Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition

Weeks of February 28th, March 7th and 14th

**2015 -2016 Marketplace Enrollment Growth/Decline by Community**

|  |  |  |  |
| --- | --- | --- | --- |
| Community | 2015 Marketplace Enrollment | 2016 Marketplace Enrollment | Percentage Change |
|  |  |  |  |
| 1. Phoenix
 | 41,331  | 38,108  | -7.80% |
| 1. Tucson
 | 30,138  | 29,238  | -2.99% |
| 1. Mesa
 | 16,097  | 15,475  | -3.86% |
| 1. Scottsdale
 | 10,843  | 11,202  | 3.31% |
| 1. Gilbert
 | 9,152  | 9,580  | 4.68% |
| 1. Glendale
 | 9,633  | 8,847  | -8.16% |
| 1. Chandler
 | 7,487  | 7,569  | 1.10% |
| 1. Peoria
 | 5,341  | 5,701  | 6.74% |
| 1. Prescott, Prescott Valley
 | 4,111  | 4,690  | 14.08% |
| 1. Tempe
 | 4,587  | 4,585  | -0.04% |
| 1. Surprise
 | 3,824  | 3,813  | -0.29% |
| 1. Buckeye
 | 3,223  | 3,271  | 1.49% |
| 1. Flagstaff
 | 2,765  | 3,154  | 14.07% |
| 1. Yuma
 | 2,977  | 2,990  | 0.44% |
| 1. San Tan Valley, Queen Creek, San Tan Valley
 | 2,502  | 2,526  | 0.96% |
| 1. Lake Havasu City
 | 2,216  | 2,408  | 8.66% |
| 1. Queen Creek, Chandler Heights, San Tan
 | 2,074  | 2,333  | 12.49% |
| 1. Goodyear
 | 2,308 | 2,310 | 0.09% |
| 1. Avondale
 | 2,422  | 2,221  | -8.30% |
| 1. Maricopa
 | 1,770  | 1,542  | -12.88% |
| 1. Kingman
 | 1,336  | 1,430  | 7.04% |
| 1. Casa Grande
 | 1,657  | 1,396  | -15.75% |
| 1. Laveen
 | 1,396  | 1,387  | -0.64% |
| 1. Paradise Valley
 | 1,344 | 1,264 | -5.95% |
| 1. Apache Junction
 | 1,471  | 1,327  | -9.79% |
| 1. Bullhead City
 | 1,368  | 1,306  | -4.53% |
| 1. Sun City, Sun City West
 | 1,237  | 1,304  | 5.42% |
| 1. Cave Creek
 | 1,121  | 1,198  | 6.87% |
| 1. Sedona
 | 1,100  | 1,194  | 8.55% |
| 1. Sierra Vista
 | 1,167  | 1,183  | 1.37% |
| 1. El Mirage
 | 1,069  | 1,070  | 0.09% |
| 1. Tolleson
 | 1,127  | 1,024  | -9.14% |
| 1. Litchfield Park
 | 953  | 992  | 4.09% |
| 1. San Luis
 | 844 | 982 | 16.35% |
| 1. Rio Rico, Nogales
 | 1,020 | 946 | -7.25% |
| 1. Nogales
 | 1,064 | 914 | -14.10% |
| 1. Kirkland, Peeples Valley
 | 490 | 890 | 81.63% |
| 1. Payson, Star Valley
 | 777 | 874 | 12.48% |
| 1. Fountain Hills
 | 808  | 869  | 7.55% |
| 1. Marana
 | 764  | 826  | 8.12% |
| 1. Sahuarita
 | 790 | 799 | 1.14% |
| 1. Chino Valley
 | 685  | 723  | 5.55% |
| 1. Vali, Coronoa, Cornoa De Tuc, Corona De Tucson
