



Health Reform Update –Week of July 28, 2014

CONGRESS

Appeals court rejects latest ACA challenge based on origination clause

A three-judge appeal for the U.S. Court of Appeals for the District of Columbia unanimously rejected an attempt last week by conservative groups to challenge the constitutionality of the Affordable Care Act (ACA) on procedural grounds.

Pacific Legal Foundation and a small-business owner had argued that the ACA violated the origination clause of the U.S. Constitution because it is a revenue-raising act that began in the Senate, not the House. The three judges on the panel (all appointed by Democratic presidents) agreed that the origination clause requires that tax bills start in the House, but pointed that the U.S. Supreme Court has held “from the early days of this nation” that the origination clause only applies to bills whose primary purpose is to levy taxes and not those enacted for other purposes that “may incidentally create revenue.”

The panel concluded that the ACA’s “paramount” purpose is to increase the number of Americans covered by health insurance and not raise revenue, thus rendering the origination clause inapplicable.

Two Republican-appointed judges on a separate panel of the D.C. Court of Appeals voted last week to invalidate the ACA subsidies for federally-facilitated Marketplace (FFM) consumers. The Obama Administration is appealing that decision to the full court, with a decision expected in the fall (see Update for Week of July 21st). ACA opponents petitioned the U.S. Supreme Court this week for an expedited review of a similar case in the Fourth Circuit Court of Appeals that upheld the FFM subsidies. Both of these challenges are funded by the Competitive Enterprise Institute with the backing of the Cato Institute.

House authorizes unprecedented lawsuit against President Obama

The House formally adopted H.Res. 676 this week, giving Speaker John Boehner (R-OH) the authority to file a lawsuit against President Obama for his implementation of any provision of the Affordable Care Act (ACA). Only five Republicans joined with every Democrat in opposing the resolution.

The move marks the first time in history that Congress has endorsed a lawsuit against a sitting President. Legal scholars have debated whether members of Congress even have standing to pursue a lawsuit over a President’s traditionally broad executive authority, given that they must show they are directly injured. However, even if dismissed, the lawsuit gives House Republicans the opportunity to demonstrate to their base during an election year the degree to which they are willing to confront the President (see Update for Weeks of June 30th and July 7th).

The resolution allows the Speaker to direct the Office of the General Counsel to represent the House in court in order to challenge the any executive action relating to the ACA. However, the Speaker made clear in recent weeks that he intends to focus on the Administration’s delay of the employer mandate, which is now slated to go into effect until 2016 for those with 51-100 employees and in 2015 for those with more than 100 employees (see Update for Week of February 10th).

House Minority Whip Steny Hoyer (D-MD) largely dismissed the lawsuit as “hypocritical and partisan”, noting that it is an attempt to enforce an employer mandate provision that House Republicans have long targeted for repeal.



The House already approved legislation last spring (H.R. 4138) designed to make it easier for Congress to sue the President, along with a related measure (H.R. 3973) requiring reports from the Department of Justice whenever the Administration delays or otherwise does not enforce specific provisions of the ACA.

House committee passes legislation to allow Americans to keep ACA-deficient plans

The House Energy and Commerce Committee approved a bill this week to permanently let group health plan subscribers remain in plans that fail to comply with the new consumer protections under the Affordable Care Act (ACA).

Two Democrats from Republican-leaning districts joined with all Republicans on the panel in passing the H.R. 3522 measure sponsored last fall by Rep. Bill Cassidy (R-LA). The Obama Administration has extended ACA-deficient plans only through 2016 (see Update for Week of March 3rd).

Senate Democrats seek to extend Medicaid payment increase for primary care doctors

As part of a flood of bills leading up to the August recess, Senators Patty Murray (D-WA) and Sherrod Brown (D-OH) introduced legislation this week that would extend by two years the temporary bump in Medicaid payments for primary care physicians authorized by the Affordable Care Act (ACA).

Primary care doctors have been heavily lobbying Congress for the extension, which temporarily made Medicaid rates equivalent to Medicare through 2014. The bill would also expand eligibility for the increase to include OB-GYN physicians, nurse-midwives, nurse practitioners and physician assistants.

