

Maine Health Exchange Advisory Committee

Thursday October 16, 2014

9:30 am

Appropriations Committee Room 228

Draft Agenda

- 9:30 am Welcome and introduction from chairs
- 9:45 am Update on Recent Developments and Requests for Information
Committee Staff
- 10:00 am Enroll207.com Update—Outreach for 2015 Open Enrollment
Morgan Hynd, Maine Health Access Foundation
- 10:30 am Tobacco Coverage and Rating under the Affordable Care Act
- Review information provided by health insurance carriers
 - Discussion of findings and recommendations for report
- 11:00 am Committee Findings and Recommendations
- Review revised draft report
 - Review draft legislative recommendations
 - Make final decisions on findings and recommendations
 - Plan for final review of report
- 12:00 pm Lunch
- 1:00 pm Continue Review of Findings and Recommendations
- 3:00 pm
(or earlier) Adjourn

FOR REVIEW 10/16/14

SEN. MARGARET M. CRAVEN, CHAIR
SEN. RODNEY L. WHITTEMORE
CHRISTINE ALIBRANDI
JOHN BENOIT
JOHN COSTIN
BOB DAWBER
SARA GAGNE-HOLMES
DOUG GARDNER
LAURIE KANE-LEWIS



REP. SHARON ANGLIN TREAT, CHAIR
REP. MICHAEL D. MCCLELLAN
REP. LINDA F. SANBORN
KEVIN LEWIS
ELIZABETH NEPTUNE
KRISTINE OSSENFORT
DAVID SHIPMAN
GORDON SMITH
MITCHELL STEIN

STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

VIA EMAIL AND U.S. MAIL

September 26, 2014

Senator Susan M. Collins
United States Senate
413 Dirksen Senate Office Building
Washington, DC 20510-1904

Senator Angus King
United States Senate
359 Dirksen Senate Office Building
Washington, DC 20510-1903

Representative Michael Michaud
United States Congress
1724 Longworth House Office Building
Washington, DC 20515-1902

Representative Chellie Pingree
United States Congress
1037 Longworth House Office Building
Washington, DC 20515

Dear Senators Collins and King and Representatives Michaud and Pingree,

We are writing to convey our concerns about the tax reconciliation process for enrollees in Maine's Federally-Facilitated Marketplace and the exemption process for Maine residents eligible to claim an exemption from the shared responsibility requirement of the federal Affordable Care Act. At our most recent meeting on September 22nd, the Advisory Committee discussed the potential problems for Maine residents seeking to file 2014 tax returns if changes are not made to the draft instructions for Forms 8962 and 8965 recently proposed by the Internal Revenue Service. The Advisory Committee believes the draft instructions and forms may be too complicated and hard to understand. We write to share these concerns with you and to ask that you share these concerns with the Internal Revenue Service.

Tax Reconciliation Process: Form 8962

Based on our understanding, Maine tax filers who purchased health insurance coverage through Maine's Federally-Facilitated Marketplace are going to be required to file Form 8962 to figure the appropriate amount for their premium tax credit and reconcile it with any advance premium tax credit already received by the tax filer. The draft instructions also prohibit those required to file Form 8962 from filing their tax return using the Form 1040-EZ. The Advisory Committee believes the instructions and forms related to the premium tax credit should be developed in a manner that will not force Mainers to use a different or longer tax return form than they are currently using. The reconciliation process for the premium tax credit should be as straightforward and easy to complete for the tax filer as possible.

In addition, as Maine has a Federally-Facilitated Marketplace, we ask that the Internal Revenue Service use information technology as much as possible to facilitate the electronic exchange of data between the FFM and the Internal Revenue Service to validate the amount of any premium tax credit received by the tax filer.

The Advisory Committee also notes that the complexity of the health coverage provisions of the federal Affordable Care Act and the proposed tax reconciliation process may have a disproportionate impact on lower-income Maine residents. We are concerned that Maine does not have adequate resources to provide tax-filing and preparation assistance. Maine's consumer outreach and education resources for navigators and certified application counselors are limited and do not have adequate capacity or adequate training to help Mainers assess the tax implications of their health coverage through Maine's FFM.

Claiming an Exemption from the Shared Responsibility Requirement—Form 8965

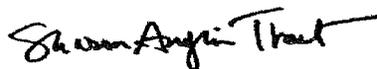
Another issue we want to address is related to the proposed Form 8965. Pursuant to the draft instructions, this form must be filed by any individual claiming an exemption from the shared responsibility requirement (individual mandate). One of the available exemptions is for individuals who live in a state that has not expanded Medicaid whose income is below 138% of the federal poverty level. As you know, Maine has not expanded its Medicaid program so thousands of Maine residents whose income is below 138% can qualify for this exemption. The draft instructions direct a tax filer claiming this exemption to obtain proof of the exemption from the Marketplace (prior to filing their tax return by April 15, 2015 unless the tax filer requests an extension) and then to enter the certificate number of that exemption on Form 8965. This requirement adds an unnecessary administrative burden on the tax filer and the Marketplace. Because Maine has a Federally-Facilitated Marketplace, the Advisory Committee recommends that the Internal Revenue Service automate the process so that the exemption can be verified through the FFM without involving the individual tax filer. Information about the individual tax filer's state of residence and income is provided on the tax return itself and should be accepted by the IRS as proof of eligibility for the exemption. The filing of additional forms like the Form 8965 is not necessary.

Before the tax forms are finalized, the Advisory Committee recommends that the Internal Revenue Service streamline its process and make changes to simplify the instructions. Thank you for your consideration. Please contact us or our Advisory Committee staff, Colleen McCarthy Reid, at colleen.mccarthyreid@legislature.maine.gov or 207-287-1670, if you would like to discuss these issues further or need additional information.

Sincerely,



Margaret M. Craven
Senate Chair



Sharon Anglin Treat
House Chair

cc: Sylvia M. Burwell, Secretary, U.S. Department of Health and Human Services
Christie Hager, Region One Director, U.S. Department of Health and Human Services
Kevin Counihan, Health Insurance Marketplace CEO
Joint Standing Committee on Taxation
Maine Health Exchange Advisory Committee members

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STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

VIA EMAIL AND U.S. MAIL

September 26, 2014

John Koskinen
Commissioner
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224-0002

Dear Commissioner Koskinen,

On behalf of Maine's Maine Health Exchange Advisory Committee, we are writing to convey our concerns about the tax reconciliation process for enrollees in Maine's Federally-Facilitated Marketplace and the exemption process for Maine residents eligible to claim an exemption from the shared responsibility requirement of the federal Affordable Care Act. At our most recent meeting on September 22nd, the Advisory Committee discussed the potential problems for Maine residents seeking to file 2014 tax returns if changes are not made to the draft instructions for Forms 8962 and 8965 recently proposed by the Internal Revenue Service. The Advisory Committee believes the draft instructions and forms may be too complicated and hard to understand.

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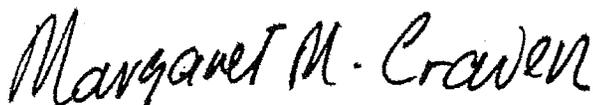
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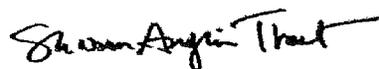
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Sincerely,



Margaret M. Craven
Senate Chair



Sharon Anglin Treat
House Chair

cc: Joint Standing Committee on Taxation
Maine Health Exchange Advisory Committee members

McCarthyReid, Colleen

From: Centers for Medicare & Medicaid Services <cmslists@subscriptions.cms.hhs.gov>
Sent: Wednesday, October 15, 2014 11:22 AM
To: McCarthyReid, Colleen
Subject: CMS NEWS: CMS kicks off effort to help Marketplace enrollees stay covered



CMS NEWS

FOR IMMEDIATE RELEASE
October 15, 2014

Contact: CMS Media Relations
(202) 690-6145 or press@cms.hhs.gov

CMS kicks off effort to help Marketplace enrollees stay covered

Consumers should come back to HealthCare.gov, reach out to the call center, or visit with an in-person assister to make sure they choose the plan that best meets their needs starting November 15.

WASHINGTON, DC - The Centers for Medicare & Medicaid Services (CMS) is committed to making it as easy as possible for current Health Insurance Marketplace enrollees to renew their coverage for 2015. It is encouraging consumers to come back at the start of Open Enrollment on November 15, update their 2015 application, and compare their options to make sure they enroll in the plan that best meets their budget and health needs for next year. This week, consumers will begin to receive notices from the Federally-facilitated Marketplace in the mail and in their HealthCare.gov accounts, explaining how they can renew their coverage during Open Enrollment.

CMS is working to make sure consumers have the assistance and information they need, this communication is just the beginning of an effort to help consumers stay covered. Importantly, to help simplify the re-enrollment process, when consumers return to HealthCare.gov starting on November 15 and initiate their 2015 application, 90 percent of their online application will already be filled out or pre-populated. In-person assistance will be available to help review an applicant's options and find a plan that best suits their needs. Also, we are staffing up an additional 1,000 call center representatives this year over last year that will be available to answer questions and walk consumers through the coverage process.

"It's important for people to come back to the Marketplace during Open Enrollment, because every year, insurance companies make changes to premiums, cost-sharing and benefits. And with 25 percent more issuers offering coverage in 2015, consumers have more plans to choose from and more issuers are competing to offer a better deal," said CMS Administrator Marilyn Tavenner. "This gives consumers the opportunity to shop and compare plans that may save them more money, offer more services or include more doctors in the network. We want consumers to have the most up-to-date information so they can make the right choice for them and their families."

The notices consumers will begin receiving this week explain the renewal process and how they can return to the Marketplace between November 15, 2014, and December 15, 2014, to update their application for next year, shop for the plan that best meets their budget and health needs, and determine if they are eligible for financial assistance for coverage that begins as early as January 1, 2015.

If consumers do not return to the Marketplace to update their application, they generally will be auto-enrolled in the same plan - with the same amount of advance payment of the premium tax credit and same cost-sharing reductions – as the 2014 plan year. They can change plans during open enrollment through February 15, with coverage in their new plan starting on the first day of the next or second month depending on when they enroll.

To help consumers better understand the renewal process, CMS is releasing today the 5 Steps to Staying Covered – to make it as simple as possible for them to choose the plan that best fits their needs and budget. The consumer tested 5-step process includes:

- 1) **Review:** Plans change, people change – review your coverage and look for a letter from your plan about how your benefits and costs may change next year,
- 2) **Update:** Starting November 15, log in and update your 2015 application - make sure your household income and other information is up-to-date for next year,
- 3) **Compare:** Compare your current plan with other plans that are available in your area,
- 4) **Choose:** Select the health plan that best fits your budget and health needs, and
- 5) **Enroll:** The marketplace opens on November 15, make sure to review, update, compare and choose by December 15 to have any changes take effect on January 1. Contact your plan after you've enrolled and make sure you pay your first month's premium.

The first piece of this education material is available at Marketplace.CMS.gov. Also, CMS will continue to adapt and modify its efforts to reach existing Marketplace consumers over the next weeks and months – using a wide range of outreach strategies including directly through mail, email, digital market efforts, and calls. Serving existing Marketplace customers and keeping them covered is a top priority this open enrollment period.

To view the Federal Marketplace notices, visit: <http://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html>.

To learn more about the 5 Steps to Staying Covered, visit: <http://marketplace.cms.gov/outreach-and-education/5-steps-to-staying-covered.pdf>

For more information about Health Insurance Marketplaces, visit: www.healthcare.gov/marketplace

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STAYING COVERED THROUGH THE MARKETPLACE

Now that you have health coverage through the Marketplace, it's time to review your plan and decide if you need to make changes for 2015. Every fall, your health insurance company sends you a letter explaining changes to premiums and benefits for the coming year.

You can choose to stay in your current plan (as long as it's still offered) or make changes. If you don't take action by **December 15, 2014**, you could miss out on better deals and cost savings.

1 REVIEW **PLANS CHANGE, PEOPLE CHANGE.** Every year, insurance companies can make changes to premiums, cost-sharing, or the benefits and services they provide. Review your plan's 2015 coverage to make sure it still meets your needs and you're getting the best plan for you.

2 UPDATE Starting November 15, visit HealthCare.gov and log into your Marketplace account. Answer a few questions to get to your 2015 application – it will be pre-filled with your latest information from 2014. Step through each page of your application and make changes if you need to. This is important – even if none of your information has changed, you might be eligible for lower costs than last year! You also can call the Marketplace Call Center at 1-800-318-2596 to review or make updates over the phone.

3 COMPARE Log into your Marketplace account and follow the "Enroll To Do List" on HealthCare.gov to compare 2015 plan costs and benefits. New and more affordable plans may be available in your area this year. If you decide to stay in your current plan, follow the directions to search by that plan's 14-digit ID – you can find the ID on the letter from your plan. Or, call the Marketplace Call Center at **1-800-318-2596** for help.

4 CHOOSE Choose a health plan for 2015. You can keep the same plan (as long as it's still offered) or select a new one that better fits your needs. If you want to stay enrolled in your 2014 plan, use the plan ID in the letter you get from your health plan.

5 ENROLL Stay covered for 2015! Contact your plan to confirm your enrollment. Make sure to pay your premium.

STEP 1 Review - Things to remember:

- Look for a letter in the mail from your health plan describing any plan changes.
- Read the letter, and contact your health plan if you have questions.
- Write down important dates and information from the letter - **like December 15**, and your 14-digit plan ID.

STEP 2 Update - Things to consider:

- Can't access your Marketplace account? Follow the steps on the screen to reset your password.
- Did any of your income, household, or personal information change? Even a small change can affect your premium tax credits and cost-sharing reductions, so make sure your information is up-to-date.
- After you submit your 2015 application, check your eligibility results carefully. Even if none of your information changed, you might get different cost savings because of changes in the Marketplace.

STEP 3 Compare - When comparing plans, consider:

- Are there more affordable plans available to you that weren't an option last year?
- Are you happy with the changes to your current plan?
- Are your current doctors in the plan's network?
- Will your prescriptions be covered?
- What will your benefits and costs be?

STEP 4 Choose - Things to remember:

- You can choose any plan available to you in your area in 2015, no matter what kind of coverage you had in 2014.
- All 2015 Marketplace plans include all benefits and protections required by the health care law.
- You can use any premium tax credits and cost-sharing reductions (if you qualify) only if you enroll in a plan through the Marketplace.

STEP 5 Enroll - Things to remember:

- For health coverage starting January 1, 2015, you must enroll in a plan by **December 15, 2014**.
- If you want to change 2015 plans after December 15, 2014, you can do that any time during Open Enrollment, which continues through February 15, 2015.
- If you make updates and enroll in a new health plan after December 15, 2014, your coverage won't start on January 1. Read the notice from your health plan to check when your coverage will start.

Complete all 5 Steps to finish enrolling in a health plan, even if you want to stay in the same plan.

This is important to get the coverage you want and the most cost savings that you're eligible for. If you don't finish all of the steps by December 15, we'll try to enroll you automatically so you stay covered. But this coverage might not be your best option for 2015 and you could miss out on cost savings.

If you have questions or need to find someone who can help you in person, we can help. Find local help at:

- Localhelp.healthcare.gov/
- The Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. The call is free.

Tell them you need help with the 5 Steps.

FOR MHEAC REVIEW 10/16/14
AND DISCUSSION

The New York Times | <http://nyti.ms/1nuJzL6>



U.S. | PAYING TILL IT HURTS | NYT NOW

Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not

By ELISABETH ROSENTHAL SEPT. 28, 2014

When Jennifer Hopper raced to the emergency room after her husband, Craig, took a baseball in the face, she made sure they went to a hospital in their insurance network in Texas. So when they got a \$937 bill from the emergency room doctor, she called the insurer, assuming it was in error.

But the bill was correct: UnitedHealthcare, the insurance company, had paid its customary fee of \$151.02 and expected the Hoppers to pay the remaining \$785.98, because the doctor at Seton Northwest Hospital in Austin did not participate in their network.

“It never occurred to me that the first line of defense, the person you have to see in an in-network emergency room, could be out of the network,” said Ms. Hopper, who has spent months fighting the bill. “In-network means we just get the building? I thought the doctor came with the E.R.”

Patients have no choice about which physician they see when they go to an emergency room, even if they have the presence of mind to visit a hospital that is in their insurance network. In the piles of forms that patients sign in those chaotic first moments is often an acknowledgment that they understand some providers may be out of network.

But even the most basic visits with emergency room physicians and other doctors called in to consult are increasingly leaving patients with hefty bills: More and more, doctors who work in emergency rooms are private contractors who are out of network or do not accept any insurance plans.

When legislators in Texas demanded some data from insurers last year, they learned that up to half of the hospitals that participated with UnitedHealthcare,

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Humana and Blue Cross-Blue Shield — Texas’s three biggest insurers — had no in-network emergency room doctors. Out-of-network payments to emergency room physicians accounted for 40 to 70 percent of the money spent on emergency care at in-network hospitals, researchers with the Center for Public Policy Priorities in Austin found.

“It’s very common and there’s little consumers can do to prevent it and protect themselves — it’s a roll of the dice,” said Stacey Pogue, a senior policy analyst with the nonpartisan center and an author of the study.

While patients have complained of surprise out-of-network charges in hospitals from some other specialists — particularly anesthesiologists, radiologists and pathologists — the situation with emergency room doctors is even more troubling, patient advocates say. For one thing, patients cannot be expected to review provider networks in a crisis, and the information to do so is usually not readily available anyway. Moreover, the Texas study found that out-of-network fees paid to emergency room physicians eclipsed the amount of money paid to those other specialists.

When emergency medicine emerged as a specialty in the 1980s, almost all E.R. doctors were hospital employees who typically did not bill separately for their services. Today, 65 percent of hospitals contract out that function. And some emergency medicine staffing groups — many serve a large number of hospitals, either nationally or locally — opt out of all insurance plans.

As more insurance plans contract with narrower networks of doctors to form offerings tailored to the Affordable Care Act, insurers have acquired greater leverage in cutting payments to physicians. While an insurer would have little power to drive a hard bargain with a major hospital that the company needs in its network, it can often pick and choose among physicians, excluding some or offering rates so low that many doctors say their practices are unsustainable.

Dr. Jeffrey Bettinger, chairman of the reimbursement committee of the American College of Emergency Physicians, said that out-of-network emergency room doctors were an unusual phenomenon and expressed doubt that the practice was widespread. When it occurred, he added, it was typically because of insurers’ unwillingness to pay doctors a reasonable rate compared to what they pay hospitals for their services.

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The average salary of an emergency room physician was \$311,000 in 2014, rising from \$247,000 since 2010 — a period when many other types of doctors experienced declines in salaries, according to Merritt Hawkins, a physician staffing firm.

Hospital charges for emergency care vary widely. A recent study found that hospital charges for a visit involving a serious medical issue in California varied between \$275 and \$6,662, just for the facility fee. “Much of the variation we observe may in fact be entirely random,” wrote the authors, emergency physicians at the University of California San Francisco Medical Center. But that variation often does not directly affect patients, since most hospitals participate in the big insurance plans in their area, and patients tend to know which are in their network, so the insurer covers most of the bill.