 | 605 | 681 | 12.56% |
| 1. Green Valley
 | 586  | 666  | 13.65% |
| 1. Show Low
 | 516 | 554 | 7.36% |
| 1. Fort Mohave, Bullhead City
 | 461  | 528  | 14.53% |
| 1. Florence
 | 484  | 460  | -4.96% |
| 1. Waddell
 | 379  | 456  | 20.32% |
| 1. Somerton
 | 430  | 445  | 3.49% |
| 1. Safford
 | 400  | 421  | 5.25% |
| 1. Dewey
 | 351 | 411 | 17.09% |
| 1. Gold Canyon, Apache Junction, Queen Valley
 | 379  | 408  | 7.65% |
| 1. Douglas
 | 420 | 386 | -8.10% |
| 1. Snowflake
 | 300  | 341  | 13.67% |
| 1. Lakeside
 | 292  | 332  | 13.70% |
| 1. New River
 | 264  | 327  | 23.86% |
| 1. Coolidge
 | 356  | 317  | -10.96% |
| 1. Thatcher
 | 247  | 301  | 21.86% |
| 1. Golden Valley, Kingman
 | 286  | 285  | -0.35% |
| 1. Hereford
 | 247  | 279  | 12.96% |
| 1. Arizona City
 | 302  | 262  | -13.25% |
| 1. Cornville
 | 234  | 260  | 11.11% |
| 1. Benson
 | 293  | 259  | -11.60% |
| 1. Bisbee
 | 280  | 247  | -11.79% |
| 1. Williams
 | 197  | 247  | 25.38% |
| 1. Globe
 | 249  | 246  | -1.20% |
| 1. Wickenburg
 | 207  | 244  | 17.87% |
| 1. Page
 | 210  | 240  | 14.29% |
| 1. Eloy, Toltec
 | 272  | 239  | -12.13% |
| 1. Clarkdale
 | 212  | 230  | 8.49% |
| 1. Tuba City
 | 208  | 213  | 2.40% |
| 1. Willcox, Ft. Grant
 | 199  | 212  | 6.53% |
| 1. Mayer, Bensch Ranch, Cordes Lakes
 | 208  | 210  | 0.96% |
| 1. Paulden
 | 221 | 202 | -8.60% |
| 1. Parker
 | 182 | 199 | 9.34% |
| 1. Taylor
 | 166  | 198  | 19.28% |
| 1. Mohave Valley
 | 184  | 196  | 6.52% |
| 1. Rimrock
 | 184  | 192  | 4.35% |
| 1. Wittmann
 | 230  | 192  | -16.52% |
| 1. Tonopah
 | 218  | 186  | -14.68% |
| 1. Youngtown
 | 231  | 179  | -22.51% |
| 1. Pine, Strawberry
 | 114  | 144  | 26.32% |
| 1. Pinetop
 | 127  | 142  | 11.81% |
| 1. Oracle
 | 131  | 137  | 4.58% |
| 1. Saint Johns
 | 116 | 135 | 16.38% |
| 1. Huachuca City
 | 170 | 133 | -21.76% |
| 1. Carefree
 | 100  | 125  | 25.00% |
| 1. Eager
 | 94  | 123  | 30.85% |
| 1. Pima
 | 132  | 121  | -8.33% |
| 1. Winslow
 | 129  | 109  | -15.50% |
| 1. Gila Bend
 | 109  | 104  | -4.59% |
| 1. Black Canyon City, Rock Springs
 | 117  | 103  | -11.97% |
| 1. Holbrook
 | 94  | 96  | 2.13% |
| 1. Wellton
 | 78  | 91  | 16.67% |
| 1. Springerville
 | 63  | 89  | 41.27% |
| 1. Tombstone
 | 80  | 89  | 11.25% |
| 1. Overgaard
 | 91 | 82 | -9.89% |