Even if it clears the Senate, S.2694 is likely to be blocked by the House as Republican lawmakers have not only opposed the increase but sought to limit it in order to help pay for a permanent fix to the Medicare physician payment formula (see Update for Week of December 9th).

Only six states and the District of Columbia will use their own funds in 2015 to sustain ACA increase in Medicaid primary care rates. Two of these states (Alabama and Mississippi) have refused to expand Medicaid under the ACA. Alabama will pay \$32 million to increase Medicaid primary care rates by 30 percent to equal Medicare, while Mississippi will spend \$12 million to hike rates by ten percent.

The other four states continuing the increase are Colorado, Iowa, Maryland, and New Mexico. (Alaska and North Dakota paid higher rates to Medicaid primary care doctors before the ACA provision took effect in 2013 in an effort to attract and retain rural doctors).

The Florida Medical Association this week came out in favor of the state expanding Medicaid, but only if Medicaid primary care rates are permanently increased (see below). It would cost Florida \$451 million to do so, as rates would have to increase 50 percent to equal Medicare.

According to a 2012 study by the Kaiser Family Foundation and the Urban Institute, the temporary bump increased Medicaid primary care payments by an average of 73 percent nationwide. Low Medicaid reimbursement has caused several states to struggle in attracting physicians (New Jersey ranks the lowest with only 40 percent of physicians participating in Medicaid). However, rural states like Wyoming have a 99 percent participation rate due to higher reimbursement.

GAO blames poor planning and oversight for flawed rollout of federally-facilitated Marketplace

A new report released this week by the Government Accountability Office (GAO) blames management failures at the Centers for Medicare and Medicaid Services (CMS) for the flawed rollout of www.healthcare.gov last fall.



GAO cites poor planning and a lack of adequate oversight of contractors for the technological glitches that plagued the web portal for the federally-facilitated Marketplace (FFM) until it was overhauled in November (see Update for Week of December 9th). It specifically attributes inconsistent and unrealistic directives from CMS for causing “significant cost increases, schedule slips” and delays that increased the costs of building the web portal from \$56 million to \$209 million.

In the first of several reports commissioned by House Republicans, GAO warns that these problems have not been resolved and that “significant risks remain” when open enrollment resumes on November 15th. The investigative watchdog for Congress also found that CMS had formally committed to spend \$840 million on the FFM through March 2014, far higher than initially anticipated.

CMS officials conceded that contractor costs for the FFM are growing exponentially in an effort to avoid the technological glitches that marred last year’s rollout, but that some “bumps” were still certain to occur. The agency also noted that it has needed to expand the scope of work for the new lead contractor it hired last winter (see Update for Week of January 6th) in order to include states like Oregon and Nevada that are temporarily reverting back to the FFM and add new features sought by Congress to more quickly verify applicant income and eligibility (see Update for Week of July 21st). These changes have already increased Accenture’s contract from \$91 million to \$190 million by early June.

A senior GAO official scoffed at the notion that all of the increased costs were attributable to such FFM changes and criticized CMS for inefficient contracting procedures and communication. He also told Congress that evidence in CMS files show that agency officials knew in spring 2013 that the FFM would be “only 65 percent complete” by the October 1st start of open enrollment. However, CMS officials altered contract requirements in order to proceed without delay, despite lacking the authority to do so.

CBO finds that Medicare Part D costs half of initial projections

The Congressional Budget Office (CBO) concluded this week that federal spending for Medicare Part D has been roughly 50 percent less than they initially projected when the prescription drug program was created by Congress in 2003.

The CBO analysis attributes the lower spending to “combination of broader trends in the prescription drug market and [a 12 percent] lower-than expected enrollment in Part D” due to an overall slowdown in consumer spending in the wake of the 2007-2009 recession. CBO found that “[d]rug spending per person for the country as a whole [as well as per person in Part D] increased by only 2 percent per year, on average, between 2007 and 2010, compared with average growth of 13 percent per year between 1999 and 2003.” This caused national drug spending in 2012 to be about 40 percent less than the amount predicted by CMS in 2003.

The non-partisan budget scorekeeper also notes that “[m]any existing brand-name drugs lost their patent protection and faced new competition from generic substitutes” during this period, and that “new brand-name drugs...were introduced at a slower rate than in the late 1990s.”