But it is a different matter with emergency room doctors who bill out-of-network fees, experts say.

When Dr. Michael Schwartz’s daughter went to an emergency room in the Philadelphia suburbs for a reaction to a medication in 2010, she went to an in-network hospital, Bryn Mawr. She was there for a few hours on a cardiac monitor. While most of her care was covered by his family’s insurer, Capital Blue Cross, a bill of more than \$2,000 from the out-of-network E.R. physicians for cardiac monitoring was not.

“I tried to negotiate with the physician group, but they wouldn’t budge,” said Dr. Schwartz, a pediatrician, who ended up paying \$1,200, the amount his plan required for his share of out-of-network care. “It was ridiculous. I’m a physician and I understand how this works. There was no sign saying, ‘Our physicians are out-of-network.’ ”

Likewise, when Luke Adami, 6, sustained a gash to his chin on a playground, his parents rushed him to an emergency room at an in-network facility, Valley Hospital in New Jersey. The parents, Greg and Madeleine Adami, asked about a plastic surgeon to sew him up. Mr. Adami recalled: “You go to a hospital that’s in network, your kid’s bleeding. What are you going to say?”

The nurse did not mention that the surgeon she called was out of network and would charge a separate fee. Neither did the plastic surgeon say anything about costs when he came in.

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He billed the Adamis \$4,878 for eight stitches that were coded as “open wound, jaw, complicated.” “When I looked at the bill, I laughed and I told the surgeon’s office, ‘Process this claim with my insurer. I’m not paying out of pocket,’ ” Mr. Adami said. “The hospital has control over who they bring in. But I do not.”

Emergency physicians say they are not to blame. “In general, E.R. physicians try to align themselves with whatever networks their hospitals are in, but sometimes the rates pale compared to what is offered to the hospitals,” said Dr. Bettinger of the emergency physicians’ group. That often leads to protracted negotiations, he said, but eventually the insurers and the doctors come to agreement and sign a contract.

In the meantime, patients are stuck with out-of-pocket charges. Regulations created by the Affordable Care Act specify that insurers must use the best-paying among three methods for reimbursing out-of-network physicians dispensing emergency care: pay the Medicare rate; pay the median in-network amount for the service; or apply the usual formula they use to determine out-of-network reimbursement, which often depends on “usual and customary rates” in the area.

But in most states, doctors can then bill patients for the difference between their charge and what the insurer paid.

In months of dickering over her husband’s bill, Ms. Hopper has learned much about health insurance in Texas. Watching her travails, her husband, a lawyer, told her: “If you were my client, I’d advise you just to pay the \$800 and move on with your life.”

She was too angry to take his advice.

But if she or her husband ends up in an emergency room again, she knows they will be vulnerable because only a handful of doctors in any of Austin’s emergency rooms participate in insurance plans. She sighed: “Even knowing everything I know now, it’s completely out of your control.”

For a continuing conversation about health care costs and pricing in the United States, please join our Facebook group, [Paying Till It Hurts](#).

A version of this article appears in print on September 29, 2014, on page A13 of the New York edition with the headline: [Costs Can Go Up Fast When E.R. Is in Network but the Doctors Are Not](#).

[The Ed Show](#)

• Austin's stuff

[Click here](#) for a link to Austin's CV, as well as a complete list of his peer-reviewed publications with links to related posts and/or ungated versions (when available).

• What should the law do about out-of-network ER docs?

📅 September 29, 2014 at 10:24 am

👤 Nicholas Bagley

I wanted to join [Aaron](#) in venting some spleen about Elizabeth Rosenthal's [maddening story](#) from this morning's New York Times. How can it possibly be legal for your doctor to charge you out-of-network rates when you show up at an in-network emergency room? And how can we change the law to get at the problem?

I [answered](#) the first question last week in response to [an earlier installment](#) in Rosenthal's series. Briefly: when you show up at an ER, you're given an incomprehensible contract to sign. Among the terms you don't read, you agree to pay the on-call ER physician for her services, whether or not the physician happens to be in-network. Given this "agreement," the out-of-network physician can name her price.

Now, the courts won't generally enforce contractual terms to the extent they deviate from what a reasonable person would agree to pay. That's especially so if you were in medical distress when you signed the contract. It should be possible, especially in these ER cases, to persuade courts that the out-of-network doc should only be paid a reasonable fee—maybe the rate that the patient's insured would have paid, maybe Medicare rates.

But the amounts in dispute will rarely be large enough to justify litigating. From the patient's perspective, the smartest thing would be to pay the damn bill.

What's to be done about this? One straightforward move would be for HHS to [invoke its authority](#) under the ACA to "establish criteria" to assure that exchange plans have adequate networks. From Rosenthal's article, it sounds like a bunch of insurers have no in-network ER docs at all. Why not require exchange plans to contract with ER docs at each of their in-network hospitals?

That'd be a good first step, but HHS's authority under the ACA does not extend to employer-based insurance purchased outside the exchanges. To get at those plans, state insurance commissioners would have to step up to the plate. State network-adequacy laws [vary widely](#), but most give the commissioners a measure of flexibility in crafting new rules. Following HHS's lead, or blazing a path on their own, they could require insurers to include ER docs in their networks.

Even if state insurance commissioners acted, however, we'd still be left with a regulatory gap. A federal law—ERISA—[strips](#) states of the power to regulate self-funded employer-sponsored plans. And there's no federal law requiring self-funded plans to have adequate networks.

So does Congress need to act? Maybe. But the Department of Labor, which oversees ERISA plans, could perhaps implement a partial solution even without new legislation. Here's what I'm thinking. The ACA [caps](#) the amount that an individual or family can pay out of pocket in a given year. Typically, out-of-network bills don't count toward the out-of-pocket cap. The idea is that, if you choose to go out of network, your insurer shouldn't be on the hook.

The absence of meaningful choice when it comes to emergency care may provide an opportunity for Labor to enact a rule treating the costs of such care differently. What if Labor issued a rule saying that payments to out-of-network ER docs would count toward the out-of-pocket spending cap, so long as the care was received at an in-network hospital?

This would be only a partial solution. Before they reach their out-of-pocket cap, patients would still be on the hook for out-of-pocket payments to ER physicians. But at least they'd have some financial security in the event that they racked up extraordinary out-of-pocket costs.

In any event, these sorts of abusive billing practices have got to end. Regulators have considerable latitude to act, even without legislative action. They should act, and soon.

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Why Can't States Do More to Protect Patients From Surprise Medical Bills?

It's complicated.

By Jordan Weissmann



Sometimes the bill is worse than the illness.

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Let's say you're pregnant. You've had months to plan the delivery and pick an in-network OB-GYN practice and a convenient hospital that's covered by your health insurance. The big day comes, you rush over to the ward, and your child is born without incident. Everyone goes home happy.

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JORDAN WEISSMANN

Jordan Weissmann is Slate's senior business and economics correspondent.

Until the bill arrives. It turns out that while you were in throes of labor, the hospital sent an out-of-network anesthesiologist to handle your epidural. Nobody told you at the time. Now he's asking for thousands of dollars that you can't spare.

In a sane health care system, this wouldn't happen. But in the U.S., it can and does. Americans regularly visit doctors' practices and hospitals that accept their insurance, only to find themselves ambushed by surprise medical bills from out-of-network physicians who somehow played a role in their treatment, as Elisabeth

Rosenthal's **recent reporting** in the *New York Times* has detailed. It happens in operating rooms and emergency rooms. And there's not much that patients can do about it.

But can't lawmakers do something about it?

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"It's hard," says Jack Hoadley, a research professor at Georgetown University's Health Policy Institute. Surprise medical bills are an old issue, yet the Affordable Care Act mostly ignored them. Just a fraction of states have passed laws to protect patients in these circumstances, **according to the Kaiser Family Foundation**, and some of those statutes are extremely narrow in scope.

The problem, according to Hoadley, is that it's incredibly difficult to make insurers and health providers reach a compromise on how much out-of-network doctors should be paid. Some patient advocates hope that a new law that will soon go into effect in New York state could serve as a national model for how to strike the right balance. But just like most obviously outrageous problems in the U.S. health care system that make you pine for a life in Canada, surprise medical bills don't have a simple solution.

To understand why surprise medical bills pose such a policy conundrum, start with some basics. Hospitals accept insurance plans for the doctors they directly employ. But most doctors are not employed by their hospitals. Instead, they're independent contractors who are free to pick and choose which health plans they participate in. So while an orthopedic surgeon might take your Aetna PPO, the neurosurgeon or the anesthesiologist might not. When multiple doctors get pulled into a procedure or are called on to assess a patient, some may not accept the same insurance.

Because doctors and insurers won't compromise on

Plus, many emergency rooms are themselves independent contractors: Patients in need of urgent care may arrive knowing the hospital is in-network, but unaware that the ER doc they're seeing isn't. The health plan will pay whatever amount it sets for out-of-network providers, and the balance of the doctor's hefty fee falls to the unlucky patient, who probably never saw the bills coming. Or, in nonemergency cases, maybe she *did* see the bill coming but had

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payments, states can't work out political solutions.

no way of heading it off. (My eight-months-pregnant editor has asked her insurance company, her doctor's practice, and the hospital where she plans to give birth how she can ensure that her anesthesiologist—should she need one—will be in-network, and the collective response has taken the form of a baffled shrug.)

"It's a pretty good bet that if you're hospitalized or having any kind of surgery, somebody along the way who touches you or your slides or films will not be in-network," Karen Pollitz, a senior fellow at the Kaiser Family Foundation, **once told Bloomberg**.

Patching up these network gaps is complicated, and the most straightforward solutions are nonstarters. For instance, we could demand that all doctors in a hospital accept the same suite of insurance plans. But hospitals fear that such a requirement would make it harder to recruit physicians, especially in parts of the country where doctors are in short supply. Another idea: We could ask hospitals themselves to make sure, whenever possible, that patients are treated by in-network doctors. But when a Texas commission **considered this seemingly straightforward concept**, it concluded that technological limitations and the rapid mutations of doctors' schedules from hour to hour would make it impossible.

So what have states actually tried? Texas attempted to make information about which doctors are in- and out-of-network more transparent to consumers, which has been largely ineffective. Colorado and Maryland have passed more serious protections, which force at least some insurers to pay surprise out-of-network charges; in these cases, patients are simply billed as if they were in-network.

The big question is: How much should insurers pay? Health plans don't want to shell out too much. Health providers don't want to be paid too little. And as Hoadley and his Georgetown colleague Kevin Lucia wrote **in a report for the California HealthCare Foundation**, finding a happy medium is tricky. In Colorado the law is set up so insurance companies essentially end up paying whatever out-of-network doctors decide to bill. Since non-network physicians are guaranteed a nice payday, they have less incentive to participate in health plans, or to accept discounted fees if they do, which drives up the cost of insurance for everybody.

Maryland has the opposite issue. There, HMOs pay out-of-network doctors standardized reimbursement rates. Physicians say those rates are far too low—which might seem like a minor policy concern, unless you're worried about doctors moving to other markets.

Because doctors and insurers are loath to compromise on payments, states have a hard time working out political solutions to protect patients. The aforementioned Texas commission, which included representatives from both health insurers and medical providers, was so contentious that its final report failed to make any recommendations. "No one wanted to be the first one to budge," commission member Dianne Longley told me.

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A law passed this year in New York, however, is giving some policy advocates hope. Much like Maryland and Colorado, it requires health plans, not patients, to cover surprise out-of-network bills. But the law, which goes into effect next year, comes with a twist: If the medical provider and insurer can't agree on a fee, it sends them into a baseball-style arbitration, in which each side makes an offer and a mediator chooses the fee.

“One of the advantages of arbitration may be that health plans and providers get more realistic about the kinds of fees they charge to patients,” says Chuck Bell, programs director at Consumers Union, which lobbied for the bill. “We hope it will calm down the markets and get everybody to be more sensible about surprise bills.”

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I have a boring solution - single payer system, were we don't have to deal with issues of insurance coverage. [More...](#)

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Why was New York able to take action where other states have not? One big factor was Gov. Andrew Cuomo, who began investigating issues surrounding insurers and payments to out-of-network doctors back when he was state attorney general, securing a \$95 million settlement in one case. In 2012 the state's Department of Financial Services also produced a long report on the problem of surprise medical bills, which helped drive attention to the issue; advocacy groups ran a grassroots campaign in which thousands of New Yorkers contacted their state

legislators.

Policymakers are already taking notice of New York's progress, Bell says—he recently hosted a conference call with 50 regulators from other states about the law. “If you put a human face on this issue, it becomes irresistible,” he says. “Politicians don't want to say no to people who have had this experience. If we can light that fire in other parts of the country, patients can win this sort of protection.”

New York Law - Excerpt
from 2014-2015 Budget Bill

WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(II) THE ENROLLEE'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

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S 25. Paragraph (d) of subdivision 2 of section 4914 of the public health law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL DENIAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(2) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE ENROLLEE; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 26. The financial services law is amended by adding a new article 6 to read as follows:

ARTICLE 6

EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS

SECTION 601. DISPUTE RESOLUTION PROCESS ESTABLISHED.

602. APPLICABILITY.

603. DEFINITIONS.

604. CRITERIA FOR DETERMINING A REASONABLE FEE.

605. DISPUTE RESOLUTION FOR EMERGENCY SERVICES.

606. HOLD HARMLESS AND ASSIGNMENT OF BENEFITS FOR SURPRISE BILLS

FOR INSUREDS.

607. DISPUTE RESOLUTION FOR SURPRISE BILLS.

608. PAYMENT FOR INDEPENDENT DISPUTE RESOLUTION ENTITY.

S 601. DISPUTE RESOLUTION PROCESS ESTABLISHED. THE SUPERINTENDENT SHALL ESTABLISH A DISPUTE RESOLUTION PROCESS BY WHICH A DISPUTE FOR A BILL FOR EMERGENCY SERVICES OR A SURPRISE BILL MAY BE RESOLVED. THE SUPERINTENDENT SHALL HAVE THE POWER TO GRANT AND REVOKE CERTIFICATIONS OF INDEPENDENT DISPUTE RESOLUTION ENTITIES TO CONDUCT THE DISPUTE RESOLUTION PROCESS. THE SUPERINTENDENT SHALL PROMULGATE REGULATIONS ESTABLISHING STANDARDS FOR THE DISPUTE RESOLUTION PROCESS, INCLUDING A PROCESS FOR CERTIFYING AND SELECTING INDEPENDENT DISPUTE RESOLUTION ENTITIES. AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL USE LICENSED PHYSICIANS IN ACTIVE PRACTICE IN THE SAME OR SIMILAR SPECIALTY AS THE

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PHYSICIAN PROVIDING THE SERVICE THAT IS SUBJECT TO THE DISPUTE RESOLUTION PROCESS OF THIS ARTICLE. TO THE EXTENT PRACTICABLE, THE PHYSICIAN SHALL BE LICENSED IN THIS STATE.

S 602. APPLICABILITY. (A) THIS ARTICLE SHALL NOT APPLY TO HEALTH CARE SERVICES, INCLUDING EMERGENCY SERVICES, WHERE PHYSICIAN FEES ARE SUBJECT TO SCHEDULES OR OTHER MONETARY LIMITATIONS UNDER ANY OTHER LAW, INCLUDING THE WORKERS' COMPENSATION LAW AND ARTICLE FIFTY-ONE OF THE INSURANCE LAW, AND SHALL NOT PREEMPT ANY SUCH LAW.

(B) (1) WITH REGARD TO EMERGENCY SERVICES BILLED UNDER AMERICAN MEDICAL ASSOCIATION CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES 99281 THROUGH 99285, 99288, 99291 THROUGH 99292, 99217 THROUGH 99220, 99224 THROUGH 99226, AND 99234 THROUGH 99236, THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE SHALL NOT APPLY WHEN:

(A) THE AMOUNT BILLED FOR ANY SUCH CPT CODE MEETS THE REQUIREMENTS SET FORTH IN PARAGRAPH THREE OF THIS SUBSECTION, AFTER ANY APPLICABLE CO-INSURANCE, CO-PAYMENT AND DEDUCTIBLE; AND

(B) THE AMOUNT BILLED FOR ANY SUCH CPT CODE DOES NOT EXCEED ONE HUNDRED TWENTY PERCENT OF THE USUAL AND CUSTOMARY COST FOR SUCH CPT CODE.

(2) THE HEALTH CARE PLAN SHALL ENSURE THAT AN INSURED SHALL NOT INCUR ANY GREATER OUT-OF-POCKET COSTS FOR EMERGENCY SERVICES BILLED UNDER A CPT CODE AS SET FORTH IN THIS SUBSECTION THAN THE INSURED WOULD HAVE INCURRED IF SUCH EMERGENCY SERVICES WERE PROVIDED BY A PARTICIPATING PHYSICIAN.

(3) BEGINNING JANUARY FIRST, TWO THOUSAND FIFTEEN AND EACH JANUARY FIRST THEREAFTER, THE SUPERINTENDENT SHALL PUBLISH ON A WEBSITE MAINTAINED BY THE DEPARTMENT OF FINANCIAL SERVICES, AND PROVIDE IN WRITING TO EACH HEALTH CARE PLAN, A DOLLAR AMOUNT FOR WHICH BILLS FOR THE PROCEDURE CODES IDENTIFIED IN THIS SUBSECTION SHALL BE EXEMPT FROM THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE. SUCH AMOUNT SHALL EQUAL THE AMOUNT FROM THE PRIOR YEAR, BEGINNING WITH SIX HUNDRED DOLLARS IN TWO THOUSAND FOURTEEN, ADJUSTED BY THE AVERAGE OF THE ANNUAL AVERAGE INFLATION RATES FOR THE MEDICAL CARE COMMODITIES AND MEDICAL CARE SERVICES COMPONENTS OF THE CONSUMER PRICE INDEX. IN NO EVENT SHALL AN AMOUNT EXCEEDING ONE THOUSAND TWO HUNDRED DOLLARS FOR A SPECIFIC CPT CODE BILLED BE EXEMPT FROM THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE.

S 603. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE:

(A) "EMERGENCY CONDITION" MEANS A MEDICAL OR BEHAVIORAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON, POSSESSING AN AVERAGE KNOW-

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LEDGE OF MEDICINE AND HEALTH, COULD REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN : (1) PLACING THE HEALTH OF THE PERSON AFFLICTED WITH SUCH CONDITION IN SERIOUS JEOPARDY, OR IN THE CASE OF A BEHAVIORAL CONDITION PLACING THE HEALTH OF SUCH PERSON OR OTHERS IN SERIOUS JEOPARDY; (2) SERIOUS IMPAIRMENT TO SUCH PERSON'S BODILY FUNCTIONS; (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART OF SUCH PERSON; (4) SERIOUS DISFIGUREMENT OF SUCH PERSON; OR (5) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E) (1) (A) OF THE SOCIAL SECURITY ACT 42 U.S.C. S 1395DD.

