

Health Reform Update – Week of September 12, 2011

CONGRESS

CBO tells “super committee” that health programs would fare better under automatic cuts

The Joint Deficit Reduction Committee created by the Budget Control Act of 2011 held its first public meeting this week, followed by closed door sessions to deliberate on recommendations for at least \$1.2 trillion in federal deficit reduction measures.

Democratic and Republicans on the 12-member panel immediately retreated to familiar battle lines in the public hearing, with Democrats demanding higher tax revenues and Republicans focused solely on spending cuts. However, the only witness, Congressional Budget Office (CBO) Director Doug Elmendorf, gave Democrats some potential leverage when he testified that Medicare and Medicaid would fare far better under the minimum reductions that would take place under the automatic cuts that would be triggered should the panel fail to agree on recommendations.

The CBO director emphasize that the Budget Control Act limits automatic Medicare cuts to only two percent or \$123 billion from 2013 to 2021, with Medicaid spared entirely. This figure is roughly only ten percent of the minimum \$1.2 trillion in new savings required by the new law (see Update for Week of August 1st).

Elmendorf refused to answer questions about what mix of spending cuts and tax revenues CBO would recommend. However, he did suggest trying to cut the deficit later in the decade without making upfront spending cuts or tax hikes that would be an “added drag on the weak economic expansion.”

Both Democrats and Republicans on the panel appeared disinclined this week to make any politically sensitive cuts to Medicare or Medicaid benefits and payment, despite urging from President Obama to find some level of entitlement cuts that will help offset his \$450 billion jobs plan.

The CBO director also emphasized to the panel that he needed their recommendations by early November in order to score them before the November 23rd deadline set by Congress.

Healthcare executives vote to recommend increasing the eligibility age for Medicare

A group representing chief executives from some of the nation’s largest health-related firms voted this week to urge the new Joint Deficit Reduction Committee to increase Medicare eligibility to age 67.

The recommendations was part of four proposals advanced this week by the Healthcare Leadership Council that it claims would save \$410 billion in a decade. Others include having private health plans cover additional Medicare recipients and make people earning more than \$150,000 pay for the full cost of their Medicare premiums.

Raising the eligibility age was proposed but not passed by the President’s deficit commission last winter and also has the support of provider groups like the American Hospital Association. It is thought to be an option considered by the so-called “super committee”, though White House officials indicated this week that it would likely not be supported by the President.

The Congressional Budget Office has estimated that increasing eligibility to age 67 would save \$124.8 billion over ten years. However, the Centers for Budget and Policy Priorities (CBPP) and Kaiser Family Foundation have issued prior studies showing that any savings from raising the Medicare age

would result in a cost shift to employers, individuals, and states, and would increase total health care spending (see Update for Week of March 28th). They also insist that Medicare and Medicaid controlled costs better than private insurance from 2000 through 2009.

Members of the Council, including the CEOs of Aetna, Johnson and Johnson, Merck, and Pfizer, also included a “provocative” recommendation to create a Medicare exchange of private plans (similar to Part D of the Federal Employee Health Benefit Plan). This model bears some resemblance to the controversial plan passed by House Republicans to turn Medicare into vouchers used in the private market. However, the council’s president insists that their plan has a “very significant” difference because seniors would retain the option of remaining in traditional Medicare.

Republican lawmakers resume effort to dismantle key provisions of Affordable Care Act

After a summer in which deficit reduction negotiations took center stage, House Republicans renewed their efforts this week to repeal the Affordable Care Act (ACA) piece-by-piece.

The House Energy and Commerce subcommittee on health held a hearing on a draft measure that would effectively block regulations by the Department of Health and Human Services (HHS) severely limiting how long certain health plans could remain exempt or “grandfathered” from key ACA provisions.

Rep. Joe Pitts (R-PA), chair of the health subcommittee, has repeatedly taken issue with the Administration for acknowledging that under these rules, most health plans will lose their “grandfathered” status in the next few years as soon as they make any significant change to plan premiums or benefits. He insists that this violates the President’s pledge that those who like their current health coverage can keep it, as employers will increasingly be forced to shop for more affordable coverage as their current plans lose exempt status.