Supports of the Affordable Care Act (ACA) have used CBO’s overestimate of Part D costs as evidence that CBO’s projection of ACA costs will likely be lower than it initially projected.

FEDERAL AGENCIES

Trustees extend Medicare’s projected solvency by four years

Medicare’s trustees reported this week that the program’s trust fund will remain solvent until 2030 instead of 2026, thanks largely to an overall decline in health care spending and cost controls in the Affordable Care Act (ACA) as well as other systemic reforms.



The report extended the solvency of Medicare Part A by 14 years since the ACA was enacted and predicted that Medicare Part B premiums will remain constant through 2015. However, it did project that the average cost per beneficiary will jump 40 percent by 2023 (from \$12,210 to \$17,360) after staying the same for the past two years.

In addition, the trustees project that Medicare spending will climb to 5.5 percent of gross domestic product (GDP) by 2040 (up from 3.5 percent now), while Medicare spending on prescription drugs will increase 9.9 percent, far more than any other category including inpatient and outpatient care.

The trustees acknowledge that it was not possible to quantify the exact impact of the ACA versus a continued transition away from traditional fee-for-service to other reimbursement methodologies or the economic downturn from 2007-2009. Their conclusions largely resemble Congressional Budget Office (CBO) projections released earlier this month, which also extended Medicare's solvency to 2030 (see Update for Week of July 14th). CBO's latest estimate released this week further downgraded their projection of federal Medicare spending over this decade by 12 percent in response to "the slowdown in health care spending during the past several years."

HHS says ACA has saved Part D enrollees \$11.5 billion in prescription drug costs

According to the most recent data released this week by the Department of Health and Human Services (HHS), 8.2 million Medicare Part D enrollees have saved \$11.5 billion in prescription drug costs since the Affordable Care Act (ACA) began winnowing down the coverage gap in 2010.

The \$1,407 that each enrollee has saved on average is significantly higher than the \$1,061 average from 2013. For 2014, consumers received roughly a 53 percent discount on brand-name drugs that fall into the so-called "doughnut hole", while generic drugs were discounted by about 28 percent.

HHS also announced that average Part D premiums are set to increase in 2015 by only \$1 (to roughly \$32 a month) as a result of these ACA measures.

CMS urged to provide "context" to physician payment sunshine disclosures

A group of medical societies and trade groups representing pharmaceuticals are asking the Centers for Medicare and Medicaid Services (CMS) what context will be provided to help the public understand the justification for soon-to-be disclosed manufacturer payments to physicians.

CMS is scheduled to start releasing data in September that it has been compiling pursuant to the *Physician Payment Sunshine Act* provisions that were incorporated into the Affordable Care Act (ACA).

Supporters of the Act insist that transparency surrounding manufacturer relationships with physicians will allow patients to make more informed decisions about and deter incidences where industry payments have unduly influenced medical care. However, a group of more than 20 societies and trade groups including the Pharmaceutical Research and Manufacturers of America (PhRMA), Biotechnology Industry Organization (BIO), and American Urological Association (AUA) fear that the payment data will be misinterpreted by the public without the "context" that they claim CMS failed to provide when it released Medicare Part B physician payments earlier this year. They insist that large payments to physicians are often not indicative of "abuse" and emphasize that physicians should be adequately compensated for speaking or consulting fees and grants regarding products in clinical trials.

Drug and device makers are currently required to report and break down payments they make to individual physicians for speaking and consulting, food, research and gifts. However, the letter expresses concern that CMS has "said nothing" about whether this data will likewise be broken down by these categories.



Physicians have been allowed to register online and review and challenge the data through August 27th. However, the letter complains that this process is burdensome and that the data contain numerous errors and misrepresentations. For example, grants provided to a physician in combination with other entities are made to appear as if the entire amount was received by the physician.

FDA begins approval process for biosimilars

The Food and Drug Administration (FDA) formally accepted an application last week from Sandoz seeking approval for Zarzio (filgrastim) a version of Amgen's biologic Neupogen, marking the first time the agency has agreed to consider a biosimilar product since the approval pathway was authorized by the Affordable Care Act (ACA).

