on November 1,” said CMS Administrator Chiquita Brooks-LaSure.

Under the Inflation Reduction Act, increased federal tax subsidies will be available to more people to help cover the cost of monthly premiums purchased through the health insurance exchange. Average savings are $800 per year for thirteen million Americans.

Four of every five customers on the Marketplace qualify for health insurance at a cost of $10 or less per month after subsidies.

The White House encouraged people who already have plans to visit the online preview to determine if another plan will better meet their needs.

The Marketplace is highly competitive for 2023, which will benefit consumers. CMS released a new report of Marketplace plans available in states using the federal health insurance marketplace, HealthCare.gov, for plan year 2023.

Ninety-two percent of enrollees will have access to plans from at least three insurance companies.

New standardized plans will also be available for 2023. These plans offer the same deductibles and cost-sharing for certain benefits, and the same out-of-pocket limits as other standardized plans in the same category. Most of the standardized plans offer some services pre-deductible, including primary care, generic drugs, preferred brand drugs, urgent care, specialist visits, mental health and substance use outpatient office visits, as well as speech, occupational, and physical therapy.

The White House also pointed to the increased number of people who will be eligible for health insurance through the marketplace and for federal tax credits due to the finalized rule fixing the so-called family glitch. People in families with access to family coverage through an employer of one family member will be able to instead obtain marketplace coverage if the employer coverage is unaffordable.

The Biden-Harris Administration also made the single largest investment to date in the Navigators program, $98.9 million. This program was quadrupled last year. Navigators assist people who are enrolling in coverage through the Marketplaces.

According to the White House, 'This continuation of historic levels of funding will help Navigators continue their work informing consumers about the enhanced tax credits and coverage available on HealthCare.gov." [FN36]

Research Shows Increased Enrollment in Marketplace Affecting Enrollment in Off-Marketplace Plans

Researchers at the Kaiser Family Foundation indicated that Marketplace enrollment is at a record high and enrollment in off-Marketplace plans has been decreasing.

Researchers looked at federal enrollment data to determine how many people were signed up for each type of individual market coverage, including on- and off-Marketplace plans, and plans with or without subsidies.

They concluded that as Marketplace enrollment reached record numbers, enrollment in off-Marketplace plans fell. Overall, the individual health insurance market increased.

Researchers pointed to the enhanced subsidies as a driving force behind increased individual market enrollment. In early 2022, 16.9 million people accessed health insurance coverage through the individual market, which was the highest enrollment since 2016.

With the passage of the American Rescue Plan Act (ARPA) and its enhanced federal subsidies, enrollment in Marketplace plans increased approximately 5% from 14.1 million in the first quarter 2020 to 14.9 million in the first quarter of 2021.

The ARPA subsidies brought people from off-Marketplace plans to the Marketplace and they helped to increase overall enrollment in the individual market. In early 2022, enrollment in the individual market increased to 16.9 million, about a 20% jump from early 2020.

The Inflation Reduction Act continued the enhanced subsidies through 2025. People with incomes over 400% of the federal poverty level who were previously ineligible for subsidies can now access them. Currently, about three in four Marketplace enrollees receive subsidies. [FN37]

Changes to Insurance Marketplace

Several changes are expected for health insurance as the 2023 Affordable Care Act (ACA) Open Enrollment period continues. Open Enrollment began November 1 and will last until January 15. Some states with state-based marketplaces will have longer open enrollment periods.

The cost of ACA Marketplace benchmark plans is expected to increase an average of 4% across all 50 states and DC. Most enrollees through the Marketplace receive federal tax subsidies, so they will generally not see their premiums increase at a significant rate.

Insurers pointed to increasing prices of healthcare and increased utilization as reasons for the increased premiums. Some insurers may have increased prices in response to lower margins in prior years.

Benchmark premiums are increasing throughout the United States.