Source: Vitalyst Health Foundation analysis of ASPE 2015 and 2016 Marketplace enrollment data as of February 22nd.

**Our View: Tell Andy Biggs that KidsCare Deserves a Vote**

Arizona Republic

How to Contact Any Biggs:

Pressure Senate President Andy Biggs to allow a vote on KidsCare. You can:

Send him an email: <http://www.azleg.gov/emailmember.asp?Member_ID=12&Legislature=52&Session_ID=115>

Call his office: (602) 926-4371

Editorial: Senate President Andy Biggs should not block a bill that is good for Arizona.

“I don’t support KidsCare,” says Arizona Senate President Andy Biggs.

So a bill to restore health-care coverage for the children of the working poor could die in the Senate. “I don’t support KidsCare,” says Biggs.

So a bill that passed the House 47-12 many not even come to a vote in the chamber Biggs controls.

I don’t support KidsCare,” says Biggs.

So a bill that could let 30,000 kids see a doctor at no cost to the state could be blocked by one state lawmaker with national political ambitions.

Don’t let it happen. If you support KidsCare, tell Biggs not to kill House Bill 2309.

As Senate president, Biggs has the power to prevent a bill from moving through the usual process that leads to a vote. That’s what he’s doing. The clock is ticking. If he doesn’t’ act soon, it will be too late.

As a candidate for Congress in the heavily Republican Congressional District 5, Biggs may hope to win points with GOP primary voters by blocking the federal program.

It could help him in the contested primary. GOP state Rep. Justin Olson, who just entered the CD 5 race, voted for KidsCare in the House. So did other Republicans who recognize this about children, not politics.

Biggs opposition to KidsCare won’t help Arizona.

Why Arizona Needs KidsCare

Arizona has the highest rate of uninsured children among the families who would benefit most from the restoration of the program.

Restoration would allow KidsCare to once again bring health care to children whose families make too much to qualify for the state’s Medicaid program, but too little to buy insurance on their own. These are children of the working poor. Despite the expansion of Medicaid eligibility, these kids are left out. Some working families whose children would be eligible for KidsCare cannot afford to buy coverage through the Affordable Care Act.

KidsCare was frozen during the recession even though doing so did not make economic sense.

In those days, KidsCare brought in a 3-to-1 federal match. Dismantling it saved Arizona $12.9 million in fiscal 2011, but cost the state $41 million in federal matching money that year according to Kaiser Commission on Medicaid and the Uninsured.

It Won’t Cost Arizona a Penny

Now the feds are willing to pay the entire cost.

That’s right. The program Biggs is blocking would not cost the state one cent. The federal government will pay 100 percent of the cost of the program at least through 2017, possibly through 2019.

In response to concern that Arizona could be on the hook for the program after that, Republican Rep. Regina Cobb’s bill was amended to make clear that Arizona can end the program if the federal money dries up.

Opponents who suggest that it would be politically tough to the stop the program once kids enroll are forgetting history: the program was frozen during the recession.

There’s Also An Exit Strategy, If We Need It

The truth is that even with a 3-to-1 match, this program made sense for Arizona. Nevertheless, an exit strategy is built into the restoration.

Those who oppose KidsCare on principle that the federal government should not be spending on social programs are ignoring reality: If Arizona doesn’t take this 100 percent deal, the money will go to some other state.

And sick kids in Arizona won’t get to the doctor.

Senate President Biggs can vote against KidsCare if he doesn’t support it. But he should not use his position to prevent other senators from voting.

Public pressure can help, and the Legislature website (azleg.gov) makes it easy to tell Biggs that KidsCare deserved fair treatment in the Senate – regardless of his personal views.

[http://www.azcentral.com/story/opinion/editorial/2016/03/12/andy-biggs-kidscare-vote/81617374/#](http://www.azcentral.com/story/opinion/editorial/2016/03/12/andy-biggs-kidscare-vote/81617374/)

**CMS Finalizes Changes to ACA Marketplace: 6 Things to Know**

Becker’s Hospital Review

Under the rule, beginning with 2018 plans, charges for services provided by an out-of-network ancillary provider in an in-network facility will go toward an enrollee's annual limitation on cost sharing. The purpose of this change is to limit surprise medical bills. However, there is an exception to the requirement if the issuer provides adequate notice to the enrollee that an out-of-network ancillary provider may be providing services and that the enrollee may incur additional costs.