(B) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (1) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION; AND (2) WITHIN THE CAPABILITIES OF S. 6914 175 A. 9205

THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(C) "HEALTH CARE PLAN" MEANS AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE PURSUANT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THE INSURANCE LAW.

(D) "INSURED" MEANS A PATIENT COVERED UNDER A HEALTH CARE PLAN'S POLICY OR CONTRACT.

(E) "NON-PARTICIPATING" MEANS NOT HAVING A CONTRACT WITH A HEALTH CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO AN INSURED.

(F) "PARTICIPATING" MEANS HAVING A CONTRACT WITH A HEALTH CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO AN INSURED.

(G) "PATIENT" MEANS A PERSON WHO RECEIVES HEALTH CARE SERVICES, INCLUDING EMERGENCY SERVICES, IN THIS STATE.

(H) "SURPRISE BILL" MEANS A BILL FOR HEALTH CARE SERVICES, OTHER THAN EMERGENCY SERVICES, RECEIVED BY:

(1) AN INSURED FOR SERVICES RENDERED BY A NON-PARTICIPATING PHYSICIAN AT A PARTICIPATING HOSPITAL OR AMBULATORY SURGICAL CENTER, WHERE A PARTICIPATING PHYSICIAN IS UNAVAILABLE OR A NON-PARTICIPATING PHYSICIAN RENDERS SERVICES WITHOUT THE INSURED'S KNOWLEDGE, OR UNFORESEEN MEDICAL SERVICES ARISE AT THE TIME THE HEALTH CARE SERVICES ARE RENDERED; PROVIDED, HOWEVER, THAT A SURPRISE BILL SHALL NOT MEAN A BILL RECEIVED FOR HEALTH CARE SERVICES WHEN A PARTICIPATING PHYSICIAN IS AVAILABLE AND THE INSURED HAS ELECTED TO OBTAIN SERVICES FROM A NON-PARTICIPATING PHYSICIAN;

(2) AN INSURED FOR SERVICES RENDERED BY A NON-PARTICIPATING PROVIDER, WHERE THE SERVICES WERE REFERRED BY A PARTICIPATING PHYSICIAN TO A NON-PARTICIPATING PROVIDER WITHOUT EXPLICIT WRITTEN CONSENT OF THE INSURED ACKNOWLEDGING THAT THE PARTICIPATING PHYSICIAN IS REFERRING THE INSURED TO A NON-PARTICIPATING PROVIDER AND THAT THE REFERRAL MAY RESULT IN COSTS NOT COVERED BY THE HEALTH CARE PLAN; OR

(3) A PATIENT WHO IS NOT AN INSURED FOR SERVICES RENDERED BY A PHYSICIAN AT A HOSPITAL OR AMBULATORY SURGICAL CENTER, WHERE THE PATIENT HAS NOT TIMELY RECEIVED ALL OF THE DISCLOSURES REQUIRED PURSUANT TO SECTION

TWENTY-FOUR OF THE PUBLIC HEALTH LAW.

(I) "USUAL AND CUSTOMARY COST" MEANS THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 604. CRITERIA FOR DETERMINING A REASONABLE FEE. IN DETERMINING THE APPROPRIATE AMOUNT TO PAY FOR A HEALTH CARE SERVICE, AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS, INCLUDING:

(A) WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE PHYSICIAN FOR SERVICES RENDERED AS COMPARED TO:

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(1) FEES PAID TO THE INVOLVED PHYSICIAN FOR THE SAME SERVICES RENDERED BY THE PHYSICIAN TO OTHER PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN IS NOT PARTICIPATING, AND

(2) IN THE CASE OF A DISPUTE INVOLVING A HEALTH CARE PLAN, FEES PAID BY THE HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED PHYSICIANS FOR THE SAME SERVICES IN THE SAME REGION WHO ARE NOT PARTICIPATING WITH THE HEALTH CARE PLAN;

(B) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE PHYSICIAN;

(C) THE PHYSICIAN'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN IS NOT PARTICIPATING;

(D) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING TIME AND PLACE OF THE SERVICE;

(E) INDIVIDUAL PATIENT CHARACTERISTICS; AND

(F) THE USUAL AND CUSTOMARY COST OF THE SERVICE.

S 605. DISPUTE RESOLUTION FOR EMERGENCY SERVICES. (A) EMERGENCY SERVICES FOR AN INSURED. (1) WHEN A HEALTH CARE PLAN RECEIVES A BILL FOR EMERGENCY SERVICES FROM A NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN SHALL PAY AN AMOUNT THAT IT DETERMINES IS REASONABLE FOR THE EMERGENCY SERVICES RENDERED BY THE NON-PARTICIPATING PHYSICIAN, IN ACCORDANCE WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW, EXCEPT FOR THE INSURED'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE, IF ANY, AND SHALL ENSURE THAT THE INSURED SHALL INCUR NO GREATER OUT-OF-POCKET COSTS FOR THE EMERGENCY SERVICES THAN THE INSURED WOULD HAVE INCURRED WITH A PARTICIPATING PHYSICIAN PURSUANT TO SUBSECTION (C) OF SECTION THREE THOUSAND TWO HUNDRED FORTY-ONE OF THE INSURANCE LAW.

(2) A NON-PARTICIPATING PHYSICIAN OR A HEALTH CARE PLAN MAY SUBMIT A DISPUTE REGARDING A FEE OR PAYMENT FOR EMERGENCY SERVICES FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(3) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL MAKE A DETERMINATION WITHIN THIRTY DAYS OF RECEIPT OF THE DISPUTE FOR REVIEW.

(4) IN DETERMINING A REASONABLE FEE FOR THE SERVICES RENDERED, AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL SELECT EITHER THE HEALTH CARE PLAN'S PAYMENT OR THE NON-PARTICIPATING PHYSICIAN'S FEE. THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE WHICH AMOUNT TO SELECT BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED

FOUR OF THIS ARTICLE. IF AN INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES, BASED ON THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE, THAT A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN IS REASONABLY LIKELY, OR THAT BOTH THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE REPRESENT UNREASONABLE EXTREMES, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY MAY DIRECT BOTH PARTIES TO ATTEMPT A GOOD FAITH NEGOTIATION FOR SETTLEMENT. THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN MAY BE GRANTED UP TO TEN BUSINESS DAYS FOR THIS NEGOTIATION, WHICH SHALL RUN CONCURRENTLY WITH THE THIRTY DAY PERIOD FOR DISPUTE RESOLUTION.

(B) EMERGENCY SERVICES FOR A PATIENT THAT IS NOT AN INSURED. (1) A PATIENT THAT IS NOT AN INSURED OR THE PATIENT'S PHYSICIAN MAY SUBMIT A DISPUTE REGARDING A FEE FOR EMERGENCY SERVICES FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY UPON APPROVAL OF THE SUPERINTENDENT.

(2) AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES BASED UPON THE SAME CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE.

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(3) A PATIENT THAT IS NOT AN INSURED SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(C) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE HEALTH CARE PLAN, PHYSICIAN AND PATIENT, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE PLAN, PHYSICIAN OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE PHYSICIAN.

S 606. HOLD HARMLESS AND ASSIGNMENT OF BENEFITS FOR SURPRISE BILLS FOR INSUREDS. WHEN AN INSURED ASSIGNS BENEFITS FOR A SURPRISE BILL IN WRITING TO A NON-PARTICIPATING PHYSICIAN THAT KNOWS THE INSURED IS INSURED UNDER A HEALTH CARE PLAN, THE NON-PARTICIPATING PHYSICIAN SHALL NOT BILL THE INSURED EXCEPT FOR ANY APPLICABLE COPAYMENT, COINSURANCE OR DEDUCTIBLE THAT WOULD BE OWED IF THE INSURED UTILIZED A PARTICIPATING PHYSICIAN.

S 607. DISPUTE RESOLUTION FOR SURPRISE BILLS. (A) SURPRISE BILL RECEIVED BY AN INSURED WHO ASSIGNS BENEFITS. (1) IF AN INSURED ASSIGNS BENEFITS TO A NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN IN ACCORDANCE WITH PARAGRAPHS TWO AND THREE OF THIS SUBSECTION.

(2) THE NON-PARTICIPATING PHYSICIAN MAY BILL THE HEALTH CARE PLAN FOR THE HEALTH CARE SERVICES RENDERED, AND THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN THE BILLED AMOUNT OR ATTEMPT TO NEGOTIATE REIMBURSEMENT WITH THE NON-PARTICIPATING PHYSICIAN.

(3) IF THE HEALTH CARE PLAN'S ATTEMPTS TO NEGOTIATE REIMBURSEMENT FOR HEALTH CARE SERVICES PROVIDED BY A NON-PARTICIPATING PHYSICIAN DOES NOT RESULT IN A RESOLUTION OF THE PAYMENT DISPUTE BETWEEN THE NON-PARTICIPATING PHYSICIAN AND THE HEALTH CARE PLAN, THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN AN AMOUNT THE HEALTH CARE PLAN DETERMINES IS REASONABLE FOR THE HEALTH CARE SERVICES RENDERED, EXCEPT FOR THE INSURED'S COPAYMENT, COINSURANCE OR DEDUCTIBLE, IN ACCORDANCE WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW.

(4) EITHER THE HEALTH CARE PLAN OR THE NON-PARTICIPATING PHYSICIAN MAY SUBMIT THE DISPUTE REGARDING THE SURPRISE BILL FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY, PROVIDED HOWEVER, THE HEALTH CARE PLAN MAY NOT SUBMIT THE DISPUTE UNLESS IT HAS COMPLIED WITH THE REQUIRE-

MENTS OF PARAGRAPHS ONE, TWO AND THREE OF THIS SUBSECTION.

(5) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL MAKE A DETERMINATION WITHIN THIRTY DAYS OF RECEIPT OF THE DISPUTE FOR REVIEW.

(6) WHEN DETERMINING A REASONABLE FEE FOR THE SERVICES RENDERED, THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL SELECT EITHER THE HEALTH CARE PLAN'S PAYMENT OR THE NON-PARTICIPATING PHYSICIAN'S FEE. AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE WHICH AMOUNT TO SELECT BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE. IF AN INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES, BASED ON THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE, THAT A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN IS REASONABLY LIKELY, OR THAT BOTH THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE REPRESENT UNREASONABLE EXTREMES, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY MAY DIRECT BOTH PARTIES TO ATTEMPT A GOOD FAITH NEGOTIATION FOR SETTLEMENT. THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN MAY BE GRANTED UP TO TEN BUSINESS DAYS FOR THIS NEGOTIATION, WHICH SHALL RUN CONCURRENTLY WITH THE THIRTY DAY PERIOD FOR DISPUTE RESOLUTION.

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(B) SURPRISE BILL RECEIVED BY AN INSURED WHO DOES NOT ASSIGN BENEFITS OR BY A PATIENT WHO IS NOT AN INSURED. (1) AN INSURED WHO DOES NOT ASSIGN BENEFITS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION OR A PATIENT WHO IS NOT AN INSURED AND WHO RECEIVES A SURPRISE BILL MAY SUBMIT A DISPUTE REGARDING THE SURPRISE BILL FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(2) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES RENDERED BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE.

(3) A PATIENT OR INSURED WHO DOES NOT ASSIGN BENEFITS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE ENTITY.

(C) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE PATIENT, PHYSICIAN AND HEALTH CARE PLAN, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE PATIENT OR INSURED, PHYSICIAN OR HEALTH CARE PLAN, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE PHYSICIAN.

S 608. PAYMENT FOR INDEPENDENT DISPUTE RESOLUTION ENTITY. (A) FOR DISPUTES INVOLVING AN INSURED, WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE HEALTH CARE PLAN'S PAYMENT IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE NON-PARTICIPATING PHYSICIAN. WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE NON-PARTICIPATING PHYSICIAN'S FEE IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE HEALTH CARE PLAN. WHEN A GOOD FAITH NEGOTIATION DIRECTED BY THE INDEPENDENT DISPUTE RESOLUTION ENTITY PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (A) OF SECTION SIX HUNDRED FIVE OF THIS ARTICLE, OR PARAGRAPH SIX OF SUBSECTION (A) OF SECTION SIX HUNDRED SEVEN OF THIS ARTICLE RESULTS IN A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN AND THE NON-PARTICIPATING PHYSICIAN SHALL EVENLY DIVIDE AND SHARE THE PRORATED COST FOR DISPUTE RESOLUTION.

(B) FOR DISPUTES INVOLVING A PATIENT THAT IS NOT AN INSURED, WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE PHYSICIAN'S FEE IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE PATIENT UNLESS PAYMENT FOR THE DISPUTE RESOLUTION

PROCESS WOULD POSE A HARDSHIP TO THE PATIENT. THE SUPERINTENDENT SHALL PROMULGATE A REGULATION TO DETERMINE PAYMENT FOR THE DISPUTE RESOLUTION PROCESS IN CASES OF HARDSHIP. WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE PHYSICIAN'S FEE IS UNREASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE PHYSICIAN.

S 27. Paragraphs 5 and 6 of subsection (a) of section 2601 of the insurance law, paragraph 5 as amended by chapter 547 of the laws of 1997 and paragraph 6 as amended by chapter 388 of the laws of 2008, are amended and a new paragraph 7 is added to read as follows:

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; ~~for~~

(6) failing to promptly disclose coverage pursuant to subsection (d) or subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter~~[-]~~; OR

(7) SUBMITTING REASONABLY RENDERED CLAIMS TO THE INDEPENDENT DISPUTE RESOLUTION PROCESS ESTABLISHED UNDER ARTICLE SIX OF THE FINANCIAL SERVICES LAW.

S 28. 1. An out-of-network reimbursement rate workgroup shall be convened and shall consist of 9 members appointed by the governor. Two
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members shall be appointed on the recommendation of the speaker of the assembly and two members shall be appointed on the recommendation of the temporary president of the senate and shall consist of two physicians, two representatives of health plans, and three consumers and shall be co-chaired by the superintendent of the department of financial services and the commissioner of the department of health. Such representatives of the workgroup must represent different regions of the state. The members shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

2. The workgroup shall review the current out-of-network reimbursement rates used by health insurers licensed under the insurance law and health maintenance organizations certified under the public health law and the rate methodology as required under the laws of 2014 and make recommendations regarding an alternative rate methodology taking into consideration the following factors:

- a. current physician charges for out-of-network services;
- b. trends in medical care and the actual costs of medical care;
- c. regional differences regarding medical costs and trends;
- d. the current methodologies and levels of reimbursement for out-of-network services currently paid by health plans, including insurers, HMOs, Medicare, and Medicaid;
- e. the current in-network rates paid by health plans, including insurers, HMOs, Medicare and Medicaid for the same service and by the same provider;
- f. the impact different rate methodologies would have on out-of-pocket costs for consumers who access out-of-network services;
- g. the impact different rate methodologies would have on premium costs in different regions of the state;
- h. reimbursement data from all health plans both public and private as well as charge data from medical professionals and hospitals available through the All Payer Database as developed and maintained by the department of health including data provided in the annual report published pursuant to section 2816 of the public health law; and

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Most Exchange Plans Charge Lower Tobacco Surcharges Than Allowed, But Many Tobacco Users Lack Affordable Coverage

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ABSTRACT Beginning in 2014, federal guidelines for health plans sold to people in the individual market allow insurers to charge tobacco users up to 50 percent more for premiums, compared to nonusers. We examined variations in tobacco surcharges for plans offered through the state and federal health insurance exchanges, or Marketplaces. The plan with the median surcharge had only 10 percent higher premiums for tobacco users compared to nonusers, and nine in ten plans charged a lower surcharge than allowed. Even with such lower-than-allowed surcharges, tobacco users lacked affordable coverage—defined as access to at least one plan with premiums of less than 8 percent of income after subsidies—in more states than did nonusers. Higher premiums could encourage tobacco users to opt out of coverage. Our results also suggest that the variation in tobacco surcharges may result in the sorting of tobacco users and nonusers into different plans.

Regulations created as part of the Affordable Care Act (ACA) have increased the availability and affordability of health insurance in the individual market for many people by establishing what is known as “modified community rating,” in which insurance premiums can vary based on only four factors: geographic region, family size, age, and tobacco use. Thus, tobacco use is the only modifiable behavioral factor that insurers can use to differentiate premiums. The level of the tobacco surcharge could significantly affect tobacco users’ choice of plans or their decision not to have insurance at all.

These regulations apply to all plans sold in the individual market, whether or not they are offered through the exchanges, or Marketplaces. As of January 1, 2014, insurers may charge tobacco users up to 50 percent more for health insurance than they charge nonusers. States may set more restrictive limits, and insurers are free to set tobacco surcharges at any level

up to those limits and also to impose differential tobacco surcharges by age.

In this policy environment, a range of tobacco surcharges could be implemented across the United States. Differences in these surcharges could lead to the sorting of tobacco users and nonusers into different plans. That in turn could result in higher costs to insurers whose plans attract more tobacco users, which could result in higher premiums in the future.

We examined insurance premiums for plans offered through health insurance exchanges to describe variations in tobacco surcharges by state and across insurance plans within states. We focused only on plans offered through the exchanges for two reasons. First, we are not aware of a consistent data source that lists all plans not available in the exchanges, so it would be difficult to collect data about them. Second, purchasers of plans not offered in the exchanges are not eligible for ACA subsidies, so those plans will likely be less popular than plans available through the exchanges.

We expected that insurers, when they were allowed to do so, would charge tobacco users surcharges approximately equal to the estimated incremental cost of health care for a tobacco user. We used data from the Medical Expenditure Panel Survey (MEPS) to provide an estimate of the additional cost associated with insuring a smoker for a year.

Study Data And Methods

PREMIUM AMOUNTS AND TOBACCO SURCHARGES

We collected premium data for tobacco users and nonusers in health insurance exchange plans published on states' insurance department websites, insurance exchange websites operated by states and by the federal government on behalf of states, and insurance company websites. As mentioned, we examined only plans that were available through the state or federal insurance exchanges.

Healthcare.gov published sample premiums for both a twenty-seven-year-old and a fifty-year-old who did not use tobacco for all plans in each state that is participating in the federal insurance exchange. Applying the published age curve allowed us to calculate premiums for nonusers ages twenty-five, forty-five, and sixty-four. However, it did not provide premium data for tobacco users.

Some states participating in the federal exchange separately released premium tables for all plans. In addition, many insurance providers had tools on their websites to allow people to look up premiums, which we validated using the published rates for people who do not use tobacco.

For each state, we identified premium amounts for all bronze-level plans for tobacco users and nonusers ages twenty-five, forty-five, and sixty-four in the premium rating area that contained the largest metropolitan area in the state.¹ We examined amounts for people ages twenty-five and sixty-four because those are the ages with the lowest and highest premiums, respectively, and for people age forty-five to be able to examine an age in the middle of the range.

We included only the thirty-six states (including the District of Columbia as a state) for which we were able to collect complete premium data for all exchange-based bronze plans in the selected rating area. We collected data on bronze plans because we expect that these plans, as the least expensive options for most people, will be popular entry-level plans for people who were previously uninsured.