House Republicans also pushed a measure this week (H.R. 2077) that would repeal the new medical-loss ratios under the ACA. The MLRs require individual and small group plans to spend at least 80 percent of premium revenue on medical care starting in 2011 (or 85 percent for large group plans). Those that fail to comply with have to issue rebates to consumers next year.

Rep. Pitts warned that the MLRs create a “perverse incentive” for insurers not to invest in quality improvement activities like fraud detection because they do not fall under the definition of medical care in HHS regulations. The Director of the Center for Consumer Information and Insurance Oversight at HHS rejected that argument, pointing out that agency rules define a “middle ground” that allows for some fraud recovery expenses to be considered medical care costs.

Rep. Mike Pompeo (R-KS) also introduced legislation this week (H.R. 2961) that would divert ACA grants returned by Republican governors to deficit reduction. Pompeo’s home state of Kansas, as well as Florida and Oklahoma recently returned nearly \$90 million in federal grants to implement a health insurance exchange and strengthen their process for reviewing increases in health insurance premiums.

Democrats that control the Senate Appropriations Committee blocked an effort this week by Senator Lindsey Graham (R-SC) to prohibit funds allocated for the Internal Revenue Service from being used to implement ACA provisions. Senator Graham attached the amendment to draft legislation funding the Treasury, federal courts, and various independent agencies in fiscal year 2012. However, the amendment was defeated along party lines.

Senate hearing debates whether poverty, lack of health care leads to death

A Senate Health, Education, Labor and Pensions subcommittee debated this week whether the nations’ record high rate of poverty (see below) leads to poorer health and death.

Senator Bernie Sanders (I-VT) and several witnesses cited Institute of Medicine data showing that 45,000 Americans die each year solely because of lack of health insurance. Senator Sanders also noted that low-income people live about 6.5 years less than those whose earn in the top 20th percentile.

Tea Party backed Senator Rand Paul (R-KY) echoed statements made by Rep. Ron Paul (R-TX) during this week's Tea Party presidential debate. The father and son members of Congress insisted the poor could still access needed health care if they really want to, and that churches and other charitable organizations should cover the health care costs for the uninsured instead of government "bureaucracy."

During the Tea Party debate, Rep. Paul was asked if those who are uninsured should be just left to die. Audience members shouted in the affirmative, statements that were denounced after the debate by other candidates on the stage.

A plastic surgeon from Senator Paul's home state also insisted during the hearing that "there is little reason other than failure to seek care that poverty should be a death sentence" and blamed adverse health outcomes among the poor on unhealthy lifestyles. The director for health policy studies at the conservative Cato Institute claimed that the poor were better-off than they were decades ago, citing statistics showing that over half have cell phones and 20 percent have a big-screen television.

HIV/AIDS gets Congressional caucus, three decades after discovery of disease

It took thirty years, but Democrats and Republicans formally convened a Congressional HIV/AIDS Caucus this week to focus attention on the epidemic.

The launch comes as AIDS Drug Assistance Programs (ADAPs) nationwide are in a financial crisis caused by a rush in enrollment by the newly uninsured and federal spending cuts. Among the first priorities of the caucus will be to prevent even deeper spending cuts as a result of the recommendations approved by the new deficit reduction "super committee".

Reps. Barbara Lee (D-CA), Jim McDermott (D-WA) and Trent Franks (R-AZ) have signed up 59 caucus members from both parties.

FEDERAL AGENCIES

HHS rejects Delaware request to phase-in new insurer payout standards

The Department of Health and Human Services (HHS) rejected Delaware's request this week to phase-in the medical-loss ratios (MLRs) that started this year under the Affordable Care Act (ACA).

The new MLRs require individual and small group plans to spend at least 80 percent of premium revenue on medical care instead of profit and administrative expenses (85 percent for large group plans). Delaware asked the agency for permission to phase-in the 80 percent standard over the next three years, arguing that immediate compliance would force out small insurers and destabilize the market.

However, HHS found that insurers in Delaware can already meet this standard. The agency issued a similar determination in rejecting North Dakota's request (see Update for Week of July 18th).

Five states (Maine, New Hampshire, Nevada, Iowa, and Kentucky) have already received approval or partial approval to phase-in the new MLRs. At least eight more states have waiver applications pending; including Oklahoma and North Carolina who submitted their requests last week (see Update for Week of September 5th). Georgia is likely the next state to receive a decision as public comments on their application are due September 19th.