"Our intent in establishing this policy beginning for the 2018 benefit year is to permit us to monitor ongoing efforts by issuers and providers to address the complex issue of surprise out-of-network cost sharing at in-network facilities," said CMS.

2. **Network transparency.** Beginning in 2017, CMS will implement a rating of each qualified health plan's network coverage. The rating will be available to consumers when shopping for coverage through HealthCare.gov.

3. **Risk-adjustment.** CMS updated the risk-adjustment formula using more recent data. The benefit year 2017 risk adjustment factors will be updated to reflect claims data for years 2012 through 2014. "To better address the data lag and more accurately account for conditions with high-cost treatments, we will also trend specialty and traditional drug expenditures at separate growth rates from medical expenditures," said CMS. In previous years, CMS had used the same growth rate for drug and medical expenditures.

4. **Standardized options.** To simplify the shopping experience for consumers, CMS finalized a proposal to designate plans offering the same level of benefits as "standardized options." For benefit year 2017, CMS developed six standardized plan designs, but issuers will not be forced to offer them.

"We recognize that these cost-sharing structures may not be appropriate for all issuers or all markets," said CMS. "We are not requiring issuers to offer standardized options, nor limiting their ability to offer other qualified health plans, and as a result, we do not believe that standardized options will hamper innovation or limit choice."

5. **Patient safety.** An insurer offering coverage through the marketplaces may only contract with a hospital with more than 50 beds if the hospital either participates with a federally listed patient safety organization or implements "an evidence-based initiative to improve healthcare quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission or improves care coordination."

6. **Annual open enrollment period.** For benefit year 2017, the open enrollment period for the individual marketplaces will begin Nov. 1, 2016, and run through Jan. 31, 2017. The enrollment period for the 2018 benefit year will correspond with 2017. Beginning with the 2019 benefit year, the signup period will be shortened to run from Nov. 1 through Dec. 15.

<http://www.beckershospitalreview.com/payer-issues/cms-finalizes-changes-to-aca-marketplace-6-things-to-know.html>

**Three Changes Consumers Can Expect in Next Year’s Obamacare Coverage**

Kaiser Health News

Health insurance isn’t simple. Neither are government regulations. Put the two together and things can get confusing fast.

So it’s not surprising that federal regulators took a stab at making things a bit more straightforward for consumers in new [rules](https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-benefit-and-payment-parameters) unveiled in late February and published Tuesday in the Federal Register. Because those rules are part of a 530-page, dizzying array of changes set for next year and beyond, here are three specific changes finalized by the Department of Health and Human Services that affect consumers who buy their own health insurance in one of the 38 states using the online federal insurance exchange.

1) Consumers could have access to more information about the size of the insurers’ network of doctors and hospitals.

Most consumers care about two things: the cost of the plan and whether their doctor or hospital is in the plan’s network. The new rules would require insurers to give consumers 30-days’ notice when a provider is being removed from the network. They must also continue to provide coverage for that provider for up to 90 days for patients in active treatment, such as those getting chemotherapy or for women in the later stages of pregnancy — unless the provider is being dropped for cause. Consumers will also see another change: The relative breadth of each plan’s network will be noted with three size designations, which are roughly equal to basic, standard and broad.

2) Consumers could be given slightly more warning about “surprise” medical bills from out-of-network providers.