For each plan, we computed the tobacco surcharge as the percentage increase in the premium paid by a tobacco user as compared with the

premium paid by a nonuser for each of the three ages. We did this to identify plans in which the tobacco surcharge varied by age. We then calculated the percentage of bronze plans in each state that had no surcharge and the percentage of plans that charged less than what their state allowed.

As a sensitivity analysis, we checked whether the tobacco surcharges differed across plan level (catastrophic, bronze, silver, gold, or platinum) for a 5 percent random sample of insurance providers in our sample. We found that the tobacco surcharge was the same for all plans that each insurer offered, regardless of plan level.

AVAILABILITY OF AFFORDABLE COVERAGE The stated goal of the ACA is to make affordable health insurance available to all Americans. The ACA exempts from the insurance mandate people who lack access to at least one bronze plan with premiums that amount, after subsidies, to less than 8 percent of their household income. For this reason, we used an 8 percent threshold in our definition of *affordable coverage*.

We computed premiums for the lowest-cost plan after subsidies for a range of incomes at all three ages (twenty-five, forty-five, and sixty-four). We then determined the number of states in which tobacco users and nonusers lacked affordable coverage, based on our definition, at income levels ranging from 100 percent to 500 percent of the federal poverty level. Subsidies are available for people with incomes of 100–400 percent of poverty. Therefore, we examined a range of incomes that included people who qualified for a subsidy as well as those with incomes too high to qualify.

INCREMENTAL COST FOR SMOKERS Using 2007–11 MEPS data, we identified adult smokers and nonsmokers based on how they answered the question, "Are you a current smoker?" We then compared weighted annual per capita health care expenditures by age group (ages 23–27, 43–47, 60–64, and 21–64) and insurance status.²

To have large enough samples to compare costs for smokers and nonsmokers, we used five-year age bands centered on the ages of interest (twenty-five, forty-five, and sixty-four). However, for the oldest group we used the sample of people ages 60–64, since those ages 65 and older would be eligible for Medicare. To compare costs across the entire target adult population for the health insurance exchanges, we compared costs for smokers and nonsmokers ages 21–64. People under twenty-one are considered children in the standard age-rating system, so they were excluded from our analysis.

Because health care costs are often skewed, we used the Wilcoxon rank-sum test to identify dif-

ferences in median expenditures between smokers and nonsmokers. In this analysis we did not attempt to determine whether smoking was causally related to medical cost because we were simply interested in whether being a smoker was related to differences in health care utilization and, thus, whether it would make sense to charge different premiums based on tobacco use. Therefore, we performed simple, unadjusted comparisons only.

LIMITATIONS This study had several limitations. First, we were able to gather data on plans only in thirty-five states and the District of Columbia. Because our sample included all fifteen states with state-run exchanges in 2014, our results provide better information about states that opted to implement their own version of the exchange than about those that opted to have a federally run Marketplace. Also, because eight of the fifteen states with state-run exchanges decided to implement a lower maximum surcharge than allowed, our data may underestimate the variation in tobacco surcharges across all states.

Of the states that opted to participate in the federal exchange, our sample was biased toward those with fewer plans and those that made rates available on state websites, because we included only states where we were able to collect premiums for every bronze exchange-based plan. We also limited our analysis to variations in tobacco surcharges for bronze plans. However, in sensitivity analyses of a 5 percent random sample of insurance providers, we found that every plan offered by a single insurer had the same tobacco surcharge, regardless of plan level.

Our analysis of the incremental costs associated with tobacco use focused on self-reported current smoking status. The ACA tobacco surcharge applies to people who report using any tobacco product more than three times per week within the past six months, which may be a slightly different population. However, because smokers make up the vast majority of tobacco users, this is unlikely to significantly bias our conclusions.

Study Results

STATE LIMITS ON TOBACCO SURCHARGES Seven states (including the District of Columbia) decided to disallow the tobacco surcharge altogether (Exhibit 1). Of these states, New York and Vermont have pure community rating, which means that premiums must be the same for all people, regardless of age or tobacco use. In addition to these seven states, three others—Arkansas, Colorado, and Kentucky—have set the maximum difference in premiums for tobacco users below the 50 percent maximum that is allowed at the

In this policy environment, a range of tobacco surcharges could be implemented across the United States.

federal level.

HEALTH INSURANCE EXCHANGE PLAN CHARACTERISTICS We collected complete premium data for tobacco users and nonusers for thirty-six states (including the District of Columbia). Our data included all fifteen jurisdictions that had state-run exchanges and twenty-one of the thirty-six states (58 percent) using the federal exchange. We excluded fifteen states where we could not obtain premiums for tobacco users in all bronze plans in the largest region in the state.³ On average, states that were not included in our sample had a higher number of bronze plans and higher average premiums for forty-five-year-olds with no tobacco use than states that were included ($p < 0.05$; Exhibit 2).

VARIATION IN TOBACCO SURCHARGE AMOUNTS Exhibit 1 shows wide variation in the tobacco surcharge for the states in our sample. We calculated the tobacco surcharge amount for all three age groups. However, we chose to present only the surcharges for forty-five-year-olds because more than 90 percent of plans did not have variable tobacco surcharges by age. The median plan charged a 10 percent tobacco surcharge, and among plans in states that allowed the maximum federal tobacco surcharge, the median plan had a 15 percent surcharge.

Only four states had any bronze plans with tobacco surcharges at the federal limit, and 41 percent of plans in states that allowed a tobacco surcharge had at least one plan with no surcharge. All of the states that allow a tobacco surcharge had plans with lower tobacco surcharges than the state allowed, and 89 percent of plans in these states charged less than the state limit. Still, in many states tobacco users faced high surcharges regardless of plan selection: Six states had a tobacco surcharge of at least 20 percent in all bronze plans.

It is interesting to note that plans with no surcharge were not always the lowest-cost bronze plans. For example, although at least

EXHIBIT 1

Summary Of Tobacco Surcharges And Premiums In The Study Of Variations In Tobacco Surcharges By State And Across Insurance Plans Within States, 2014

State	Exchange type	Median tobacco surcharge (%)	Unsubsidized monthly premium (\$) for 45-year-old			
			No tobacco use		Tobacco user	
			Minimum	Median	Minimum	Median
NO SURCHARGE ALLOWED						
All states in this subcategory	—	0	209.36	336.67	209.36	336.67
CA	State	0	221.90	266.66	221.90	266.66
DC	State	0	209.36	260.95	209.36	260.95
MA	State	0	219.74	308.13	219.74	308.13
NJ	Federal	0	277.49	345.56	277.49	345.56
NY	State	0	307.12	374.27	307.12	374.27
RI	State	0	240.00	244.00	240.00	244.00
VT	State	0	336.13	350.71	336.13	350.71
MAXIMUM SURCHARGE LESS THAN 50%*						
All states in this subcategory	—	10	183.26	297.96	201.58	323.34
CO	State	10	210.39	309.34	241.94	327.77
AR	Partnership	20	261.44	301.59	261.44	361.92
KY	State	20	183.26	242.97	201.58	291.57
MAXIMUM SURCHARGE 50%*						
All states in this subcategory	—	15	130.30	267.24	148.54	314.43
CT	State	0	285.78	313.23	285.78	313.23
NC	Federal	0	252.71	313.37	290.00	316.05
WA	State	7	209.88	268.23	209.88	288.34
OR	State	7	187.00	235.00	187.00	272.00
AK	Federal	8	349.98	429.89	349.98	462.14
MI	Partnership	10	189.73	293.84	208.70	320.22
AL	Federal	10	234.84	244.48	258.33	268.93
PA	Federal	10	268.52	327.93	335.65	360.72
IL	Partnership	10	172.01	283.50	226.82	332.91
MIN	State	14	130.30	182.48	148.54	194.17
TN	Federal	15	156.80	208.56	180.32	239.85
WV	Partnership	15	242.83	245.87	278.05	281.52
KS	Federal	18	212.66	261.43	255.19	309.53
MD	State	20	165.00	255.76	165.00	306.91
DE	Partnership	20	279.50	290.76	288.98	348.28
ND	Federal	20	241.06	274.40	262.75	329.28
ID ^b	State	20	199.85	235.75	239.81	280.72
HI	State	20	164.63	179.54	197.56	215.44
MO	Federal	25	202.34	253.66	242.81	311.76
OH	Federal	25	284.74	308.13	358.85	392.71
ME	Federal	30	265.11	274.99	274.99	347.50
NV	State	30	206.00	258.00	264.00	346.00
NH	Partnership	30	256.21	268.24	333.64	349.31
NM ^b	State	32	174.07	216.35	201.19	240.66
NE	Federal	32	222.64	276.25	293.88	358.21
MT	Federal	50	223.90	246.23	257.49	353.57
TOTAL						
All study states	—	10	130.30	272.44	148.54	318.18

SOURCE Authors' analysis of state insurance premium data. **NOTES** The study states include the District of Columbia. Appendix Exhibit A3 is a version of this exhibit with surcharge ranges (see Note 4 in text). *Tobacco surcharge limit is 15 percent for CO, 20 percent for AR, and 40 percent for KY. ^bDeclared state-run exchange but using healthcare.gov in 2014.

one plan in Colorado charged no surcharge, the lowest-cost plan in the state for both tobacco users and nonusers—offered by Kaiser Permanente—charged a 15 percent surcharge. This may be important because, in this case, tobacco users choosing the lowest-cost plan will still pay

higher premiums than nonusers.

DIFFERENTIAL TOBACCO SURCHARGE BY AGE

Six states—Illinois, Maryland, Michigan, Nevada, New Mexico, and West Virginia—had at least some plans with differential tobacco surcharges by age. Maryland and Nevada, which had

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EXHIBIT 2

Characteristics Of State Health Insurance Exchanges For States Included And Not Included In The Study Of Tobacco Surcharge Variations, 2014

Characteristic	Included (n=36)	Not included (n=15)	p value*
Number of insurance companies with bronze plans (average)	3.7	4.5	0.248
Number of bronze plans (average)	11.1	16.1	0.030
State-level tobacco premium surcharge limit (average)	38%	50%	0.030
States participating in federal exchange	58%	100%	<0.01
Monthly unsubsidized premium for 45-year-old with no tobacco use (average)	\$275.4	\$316.0	<0.01

SOURCE Authors' analysis of state insurance premium data. **NOTES** States include the District of Columbia. Appendix Exhibit A4 is a version of this exhibit with standard deviations (see Note 4 in text). *From a t-test comparing characteristics of states included and not included in tobacco surcharge analysis.

state-run exchanges, had some plans with surcharges that strictly increased with age, meaning that sixty-four-year-old tobacco users paid the highest surcharge. In Illinois, Michigan, New Mexico, and West Virginia, some plans had tobacco surcharges that first increased with age and then decreased, so that forty-five-year-olds paid higher surcharges than twenty-five-year-olds or sixty-four-year-olds.

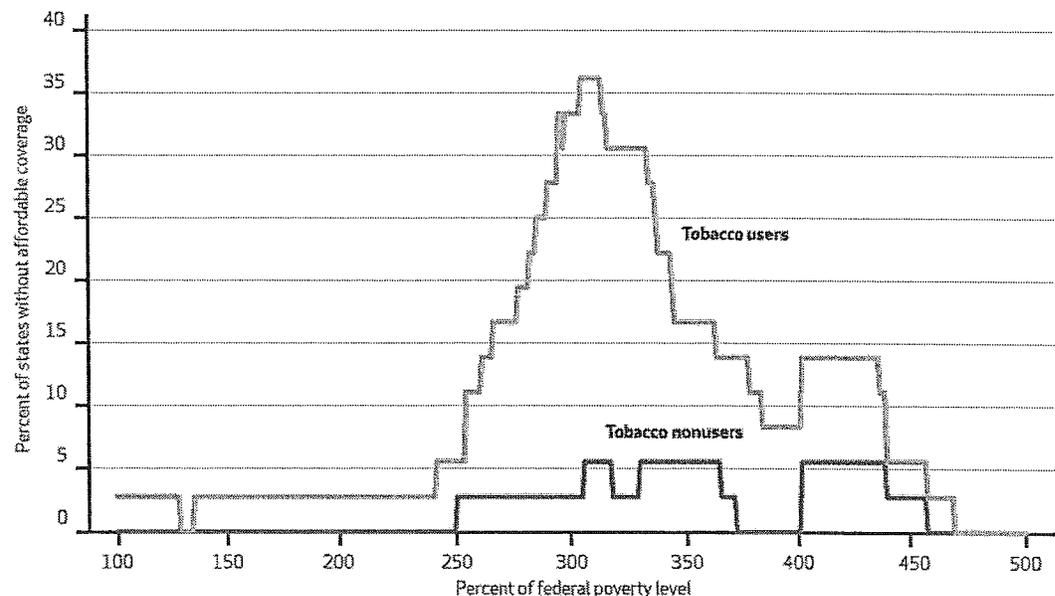
POTENTIAL FOR SORTING In six states—Delaware, Idaho, Maine, New Mexico, North Caro-

lina, and Ohio—choosing the lowest-cost plan would lead to different plan choices for tobacco users and nonusers. To the extent that people choose plans based on premiums, this could lead to tobacco users' being covered by plans with lower tobacco surcharges and nonusers' being in plans with higher tobacco surcharges and lower base costs.

AFFORDABLE COVERAGE Exhibit 3 shows the number of states where forty-five-year-olds lacked affordable coverage by income and tobac-

EXHIBIT 3

Percent Of States In The Study Of Tobacco Surcharge Variations Lacking Any Affordable Coverage For Forty-Five-Year-Olds, By Income And Tobacco Use, 2014



SOURCE Authors' analysis of state insurance premium data. **NOTES** Affordable coverage is defined as the lack in availability of at least one plan that costs less than 8 percent of income after subsidies. Subsidies are available for people with incomes below 400 percent of the federal poverty level, or \$45,960 in 2014.

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co use. Online Appendix Exhibits A1 and A2 are similar figures for twenty-five-year-olds and sixty-four-year-olds.⁴ Subsidies are generally available for people with incomes of less than 400 percent of poverty. However, despite the fact that tobacco users pay higher premiums in most states, they receive the same subsidies as do nonusers. As a result, we found that tobacco users lacked affordable coverage in more states than nonusers did. The difference was greatest for people with incomes just above 300 percent of poverty: At that income level, forty-five-year-old tobacco users lacked affordable coverage in thirteen of the thirty-six states (including the District of Columbia) in our sample, but nonusers lacked affordable coverage in only two states.

COSTS FOR SMOKERS AND NONSMOKERS Overall, we found that health care expenditures were modestly lower for smokers than for nonsmokers (\$4,280 versus \$4,417; Exhibit 4). In our age-stratified analyses, we found that older smokers (those ages 60–64) had 13.7 percent higher health care expenditures than older nonsmokers. However, expenditures were not significantly different in the younger age groups (people ages 23–27 and 43–47).

Discussion

We found substantial variation in tobacco surcharges across states and across plans within states. State upper limits for tobacco surcharges did not appear to be binding, since nine out of ten plans charged less than their state limit. Among states that allowed the federal maximum tobacco surcharge of 50 percent, the median surcharge was just 15 percent, and one in three plans in these states had no surcharge at all.

Our expenditure analysis that compared health care costs for smokers and nonsmokers suggests that as a group, smokers may cost slightly less than nonsmokers. Therefore, insurers may be warranted in having no tobacco surcharge at all, even when such a surcharge is allowed. However, despite lower surcharges, tobacco users were more likely than nonusers to lack affordable coverage.

THE COST OF INSURING A SMOKER We found that privately insured adult smokers had modestly lower health expenditures than nonsmokers. This difference varied by age, with older smokers having significantly higher health care expenditures than older nonsmokers. In contrast, previous studies found that adult smokers generally incur about 20 percent higher health expenditures than nonsmokers do.^{5–7} Still, it is important to note that these studies were not designed to determine the unadjusted difference in one-year cost between a self-

reported current smoker and a nonsmoker.

This subtlety may be important, because the ACA does not allow adjustment for sex or other health conditions. Thus, to an insurer, it does not matter if smoking is a causal factor in determining health expenditures or if it simply identifies a person who may use different amounts of care.

Another important difference is that the ACA allows rate adjustment only for current tobacco use. Thus, in our analysis we compared current smokers to current nonsmokers. However, several previous studies have demonstrated that former smokers may have significant health care costs associated with smoking.^{8,9} If more people quit smoking as they age, then the costs of the nonsmoking group will likely increase. This could explain why we found smaller differences between the two groups than was the case in previous studies,^{5–7} which typically grouped former smokers with current smokers.

AGE-DEPENDENT TOBACCO SURCHARGE The fact that most plans impose tobacco surcharges that are less than the limit allowed may not be surprising, given that we found that smokers cost at most about 14 percent more than nonsmokers in the group ages 60–64 and not significantly more than nonsmokers in the younger age groups (Exhibit 4). Other studies that examined the cost difference for smokers by age also found that the difference in health expenditures between smokers and nonsmokers increased with age.^{10,11}

In light of these findings, it is somewhat surprising that tobacco surcharges were age-dependent in only 10 percent of the plans we studied. This may be the result of a glitch reported by the Centers for Medicare and Medicaid Services, in which the system that processed rates for the federally run exchanges would not allow rates

EXHIBIT 4

Average Annual Per Capita Health Care Expenditures, By Age Group And Smoking Status, 2007–11

	Age (years)			
	23–27	43–47	60–64	21–64
Smoker	\$2,269	\$4,302	\$9,197	\$4,280
Nonsmoker	\$2,405	\$3,811	\$8,087	\$4,417
Difference (%)	–5.7	12.9	13.7	–3.1
p value ^a	0.218	0.081	0.008	<0.001
Number	4,197	6,434	3,940	51,133

SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey for 2007–11. **NOTES** Expenditures are for private insurance, adjusted to 2011 dollars. Smoking status is self-reported. Results are weighted for sampling strata using the Standard Adult Questionnaire weight. ^aCalculated using the two-sided Wilcoxon rank-sum test to compare differences in expenditures between smokers and nonsmokers.



for sixty-four-year-old tobacco users to be more than three times higher than rates for twenty-one-year-old tobacco users, although this is expressly allowed by the law.¹² We expect that in future years, after the glitch has been corrected, more insurers may choose to have a tobacco surcharge that either increases with age or applies only to older age groups.

PREMIUM SUBSIDIES AND AFFORDABLE COVERAGE The ACA provides subsidies for people with incomes below 400 percent of poverty. These subsidies provide enough support so that the second-lowest-cost silver plan can be purchased with a fixed percentage of total income (for example, the plan can be purchased with 4 percent of income for people with incomes at 150 percent of poverty or with 9.5 percent of income for people at 400 percent of poverty). The same subsidy can be used to purchase any plan, meaning that the lowest-cost bronze plan will be even less expensive.

However, when the price of the second-lowest-cost silver plan is calculated, the tobacco surcharge is not taken into consideration. Thus, tobacco users often pay a higher proportion of their incomes for insurance than nonusers do. As a result, tobacco users, especially those eligible for subsidies, lacked affordable coverage in more states than nonusers did.