The American Rescue Plan (ARP) enhanced and expanded subsidies for many people purchasing individual health insurance plans. The Inflation Reduction Act (IRA) extended those changes through 2025. The federal tax subsidy fully covers the monthly premiums for the benchmark silver plan for consumers with incomes up to 150% of the federal poverty level (FPL). Prior to the enhanced subsidies, households at 150% FPL ($20,385 for a single person, $41,625 for a family of 4) had to pay 4% of income for the benchmark plan. Now those same people have access to silver plans with generous cost sharing reductions that significantly reduce the cost of deductibles and copays for a monthly cost of $0 or close to $0.

Under the Inflation Reduction Act, people with incomes over 400% FPL ($54,360 for a single person in 2023 $111,000 for a family of four) will now be eligible for federal tax subsidies for Marketplace coverage. Consumers will have to pay no more than 8.5% of their income for the benchmark silver plan. Older marketplace consumers age 50 and over will particularly benefit from this provision. Under the original Aca, people with incomes over 400% FPL did not qualify for a subsidy. Some older people owed over 20% of their income on insurance premiums.

Now insurance premiums are capped at 8.5 percent of income, regardless of income level.

Enrollment in marketplace plans reached a record high of 13.8 million people in 2022. Increased were likely due to affordability from the new expanded subsidies and the extended enrollment period. Increases outreach and enrollment assistance likely also played a part.

Millions of people remain uninsured. Many of those people have high school educations or less, are Hispanic, young adults, live in rural areas, and lack internet access.

Another significant change this year is the elimination of the family glitch. A new federal rule allows family members of people with employer sponsored health insurance plans to obtain individual insurance plans through the Marketplace. Employer sponsored insurance only disqualifies family members from Marketplace insurance if the cost of the entire family plan is affordable. Prior to the change, affordability was calculated only by the cost of insurance for the employed individual.

If the employer sponsored insurance costs over 9.12 percent of income, family members are eligible for subsidized coverage through the Marketplace.

Another rule change will permit people who fell behind on premium payments to renew their coverage in 2023. The payment on the January 20233 monthly premium payment cannot be applied to past-due premiums.

At the end of open enrollment, people will still be able to sign up for health insurance coverage if they have a qualifying life event, including loss of other coverage, marriage or divorce, or a permanent move. They will receive a 60-day special enrollment period

Beginning in 2023, the federal Marketplace, HealthCare.gov, will only require pre-enrollment verification for SEPs because of loss of prior coverage. Other qualifying events can be verified through self-attesting during the enrollment process.

Some new insurers are entering the Marketplace while others exit. The average consumer will have a choice of 6 to 7 qualified health plan issuers in 2023.92% of enrollees will have a choice of 3 or more health plan issuers.

Bright Health is making a significant exit from the market. It had provided access to low-cost insurance for residents of several states.

Current enrollees might be automatically re-enrolled if they do not update their application and plan selection. Recently, 4 in 10 participants automatically re-enrolled in plans. Consumers will benefit from actively re-enrolling to determine if they are receiving the best quality and value plan with shifting benchmark plans and subsidies.

The enhanced subsidies changed metrics for low-income enrollees who are now eligible for $0 silver plans with low deductibles. Only the benchmark, the 2nd lowest cost silver plan, and the lowest cost silver plan are $0. Other higher cost silver plans will have costs beyond the subsidies for monthly premiums.

Also, people who applied their federal subsidies to the cost of a bronze plan in the past to obtain a $0 monthly plan will not be taking full advantage of the cost sharing subsidies to reduce the cost of deductibles and coinsurance that are only available for silver plans. The maximum allowable out of pocket costs will increase from $8,700 to $9,100 in 2023.

Increased assistance for enrollment will be available. In states using HealthCare.gov as their Marketplace, funding for Navigators has been restored after years of funding cuts. Navigators are trained enrollment experts and are certified by the marketplace. They provide free assistance to consumers looking to enroll in marketplace coverage. They also help people sign up for coverage through Medicaid and CHIP.

People with incomes up to 150% FPL will be able to enroll in marketplace plans year-round, not only during the open enrollment period. People signing up during the low-income SEP will receive new coverage beginning on the first day of the month after they sign up for coverage. [FN38]

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