New biosimilar applications are subject to ten-month review timelines under the Biosimilar User Fee Act that was included with other user fee authorizations in the FDA Safety and Innovation Act of 2012. Under those timelines, FDA has 74 calendar days to report substantive review issues. Because FDA has done the initial review and accepted the application, FDA has about seven-and-a-half months to complete the review for Zarzio.

According to Sandoz, Zarzio is already marketed in more than 40 countries and is the leading biosimilar globally.

Express Scripts, the country's largest prescription benefit manager, estimated last year that the U.S. could save \$250 billion from 2014-2024 if 11 biosimilars including filgrastim were approved.

STATES

California

Marketplace premiums to increase by only 4.2 percent average

Covered California officials announced this week that premiums for the health insurance Marketplace created by the Affordable Care Act (ACA) will increase by only 4.2 percent on average for 2015, with rates for some plans to decrease by an average of 8.5 percent.

The modest increases contrast starkly with double-digit increases in states like Florida that lack any rate review and have allowed ACA-deficient plans to continue to be offered (see above). However, they are consistent with an analysis released last week by PricewaterhouseCoopers (PwC) predicting that average premiums for 18 states are likely to increase by less than ten percent.

Covered California rates vary by region, but most will increase only slightly. For example, costly areas like Alameda County in the bay area and Los Angeles County will see only an average increase of 2.8 and 4.4 percent respectively. The highest average increase of 6.6 percent belongs to San Francisco County, while Orange County in suburban Los Angeles will experience a 6.3 percent average jump.

San Joaquin, Stanislaus, Merced, Mariposa and Tulare counties are the only ones that will see lower premiums (with an average decrease of 1.9 percent).

Covered California officials attributed a late surge in sign-ups of younger and healthier adults for the modest rate hikes, as well as the state's "active purchaser" model that allows the Covered California board to selectively contract only with the most affordable plans that meet minimum standards (see Update for Week of May 27, 2013).



Insurance Commissioner David Jones (D) and Consumer Watchdog used the modest rate hikes as evidence of why voters need to pass their ballot referendum this fall that would give the commissioner authority to reject or modify unreasonable rate hikes outside of the Marketplace (see Update for Weeks of June 30th and July 7th). Covered California rates are still subject to the commissioner's limited review, but no dramatic changes are anticipated.

The four largest Marketplace insurers criticized the commissioner for claiming this week that their 2014 rates were 22-88 percent higher than consumers paid for their individual plans in 2013, in an effort to bolster support for the rate review referendum. They stressed that the commissioner's study did not account for ACA subsidies and made a misleading "apples to oranges" comparison since pre-ACA plans were often far more limited than ACA-compliant plans.

All ten insurers that participated in the Marketplace last year are expected to return in 2015, including industry giants Anthem Blue Cross, Blue Shield of California, Health Net, and Kaiser Permanente. (Aetna and UnitedHealth Care will continue to sit out.) However, some insurers will offer broader provider networks than last year, in response to consumer complaints.

Covered California expects that 90 percent of consumers will again be eligible for premium and cost-sharing subsidies offered by the ACA, as was the case for 2014.

Study finds 3.4 million uninsured adults gained coverage since ACA Marketplaces opened

The Longitudinal Panel Survey released this week by the Kaiser Family Foundation revealed that 58 percent of previously uninsured California adults report that they obtained health insurance since the opening of the Affordable Care Act (ACA) Marketplaces last fall.

The largest share (25 percent) gained coverage through the expanded Medicaid program. Another 12 percent became uninsured through an employer while nine percent signed-up for private plans through Covered California. Five percent purchased other individual market coverage.

Among all previously uninsured Latinos, 52 percent gained coverage, compared to more than 60 percent of uninsured whites and African-Americans. The survey also showed that 43 percent of those who had never been insured were able to obtain coverage.

Researchers credit outreach and education for these gains, as a larger share of those who report being contacted about signing-up for health insurance say they gained coverage than the share of those who were not contacted (69 to 52 percent). At least 60 percent of those gaining Medi-Cal or Covered California coverage had assistance from a third-party to enroll.

The ACA was cited as a motivating factor for gaining insurance by 21 percent of respondents, most of which pointed to the law's mandate that they purchase coverage they could afford or incur a tax penalty. Others responded that they purchased coverage because of ongoing health issues (17 percent), a safeguard against high medical bills (14 percent), or preventive needs (13 percent).