We defined *affordable coverage* as the availability of at least one bronze or higher-level plan with after-subsidy premiums that were less than 8 percent of income. This is an important threshold because people lacking affordable coverage are exempted from the insurance mandate.

We estimated that a forty-five-year-old tobacco user making \$35,000 (approximately 300 percent of poverty) did not have access to affordable health insurance in thirteen of the thirty-six states in our sample. In contrast, someone of the same age and with the same income who did not use tobacco lacked affordable coverage in just two states. Because people without access to affordable coverage are exempt from the mandate, we expect that more tobacco users will choose to stay uninsured, compared to nonusers.

POTENTIAL FOR MARKET INSTABILITY The price differential and the fact that more tobacco users are exempt from the insurance mandate because of a lack of affordable coverage in many states may prove to be a disincentive for enrollment in health plans. Additionally, among those who enroll, differences in tobacco surcharges across states and plans create variations that may cause unfavorable insurance market outcomes because tobacco users and nonusers are likely to choose different health plans. When there is a range of tobacco surcharges, tobacco users may favor plans with lower surcharges, while

We found that privately insured adult smokers had modestly lower health expenditures than nonsmokers.

nonusers may be attracted to different plans that have lower base prices but higher tobacco surcharges. In several states the lowest-cost plan was different for tobacco users and nonusers.

If there is sorting of smokers and nonsmokers into different plans, this could lead to higher-than-expected costs for some insurers, especially those that attract older smokers. In future studies it will be important to assess whether such sorting occurs and, if it does, whether it results in market instability.

FUTURE RESEARCH Once enrollment data become available, it will be important to study whether tobacco surcharges are effective policies for influencing tobacco use. According to a recent review, there is no strong evidence that tobacco surcharges are associated with quitting.¹³

Many organizations, including the American Lung Association, have opposed tobacco surcharges, worrying that they will lead tobacco users to not obtain health insurance.¹⁴ Indeed, our results confirm that tobacco users are more likely than nonusers to be exempt from the mandate in many states because of a lack of affordable coverage. Variation in state tobacco surcharge policies creates an interesting natural experiment to study how these policies affect tobacco use and enrollment in plans by tobacco users compared with nonusers.

Conclusion

Overall, we found that most plans offered through the health insurance exchanges had significantly lower tobacco surcharges than allowed, and that a third of plans had no tobacco surcharge in states where one was allowed. As a result of the lower-than-expected tobacco surcharges, fears raised by organizations such as the American Lung Association that tobacco users would lack affordable coverage and would opt out of coverage are perhaps less likely to become a reality in many states where they can

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States

A 45-year-old tobacco user earning \$35,000 did not have access to affordable health insurance in 13 of the 36 states in our sample.

choose plans with a low or no surcharge. Still, the surcharges vary significantly across states and will lead to differences in the options facing tobacco users in different states.

In California, Connecticut, the District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, and Vermont, tobacco users will pay exactly the same premiums as nonusers. However, in Nevada, New Hampshire, and Ohio, all tobacco users will pay rates that are more than 25 percent higher than those paid by nonusers.

This means that tobacco users will lack affordable coverage in more states than nonusers with similar characteristics.

Smokers represent one-fifth of the US population,¹⁵ and smoking may be even more prevalent among the target population for the health insurance exchanges: people who previously lacked insurance.¹⁶ As the health insurance exchanges develop, it will be important to study how tobacco users fare in obtaining health insurance. ■

NOTES

- 1 The ACA specifies that each state will determine boundaries for one or more geographic rating area that all insurers must use to set premiums.
- 2 The weight we used was the Standard Adult Questionnaire weight.
- 3 Premiums for people who did not use tobacco were available in every state.
- 4 To access the Appendix, click on the Appendix link in the box to the right of the article online.
- 5 Moziarty JP, Branda ME, Olsen KD, Shah ND, Borah BJ, Wagie AE, et al. The effects of incremental costs of smoking and obesity on health care costs among adults: a 7-year longitudinal study. *J Occup Environ Med.* 2012;54(3):286–91.
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Health Policy Institute

Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments

November 26, 2012

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Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments

EXECUTIVE SUMMARY

In 2010 the Obama Administration and Congress took a major step through the Affordable Care Act (ACA) to address the significant human life and financial costs of tobacco use in America by requiring insurance companies and employers to cover tobacco cessation treatment. This report focuses on a new consumer protection provision under the ACA that requires individual and group health insurance to cover these treatments.

Tobacco use is the leading cause of preventable death in the United States, killing more than 400,000 Americans and costing the nation \$193 billion annually in direct medical costs and productivity losses. Nicotine addiction is treatable, and evidence suggests that most smokers (nearly 70 percent) want to quit and that covering treatment improves the chances that a person will quit smoking. According to the U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence:

- Tobacco cessation treatments help people quit smoking.
- Participation rates for treatment programs are higher when there is no cost-sharing.
- Combining counseling with tobacco cessation medications is more effective than using one type of treatment alone.
- Quit rates are higher when health insurance covers tobacco cessation treatments.

Additional studies have looked at the cost of tobacco cessation treatment and the resulting cost savings to both private employers and state programs, finding significant short-term and long-term savings.

The ACA requires all new private health insurance plans to cover services recommended by the U.S. Preventive Services Task Force (USPSTF) with no cost-sharing. These recommendations include tobacco cessation treatments. The USPSTF recommends that clinicians ask adults about tobacco use and provide interventions for those who use tobacco products, with pregnancy-tailored counseling for pregnant women who smoke. The USPSTF has found that longer counseling sessions improve quit rates and combining counseling with medication is more effective at increasing cessation rates than either therapy used alone. FDA-approved medication effective for treating tobacco dependence in nonpregnant adults includes several forms of nicotine replacement therapy (gum, lozenge, transdermal patch, inhaler and nasal spray), sustained-release bupropion, and varenicline.

The report examines how the tobacco cessation benefit is working under the new law. To understand how the regulated community has responded to the new coverage requirements, researchers selected 39 insurance contracts for a comprehensive analysis. These policies were being sold in six states (Florida, Kentucky, Nevada, New Jersey, Oregon and South Dakota). States were selected based on population, regional diversity, pre-ACA requirement for insurers to cover tobacco cessation programs, prevalence of tobacco use, and lung cancer rates. Thirty-nine contracts included:

- twelve individual market health insurance contracts;
- eighteen small group market health insurance contracts, six of which qualify as a potential benchmark plan (state specified minimum benefit and treatments required to be covered under the ACA);
- six state employee benefit plans (also could be chosen as a benchmark); and
- three federal employee benefit plans (two of which could be chosen as a benchmark).

Researchers analyzed the full insurance contract to determine what is covered, limitations and exclusions for coverage. Researchers also obtained formularies to identify tobacco cessation prescription drugs on the formulary. Analysis included reviewing contract provisions referencing tobacco cessation as a covered benefit and USPSTF preventive care recommendations as covered benefits; exclusions; prerequisites to receiving tobacco cessation treatment; cost-sharing requirements; limitations or restrictions to coverage; and restrictions on types of providers who can be reimbursed for tobacco cessation treatment. To understand the scope of coverage, researchers focused on type of counseling (individual, phone, group) and medications (prescription drugs, over-the-counter drugs (OTCs)).

Contract Analysis

In reviewing insurance contracts, researchers found significant variation in how private health insurance coverage works for tobacco cessation treatment. Some insurance contracts have provisions that appear to exclude tobacco cessation benefits from coverage altogether, or conflicting provisions that make the scope of the benefit unclear. Contracts are ambiguous on medical necessity determinations and other potential restrictions to accessing covered treatments. Some are not clear whether there is cost-sharing for tobacco cessation treatment and prescription medication, creating uncertainty whether consumers can receive benefits required under the ACA without cost-sharing.

None of the 39 contracts analyzed did all of the following:

- stated clearly that tobacco cessation treatment was a covered benefit (without general exclusions);
- provided coverage for individual, group and phone counseling, and FDA approved tobacco cessation medication;
- provided tobacco cessation treatments by in-network providers with no cost-sharing; **and**
- provided access to treatment without prerequisites such as medical necessity or health risk assessment.

Coverage of Tobacco Cessation Treatments

The insurance contracts are not clear on whether tobacco cessation is a covered benefit. While 36 of the 39 analyzed insurance contracts indicate they are providing coverage for tobacco cessation or are providing coverage consistent with the USPSTF recommendations, 26 of these contracts also included language excluding tobacco cessation from coverage entirely or partially. For example, one contract states:

Preventive adult wellness Services are covered under your plan. For purposes of this benefit, an adult is 17 years or older. In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with: 1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act.

However, under the “what is not covered?” section, the same contract states:

Smoking Cessation Programs including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

Some contracts use exclusionary language that makes it difficult to determine what is actually covered for tobacco cessation. For example, one contract states:

We cover tobacco use cessation services. For the purpose of this provision, "tobacco use cessation" means services that follows the United States Public Health Service guidelines for tobacco use cessation, including education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

In the exclusions section, the same contract states:

Except as specifically provided in this Policy, We do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

As a result of conflicting contract language, it is nearly impossible to determine with certainty whether tobacco cessation treatment is a covered benefit. Conflicting contract language may mean that a company did not carefully review contracts to delete exclusions for tobacco cessation treatment after updating the contracts for ACA compliance, or this could mean that the issuer is intentionally not complying with the ACA. Even if the issuer no longer uses the exclusion in the contract to deny benefits for tobacco cessation, it would be difficult for a person to figure out whether tobacco cessation treatment is a covered benefit, which could discourage him or her from using these treatments.

Scope of Coverage: Lack of Specificity

Due to the lack of specificity in many contracts it is nearly impossible to figure out what benefits a consumer has coverage for. Some policies cover all types of counseling – individual, phone and group – while some only cover individual counseling but not phone or group counseling, and yet others cover individual and group but not phone counseling. While some contracts specifically state that individual, group and phone counseling are or are not covered, many contracts do not provide enough details with respect to type of counseling covered:

- Seventeen policies specifically included individual counseling as a covered benefit, four excluded it and 16 referenced the recommendations of the USPSTF without detail on whether individual counseling was covered.
- Eleven policies specifically included phone counseling as a covered benefit, 10 excluded it, and 16 referenced recommendations of the USPSTF without detail on whether phone counseling was covered.
- Seven policies specifically included group counseling as a covered benefit, 10 excluded it, and 20 referenced the recommendations of the USPSTF without detail on whether group counseling was covered.

Significant variation in how health insurance coverage works for tobacco cessation treatment makes it unwise to make any assumptions about scope of coverage when contracts lack detail. Without additional detail, a reference to covering USPSTF recommendations is not adequate to accurately convey to a consumer what specific treatments are covered.

It is also difficult to determine what if any prescription or OTC medication coverage is available for tobacco cessation due to either general references to such benefits, exclusions for some of these benefits,

or conflicting contract language. There is wide variation in how and when prescription and over-the-counter medications are covered and what is covered – patches, gum and drugs:

- Twenty-three of 39 contracts included coverage for prescription drugs for tobacco cessation and 15 contracts did not cover prescription drugs. One contract was not clear on whether prescription drugs were covered.
- Coverage for OTC medication also varied greatly. Twelve of 39 contracts specifically covered OTC for tobacco cessation and 24 contracts excluded OTCs. Three of 39 contracts referenced the USPSTF recommendations without detail on whether OTCs was covered. Of the 12 contracts covering OTC benefits, eight required a prescription for OTC medication.

Scope of Coverage: Not Consistent with USPSTF Recommendations

Most policies did not list as a covered benefit all categories of treatments found to be effective by the USPSTF. Only 10% (4 of 39) of contracts reviewed included as a covered benefit individual counseling, phone counseling, group counseling, prescription drugs and OTCs. In addition to potential confusion around what is covered, consumers may find that a treatment method that their physician recommends and is found to be effective by the USPSTF is not covered by the plan.

Cost-sharing

Health insurance issuers also had different approaches to cost-sharing for tobacco cessation counseling provided by in-network providers:

- Seven of the 36 contracts that clearly covered counseling required cost-sharing for tobacco cessation counseling by in-network providers, appearing to conflict with ACA coverage requirements for no cost-sharing for preventive benefits.
- Six of the 24 contracts that covered prescription drugs applied cost-sharing requirements for these drugs. Of the 24, one contract was not clear about covering prescription drugs for tobacco cessation; however, all prescription drugs under this contract included cost-sharing.

Access Restrictions

In many contracts, access to tobacco cessation treatment is limited through medical necessity requirements, pre-existing condition exclusions, requirements to participate in a formal program, and, in one case, a requirement for a health risk assessment to access prescription drugs and OTC medications for tobacco cessation. These limitations may mean that in some cases smokers would not be able to access treatment. For example, while the application of preexisting condition exclusions will no longer be allowed beginning in 2014, insurers are currently allowed to exclude coverage for a preexisting condition. Absent federal guidance on the use of preexisting condition exclusion periods for smokers, people trying to quit may not be able to access coverage until the exclusion period for their preexisting condition ends.

Requirements for participation in formal programs may deter some consumers from accessing cessation treatment. While the incentive of a formal program that provides enhanced benefits not otherwise covered is not problematic, the required participation as a prerequisite to accessing basic benefits required by the ACA could be a barrier for consumers.

The general requirement for medical necessity determinations for tobacco cessation treatment could also work to inappropriately restrict access to cessation treatments for smokers. While medical necessity determinations may be a good tool to ensure appropriate access to treatments and to address overuse and unnecessary expenses, medical necessity determinations make little sense for preventive benefits that are often under-used.

Understanding the Significant Variations in Coverage

To better understand the reasons for these variations, researchers interviewed current and former staff from different insurance companies and staff at a tobacco cessation treatment company. Researchers found the variations in coverage for tobacco cessation treatment are mostly due to cost considerations. A former medical director noted that because turnover is so high (25-30% per year) in the commercial market (private health insurance), health plans have a disincentive to cover prevention and wellness that shows cost-savings over the long-term because they will not actually realize those cost savings.

Recommendations

These findings raise serious questions about whether consumers have access to all tobacco cessation services required by the ACA and that the USPSTF has found to be effective. Conflicting and confusing contract language also may leave consumers uncertain if tobacco cessation treatments are covered, which could discourage them from seeking these treatments.

We recommend that federal and state regulators issue further guidance to address problems in insurance contracts affecting coverage for tobacco cessation treatment.

- Regulators should require issuers to have a clear statement in health insurance policies that says that treatment for tobacco cessation is a covered benefit. Furthermore, policies should specifically state which treatments are covered and that cost-sharing does not apply.
- Regulators should provide guidance on permissible and prohibited limitations to coverage under the ACA, including number of covered quit attempts, medical necessity determinations, program participation and exclusionary language.
- Federal regulators should provide model contract language for this benefit, which would help address ambiguities and uncertainties over what benefits are available to consumers and how to access such benefits.

We also recommend that insurers reexamine their products and that states provide an expedited approval process for insurers that need to correct misleading or ambiguous contracts.

Absent detailed guidance, huge variation in benefits will continue to be a problem, and tobacco users' access to tobacco treatment will continue to be limited. Finally, absent additional steps by federal or state regulators, the promise of reducing tobacco use – saving lives and saving health care resources – will not be realized fully.



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October 14, 2014

Colleen McCarthy Reid, Esq.
Legislative Analyst
Joint Standing Committee on Insurance and Financial Services
Office of Policy and Legal Analysis
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Dear Ms. Reid:

Thank you for the opportunity to provide information on smoking cessation benefits available through plans offered by Aetna in the Small Group and Individual Market. Please be advised that Aetna does not currently offer products in the Individual Market in Maine, and the responses below reflect our Small Group segment, unless noted otherwise. It might also be helpful for the Advisory Committee members to be aware that much of the information requested remains "under development" as the 2014 plan year is still underway for the small group and individual market. Credible data is not yet available for review and analysis for us to share with the Committee.

Under the ACA, tobacco cessation coverage must be provided as a preventive service. The federal government has provided guidance in the form of an FAQ for health plan issuers to comply with the ACA requirements: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>. See Q5. Please provide a summary of tobacco cessation coverage provided in individual and small group health plans offered for sale in Maine, including any exclusions.

Aetna does not offer Individual plans in Maine for the 2014 calendar year.

Aetna Small Group products provide smoking/tobacco cessation preventive counseling limited to 8 visits per 12 months. These benefits are covered under the preventive care rules of the ACA and are paid at 100%, with no deductible or copay for fully compliant ACA plans.

In 2014, Aetna Small Group Plans currently covers prescription smoking cessation products that are generics (bupropion, nicotine) at tier 1 and single source brands (Chantix) at Tier 3. Brand and generic over-the-counter products (nicotine patches, gum, lozenges) are covered if they are filled using a prescription. Copays are applied to these drugs. Anyone receiving smoking cessation drugs since May 1, 2014, will also receive remediation.

In 2015, Individual plans (off-Exchange) will operate with a closed formulary and will cover the generics, single sources brands and over-the counter drugs with a prescription for 2

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courses of 90 days each at \$0 copay. Quantity limits will apply. If the members needs more than the 2 courses of therapy, the member cost share will apply. Small Group plans in 2015 will have an open formulary which will include multi-source brands at the appropriate member cost share. Remediation will be required for any member (Individual or Small Group) who is receiving smoking cessation drugs.

How many enrollees receive tobacco cessation benefits? What are the total claims paid to date for tobacco cessation coverage? If possible, please categorize the services received, e.g. counseling, medications, etc.

Given the tight turnaround time from receipt of request to due date for the response, Aetna is not able to provide information to answer these questions at this time. As noted in our opening, the 2014 plan year remains underway and credible data is not yet available. A data request has been submitted and when that is available, the information will be provided to Ms. Reid.

Is "medical necessity" a requirement for coverage? Is coverage limited to a certain number of "quit attempts"?

No. Aetna provides coverage consistent and compliant with the ACA. Benefits are applied consistent with the information provided in answer to question #1.

Are there any restrictions on the types of providers who can be reimbursed for tobacco cessation treatment?

No, although it should be noted that members should consult the list of participating providers in their plan's network to ensure claims for smoking cessation benefits will be processed consistent with the plan's certificate of coverage.

Tobacco Rating Factors

Is a tobacco surcharge used in rating for individual health plans? In small group health plans? What factor/surcharge is applied? What is the premium impact? Please provide examples.

It might be helpful for the Committee to request a presentation from the Maine Bureau of Insurance on how rates are developed and then how a tobacco surcharge factors into the overall rate for a given plan and then how it is applied upon enrollment.

Aetna does not offer Individual Plans in Maine in 2014.

In 2014, Aetna's Small Group products do include a tobacco rating surcharge if a subscriber responds "yes" on the enrollment form that he/she currently smokes. A 20% factor is applied.

In 2015, Aetna's Small Group and Individual products will include a tobacco rating surcharge where a 10% factor will be applied if subscriber answers "yes" to being a smoker on the enrollment form.

Aetna

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Please provide information on how many enrollees are subject to a tobacco surcharge, if any. How many small group enrollees have enrolled in tobacco cessation to avoid surcharge as required by federal rule?