Census data shows record poverty, more uninsured, and decline in employer-sponsored coverage

Data released this week by the U.S. Census Bureau and the Urban Institute showed that nearly one in six Americans and over one in five American children lived in poverty last year, the highest recorded level since 1993.

The report illustrates how the economic downturn continues to push many Americans backwards; as the median household income declined to the point where the typical American household now earns less than it did in 1997 (California residents lost 4.6 percent in income just in 2010, the largest decrease ever recorded). Over 46 million people or 15 percent of Americans now live below the poverty line (\$22,314 a year for a family of four); marking the fourth year in a row that poverty has increased.

The figures also demonstrated how income inequality has grown over the past decade. Median household income has now declined by 7.1 percent since peaking in 1999. However, the bottom ten percent of earners lost 12.1 percent in income, while income losses for the top income gainers registered a mere 1.5 percent. The richest one percent of Americans actually had higher incomes over the decade.

Minorities and children were especially hard hit. The poverty rate for Hispanics climbed over one percentage point to 26.6 percent last year, with 37 percent of Hispanic children now under the poverty line. Poverty among African Americans jumped even more, now approaching 27.5 percent or 40 percent for children. However, poverty among white Americans only rose half as much to nearly ten percent.

The Census Bureau attributed much of the increase to the loss of employer-sponsored health insurance that comes with persistently high unemployment. Slightly under 50 million Americans are now uninsured, the highest number ever recorded. This figure increased by nearly one million in 2010 as employer-based coverage dropped from 56 to 55 percent. However, the percentage of Americans that are uninsured held steady at just over 16 percent as many of the newly uninsured had to enroll in Medicaid (which experienced a one percent jump in enrollment).

The Urban Institute noted that the figures would have been much worse if it were not for the American Recovery and Reinvestment Act (ARRA) and Affordable Care Act (ACA). Enhanced unemployment benefits under the ARRA stimulus package kept 3.2 million more Americans out of poverty in 2010, while 500,000 more young adults gained health insurance under the ACA.

Both political parties immediately sought to assign blame for the depressing data. In particular, the Republican Policy Committee claimed the increase in the uninsured was evidence of the ACA's failure, while the Obama Administration documented that the number of insured 18-to-24-year-olds increased over two percentage points just in the first year of the new law, largely thanks to provisions allowing young adults to remain on their parents' health plans.

The Administration also noted that employer-sponsored health insurance has been eroding for over a decade due to higher health plan premiums, falling from 64 percent in 1999 to just over 55 percent in 2010. The ACA will not be able to curb this trend until its main provisions go into effect in 2014.

Fears that Affordable Care Act would harm Medicare Advantage prove to be misguided

The Secretary for the Department of Health and Human Services (HHS) announced this week that enrollment into Medicare Advantage (MA) plans is projected to grow by ten percent next year while premiums drop by at least four percent.

The Affordable Care Act (ACA) "cut" \$200 billion from the program by restraining the rate of growth in MA payments. Republican lawmakers had pounced on 2009 projections by the Congressional Budget Office (CBO) that these "cuts" would cause enrollment to drop from more than 11 million to 7.5 million by 2018.

However, Secretary Kathleen Sebelius proclaimed that the new projections provide clear evidence to rebut any claims that the ACA “cuts” would harm the private Medicare plans that provide extra benefits like eyeglasses and hearing aids not covered under traditional Medicare. Nearly 12 million of the 47 million total Medicare enrollees are already enrolled in MA plans, up from 11 million last year.

FDA to revamp rare disease program

The Food and Drug Administration (FDA) released a draft five-year plan this week to revamp how the agency helps drug manufacturers develop treatment for rare diseases (those afflicting fewer than 200,000 Americans).

Starting late next year, the FDA’s Center for Drug Evaluation and Research will bolster its Rare Disease Program (RDP) by providing pharmaceutical and biotech companies specialized training on the development of drugs for rare or orphan diseases, and improving its outreach to rare disease patient organizations. According to the draft plan, the RDP will also add five new staff positions, retool program evaluations, and hold public hearing to hear concerns and suggestions from stakeholders in rare disease drug development. (The first hearing on the draft recommendations is scheduled for October 14th.)