A significant majority (73 percent) believe that their plan was a good value for the cost. However, 34 percent of those that remain uninsured cite affordability as the main reason.

Fears of having a family member deported still are cited as a major impediment to insuring much of the Latino population in California. Roughly 62 percent of the remaining uninsured are Latino and nearly half of this group is not eligible for Covered California or Medi-Cal due to their immigration status. In addition, most remaining uninsured Hispanics (54%) and 37 percent of those Hispanics eligible for ACA coverage options stated that they were concerned that enrolling in coverage would bring attention to their family's immigration status, despite Department of Homeland Security assurances last fall that applications for health insurance would not be used as a basis for deportation.



Connecticut

Insurance department downgrades rate hikes for Anthem, other insurers

The Department of Insurance (DOI) rejected rate hikes this week that were proposed by the several of the state's biggest insurers.

Anthem Blue Cross and Blue Shield had sought an average rate hike of 12.5 percent for all individual health plans, which DOI deemed "excessive" and ordered the insurer to revise. DOI limited Connecticut's proposed 12.8 percent average rate hike for all individual plans to only 3.1 percent, while United Healthcare was directed to submit a new proposal for individual plans offered through AccessHealth CT, after not participating in the Affordable Care Act (ACA) Marketplace for 2014.

Anthem has largely blamed rising drug costs for most of their proposed hike, citing the \$1,000 per pill price tag for the latest Hepatitis C treatment (see Update for Week of June 30th and July 7th). However, the DOI actuary rejected many of the other assumptions used by Anthem to calculate the hike, including its assessment of how far medical prices would rise in the coming year. It also determined that the federal government will likely provide a higher level of assistance to insurers that incur exceptional claims cost due to the Obama Administration's to extend ACA-deficient plans for up to three years (see Update for Week of March 3rd).

However, DOI approved Healthy CT's proposal to lower its Marketplace premiums by 8.5 percent. Healthy CT is a non-profit consumer oriented health plan created by ACA loans, which relied on low premiums to garner the highest AccessHealth CT market share for 2014.

Florida

Florida Medical Association endorses Medicaid expansion, with a catch

For the first time, members of the Florida Medical Association have endorsed the state's participation in the Medicaid expansion under the Affordable Care Act (ACA). However, the resolution approved at FMA's annual meeting this week comes with the caveat that Florida permanently raise Medicaid reimbursement rates to be comparable to Medicare payments for physicians (see above).

Approval of the resolution was surprisingly unanimous, given the acrimony that the issue has caused in recent years. The FMA initially opposed the entire ACA and approved "no confidence" resolution in the American Medical Association for its support of the new law (see Update for Week of August 16, 2010). A resolution supporting the ACA's Medicaid expansion failed to receive a majority vote last year.

FMA delegates stressed that accepting the \$51 billion in ACA funds over the next decade would help resolve major problems in Florida's Medicaid program, especially if combined with a reimbursement increase. Florida Medicaid already suffers from limited physician participation due to reimbursement that is among the nation's lowest.

Surveys showed that the resolution had the backing of 58 percent of FMA members. Doctors for America, a national group chaired by a Florida physician, praised the move and insisted that 2,200 Floridians die every year because they lack access to medical care.

Florida's largest insurer to increase Marketplace rates by nearly 18 percent

Florida Blue, the state's largest health insurer, disclosed this week that it will increase individual plan premiums by an average of 17.6 percent next year for consumers in the Affordable Care Act (ACA) Marketplace.



The non-profit Blue Cross and Blue Shield affiliate blamed higher health costs for the increase. It also claimed that even though overall Marketplace enrollment exceeded its expectations, it incurred a higher proportion of older and more costly adults than initially projected due to Florida's decision to exercise the discretion afforded by the Obama Administration to extend ACA-deficient plans through 2016 (see Update for Week of April 21st). However, Florida Blue was quick to point out that double-digit rate hikes have been "typical" for the individual market long before the implementation of the ACA, noting that this is the insurer's fourth consecutive average increase of at least 11 percent.

Florida Blue will limit the average increase to 13 percent for consumers that choose the BlueSelect plan offering a narrower provider network. Roughly 40 percent of Florida Blue's Marketplace consumers chose this lower cost option in 2014.