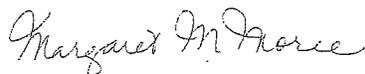
Credible data is not yet available to provide context for the number of enrollments in our 2014 Maine Small Group plans subject to the tobacco rating surcharge. What Aetna actuaries report, however, and are working to better understand across our national book of business, is that individual are not answering truthfully the question posed on the enrollment form. Aetna determined its tobacco rating factors for 2014 using a wide variety of data sources including research from Kaiser, Robert Wood Johnson, and the US Census. Prior to the tobacco surcharge being implemented, non-smokers were subsidizing the premiums of smokers. In theory, with the implementation of the tobacco surcharge, smokers would be carrying a more proportionate weight in their rates from an actuarial rating perspective. Given the very limited data available from the implementation of the 2014 tobacco surcharge, and the inconsistency between the various national data on smokers (noted above) versus the percent of "yes" responses received on enrollment forms in the Small Group market, Aetna has moved for 2015 to a different actuarial formula in both the Individual and Small Group markets, leading to the factor being reduced for smokers to 10% (see question above). This reduction in the factor means in 2015 non-smokers are assuming more of that load in their rates, given the questionable rate of truthful responses from smokers.

Aetna offers subscribers three choices on the enrollment form: smoker, non-smoker, smoker enrolled in a sanctioned cessation program. If that individual answers that he/she is a smoker enrolled in a sanctioned cessation program, that individual is not subject to the tobacco surcharge.

Are there any financial incentives offered to health plan enrollees who participate in a tobacco cessation program (wellness program as permitted by the ACA)? How many participate?

No.

Sincerely,



Maggie Moree
Senior Government Relations Specialist
Aetna

Aetna (3)

Maine Health Exchange Advisory Committee

Response of Anthem Blue Cross and Blue Shield to Information Request Related to Tobacco Cessation Coverage and Tobacco Rating Factors

Tobacco Cessation Coverage

1. Under the ACA, tobacco cessation coverage must be provided as a preventive service. The federal government has provided guidance in the form of an FAQ for health plan issuers to comply with the ACA requirements: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>. See Q5. Please provide a summary of tobacco cessation coverage provided in individual and small group health plans offered for sale in Maine, including any exclusions.

FDA-approved smoking cessation products, including over the counter nicotine replacement products, are covered when obtained with a prescription for a Member age 18 or older. These products are covered under the "Preventive Care" benefit.

- Over the counter Nicotine Replacement Therapy products
 - Nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation when prescribed by the member's physician;
 - NRT products can include but are not limited to, nicotine patches, gum, or nasal spray;
 - follow-up smoking cessation education and counseling;
 - completing an approved smoking cessation program.

With respect to over-the-counter NRT products, the following applies:

- Brand name Nicoderm CQ patches and Nicorette gum are not covered; however store brands/generics to Nicoderm CQ patches and Nicorette gum are covered as Tier 1;
 - Brand name Nicorette Lozenge and Commit Lozenge are Tier 3;
 - Store brands/generics to Nicorette and Commit Lozenge are Tier 1.
- Covered Prescription Drugs
 - To be covered, prescription drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription. Prescription drugs must be prescribed by a licensed Provider and obtained from a licensed pharmacy.

2. How many enrollees receive tobacco cessation benefits? What are the total claims paid to date for tobacco cessation coverage? If possible, please categorize the services received, e.g. counseling, medications, etc.

We are not able to provide information about the number of members using tobacco cessation benefits or claims information at this time.

Anthem (4)

3. Is “medical necessity” a requirement for coverage? Is coverage limited to a certain number of “quit attempts”?

Medical necessity is not a requirement for coverage. There are no lifetime or policy limits; however, in accordance with generally accepted medical guidelines, coverage within a 12 month period is limited because these medications are not without risk and should not be taken continuously. For example, Chantix is limited to 24 weeks of coverage in a 12-month period.

4. Are there any restrictions on the types of providers who can be reimbursed for tobacco cessation treatment?

No, so long as the services provided are within the provider’s scope of practice. Network requirements do apply, so coverage may be subject to greater member cost-shares or may not be covered if rendered by a non-network provider.

Tobacco Rating Factors

1. Is a tobacco surcharge used in rating for individual health plans? In small group health plans? What factor/surcharge is applied? What is the premium impact? Please provide examples.

A tobacco surcharge is applied in both the individual and small group markets. In 2014, a tobacco rating factor of 1.3 was used. In 2015, the factors for both the individual and small group markets will increase with age and are shown in Table 1.

Table 1: 2015 Tobacco Factors

Age	Tobacco Rating Factor
0-29	1.000
30-34	1.050
35-39	1.100
40-44	1.250
45-49	1.400
50-64+	1.490

2. Please provide information on how many enrollees are subject to a tobacco surcharge, if any. How many small group enrollees have enrolled in tobacco cessation to avoid surcharge as required by federal rule?

We are only able to identify those individual and small group members who are currently paying the tobacco rate. Because those members who have enrolled in a tobacco cessation program receive the non-tobacco rate, we have no way to identify them.

In addition, in the small group market, the tobacco rating only applies to new enrollees after January 1, 2014. We did not collect this information prior to January 1, 2014 and therefore did not have information about tobacco use by existing group members available to us in preparing their 2014 rates.

Table 2: Number of members receiving tobacco rating

Individual			Small group		
Age	#/Rate of Tobacco Use		Age	#/Rate of Tobacco Use	
0-1		0%	0-1		0.0%
2-17		0%	2-17		0.0%
18-20	6	2.1%	18-20	1	3.1%
21-25	12	4.2%	21-25	2	6.3%
26-34	47	16.3%	26-34	8	25%
35-44	50	17.4%	35-44	8	25%
45-54	69	24.0%	45-54	9	28.1%
55+	104	36.1%	55+	4	12.5%
Total	288		Total	32	

3. Are there any financial incentives offered to health plan enrollees who participate in a tobacco cessation program (wellness program as permitted by the ACA)? How many participate?

A significant financial incentive to participate in a tobacco cessation program is that members who do so receive the non-smoker rate.

Authem (6)

**Harvard Pilgrim Health Care:
Information Requested Related to
Tobacco Cessation Coverage and Tobacco Rating Factors**

Provided to the Maine Health Exchange Advisory Committee 10/14/14

Tobacco Cessation Coverage

Harvard Pilgrim provides medical benefits related to smoking cessation, as well as member rewards programs to aid in smoking cessation.

Harvard Pilgrim meets the federal requirement that smoking cessation be provided, without any cost-sharing, as a preventive benefit. The benefit provided by the member's primary care doctor includes:

Tobacco use screening and counseling, including smoking cessation counseling and FDA-approved nicotine replacement therapy (primary care visits only).

The FDA-approved replacement therapies include:

Rx and over-the-counter nicotine replacement products are covered with \$0 cost share for members with or without Rx coverage. Member must obtain a prescription and present it at a pharmacy with HPHC ID card.

Nicotine Patches: Max.30 patches/month; Limit 180-day supply per year.

Nicotine gum: Max.480/month; Limit 180-day supply per year.

Nicotine lozenge: Max.480/month; Limit 180-day supply per year.

Nicotrol inhaler: Max. 168 units/fill; Limit 180-day supply per year

Nicotrol NS: Max. 4 units/fill; Limit 180-day supply per year

bupropion, smoking cessation: Max. 360 tabs/180 days per year.

Chantix: Annual limit of 26 weeks

In addition, Harvard Pilgrim provides members, as part of our member reward program, access to free smoking cessation telephone counseling, or online counseling, as well as discounts on commercially available tobacco cessation programs.

Tobacco Rating Factors

1. Is a tobacco surcharge used in rating for individual health plans? In small group health plans? What factor/surcharge is applied? What is the premium impact? Please provide examples.

Harvard Pilgrim uses a tobacco surcharge of 1.207 for individual health plans only, which is within the allowable range of 1 to 1.5 permitted by federal regulation. No tobacco rating surcharge is used in small

HPHC (7)

group. Premiums for individual members rated as tobacco users are 20.7% higher than non-tobacco users.

Below are some examples of the rates:

Illustrative rates for rating with and without tobacco rating				
Plan ID	Rating Area	Age	Individual Rate	Individual Tobacco Rate
96667ME0130002	Rating Area 3	25	388.89	469.39
96667ME0150002	Rating Area 2	55	710.00	856.97
96667ME0150002	Rating Area 4	45	599.93	724.12
96667ME0110002	Rating Area 1	35	267.91	323.36

2. Please provide information on how many enrollees are subject to a tobacco surcharge, if any. How many small group enrollees have enrolled in tobacco cessation to avoid surcharge as required by federal rule?

Harvard Pilgrim currently has several hundred individual members, and has less than 50 members who are subject to the tobacco rating factor. It is important to note, that per federal regulations members self-certify that they do or do not use tobacco products.

As stated above Harvard Pilgrim does not rate for tobacco in the small group marketplace.

3. Are there any financial incentives offered to health plan enrollees who participate in a tobacco cessation program (wellness program as permitted by the ACA)? How many participate?

As stated above Harvard Pilgrim does not rate for tobacco in the small group marketplace in 2014, and does not intend to in 2015. Incentive based wellness programs are only available to group health plan members per the ACA and federal regulations and not available in the individual market. Therefore, Harvard Pilgrim does not currently have any members in such a program. Individual market members are eligible for smoking cessation programs through Harvard Pilgrim and for medical benefits related to smoking cessation. However, as previously stated federal regulation prohibits providing a financial incentive for participation.



October 14, 2014

TO: Senator Margaret Craven, Co-Chair
Representative Sharon Treat, Co-Chair
Members, Maine Health Exchange Advisory Committee

CC: Colleen McCarthy-Reid

FROM: Kevin Lewis, CEO, Maine Community Health Options

RE: Information Requested Related to Tobacco Cessation Coverage and Tobacco Rating Factors

Please find in the information below my responses to the request on MCHO's coverage of tobacco cessation treatment as well as consideration of tobacco rating factors. Please let me know if there are any additional information needs.

Tobacco Cessation Coverage

1. *Under the ACA, tobacco cessation coverage must be provided as a preventive service. The federal government has provided guidance in the form of an FAQ for health plan issuers to comply with the ACA requirements: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>. See Q5. Please provide a summary of tobacco cessation coverage provided in individual and small group health plans offered for sale in Maine, including any exclusions.*

MCHO covers the full range of tobacco cessation benefits as described within the ACA requirements. MCHO plans provide benefits for FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) with no out-of-pocket costs when prescribed by a health care provider.

The MCHO benefit currently covers prescription (legend) tobacco cessation products at \$0 copay for up to 180-days-supply (DS) per calendar year, and over-the-counter (OTC) products at \$0 copay with no DS limit per calendar year. After the maximum number of DS has been exhausted for the legend products, the member is responsible for 100% of cost. MCHO's OTC coverage is more generous than what is required under the ACA, which only requires coverage for 180-DS per year. (Although OTCs are covered, the member must present a prescription in order for the item to be covered via the pharmacy benefit. This is required for all OTC items, and not just tobacco cessation.)

Following are the tobacco cessation products currently on the formulary, with the items marked as QL-SMKG being the legend products:

SMOKING DETERRENENTS

bupropion (ZYBAN equiv) (Limited to 180 days/calendar year)	QL-SMKG	\$0
CHANTIX (Limited to 180 days/calendar year)	QL-SMKG	\$0
nicotine gum (NICORETTE equiv)	OTC-SMKG	\$0
nicotine lozenge (COMMIT LOZENGE equiv)	OTC-SMKG	\$0
nicotine patch (NICODERM CQ equiv)	OTC-SMKG	\$0
NICOTROL INHALER (Limited to 180 days/calendar year)	QL-SMKG	\$0
NICOTROL NASAL SPRAY (Limited to 180 days/calendar year)	QL-SMKG	\$0

Additionally, for both our non-group and small group health plans, MCHO provides benefits for tobacco cessation programs, including counseling, follow-up education, and completion of an MCHO-approved tobacco cessation program at no charge to the Member. All preventive services must be delivered by in-network providers for them to be paid without any Member cost sharing.

- How many enrollees receive tobacco cessation benefits? What are the total claims paid to date for tobacco cessation coverage? If possible, please categorize the services received, e.g. counseling, medications, etc.

As of the end of August, we have had limited claims for tobacco cessation benefits. MCHO has received 119 claims for counseling treatment and 416 prescriptions for tobacco cessation products.

Benefit	Claims	Plan Paid	Member Paid*
Medical / Counseling	119	\$ 1,512.25	\$ 236.33
Pharmacy	416	\$ 68,487.34	\$ 379.99

*The Member is responsible for standard cost sharing if the provider is out of network.

- Is "medical necessity" a requirement for coverage? Is coverage limited to a certain number of "quit attempts"?

Medical necessity is not a requirement for coverage, however, a prescription is required for the tobacco cessation product – whether legend or OTC – to be covered.

- Are there any restrictions on the types of providers who can be reimbursed for tobacco cessation treatment?

As noted above, providers must be in-network providers in order for the member to receive the preventive service benefit at no cost sharing.

Tobacco Rating Factors

- Is a tobacco surcharge used in rating for individual health plans? In small group health plans? What factor/surcharge is applied? What is the premium impact? Please provide examples.
MCHO doesn't impose a surcharge in rating for either non-group or small group health plans.

- Please provide information on how many enrollees are subject to a tobacco surcharge, if any. How many small group enrollees have enrolled in tobacco cessation to avoid surcharge as required by federal rule?

Not applicable to MCHO given that we don't impose a surcharge.

3. *Are there any financial incentives offered to health plan enrollees who participate in a tobacco cessation program (wellness program as permitted by the ACA)? How many participate?*

At this time, there is only the incentive of no cost sharing for the preventive service as described above. We encourage Members to engage in tobacco cessation activity, and may build additional incentives to utilize the benefit in the future.

Tobacco Surcharges



In an attempt to discourage use of tobacco products and cover additional health care costs associated with tobacco use, many employers and insurance companies are considering tobacco surcharges. The Affordable Care Act has changed policies regarding these surcharges – making health coverage potentially unaffordable for tobacco users.

What is a tobacco surcharge?

- A tobacco surcharge is a variation in insurance premiums based on a policyholder (or dependent's) tobacco use.
- Tobacco surcharges are sometimes called tobacco premiums, premium incentives or nonsmoker discounts.
- Starting January 1, 2014, many insurers and employers are able to charge tobacco users up to 50 percent more in premiums.
- The rule implementing this provision in the Affordable Care Act requires insurers in the small group market to remove the tobacco surcharge for a tobacco user who agrees to enroll in a program that will help them quit.

The American Lung Association opposes the use of tobacco surcharges.

- Punitive measures like tobacco surcharges have not been proven effective in encouraging smokers to quit and reducing tobacco use.
- There are plenty of other policies that are proven to reduce tobacco use: like increasing tobacco taxes, enacting smokefree laws, funding tobacco control programs and making tobacco cessation treatment accessible through health insurance coverage and quitlines.
- Tobacco surcharges can result in tobacco users paying thousands of dollars more in health insurance premiums – a study in California showed that an average tobacco user could end up paying 18.7 percent of his annual income in premiums because of the surcharge allowed.¹
- Large additional costs may make health insurance unaffordable for tobacco users, causing them to remain uninsured. This would leave tobacco users without coverage for treatments that will help them quit, in addition to other needed healthcare. Their families and/or children may also remain uninsured or be affected by the uninsured tobacco user.
- While the Affordable Care Act allows tobacco surcharges up to 1.5 times the regular premium, states are able to limit these surcharges or prohibit them altogether. Making health insurance affordable for tobacco users is something state legislatures and insurance commissioners should consider.
- If an employer or insurer chooses to penalize tobacco users through a tobacco surcharge, it is only fair that policyholders have access to a comprehensive tobacco cessation benefit that will help them quit.

Tobacco Cessation Benefits Should Include

ALL of These:

Nicotine Patch	Individual Counseling
Nicotine Gum	Group Counseling
Nicotine Lozenge	Phone Counseling
Nicotine Nasal Spray	
Nicotine Inhaler	
Bupropion	
Varenicline	

Comprehensive Tobacco Cessation Benefit

Providing a comprehensive tobacco cessation benefit means requiring easy access to seven medications and three types of counseling recommended by the U.S. Department of Health and Human Services (HHS) to treat tobacco use and nicotine dependence. Quitting tobacco is extremely hard, and everyone responds to treatment differently. It is important that potential quitters have access to all treatments.

¹ Curtis, Rick and Ed Neuschler, Institute for Health Policy Solutions. "Tobacco Rating Issues and Options for California under the ACA." June 2012. Available at: http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf

**Maine Health Exchange Advisory Committee
Discussion Draft---Potential Findings and Recommendations**

Pursuant to H.P. 1136, the Maine Health Exchange Advisory Committee was directed by the Legislature to consider the issues described below. Based on its review and discussions, the Advisory Committee makes the following findings and recommendations.

1. Whether Maine's federally-facilitated marketplace is effective for individuals and small businesses and whether the State should transition to a partnership exchange or state-based exchange in the future.

The Advisory Committee recommends that the State continue with a Federally-Facilitated Marketplace in Maine in 2016. More than 44, 000 people selected qualified health plans through Maine's Marketplace; 90% of those selecting health plans qualified for premium assistance. Despite the initial problems with the healthcare.gov website, Maine's first year in the Marketplace was very successful for individuals and families. While the 2015 enrollment period may present different challenges, the Advisory Committee believes the FFM has provided those individuals enrolled with comprehensive health care coverage and critical financial assistance to those eligible for that assistance. The success of Marketplaces in other states was mixed. Some states that chose to establish state-based Marketplaces like Connecticut and Kentucky successfully launched their Marketplaces, while other states like Oregon and Maryland were not as successful in implementing their Marketplaces.

While Maine's FFM operated effectively for individuals, full implementation of the SHOP Marketplace for small businesses through healthcare.gov was delayed in FFM states like Maine until 2015. , It is premature for the Advisory Committee to assess the effectiveness of the FFM model for small businesses. During its meetings in 2013, the Advisory Committee did discuss the potential for the State to establish a state-based SHOP Marketplace to serve small businesses. The Advisory Committee received a briefing on Kentucky's health benefit exchange, "kynect." After the first year, Kentucky's Marketplace appears to be one of the most successful state-based Marketplaces in terms of small business enrollment. The Advisory Committee was impressed with Kentucky's approach to its small business Marketplace and the broad involvement of health insurance brokers. The Advisory Committee may be interested in exploring this potential model if the Federally-Facilitated SHOP Marketplace fails to attract enrollment from small businesses in Maine.

The Advisory Committee has also considered whether a transition to a formal partnership model would provide any added benefit. Under the partnership model, states can assume responsibility over the plan management functions and/or consumer assistance functions of the Marketplace in conjunction with the federal government. Through an exchange of letters, the Bureau of Insurance has assumed certain plan management functions for the FFM. The Bureau oversees the regulation of health insurance carriers participating in the FFM, including review of premium rates. The Advisory Committee believes current coordination of plan management activities by the Bureau of Insurance with the FFM has been effective for the health plans operating in Maine as well as Maine insurance consumers. The Advisory Committee does not recommend any changes to this oversight model, but the Legislature's Joint Standing Committee on Insurance and Financial Services should monitor the relationship of the FFM with the Bureau of Insurance and determine whether a future transition to a formal partnership model should be considered.