INSURERS

Denial rates for individual health plans often far exceed 20 percent

Denial rates reported by the federal government reveal that individual health plans routinely deny at least one of every five applicants, with far higher rates for specific insurers.

The Department of Health and Human Services (HHS) started posting denial rates obtained from health insurers on www.healthcare.gov last fall, pursuant to the Affordable Care Act (ACA). (Maryland is the only state that requires insurers to report similar denial rates.)

The most current information furnished by individual health plans for the first quarter of 2011 show denial rates varied widely by state, with large health plans like Humana or United Healthcare denying around 40 percent of applicants in Kentucky, while Kaiser Permanente and John Alden denied up to 50 and 70 percent respectively in Georgia and Texas.

The figures affirm findings by the Government Accountability Office (GAO), which studied denial rates for 459 insurers published on www.healthcare.gov earlier this year and found that an average of 19 percent of applicants nationwide were denied coverage. GAO also documented wide variability, reporting that a quarter of insurers had denial rates of 15 percent or below while a quarter had rates of 40 percent or higher.

America's Health Insurance Plans (AHIP) insists that the figures are misleading because they do not include those turned down for one policy but offered another cheaper limited-benefit plan. Their most recent 2009 survey claims that only about 13 percent of individual applicants are denied coverage.

The ACA requires guaranteed issue for children as of the 2011 plan year and will extend that mandate to adults beginning in 2014.

Insurance industry leads the way in forming coalition to enroll uninsured

An unusual alliance of insurers, providers, and consumer groups formed this week to help uninsured Americans enroll in private or public plans for which they might be eligible.

Called Enroll America, the coalition launched only one day after the Census Bureau reported that a record number of American are uninsured or in poverty (see above). Insurers have committed \$1.5

million to the effort, while pharmaceutical companies and hospitals have pitched in \$2.5 million and \$2 million respectively.

America's Health Insurance Plans was among the first donors, providing \$100,000 for the development of a business plan to recruit other donors. More than 40 members have participated so far, including AARP, Aetna, the American Hospital Association, and the National Association of Health Underwriters.

Enroll America identifies two primary missions. The first is to encourage states to facilitate enrollment by providing states with model regulations. The other is to get the word out among the uninsured through advertising and community outreach.

The Affordable Care Act (ACA) is projected to give insurers 32 million new customers starting in 2014. However, a recent poll by the Kaiser Family Foundation found that over half the uninsured did not know the ACA expanded Medicaid coverage, and nearly half were unaware it would provide them with needed subsidies to purchase affordable coverage through health insurance exchanges (see Update for Week of August 29th).

STATES

Kaiser survey confirms that states are rapidly expanding Medicaid managed care

The Kaiser Family Foundation released a survey this week concluding that states are rapidly expanding Medicaid managed care, with mixed results on access to care.

The 50-state survey completed in conjunction with the consulting firm Health Management Associates found that roughly 66 percent of all Medicaid enrollees have been transitioned to managed care as of late 2010. Only three states (Alaska, New Hampshire, and Wyoming) did not operate comprehensive managed care programs for Medicaid enrollees.

Since the 1990s, states have steadily moved healthier Medicaid enrollees into managed care. The survey found that 46 states now mandate managed care for most children and 44 do so for pregnant women, parents, and other caretaker adults.

However, cost pressures are increasingly forcing states to move medically complex and fragile enrollees into managed care as well, including the disabled, elderly, and children with special needs. At least half of the states had also already begun to move those eligible for Medicaid and Medicare into managed care. While enrollment of these populations remained relatively low in 2010, some states (like California, Florida, Louisiana, Kentucky, and Texas) have sought over the past year to move most or all enrollees into managed care. (New York has a three-year plan to largely end fee-for-service).

The amount of Medicaid enrollees in managed also still varies widely from state to state. Nine states that use Medicaid managed care enroll fewer than half of their Medicaid enrollees, while another nine states already had more than 80 percent of Medicaid enrollees in managed care in 2010.

At least one state, Connecticut, has decided to move away from Medicaid managed care, claiming that higher administrative costs may not lead to savings (see Update for Week of June 13th).

The report acknowledges that access problems have resulted in at least 25 states from the use of Medicaid managed care. (Access problems under Florida's Medicaid managed care demonstration have been well documented, see Update for Week of June 20th). The authors conclude that access problems are primarily the result of capitated payments that are set too low, and that with appropriate safeguards "managed care offers significant potential to improve access and care for Medicaid beneficiaries."