Florida Blue controlled more than 34 percent of Florida's ACA Marketplace during the inaugural open enrollment period. It was the only Marketplace carrier offering plans in several rural counties, resulting in dramatically higher premiums for those areas (see Update for Week of September 23rd).

Monthly Florida Blue premiums for a 40-year old living in Palm Beach County and purchasing silver-level coverage ranged last year from \$303-\$404. However, 90 percent of consumers in Florida's Marketplace received ACA subsidies that brought down those premiums.

Florida's Marketplace will have competition from an additional carrier in 2015 (three including United Healthcare are joining while two dropped out). However, only two other carriers have publicly disclosed their rates for next year, with most (including Florida Blue) initially entering "zero" into the state website, claiming that Florida laws governing trade secrets allowed them to conceal any rate hikes until they were all released by the state (see Update for Week of June 30th and July 7th). Florida Blue's rate hike exceeds the 14.1 percent increase for Humana's HMO plans (compared to only 2.2 percent for PPOs), as well as the 11.6 percent average increase announced by Molina.

Proposed rate hikes in Florida are likely to remain final as state law suspended all rate review for two years and directed insurers to identify how much of each consequential rate hike is due to the ACA (see Update for Week of June 17, 2013). The federal government can step in and require each insurer to provide actuarial data justifying any double-digit rate hike. However, it lacks the authority to do anything more than "shame" each insurer by deeming the increases "unreasonable" and making insurers publicly disclose the data (see Update for Week of August 29, 2011).

Florida's double-digit rate hikes stand in stark contrast to California, where premiums for Marketplace plans are set to only increase by 4.2 percent on average due to limited rate review and their Marketplace's refusal to extend ACA-deficient plans (see above).

Georgia

Federal scrutiny results in reduced backlog of Medicaid applications

The Department of Community Health announced this week that it has reduced its backlog of new Medicaid applications by 70 percent since being cited by the federal Centers for Medicare and Medicaid Services (CMS).

Georgia was one of 12 states that received letters from CMS warning it to promptly develop an action plan to reduce the backlogs, which totaled more than 88,800 in Georgia alone (see Update for Week of July 14th). However, unlike other states, Georgia was not overwhelmed by applications from newly-eligible populations, since it was one of 24 states that have refused to participate in the Medicaid expansion under the ACA. Instead, it is experiencing a "woodwork" effect where those that were previously eligible are deciding to enroll due either to simplified application procedures mandated by the ACA or the law's individual mandate. State officials estimate that up to 120,000 Georgians will ultimately enroll in Medicaid or SCHIP due to this effect.



Unlike neighboring Tennessee, where a class-action lawsuit alleges that the state is deliberately creating obstacles to enroll (see Update for Week of July 21st), Georgia's backlog is largely blamed on erroneous information provided by the federal data hub. State officials claim that it took until May before it could receive a seamless transfer of data from the federally-facilitated Marketplace operated in Georgia.

Minnesota

Marketplace board authorizes \$3 million more in web portal repairs

The board overseeing the health insurance Marketplace created pursuant to the ACA voted this week to give a newly-hired consultant an additional \$3.16 million to fix continued glitches in the MNSure web portal.

The board had already awarded Deloitte nearly \$5 million to identify needed fixes and manage their resolution. The new funds are intended to ensure the web portal is fully-tested and operational when open enrollment resumes on November 15th.

Both awards are being funded by the state's \$155 million federal exchange establishment grant, which must be spent by the end of 2014.

Governor calls for earlier release of ACA Marketplace premiums

Governor Mark Dayton (D) called this week for the Department of Commerce to release final MNSure premiums for 2015 by October 1st, instead of the November 15th start of open enrollment.

State officials had come under heavy criticism for not releasing any premium data in advance of open enrollment and instead delaying them past the November elections. MNSure had relied on the nation's lowest premiums (which were an average of 88 percent lower than neighboring Wisconsin) to overcome a number of persistent software flaws that have yet to be fully resolved (see above). However, these premiums are likely to rise in 2015 as the share of premiums that MNSure will withhold to fund operations grows from 1.5 to 3.5 percent. In addition, Minnesota will close its state high-risk pool for persons with pre-existing conditions in 2015, forcing MNSure insurers to assume greater numbers of sicker and more costly subscribers.