Legal challenges to the validity of premium subsidies in states with Federally-Facilitate Marketplaces may affect the future operation of Maine's marketplace and cause policymakers to reconsider Maine's current model. At this time, however, the Advisory Committee does not believe that changes to Maine's Federally-Facilitated Marketplace model are necessary.

**Maine Health Exchange Advisory Committee
Discussion Draft---Potential Findings and Recommendations**

The Legislature should continue to monitor the operations of the FFM and, after the 2015 enrollment period, assess whether any changes can be made to make the Marketplace more effective for individuals and small businesses.

2. Evaluate the implementation and operation of any exchange with respect to the essential health benefits benchmark plan designated in this State under the federal Patient Protection and Affordable Care Act, including whether the State should change its designation.

The current federal guidance under which States designated Essential Health Benefits medical and dental benchmark plans applies through plan year 2015. When the current benchmark plan selection process was announced, CMS indicated that additional guidance as to any changes in that selection process might be provided for plan years beginning in 2016 and thereafter. The Advisory Committee wrote letters in June and August 2014 urging CMS to issue immediate notification to States as to whether the current federal guidance permitting States to designate a benchmark plan for Essential Health Benefits will be continued without change or modified for the 2016 plan year. If changes are anticipated, the Advisory Committee believes guidance must be provided no later than in the last quarter of 2014 so that health insurance carriers are able to incorporate any changes into 2016 health plans submitted for approval to the Maine Bureau of Insurance in the spring of 2015. In addition, if changes to Maine's designation of Essential Health Benefits will be permitted for the 2016 plan year, the Legislature will need adequate time to consider any policy options carefully and receive public input on those options before making any recommendations.

Maine's benchmark plan for Essential Health Benefits is based on the largest small group health plan and incorporates all mandated health benefits that were enacted as of December 2011. Pursuant to the federal Affordable Care Act, the State is required to defray the costs of all additional mandated health benefits required in qualified health plans on or after January 1, 2014. In 2014, Maine enacted a law requiring all individual and small group health insurance policies to provide coverage for bone marrow testing. While initial estimates of the costs of this added mandate are modest (approximately \$40,000 annually), the federal government has not provided guidance to States for how States will be required to pay these costs. The Advisory Committee believes guidance must be provided so that the Legislature can evaluate future legislative proposals for mandated health benefits knowing the financial impact of the proposal on the State budget.

3. Evaluate the impact of federal and state laws and regulations governing the health insurance rating for tobacco use and coverage for wellness programs and smoking cessation programs on accessibility and affordability of health insurance.

(to be added after Advisory Committee discussion at Sept. 22 and Oct. 16th meetings)

4. Evaluate the consumer outreach and enrollment conducted by the exchange and whether the navigator program is effective and whether navigators or other persons providing assistance to consumers are in compliance with any federal or state certification and training requirements.

The Advisory Committee believes that consumer outreach and enrollment efforts in Maine have been successful despite limited federal resources. 44,258 Maine residents selected health care plans during the open enrollment period. It is a remarkable achievement that would not have been possible without the

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coordinated effort of Maine's recognized navigators, certified application counselors and other community partners. In addition, the Maine Health Access Foundation provided significant leadership and resources as well as the enroll207.com website. The Advisory Committee also wants to acknowledge the important role that libraries throughout Maine played in sponsoring information sessions and providing assistance to consumers.

However, the Advisory Committee believes additional resources are needed to enhance the consumer education, outreach and assistance efforts currently being provided. The Advisory Committee believes consumer education and outreach efforts must continue for both individuals and small businesses. The delays in full implementation of the SHOP marketplace highlight the continued need for assistance to small businesses. Individuals and small businesses must be informed of regulatory changes and other implementation developments so they are able to make good decisions based on current information about their health coverage options. The Advisory Committee supports the Navigator program and was pleased that federal resources for Maine's two recognized navigators has been extended and increased for 2015. Funding should be available to support the Navigator program as long as Maine's FFM is operating.

The Advisory Committee believes Maine's navigator program is effective. Navigators have fulfilled federal and state requirements for certification and training. During the 2014 enrollment period, the Bureau of Insurance did not receive any consumer complaints about the conduct of navigators.

As over 44,000 Mainers begin to use their new health insurance coverage and with more Mainers expected to join the Marketplace in the upcoming open enrollment period, the Advisory Committee also believes that consumer assistance programs are needed more than ever. Many people who are now covered have never had health insurance before, and need help to understand their health care coverage and access the new protections that the federal Affordable Care Act has provided. Maine consumers also need help with navigating their coverage, including filing complaints and appeals if needed. The Advisory Committee sent a letter in support of Consumer for Affordable Health Care's application for continued federal funding for its consumer assistance program. Given the limited federal resources being spent in Maine, the Advisory Committee feels that this valuable assistance needs to continue in 2015.

5. Evaluate the coordination between the state Medicaid program and the exchange.

The Advisory Committee has had limited information about the coordination of the Medicaid program and Maine's FFM. The Maine Department of Health and Human Services has not been responsive to the Advisory Committee's requests for information and has not attended any meetings or accepted the Advisory Committee's invitations to make presentations. While the Maine Department of Health and Human Services (DHHS) has responded to written requests for information, it has been difficult for the Advisory Committee to evaluate the Department's coordination efforts without meaningful input from its representatives. Based on input provided by Christie Hager, the Advisory Committee understands that the FFM and DHHS are working to improve the coordination and exchange of information needed to determine eligibility of individuals for health coverage through Medicaid or the FFM.

In order to assess the implementation of the Marketplace and the relationship between the marketplace and the State's MaineCare program, the Advisory Committee recommends that uniform data elements and common definitions be developed for use, to the extent possible, by the Maine Department of Health and Human Services (DHHS), Bureau of Insurance, state agencies, navigators, certified application counselors and other entities to collect and report data. The Advisory Committee believes it is very important to develop a uniform system to collect and report demographic, eligibility and enrollment data on those individuals and small businesses seeking assistance in obtaining health care coverage through the

**Maine Health Exchange Advisory Committee
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Marketplace or through public programs like MaineCare. Advisory Committee believes that the data should be reported on a regular basis to the Advisory Committee, policymakers and the public to provide objective data to assess the operation of the Marketplace in Maine and to inform future recommendations for changes in policy or law affecting the marketplace. The Advisory Committee recommends that the DHHS develop partnerships with interested organizations to adopt uniform data elements and survey instruments to collect and report demographic, eligibility and enrollment data.

The Advisory Committee has also reviewed sample notices used by DDHS and believes that these notices provide incomplete information to consumers. The Advisory Committee recommends that notices sent by DHHS provide accurate information on all of the coverage options, all of the ways consumers can apply for coverage and all of the resources available to the consumer for assistance in evaluating health coverage options. Copies of the sample notices provided by DHHS can be found in Appendix ____.

6. Evaluate whether health insurance coverage through the exchange is affordable for individuals and small businesses, including whether individual subsidies are adequate.

In its preliminary report from December 2013, the Advisory Committee recommended that the State take action to close the coverage gap to ensure individuals have access to affordable health insurance coverage. As changes in MaineCare eligibility have been implemented, individuals have lost eligibility for MaineCare and will not qualify for subsidies to provide assistance to access private health coverage through the Marketplace. In addition to the individuals who lost eligibility for coverage, there are individuals who are also ineligible for subsidies due to their low incomes. These individuals are described as being in the “coverage gap.”

Since the implementation of the ACA only began on January 1, 2014, the Advisory Committee has not had an opportunity to gather data about the impact of the coverage gap on “churn”. Churning is the movement of consumers between systems of health coverage. Churn can occur between public and private health coverage and between private health plans in and outside of the Marketplace. Churning makes programs more complicated and costly to administer and interrupts continuity of coverage and care. It can also create gaps in coverage when consumers need to move between programs or health plans, and interfere with accurate and comprehensive quality measurement. The coverage gap and churn can also have an effect on the financial stability of federally-qualified health centers, hospitals and other health care providers depending on reimbursement for services provided to individuals enrolled in public and private health plans. The Advisory Committee is concerned about the effects of the coverage gap and churn on the effectiveness of the Marketplace and believes these effects should be monitored.

The Advisory Committee supports providing access to affordable health care coverage for all Maine people as well as the goal of reducing the uninsured and would support policy changes that would close the coverage gap as soon as possible and expand access to affordable health coverage. For the Advisory Committee, affordable health coverage means the availability of the appropriate health care at the right time, at the right place and at the right price. While individuals may be eligible to purchase private health care coverage through the marketplace, the affordability of that coverage is a significant issue for those with limited income.

All policy options should be explored, including amendments to the ACA to expand the availability of premium tax credits to individuals with lower income levels and expanded eligibility for MaineCare, an option which is currently available to the State in accordance with federal law and regulation. The Advisory Committee acknowledges that this recommendation is significant because it represents the consensus of its members; individual members of the Advisory Committee have differing opinions on specific policy options available to address the coverage gap, but all support this recommendation in the

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interest of achieving consensus.

Although the Marketplace and other reforms under the Affordable Care Act have only been in effect for 1 year, the Advisory Committee wants to highlight the positive impact these reforms appear to have on health insurance premium rates in Maine. Based on information provided by the Maine Bureau of Insurance, average individual health insurance rates for 2015 have decreased from 2014 for plans participating in Maine's FFM--- average rates for Maine Community Health Options decreased 0.8% and average rates for Anthem Health Plans of Maine decreased 1.1%. While not all consumers will experience premium rate decreases because of their age or geographic area, the rate reduction and moderation of rate increases are promising.

The Advisory Committee also notes that the design and structure of the ACA has had an effect on affordability of coverage. Current IRS guidelines interpret the ACA in a manner that prevents an employee's family from being eligible for premium subsidies and other financial assistance through the Marketplace even if the cost of coverage for the family is unaffordable. These rules state that an employer's offer of *individual* coverage is used to determine if that coverage is affordable (costs less than 9.5 percent of the employee's income). Even if that employer also offers the employee's family members coverage in its plan, the cost of the family coverage is not used to determine the affordability of the employee's coverage. While the employee's family may purchase coverage through the FFM, they will not be eligible for financial assistance. The Advisory Committee supports efforts at the federal level to address the "family glitch."

7. Evaluate whether the exchange is effective in providing access to health insurance coverage for small businesses.

Because full implementation of the SHOP Marketplace through healthcare.gov was delayed in FFM states like Maine until 2015, it is premature for the Advisory Committee to assess the effectiveness of the FFM model for small businesses. During its meetings in 2013, the Advisory Committee did discuss the potential for the State to establish a state-based SHOP Marketplace to serve small businesses. The Advisory Committee received a briefing on Kentucky's health benefit exchange, "kynect." After the first year, Kentucky's Marketplace appears to be one of the most successful state-based Marketplaces in terms of small business enrollment. The Advisory Committee was impressed with Kentucky's approach to its small business Marketplace and the broad involvement of health insurance brokers. The Advisory Committee may be interested in exploring this potential model if the Federally-Facilitated SHOP Marketplace fails to attract enrollment from small businesses in Maine.

For 2015 open enrollment, improvements in functionality are expected for the SHOP Marketplace, including enrollment through the healthcare.gov website (which was not available in 2014). However, due to an additional delay permitted by the federal government and agreed to by Maine's Superintendent of Insurance, Maine's small employers will not be able to offer their employees a choice of qualified health plans through the SHOP Marketplace in 2015.

The Advisory Committee is concerned that the SHOP marketplace does not provide adequate financial assistance to small employers and their employees to access affordable coverage. Although tax credits are available to certain small businesses for 2 years, small employers do not qualify for any ongoing financial assistance to help pay premium costs when enrolling the business in the SHOP marketplace. The Advisory Committee notes that the Dirigo Health program which operated in Maine prior to the FFM did provide financial assistance to employees based on income. As noted above, the "family glitch" also

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prevents an employee's family from being eligible for premium subsidies and other financial assistance through the Marketplace even if the cost of employer-sponsored coverage for the family is unaffordable.

The Legislature should monitor the operations of the SHOP in Maine and, after the 2015 enrollment period, assess whether any changes can be made to make the Marketplace more effective for small businesses.

8. Evaluate the implementation of rebates under the federal Patient Protection and Affordable Care Act and the Maine Revised Statutes, Title 24-A, section 4319.

Since 2011, the Affordable Care Act has required health insurance companies to maintain a minimum medical loss ratio of at least 80% in the individual and small group markets and at least 85% in the large group market. Insurers that do not meet the minimum standards are required to issue annual rebates in the form of premium reductions or refunds. The medical loss ratio requires that a significant percentage of each premium dollar (80 or 85% depending on the market) be spent on medical care and quality improvement activities.

For Maine in 2011, only the large group market was touched by the rebates, with Connecticut General Life Insurance Co. required to pay a rebate of \$2,579,922.ⁱⁱ No insurers in the individualⁱⁱⁱ or small group markets were required to issue a rebate. For Maine in 2012, CMS reported \$501,240 in rebates in the large group market with 8,796 consumers benefitting from the rebates which averaged \$106 per family.^{iv} As with 2011, there were no rebates reported for the small group or individual market. For the 2013 claim year in Maine, a total of \$1,845,006 in rebates were due in the small group (\$237,887 benefitting 6,002 consumers, \$50 average rebate) and large group (\$1,607,119 benefitting 13,540 consumers, \$211 average rebate).^v

9. Evaluate the coordination of plan management activities between the Department of Professional and Financial Regulation, Bureau of Insurance and the exchange, including the certification of qualified health plans and rate review.

Through an exchange of letters, the Bureau of Insurance has assumed certain plan management functions for the FFM. The Bureau oversees the regulation of health insurance carriers participating in the FFM, including review of premium rates. The Advisory Committee believes current coordination of plan management activities by the Bureau of Insurance with the FFM has been effective for the health plans operating in Maine as well as Maine insurance consumers. The Advisory Committee does not recommend any changes to this oversight model, but the Legislature's Joint Standing Committee on Insurance and Financial Services should monitor the relationship of the FFM with the Bureau of Insurance and determine whether a future transition to a formal partnership model would provide any added benefit. The Advisory Committee also supports the outreach efforts undertaken by the Bureau of Insurance and urges the State, through the Bureau of Insurance, to apply for any available federal grant funds to leverage the available resources to help pay the costs of the Bureau's plan management and consumer outreach activities.

The Advisory Committee wants to compliment the Bureau of Insurance for its exemplary effort to oversee the qualified health plans in Maine's FFM and provide assistance to Maine consumers. Health insurance carriers, consumers and Legislators have all had positive experiences with the Bureau's professional staff.

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10. Study the basic health program option, as set forth in the federal Affordable Care Act and make recommendations as appropriate, that examine the potential for establishing a basic health program for eligible individuals in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan.

The Advisory Committee received a presentation on the Basic Health Program option and other alternative coverage options from Jessica Schubel of Center for Budget Policies and Priorities. The Advisory Committee reviewed the federal law and regulations and discussed the activities of other States that are considering the Basic Health Program option or alternative coverage programs. At this time, Minnesota is the only state that appears poised to establish a Basic Health Program beginning in January 2015. However, other states like New York, Oregon and Vermont are considering a Basic Health Program or other alternatives for universal coverage. Without additional information about the feasibility of a Basic Health Program or other alternatives, it is premature for the Advisory Committee to make a specific policy recommendation. Instead, the Advisory Committee recommends that the State conduct an independent study of the feasibility of operating a Basic Health Program as well as other alternatives for coverage. A draft of the recommended legislation is attached in Appendix ____.

11. Advocate for changes to simplify the tax reconciliation process for enrollees in Maine's Federally-Facilitated Marketplace and the exemption process for Maine residents eligible to claim an exemption from the shared responsibility requirement of the federal Affordable Care Act

The Advisory Committee discussed the potential problems for Maine residents seeking to file 2014 tax returns if changes are not made to the draft instructions for Forms 8962 and 8965 recently proposed by the Internal Revenue Service. The Advisory Committee believes the draft instructions and forms may be too complicated and hard to understand. The Advisory Committee wrote letters to Maine's Congressional delegation and to the Internal Revenue Service to advocate that the process be streamlined and the instructions simplified. Copies of the letters are attached in Appendix ____.

12. Evaluate the continued necessity of a state health exchange advisory committee, including, including the staffing and funding needs of such an advisory committee and recommend , whether such an advisory committee should be established by the 127th Legislature and whether any changes should be made to the Maine Revised Statutes governing such an advisory committee.

The Advisory Committee recommends that the Legislature establish a state health exchange advisory committee on a permanent basis. The Advisory Committee believes there is a continuing need for such a committee to advise the Legislature regarding the implementation of the federal Affordable Care Act through the Marketplace and other health reforms.

The Advisory Committee would recommend two changes to the original joint order: 1) to add a member with expertise in taxation matters, and 2) to provide annual staff support so the Advisory Committee can meet year-round, including during the legislative session. A draft of the recommended legislation is attached in Appendix ____.

The Advisory Committee has identified the following issues that should be considered by the future Advisory Committee:

- ◆ Whether changes should be considered in federal law or regulation to address dental health coverage available through the marketplace, including but not limited to, premiums and out-of-pocket costs;
- ◆ Whether the State should consider changes to its designated rating areas for geographic area to the extent permitted by federal law and regulation;

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- ◆ The impact of “churn” on the effective operation of the marketplace, public health programs and the private health insurance market;
- ◆ The impact of federal requirements to provide employer-sponsored health coverage on the health care workforce;
- ◆ The impact of the statutory change in the definition of “small group” for health insurance purposes in 2016 ; and
- ◆ The impact of federal transitional risk adjustment programs and whether the State should consider ending the suspension of the Maine Guaranteed Access Reinsurance Association.
- ◆ Whether the State should pursue the Basic Health Plan program or other coverage alternatives following review and evaluation of the feasibility study recommended by the Advisory Committee.
- ◆ *(other issues to be added after Advisory Committee discussion at Oct. 16th meeting ???)*

ⁱ Health Insurance Marketplace: Summary Enrollment Report, October 1, 2013 – April 19, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014. http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf

ⁱⁱ Consumers Union, <http://yourhealthsecurity.org/health-insurance-refund-list-2011>

ⁱⁱⁱ In the individual market, Maine was granted a temporary waiver of the 80% medical loss ratio under federal law for 2011 and 2012; carriers in the individual market were required to meet a 65% MLR.

^{iv} <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-and-market.pdf>

^v http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf

Maine Health Exchange Advisory Committee
Draft: Establish Advisory Committee on permanent basis

Sec. 1. 5 MRSA § 12004-I, sub-§ 50-B is enacted to read:

50-B.