Health Management Associates noted in the press briefing to announce the study that safeguards commonly sought by states include plan accreditation. They found that every state with Medicaid managed care requires plans to be rated based on quality performance measures and 15 states prepare quality “report cards” for beneficiaries to be used in picking a plan.

The survey results were mixed about the impact of the Affordable Care Act (ACA) on Medicaid managed care. Only 30 states responded to a question about whether their managed care plans can absorb the expanded Medicaid population in 2014, with 20 saying they could (including states like Texas whose Governor opposes the expansion).

The survey also found that states were still largely unsure about whether at least one Medicaid managed care plan will be required to participate in their new health insurance exchange (or whether at least one exchange plan must participate in Medicaid).

Connecticut

Elimination of premium subsidies causes dramatic drop in state health plan enrollment

More than 1,150 people dropped out of the state’s Charter Oak Health Plan when premiums dramatically rose this month, largely because of legislation curtailing state subsidies for the program.

Former Governor Jodi Rell (R) began Charter Oak in 2008, offering affordable state coverage to low-income uninsured adults not eligible for Medicaid. However, it was best by higher than expected costs due to adverse selection (i.e. attracting an older, sicker population). Charter Oak is currently run by three managed care plans, who all report losing money on the program because the cost of medical claims exceeded the premiums paid.

Connecticut had offered sliding-scale subsidies enabling those with lower incomes to enroll. However, legislation passed earlier this year eliminated those subsidies for those who joined after May 31st, causing premiums to rise from 45-67 percent. As a result, enrollment dropped by nearly 12.5 percent to 8,190 residents, with a 35 percent increase in the number of enrollees who simply failed to pay their monthly premiums.

The Director of the Department of Social Services (DSS) plans to urge Governor Dan Malloy (D) to reinstate the premium subsidies, at least for the lowest income groups. Business members of the state’s Medicaid oversight council have also suggested raising copayments and deductibles in order to keep premium costs down. Current copayments are already fairly high (\$25 for primary care, \$35 for specialists) and were not increased under the new legislation.

Charter Oak members will no longer be enrolled in managed care plans starting in January, and the program will end in 2014 once the Affordable Care Act is fully implemented.

Indiana

Individual plans abandon Indiana instead of complying with new federal medical-loss ratios

Five health insurers have stopped selling individual health plans in Indiana, in direct response to new medical-loss ratios under the Affordable Care Act (ACA) that limit how much insurers can spend on profits, salaries, and administration.

Aetna and CIGNA, the nation’s third and fifth largest health insurers respectively, announced their departure from the individual health insurance market last month. Pekin, American Community Mutual, and Guardian Life have followed. The five companies cover more than 20,000 Hoosiers, or about ten percent of all those who have individual health insurance.

The Insurance Commissioner sought a federal waiver last May that would allow the state to phase-in the new medical-loss ratios (MLRs) over the next three years. The Commissioner subsequently notified the U.S. Department of Health and Human Services (HHS) about the exodus of individual plans, as well as several other plans that are contemplating leaving.

The ACA requires individual and small business plans to spend at least 80 percent of premiums on medical care. The Commissioner documented that only 44 of the 63 individual and small business plans in Indiana were meeting this standard in 2010.

HHS has already granted waivers to five states (including neighboring Kentucky) that have demonstrated that immediate compliance with the new MLRs will destabilize the market.

The individual market is highly concentrated in Indiana, with Anthem Blue Cross and Blue Shield claiming 65 percent of the market. The nearest competitor, Golden Rule covers only about ten percent.

Kansas

Republican lawmaker seeks to block Medicaid system upgrades, fear exchanges will results

The state lawmaker who pressured Governor Sam Brownback (R) to return the state's \$31.5 million federal exchange implementation grant is now targeting an even larger federal grant that she fears could be a precursor to a health insurance exchange.

Rep. Charlotte O'Hara (R) has lead the charge by "tea party" lawmakers to block any provision of the ACA from being implemented in Kansas, despite the support of the state's Republican Governor and Insurance Commissioner to create their own health insurance exchange and not default to the federal government. Even though the Governor ultimately acceded to their demands to return the Early Innovator exchange grant obtained by former Governor Mark Parkinson (D) (see Update for Week of August 8th), Rep. O'Hara is now demanding that the Governor also reject the federal grants that cover 90 percent of the \$85 million contract the Governor recently negotiated with Accenture to install a state-of-the-art computerized system for Medicaid.