One of the most common complaints from consumers — even before the federal health law passed — concerns bills they get from out-of-network providers. Such bills can hit consumers even when they go to facilities that are in an insurer’s network because not all of the doctors and other medical staff in those facilities are part of the network. The new rules make a small change, requiring that amounts paid by consumers for ancillary care — such as anesthesiology or radiology — count toward their annual out-of-pocket maximum. That’s important because once a patient hits that out-of-pocket maximum, the insurer is responsible for all in-network medical costs for the rest of the year. But the new rule only applies in cases where the insurer hasn’t warned patients — generally at least 48 hours before the hospitalization or procedure — that they might receive care and bills from such out-of-network providers. Consumer advocates say insurers will simply issue form letters to as many patients as they can to avoid the rule, while insurers complain the rule doesn’t get at the heart of the matter: the high charges they say are set by out-of-network providers.

3) Consumers’ out-of-pocket costs could be more standardized.

This provision could be the rule’s most substantive change. Regulators are requesting that next year insurers voluntarily offer plans with a standard set of coverage costs — from deductibles to copayments for drugs or doctor visits.

The new rules aim to make comparison shopping easier. The change also gives a nod to a cost hurdle that may keep some consumers from enrolling: having to pay hundreds if not thousands of dollars in deductibles before some common services are covered. To entice those consumers, federal regulators created six standard plans that include specific flat-dollar copayments for urgent care visits, most prescription drugs, primary care, mental health and substance abuse treatment — without the consumer first having to spend money to meet an annual deductible. “Insurers will have to compete head-to-head providing the same benefit package, one that most consumers will find fairly attractive,” said Tim Jost, a consumer representative to the National Association of Insurance Commissioners and former law professor who writes widely on the health law.

Still, the standard copayments in plans will likely seem high for some consumers. For example, the bronze plan standard design sets a $45 copayment for a primary care visit and $35 for a generic drug prescription. Copayments are smaller in the standardized silver plans, which set a $30 flat rate for a primary care visit, $65 for a specialist, $15 for generic drugs, $50 for brand name products and 40 percent of the total cost for the most expensive type of drugs, deemed “specialty drugs.” Those amounts are slightly higher than the average costs in silver-level plans sold this year, according to an analysis by consulting firm Avalere.

Insurers opposed the idea of standardized plans, saying they could stifle innovation, lead to higher premiums and make it less likely they will be able to create plans that appeal to a broad variety of consumers. Still, a handful of states, including California, Connecticut, Massachusetts, New York, Oregon, Vermont and the District of Columbia, have designed standardized plans that all insurers in the state marketplace are required to sell. But, because this part of the regulation is voluntary — meaning the federal government is requesting rather than compelling insurers to make these changes — it is unclear how much impact it will have on consumers and the marketplace.

So, in the next open enrollment period, consumers could see such standardized plans available in addition to the varied policies currently sold, which can have widely different payment packages. For example, one plan may have a lower deductible but higher out-of-pocket costs for doctor visits, while another might exclude certain office visits from the annual deductible, while a different option does not. Such variations have provided choice for consumers but also made comparing and contrasting plans difficult.

Meanwhile, HHS also finalized its annual increase in the cap on how much consumers can be charged out of pocket annually for such things as deductibles and copayments. The rule applies to those who buy their own coverage and many employers plans. Next year the cap will be $7,150 for an individual or $14,300 for family coverage.

<http://khn.org/news/three-changes-consumers-can-expect-in-next-years-obamacare-coverage/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=27282122&_hsenc=p2ANqtz-9MLz-nCpDpEwOMWbueRexEMJ40cmz0o_MJZsMv69vf10NnrK5llj_q&tr=y&auid=16539259>

**A New Sign Obamacare is Helping the People who Really Need It**

The Washington Post

People enrolled in health plans through the Affordable Care Act exchanges are ramping up their use of prescription medications more rapidly than those in employer or government-sponsored plans, according to a [new report](http://lab.express-scripts.com/lab/drug-trend-report) from Express Scripts, the largest prescription drug benefits company.