Commerce officials told the MNSure Legislative Oversight Committee that an October 1st release date would still allow sufficient time for the Department to complete their review and modifications to proposed rates.

New Mexico

Marketplace board votes to stick with federal model for an additional year

The board overseeing New Mexico Health Connections voted 11-1 this week to delay plans to transition the Affordable Care Act (ACA) Marketplace to full state control for 2015.

The acting chief executive officer for the Marketplace as well as information technology vendors had informed the board that the computer system for the individual Marketplace was being tested and should be operational before the November 15th start of open enrollment. New Mexico has operated its own small business version since the Marketplaces opened last October and had initially planned to default to federal control of the individual Marketplace only for 2014 (see Update for Weeks of May 13 and 20, 2013).

However, all but the board's vice chairman were concerned about moving to a state-based model before all testing was completed and were upset that the call center would not be at 100 percent



capability until after November 15th. As a result, the board opted for a delay until greater assurances could be provided.

A spokesperson for Governor Susana Martinez (R) supported the delay, citing the “disaster” that occurred when the federally-facilitated Marketplace was plagued with technical glitches early in the 2014 open enrollment period. New Mexico had initially projected that 80,000 consumers would enroll in Marketplace plans, but was only able to sign-up 35,000 through mid-April due to continued software problems.

Oregon

Oregon follows Illinois in limited Medicaid coverage for costly Hepatitis C drug

The Pharmacy and Therapeutic Review Committee voted this week to recommend that Medicaid coverage for the recently-approved “cure” for Hepatitis C be limited to all but the most severely ill patients.

The decision by the volunteer panel of physicians, providers, and consumer representatives follows the move earlier this week by Illinois Medicaid to likewise restrict Sovaldi coverage by requiring patients to meet 25 coverage criteria and get prior authorization. However, Oregon goes a step further by explicitly rationing coverage for the \$1,000 per pill drug only to those with later stages of liver diseases who have been drug-free for at least six months. The drug could also only be prescribed by a liver or gastrointestinal specialist, which may require months of waiting for an appointment.

Local Hepatitis C advocates reacted angrily to the “horrific” guidelines. However, a separate Medicaid panel could make the restrictions more onerous next month by removing Sovaldi from the list of Medicaid-covered treatments and requiring physicians to make individualized appeals.

Oregon is the only Medicaid program in the country that can make such explicit rationing decisions. Under a federal demonstration waiver granted in 1993, the Oregon Health Plan prioritizes treatments on a numeric list according to cost, quality of life, and societal preferences, and then cuts off coverage at a designated number depending on annual budget constraints.

Panel members insisted the move was necessary, as coverage of Sovaldi would cost the state more than \$360 million, nearly eclipsing the \$377 million Medicaid spent for all prescription drugs in 2013. Limiting coverage to those most in need was projected to save the state \$128 million of this amount (see Update for Week of July 14th).

The \$84,000 per treatment cost for Sovaldi has resulted in significant pushback from insurers nationwide, with U.S. Senators Ron Wyden (D-OR) and Chuck Grassley (R-IA) also demanding data from the manufacturer justifying why a drug that was predicated to be profitable at a price of \$36,000 now costs 133 percent more (see Update for Weeks of June 30th and July 7th).

Washington

Payment glitch in ACA Marketplace could lead to special enrollment period

One of the contractors assigned to fix remaining problems with the web portal for the Washington Healthplanfinder informed the legislature this week that the software glitches have caused some premium payments not to reach applicable insurers and caused roughly three percent of paid subscribers to languish without coverage.

The Operations Committee for the health insurance Marketplace created pursuant to the ACA has directed Deloitte make a resolution their “top priority” and direct all necessary resources to correcting the payments before the November 15th start of open enrollment. Insurance Commissioner Mike Kreidler (D) warned that he would create a special enrollment period allowing consumers to purchase Marketplace



plans directly from insurers if the glitches are not fixed by August 1st, although lawmakers have debated his jurisdiction to do so.

Despite persistent software flaws, the Washington Healthplanfinder was among the most successful state-based Marketplaces for 2014, trailing only California and New York in total enrollment (see Update for Week of April 21st).