Even though upgrading Kansas' antiquated Medicaid billing systems will save the state money through more efficient and accurate payments, Rep. O'Hara fears that the enhancements will also make it easier for the Governor to change his mind and create an ACA-compliant health insurance exchange down the road, since the needed information technology will already be in place.

Governor Brownback insists that upgrading the Kansas' Medicaid Management Information System is wholly unrelated to the ACA and long overdue.

Kentucky

Kentucky receives federal approval to move most Medicaid enrollees into managed care

The Centers for Medicaid and Medicare Services approved Kentucky's plan to save \$1.3 billion by moving two-thirds of its Medicaid enrollees into managed care plans. Kentucky awarded contracts to four insurers earlier this year and plans to start the new program on October 1st (see Update for July 11th).

Massachusetts

Committee hears bill that requires public hearings for rate hikes of at least seven percent

The Joint Committee on Health Care Financing held a hearing this week on H.B. 345. Introduced last January by Rep. John Scibak (D), the measure would create a Division of Health Insurance within the Division of Insurance that would set minimum standards for each type of health benefit plan and require public hearing for any increase in premiums of at least seven percent.

Federal regulations promulgated under the Affordable Care Act (ACA) require states or the federal government to review health plan premium increases of at least ten percent. However, aggressive efforts by Governor Deval Patrick (D) over the past year have already restrained the growth in health plan premiums in Massachusetts to single digits (see Update for Week of February 14th).

New Jersey

Governor nixes plan to dramatically slash Medicaid

Citing widespread concern, Governor Chris Christie (R) elected this week to abandon his controversial plan to dramatically slash Medicaid eligibility to one of the lowest levels in the nation.

The Affordable Care Act (ACA) prevents states from cutting Medicaid eligibility below 133 percent of the federal poverty level (FPL), the minimum at which all states must move to by 2014. However, the New Jersey Department of Human Services submitted a request for a comprehensive federal waiver last spring that would cut eligibility for future enrollees to as low as 25 percent of FPL, or less than the minimum wage for a full-time employee (see Update for Week of May 16th). Governor Christie estimated that the “bare bones” eligibility would save the state \$300 million and eliminate coverage for only 23,000 enrollees of the 1.25 million Medicaid enrollees in New Jersey (see Update for Week of June 13th).

Governor Christie had previously insisted that the cuts were needed to fill the Medicaid program’s \$1.4 billion deficit and make-up for the loss of \$1 billion in federal stimulus funds that expired June 30th. He had previously cut Medicaid eligibility from 200 to 133 percent of FPL.

However, the Governor abruptly backed off the eligibility cut this week, likely because the plan engendered broad opposition from state lawmakers and the Obama Administration has yet to approve any state’s request to cut Medicaid eligibility for non-waiver enrollees. Governor Christie also elected to no longer pursue \$25 Medicaid copayments for non-emergency use of emergency rooms, calling it an “ineffective” way to encourage the use of primary care providers.

Ohio

Governor taking “wait and see” approach to exchange implementation

Ohio is one of only 11 states that have yet to even introduce legislation authorizing the creation of the health insurance exchange required by the Affordable Care Act (ACA). Governor John Kasich (R) has instead elected to “wait and see” if the new law will be overturned, either by the U.S. Supreme Court or a new President and Congress.

However, the Department of Insurance has used the initial \$1 million federal exchange grant obtained by the Governor’s predecessor to contract with both Milliman and KPMG consultants to research the state’s health insurance market and assess the information technology infrastructure required to implement such an exchange. Results from both analyses are expected later this fall.

Governor Kasich has thus far refused to apply for a second round of federal exchange establishment grants under the ACA.

Pennsylvania

Lower court strikes down key anti-discrimination provisions of Affordable Care Act

A federal judge appointed by President George W. Bush held this week that the Affordable Care Act (ACA) mandate requiring all Americans to buy health insurance goes beyond the traditionally broad powers of Congress to regulate interstate commerce.