In 2015, people in the exchanges increased their number of prescriptions filled by 8.6 percent, four times the rate of people who receive insurance through commercial plans outside of the exchanges. That, along with price increases, led to a 14.6 percent jump in drug spending for people in tthe exchanges, nearly three times faster than all drug spending. The findings are based on Express Scripts data, which includes about a third of the pharmacy claims filled by all people insured through the exchanges.

This "has impact for insurers who are going to want to manage this program, given that people who need more care are more likely to join the program," said Glen Stettin, senior vice president and chief innovation officer at Express Scripts. "If they want to continue to have an affordable benefit, they’re going to have to manage this tightly."

Although the growth in spending and use of prescription drugs was faster for patients in the exchanges than for those in commercial plans, the overall amount spent was much lower per person -- $777.27 compared to $1060.75.

The rapid uptake of the prescription drug benefit suggests there was a significant unmet medical need for many people gaining insurance through the exchanges, some of whom could have preexisting conditions and may not have previously had access to medicines. Before 2014, insurance companies could refuse coverage or charge much higher premiums for people with preexisting conditions, a practice largely forbidden under the Affordable Care Act. An April 2014 report from Express Scripts found that people insured through the exchanges were four times more likely to have a prescription for an HIV medication than those in commercial plans.

<https://www.washingtonpost.com/news/wonk/wp/2016/03/15/a-new-sign-obamacare-is-helping-the-people-who-really-need-it/?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=27336456&_hsenc=p2ANqtz-8oM6nB4QRpFBjJ01RG-peh4Fu&tr=y&auid=16543923>

**Final Obama Era Insurance Rules Makes Incremental Progress but Leave Many Issues Unresolved**

Community Catalyst

Every year, the Department of Health and Human Services (HHS) issues an update to the rules governing insurance companies and marketplaces. While there were many small adjustments the final update released Monday, the last under President Obama, can most fairly be considered a continuation of past policy rather than one that breaks much new ground.

One notable area of improvement was in the information that insurers have to file with respect to their rates. The new rule requires that additional information be available regardless of whether there is a increase, decrease or no change in proposed rates and makes all information that is not a trade secret available to the public. This improved transparency should support a better understanding of rates overall and will help inform the review process. In addition, HHS stuck by a proposal regarding the creation of standardized plans. However, because the creation of plans that conform to the standard parameters is left to the discretion of insurers, it is not clear how much impact the proposal will have.

The rule also creates some very limited protection for consumers with regard to surprise out-of-network charges. The Centers for Medicare and Medicaid Services had proposed that issuers be required to let out-of-network services conducted in an in-network setting apply to the out-of-pocket maximum unless the issuer had informed the consumers about the charges within 10 days. In the final rule, the scope of this protection was cut back, its effective date was delayed and even the limited protection that remains could be voided by the insurer informing a patient 48 hours before a service was delivered that care could be delivered by an out-of-network provider.

In another disappointment for consumers, HHS backtracked from a proposal to create numeric time and distance standards when judging the adequacy of health plan networks. The proposal was opposed by insurers and also received a lot of pushback from state insurance commissioners who had recently created a model network adequacy statute. In deferring to the commissioners, HHS has left the ball with the states to actually adopt the model act but it is unclear how many states will actually do so. Unless substantial progress is made, HHS will need to put this issue back on the federal to-do list.

**Issuer Warnings Cast Doubt on ACA Exchange Future**

The Associated Press

Political uncertainty isn't the only threat to the Affordable Care Act's future. Cracks also are spreading through a major pillar supporting the law

Health insurance exchanges created to help millions of people find coverage are turning into money-losing ventures for many insurers.

The nation's largest, UnitedHealth Group Inc., could lose as much as $475 million on its exchange business this year and may not participate in 2017. Another major insurer, Aetna, has questioned the viability of the exchanges. And a dozen nonprofit insurance cooperatives created by the law have already closed, forcing around 750,000 people to find new plans.

More insurer defections would lead to fewer coverage choices on the exchanges and could eventually undermine the law, provided the next president wants to keep it.