Insurance:Health
Exchange

Maine Health
Exchange Advisory
Committee

Legislative Per
Diem and Expenses
for Legislators and
Expenses Only for
Other Members
upon Demonstration
of Financial
Hardship

24-A MRSA § 4320-J

Sec. 2. 24-A MRSA § 4320-J is enacted to read:

§ 4320-J. Maine Health Exchange Advisory Committee

The Maine Health Exchange Advisory Committee, referred to in this section as "the advisory committee," is established to advise the Governor and the Legislature regarding the interests of individuals and employers with respect to any health benefit exchange, referred to in this section as "the exchange," that may be created for this State pursuant to the federal Patient Protection and Affordable Care Act.

1. Appointment; composition. The advisory committee consists of 21 members appointed as follows:

A. The following 5 members of the Legislature, of whom 3 members must serve on the Joint Standing Committee on Insurance and Financial Services and 2 members must serve on the Joint Standing Committee on Health and Human Services or the Joint Standing Committee on Appropriations and Financial Affairs:

(1) Two members of the Senate, appointed by the President of the Senate, including one member recommended by the Senate Minority Leader; and

(2) Three members of the House of Representatives, appointed by the Speaker of the House, including one member recommended by the House Minority Leader;

B. Two persons representing health insurance carriers, one of whom is appointed by the President of the Senate and one of whom is appointed by the Speaker of the House of Representatives;

C. One person representing dental insurance carriers, appointed by the Speaker of the House of Representatives;

D. One person representing insurance producers, appointed by the President of the Senate;

E. One person representing Medicaid recipients, appointed by the Speaker of the House of Representatives;

F. Two persons representing health care providers and health care facilities, including one member representing federally qualified health centers, appointed by the Speaker of the House of Representatives;

G. One person who is an advocate for enrolling hard-to-reach populations, including individuals with mental health or substance abuse disorders, appointed by the President of the Senate;

Maine Health Exchange Advisory Committee
Draft: Establish Advisory Committee on permanent basis

H. One member representing a federally recognized Indian tribe, appointed by the President of the Senate;

I. One member who has expertise in tax matters, appointed by the President of the Senate;

J. Four members representing individuals and small businesses, including:

(1) One person, appointed by the President of the Senate, who can reasonably be expected to purchase individual coverage through an exchange with the assistance of a premium tax credit and who can reasonably be expected to represent the interests of consumers purchasing individual coverage through the exchange;

(2) One person, appointed by the Speaker of the House of Representatives, representing an employer that can reasonably be expected to purchase group coverage through an exchange and who can reasonably be expected to represent the interests of such employers;

(3) One person, appointed by the President of the Senate, representing navigators or entities likely to be licensed as navigators; and

(4) One person, appointed by the Speaker of the House of Representatives, employed by an employer that can reasonably be expected to purchase group coverage through an exchange and who can reasonably be expected to represent the interests of such employees;

K. The Superintendent of Insurance, or the superintendent's designee, who serves as an ex-officio nonvoting member; and

L. The Commissioner of Health and Human Services, or the commissioner's designee, who serves as an ex officio nonvoting member.

2. Term. Except for members who are Legislators, all members are appointed for 3-year terms. A vacancy must be filled by the same appointing authority that made the original appointment. Appointed members may not serve more than 2 terms. Members may continue to serve until their replacements are designated. A member may designate an alternate to serve on a temporary basis. Members of the Legislature serve 2-year terms coterminous with their elected terms. Except for a member who is a Legislator, a member may continue to serve after expiration of the member's term until a successor is appointed.

3 Chair. The first-named Senator is the Senate chair of the advisory committee and the first-named member of the House of Representatives is the House chair of the advisory committee.

4. Duties. The advisory committee shall:

A. Advise the Governor and Legislature regarding the interests of individuals and employers with respect to any exchange that may be created for this State;

B. Serve as a liaison between any exchange and individuals and small businesses enrolled in the exchange;

C. Evaluate the implementation and operation of any exchange with respect to the following:

(1) The essential health benefits benchmark plan designated in this State under the federal Patient Protection and Affordable Care Act, including whether the State should change its designation;

(2) The impact of federal and state laws and regulations governing the health insurance rating for tobacco use and coverage for wellness programs and smoking cessation programs on accessibility and affordability of health insurance;

Maine Health Exchange Advisory Committee
Draft: Establish Advisory Committee on permanent basis

(3) The consumer outreach and enrollment conducted by the exchange and whether the navigator program is effective and whether navigators or other persons providing assistance to consumers are in compliance with any federal or state certification and training requirements;

(4) The coordination between the state Medicaid program and the exchange;

(5) Whether health insurance coverage through the exchange is affordable for individuals and small businesses, including whether individual subsidies are adequate;

(6) Whether the exchange is effective in providing access to health insurance coverage for small businesses;

(7) The implementation of rebates under the federal Patient Protection and Affordable Care Act and the Maine Revised Statutes, Title 24-A, section 4319; and

(8) The coordination of plan management activities between the Department of Professional and Financial Regulation, Bureau of Insurance and the exchange, including the certification of qualified health plans and rate review;

~~D. Following the release of guidance or regulations from the federal Centers for Medicare and Medicaid Services addressing the basic health program option, as set forth in Section 1331 of the federal Patient Protection and Affordable Care Act, conduct a study, and make recommendations as appropriate, that examines the potential for establishing a basic health program for eligible individuals in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan. In conducting the study, the advisory committee shall consider the affordability of coverage for low-income populations, the potential cost savings to the state Medicaid program, the systems needed to create a seamless transition between a basic health program and Medicaid coverage, the impact of a basic health program on the negotiation of rates or receipt of rebates and the cost-effectiveness of delivering coverage through a basic health program; and~~

E. Based on the evaluations conducted by the advisory committee pursuant to this section, make recommendations for any changes in policy or law that would improve the operation of an exchange for consumers and small businesses in the State.

5. Compensation. The legislative members of the advisory committee are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the advisory committee. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the advisory committee.

6. Quorum. A quorum is a majority of the members of the advisory committee.

7. Meetings. The advisory committee shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chairs. Meetings of the advisory committee are public proceedings as provided by the Maine Revised Statutes, Title 1, chapter 13, subchapter 1.

8. Records. Except for information designated as confidential under federal or state law, information obtained by the advisory committee is a public record as provided by the Maine Revised Statutes, Title 1, chapter 13, subchapter 1.

9. Staffing. The Legislature, through the advisory committee, shall contract for staff support for the advisory committee, which, to the extent funding permits, must be year-round staff

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Draft: Establish Advisory Committee on permanent basis

support. In the event funding does not permit adequate staff support, the advisory committee may request staff support from the Legislative Council, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

10. Accounting; funding for advisory committee activities. All funds appropriated, allocated or otherwise provided to the advisory committee must be deposited in an account separate from all other funds of the Legislature and are nonlapsing. Funds in the account may be used only for the purposes of the advisory committee. The council may apply for grants and other nongovernmental funds to provide staff support or consultant support to carry out the duties and requirements of this section. Prompt notice of solicitation and acceptance of funds must be sent to the Legislative Council. All funds accepted must be forwarded to the Executive Director of the Legislative Council, along with an accounting that includes the amount received, the date that amount was received, from whom that amount was received, the purpose of the donation and any limitation on use of the funds. The executive director shall administer all funds received in accordance with this section. At the beginning of each fiscal year, and at any other time at the request of the cochairs of the advisory committee, the executive director shall provide to the advisory committee an accounting of all funds available to the advisory committee, including funds available for staff support.

11. Reports. Beginning March 1, 2016 and annually thereafter, the advisory committee shall report annually and make specific recommendations, including any necessary legislation, relating to its duties in section 4 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters and to any appropriate state agency.

SUMMARY

This draft proposes to establish the Maine Health Exchange Advisory Committee on a permanent basis. The proposal adds one additional member with expertise in taxation matters and requires that the Advisory Committee meet on a year-round basis.

Sec. 1. Feasibility study; Basic Health Program and other alternative coverage programs. Resolved: That the Legislative Council, through the Maine Health Exchange Advisory Committee, shall contract with a qualified consultant to conduct an independent study of the feasibility of operating the following coverage affordability programs in this State pursuant to the federal Affordable Care Act:

1. A basic health program;
2. An optional Medicaid State Plan “XX” Group; and
3. A State Innovation waiver.

Sec. 2. Study requirements. Resolved: That the study must meet the following requirements:

1. For each alternative coverage option, provide estimates of the:
 - (a) Number and characteristics of individuals who would be eligible to enroll in the basic health program or in the other alternative options;
 - (b) Federal funds available to operate each coverage program option;
 - (c) State expenses and administrative costs to operate each coverage program option;
 - (d) Impact of each coverage program option on the number of individuals enrolled in qualified health plans through the State’s federally-facilitated exchange;
 - (e) Impact of each coverage program option on the rates at which individuals with incomes below 200 percent of the federal poverty guidelines lack health insurance coverage compared to such rates in the absence of each coverage program option;
 - (f) Extent to which individuals would be expected to:
 - (A) Cycle in and out of each coverage program option and the exchange due to changes in income; and
 - (B) Maintain continuity of care;
 - (g) Premium and out-of-pocket costs of health care to consumers with and without each coverage program option; and
 - (h) Impact of each coverage program option on premiums charged in the private insurance market.
2. The study must evaluate the financial feasibility of operating each coverage program option using at least two alternatives for:
 - (a) Health benefit packages, including packages that mirror the State’s MaineCare benefit package and the essential health benefits package offered through the exchange;
 - (b) Provider reimbursement rates, including rates that mirror provider reimbursement rates in the MaineCare program and the private insurance market in this state; and
 - (c) Premium and out-of-pocket cost limits.
3. The Advisory Committee shall solicit input using a public process to determine the factors and assumptions on which the study will be based.

4. The Legislative Council shall seek outside grant funding to fully fund all costs of the updated study, which may not exceed \$60,000. If sufficient outside funding has not been received by the Legislative Council by October 1, 2015 to fully fund all costs of the updated study, no expenses of any kind related to the study may be incurred.

5. The study must be submitted no later than October 15, 2015 to the Advisory Committee. The Advisory Committee may submit legislation based on the feasibility study to the Joint Standing Committee on Insurance and Financial Services for its consideration during the Second Regular Session of the 127th Legislature; and be it further

Sec. 2 Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Legislature 0081

Initiative: Allocates funds to the Legislature to contract for a study of the feasibility of establishing a basic health program or other coverage alternatives for the State.

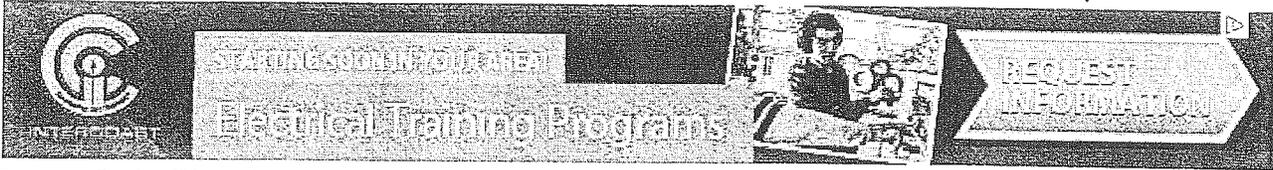
OTHER SPECIAL REVENUE FUNDS	2015-16	2016-17
All Other	\$60,000	\$0
OTHER SPECIAL REVENUE FUNDS TOTAL	\$60,000	\$0

SUMMARY

This draft directs the Legislative Council, through the Maine Health Exchange Advisory Committee, to contract for a study of the feasibility of establishing a basic health program or other alternative health coverage options under the federal Affordable Care Act. The study must be submitted to the Advisory Committee by October 1, 2015.

FOR MHEAL REVIEW

10/16/14



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CAREERS

Wellness Programs Get a Health Check

Designed to Motivate Workers to Get in Shape, Employers Tread Carefully With Toughened Plans

By LAUREN WEBER

Oct. 7, 2014 7:49 p.m. ET

Wellness programs are supposed to help workers stay fit but some lawsuits say employers are crossing the line. WSJ's Adam Auriemma reports on the News Hub. Photo: Getty.

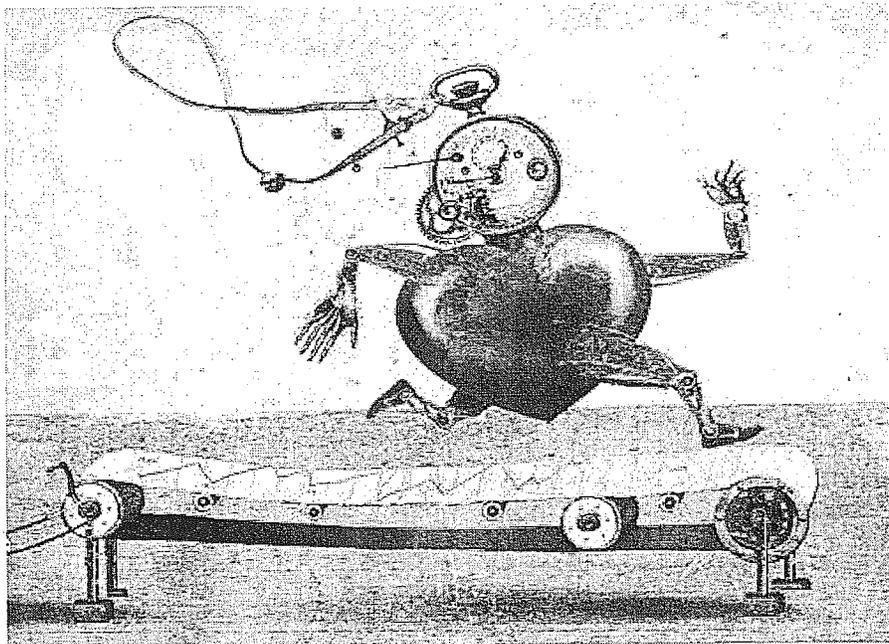
Companies are trying to figure out just how far they can go to keep their workers fit and healthy.

Employer wellness programs, designed to motivate employees to get in shape and address medical and lifestyle issues, have proliferated in recent years as bosses look for new ways to manage health-care costs. Nearly every major employer has some sort of initiative, many of which reward workers for their participation with discounts on insurance premiums or extra cash in their reimbursement accounts.

Those are the carrots. Sticks—adding a surcharge to premiums for those who don't complete certain requirements, for example—are being applied as well. That's due in part to the Affordable Care Act, which encouraged the growth of wellness programs by increasing both the maximum incentives and the maximum penalties employers may use.

The state of Maryland this week said its wellness program, required as part of insurance coverage, could bring penalties of as much as \$450 per person by 2017 for those who fail to undergo certain screenings and fail to follow treatment plans for chronic conditions. The state said the program could save \$4 billion over the next 10 years, according to news reports.

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Bruno Mallart

Workers at CVS Health Corp. who don't complete an annual health risk assessment and health screening pay \$600 more per year for their insurance premiums. CVS said the information is kept confidential by a third party and cannot be accessed by company management.

But employers are trading carefully when it comes to toughened wellness programs, lawyers and benefits executives say, as two federal lawsuits raise the volume on concerns about workers' privacy and the border between voluntary and compulsory participation.

The suits, and the lack of firm guidance from the Equal Employment Opportunity Commission, which brought them to court, complicates an already fraught question: How to get involved in employees' well-being without sowing discontent among the workforce or inviting legal and ethical complaints.

The EEOC has "thrown a fly in the ointment" by cautioning that wellness programs might violate the law when they are nominally optional but essentially required in practice, said Jim Napoli, a benefits attorney at employer-side law firm Constangy, Brooks & Smith LLP.

One suit, filed last week, alleges that Flambeau Inc., a Wisconsin-based plastics manufacturing firm owned by Nordic Group of Companies Ltd., canceled the insurance coverage of an employee and shifted the full cost of his premium to him after he failed to complete biometric testing, which can include cholesterol or glucose checks, and a questionnaire about health risks.

The other suit, filed in August, claims Orion Energy Systems Inc., also in Wisconsin, essentially required employees to take medical exams and then fired a worker after she objected to the wellness program.

Orion declined to comment. A call to Flambeau wasn't returned.

Both suits allege violations of the Americans with Disabilities Act, which forbids employers from requiring medical exams and making disability-related inquiries. The EEOC held hearings on wellness programs last year that addressed, among other things, concerns that the plans might single out people with specific conditions such as obesity.



The actions “will definitely have us take extra precautions,” said the head of benefits at a New York financial institution, who didn’t want to be named because of the current compliance spotlight on wellness.

Kristen Brown, benefits director at JetBlue Airways Corp. , said the “marketplace for wellness is new and ever-evolving.” The airline places as much as \$400 a year into full-time employees’ health savings or reimbursement accounts for about 45 different activities such as signing up for smoking-cessation programs or completing an Ironman race. JetBlue canvasses workers annually and adds or deletes activities based in part on that feedback.

JetBlue is currently testing a program in the New York area with a company called LifeVest that ties monetary incentives of as much as \$500 to employees’ body-mass index. “You’ve got to see the real results. It can’t be something that’s a health game you can play online while still eating your bag of Doritos,” said Ms. Brown.

In terms of compliance, she said, “the key issue is making sure there are alternatives for someone who is incapable of getting the benefits [through a single component of the plan]. That’s one of the reasons we offer a lot of choices.”

Beyond legal and ethical issues, understanding what inspires people to improve their health is also a challenge, companies are finding.

At Johnson & Johnson, which has had a wellness program in place for decades, employees receive a \$500 credit toward their annual medical premium if they participate in a health assessment as well as health coaching. In 2010, the company created an additional incentive to reward obese and overweight workers who reduced their weight by 10%. That effort was discontinued in 2012 because of low participation, said Fik Isaac, J&J’s vice president for global health services.

“They were not interested in taking J&J up on the offer,” he said. Instead, the company is focusing on non-monetary campaigns, such as a walking program that recognizes people who take more than one million steps in a year.

Workers are wary of anything that smacks of coercion or discipline. In a June poll by the Henry J. Kaiser Family Foundation, 62% of those surveyed said it is inappropriate for employers to require workers to pay more for their health insurance premiums if they don’t participate in wellness programs, and 74% said companies shouldn’t charge higher premiums if employees don’t achieve predetermined health goals.

On the other side of the equation, employers are stymied by the difficulties of measuring the financial and health impact of wellness programs that can be as varied as providing an advocate to manage a worker’s heart-transplant process to hosting walking challenges that use FitBit, a fitness tracking bracelet.

A September report from the Bipartisan Policy Center’s CEO Council on Health and Innovation found that “results of studies about the return on investment of wellness programs are mixed.”

Despite that, the use of incentives appears to be on the rise. Seventy-four percent of employers with wellness programs planned to offer incentives this year compared with 57% in 2009, according to the National Business Group on Health. The median incentive has risen to \$500 from \$338 in 2010.

Even carrots, however, have some employers nervous. The New York financial firm offers incentives in the form of gift cards for workers who complete health assessments and screenings, but has shied away

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from discounts on premiums. "We're just not there yet and given everything that's going on, I'm not sure it's a good place to be," the executive said.

—Adam Auriemma contributed to this article.

Write to Lauren Weber at lauren.weber@wsj.com

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