The decision is significant in that Judge Christopher Conner for the Middle District of Pennsylvania ruled that because the individual mandate was so intertwined with the ACA ban on pre-existing condition denials and guaranteed issue requirement, he struck down all three of the provisions. Judge Conner ruled that the provisions could not be severable from each other, meaning all are unenforceable if just one is found unconstitutional.

Judge Roger Vinson from the Northern District of Florida is the only other federal judge to declare that the individual mandate cannot be severed from the rest of the law. However, Judge Vinson struck down the entire law, and not just those provisions requiring health insurers to offer coverage to everyone (see Update for Week of January 31st). Vinson's decision was largely overturned last month by the 11th U.S. Circuit Court of Appeals (see Update for Week of August 8th).

Despite siding with the plaintiffs, a couple from York, Pennsylvania, Judge Conner was very critical of their "unproductive and unpersuasive" rhetoric that compared the individual mandate to "tyranny" and predicted "cataclysmic results" if it was upheld.

The impact of Judge Conner's ruling today is likely to be limited as the Third Circuit appellate court in which Pennsylvania is based (as well as the Fourth and Ninth circuits) have already declared that plaintiffs lack standing to sue until the individual mandate goes into effect in 2014. Only two appellate courts have ruled on the individual mandate's constitutionality, with the Sixth Circuit upholding it and the 11th Circuit declaring it unconstitutional.

The U.S. Supreme Court is expected to ultimately rule on the mandate's constitutionality in 2012.

Texas

CMS tentatively approves plan to expand Medicaid managed care statewide

The Texas Health and Human Services Commission appears to have received the quick federal approval it was seeking to expand Medicaid managed care to all counties statewide.

Texas only submitted their waiver request last July, seeking a September 1st effective date for their managed care plan. The Centers for Medicare and Medicaid Services (CMS) indicated this week that it has approved the waiver "in principle" with a final notice expected to issue before September 30th.

Most Texas counties already have Medicaid managed care plans. However, legislation passed earlier this year (S.B. 7) allowed Medicaid managed care to expand to the poorer Rio Grande valley counties for the first time, subject to federal approval (see Update for Week of June 6th).

Virginia

Health reform council approves outline of exchange recommendations

The Virginia Health Reform Initiative Advisory Council approved a broad outline this week for their final recommendations on establishing a health insurance exchange that meet the standards of the Affordable Care Act (ACA).

Legislation enacted last session created the council and requires it to submit recommendations to Governor Bob McDonnell (R) by October 1st. However, separate authorizing legislation will be needed to actually proceed, as H.B. 2434 only declares the intent of the General Assembly that Virginia create and operate its own health insurance exchange, instead of defaulting to the federal government.

The council voted to recommend that the exchange be a quasi-governmental agency that is financially self-supporting. It also recommends that the board overseeing the exchange be comprised of 11-15 members appointed by the Governor and chaired by Dr. Bill Hazel, MD, the Health and Human Resources Secretary.

Wyoming

Exchange panel votes to keep their options open on federal partnerships

The committee developing legislative recommendations for a health insurance exchange required by the Affordable Care Act (ACA) elected this week to consider partnering with the federal government.

Members of the Wyoming Health Benefits Exchange Steering Committee acknowledged that their recommendation stood little chance of passing the highly conservative state legislature. However, members including Rep. Elaine Harvey (R) instead that a federal partnership was a “pragmatic” approach that was far more preferable than simply allowing a “federal takeover” of the exchange.

The committee had tabled key decisions until this month (see Update for Week of August 15th), pending consultation with federal regulators from the regional office of the U.S. Department of Health and Human Services. After meeting with HHS, the committee voted to eliminate one partnership model offered by HHS where Wyoming would operate the exchange for small business workers while HHS would operate a separate exchange for individuals.

However, committee members voted not to dismiss two other options where the federal government would only handle certain exchange functions like enrollment, or where Wyoming would simply make policy decisions involving a federally-operated exchange. Senator Bill Landen (R) noted that these models are similar to existing federal partnerships with Wyoming on other Medicaid issues.

The committee also voted to send a delegation to a Utah health care summit in order to explore potential partnerships with other states. They determined that they were still not prepared to make other key decisions.

Members will meet again in October before sending an interim report to the Legislature. Legislation authorizing the committee (H.B. 50) requires a final report by January.