However, insurance experts aren't writing an ACA obituary yet: Enrollment is growing and appears to getting younger in some markets, a crucial factor for stability. Insurers also are learning more about their new customers and adjusting their coverage to do better financially. The future of the exchanges depends on whether those improvements continue and some other, big worries ease.

"Sometimes I think of (the exchanges) as a little campfire that's going to grow, but right now it needs a little more oxygen or kindling," said Katherine Hempstead, director of health insurance coverage programs for the Robert Wood Johnson Foundation, a nonpartisan organization that has assisted state governments on ACA insurance expansions.

Balancing the Sick and Healthy

The biggest problem with the exchanges reflects a basic insurance rule: Insurers need healthy, premium-paying customers to balance claims they cover from the sick. Insurers have struggled in many markets because people who couldn't get coverage previously due to a condition were among the first to sign up when the exchanges opened a few years ago. Healthy customers have been slower to enroll.

Insurers say they've also been hurt by customers who appear to be waiting until they become sick to buy coverage. The companies blame liberal enforcement of the ACA's special enrollment exceptions.

The law provides an annual enrollment window for several weeks starting in the fall. This is the main chance most people have to enroll or change coverage.

But customers can enroll outside that window if insurance needs change because they've moved, gotten married or had a child, among other exemptions.

Exchanges have not been asking for birth certificates, marriage licenses or other proof of these life-changing events. Insurers say that leaves them vulnerable.

The Montana Health Co-Op had a severely ill customer in a hospital sign up for its coverage in October and then drop a $250,000 bill on the insurer. CEO Jerry Dworak said he asked the exchange operator for details on whether the patient had a legitimate reason for the special enrollment. The exchange would only say that the patient changed ZIP codes.

"They've got to do something about the special enrollment because we just got killed on that," Dworak said.

The federal government runs exchanges in most states and announced Wednesday that it will start seeking proof that customers qualify for these special enrollment periods. This new requirement will unfold over the next several months.

Its effectiveness will depend on how aggressively the government enforces it, Goldman Sachs insurance industry analyst Matthew Borsch said in a research note.

Higher Costs

Many insurers also are struggling with higher-than-expected costs in general. Part of that comes from either starting an insurance business from scratch, as the co-ops did, or breaking into a new market.

Medical costs almost tripled to more than $181 million through the first nine months of 2015 for Maine Community Health Options. Outpatient services like expensive drug infusions and orthopedic procedures for hips and knees, in particular, hurt the insurance cooperative.

CEO Kevin Lewis isn't sure yet whether they need to consider that higher-than-expected use in setting future rates or if it was pent-up demand from people who haven't had coverage.

Community Health Options covered nearly 71,000 people as of late September. That's up 78 percent from the end of 2014, and Lewis said the customer base is getting younger, which is important because those customers generally contribute fewer expenses.

Now the insurer has to hit the right balance of raising rates enough to cover claims but not so high that it scares away those newer customers.

"If higher prices prompt healthier people to bail, it won't be long until it unravels," Lewis said.

The Future

Challenges remain for companies selling coverage on the exchanges.

Some government programs that provided temporary financial support for insurers as they set up their exchange business are winding down.

At the same time, premiums are rising in many markets, and that makes the high-deductible coverage found in many exchange plans a tough sell for healthy people.

Despite all the concerns, insurers aren't anxious to dump exchange coverage. Companies like Molina Healthcare Inc. say they make money off this business. Even Mark Bertolini, the Aetna Inc. CEO who spoke cautiously about the future, has said it is too early to give up.

The Montana Health Co-Op lost nearly $38 million in the first nine months of 2015, but Dworak thinks it can turn a slight profit this year. Most of the loss came from a charge the co-op took when the federal government delivered only a fraction of a payment due under a program designed to limit insurer losses.

The co-op has dropped an unprofitable plan and caught a break when a state Medicaid expansion took away high-cost patients.

"We're cautiously optimistic," Dworak said.

Insurers will continue to shuffle in and out of the exchanges for a few years, predicts Larry Levitt, a senior vice president for the Kaiser Family Foundation, which studies health care issues.

But ultimately, he expects them to keep supporting this still-new business opportunity, which also is important to customers because the exchanges offer income-based tax credits to help buy coverage.

"That money is just too important to walk away from, for both people and insurers," Levitt said.

<http://bigstory.ap.org/article/bc5b5bf5347c4dcbbb92aa4d4eb8b6a2/insurer-warnings-cast-doubt-aca-exchange-future>

**AHCCCS Enrollment by Plan, January 2015 v. January 2016**

The Hertel Report



**Unplanned Pregnancies Hit Lowest Level in 30 Years**

The New York Times

The rate of unintended [pregnancy](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/pregnancy/index.html?inline=nyt-classifier) in the United States has declined to its lowest level in the last three decades.

The level in 2008 was 54 per 1,000 women and girls aged 15 to 44. By 2011, it was 45 per 1,000. Of the 6.1 million pregnancies in 2011, 2.8 million were unintended.

A recent analysis in The [New England Journal of Medicine](http://topics.nytimes.com/top/reference/timestopics/organizations/n/new_england_journal_of_medicine/index.html?inline=nyt-org) found variations in rates of unintended pregnancy by income, race, ethnicity, education and age. But there were declines, some quite large, [in almost every demographic group](http://www.nejm.org/doi/full/10.1056/NEJMsa1506575).

The rate among teenagers, for example, declined by 28 percent. The rate of all income groups dropped, with the largest decrease — 32 percent — among people with incomes at 100 percent to 199 percent of the poverty level.

The rate fell 28 percent among women who had not graduated from high school, 2 percent among high school graduates, 16 percent among women who had attended some college, and 14 percent among college graduates.

The rate for non-Hispanic whites and blacks went down 13 percent and 15 percent, and the figure among Hispanics declined by 26 percent.

Among religious groups, evangelical Protestants had the largest decline in unintended pregnancies — 27 percent. Mainline Protestants, Roman Catholics and the category “other religions” also had lower rates. Among women without religious affiliation, the rate of unintended pregnancy declined by 26 percent.

Still, 81 percent of pregnancies among women who were cohabiting were unintended in 2011, as were 75 percent of teenage pregnancies, 60 percent of those among women living below the poverty line, 50 percent of pregnancies among Hispanics and 64 percent among non-Hispanic blacks.

The authors of the new analysis concluded that it was unlikely that alterations in sexual behavior could explain the numbers. The incidence of sexual activity generally changes little among adults, and there was no change in these years in the number of teenagers reporting ever having sex.

Fluctuations in the composition of the population are also an unlikely explanation, because groups that are increasing — Hispanics, for example — have relatively high rates of unintended pregnancy.

“We hypothesize that changes in contraceptive use are driving the decline,” said the lead author of the report, Lawrence B. Finer, the director of domestic research at the Guttmacher Institute.

“The biggest change is women using some form of [contraception](http://health.nytimes.com/health/guides/specialtopic/birth-control-and-family-planning/overview.html?inline=nyt-classifier), and a [substantial shift toward the use of long-acting methods](http://www.nytimes.com/2015/11/10/health/use-of-long-acting-birth-control-methods-surges-among-us-women.html)” like intrauterine devices and contraceptive patches.

On the whole, Dr. Finer said, the results are good news.

“This is the first substantial decline since we’ve been tracking it,” he said. “Whereas in the past we saw decreases among advantaged groups but increases among disadvantaged groups, now we’re seeing decreases across the board. Something broad-based is going on here.”

<http://mobile.nytimes.com/2016/03/08/science/unplanned-pregnancies-hit-lowest-level-in-30-years.html>

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at kim.vanpelt@slhi.org. As always, special thanks to Meryl Deles for much of the content.