

Health Reform Update – Week of October 24, 2011

CONGRESS

Democratic concessions fail to bring deficit “super committee” any closer to agreement

Competing plans introduced this week by Democrats and Republicans serving on the Joint Deficit Reduction Committee revealed that members remain dug into the same ideological trenches that nearly forced the federal government to default on its debt last summer.

The so-called “super committee” must pass recommendations by November 23rd to decrease the federal deficit by up to at least \$1.2 trillion over ten years. Failure to reach any agreement will trigger automatic across-the-board cuts starting in 2013 (see Update for Week of August 1st).

Senate Finance Committee chair Max Baucus (D-MT) presented the Democratic plan that far exceeds this mandate and would reduce the deficit by almost \$3 trillion over ten years. However, it was summarily rejected by Republican leaders as the amount of revenue hikes nearly equals the level of spending cuts. A sizeable number of Democrats also strongly opposed the \$500 billion in unspecified Medicare and Medicaid spending cuts included in the plan, which are significantly greater than even the federal health program cuts proposed by two bipartisan debt commissions last winter (see Update for Week of December 6th).

A counter plan presented by Republican members of the panel also hit a stone wall with Democrats, as it was comprised solely of \$1.2 trillion spending cuts and only \$640 billion in revenue increases through the elimination of certain tax loopholes.

The panel has made little progress in secret meetings (see Update for Week of October 17th). However, it called back the Congressional Budget Office Director for its third public hearing this week and will hold another open meeting on next week to hear from the leaders of unsuccessful bipartisan debt reduction commissioners assembled last winter.

The impasse compelled some House Democrats to study how to “dismantle” the automatic cuts that would be triggered if no deal is reached by Thanksgiving. However, at least one rating agency, Standards & Poors, warned that failure of Congress to enact any cuts would result in further downgrades in the nation’s credit rating (see Update for Week of August 8th).

Supreme Court to consider Affordable Care Act cases starting November 10th

The U.S Supreme Court has scheduled a private conference on November 10th to decide whether to accept any of the pending petitions to review whether the Affordable Care Act (ACA) mandate that everyone buy health insurance is constitutional.

The conference will be the Court’s first formal consideration of the hotly-contested issue. The Court is widely expected to accept one or more of the petitions for review, given the conflict in opinions among the federal appellate courts.

The White House has urged the Court to accept the most prominent of these challenges, which was joined by 26 state attorneys general (see Update for Week of October 3rd). The 11th U.S. Circuit Court of Appeals upheld a lower court decision in that case, which declared the individual mandate unconstitutional. However, they upheld the remainder of the law, as has every other appellate court to rule on its merits (see Update for Week of August 8th).

One key case will not be among the five petitions the Court considers on November 10th. The Virginia Attorney General challenged the law on separate grounds, since Virginia passed its own law declaring the individual mandate to be null and void. As a result, the justices will consider at a later date whether to accept that case.

Their decision on the Virginia case may prove critical to the final resolution, as the Fourth Circuit held that the individual mandate could not be challenged until it actually goes in 2014 (see Update for Week of September 5th). The White House would prefer that the Supreme Court not follow the Fourth Circuit decision, as it would effectively “punt” a definitive resolution until after the 2012 elections.

The insurance industry filed a “friend of the court” brief this week urging the Court to uphold the individual mandate, as it would render other interrelated provisions “unworkable”. America’s Health Insurance Plans has largely supported the ACA, but only if the ban on pre-existing condition denials and guaranteed issue requirement were connected to a mandate that everyone buy health insurance, in order to ensure that risk was adequately spread out among healthier and less costly subscribers.

The Obama Administration’s Supreme Court briefs took essentially the same risky position, urging the Court to either uphold all three or strike them all down. A federal district court in Pennsylvania did exactly the latter last month (see Update for Week of September 12th).

A three-judge panel for the Eighth Circuit U.S. Court of Appeals heard oral arguments last week in the challenge to the individual mandate filed by Missouri Lt. Governor Pete Kinder (R) (See Update for Week of September 19th). The Republican-controlled panel did not indicate which way they may rule.

House votes to scale-back exchange subsidies, with President Obama’s support

The House approved legislation this week that would require Social Security benefits to be counted as income when determining whether individuals will be eligible for federal subsidies under the Affordable Care Act (ACA).

Those with incomes up to 400 percent of the federal poverty level (FPL) will be eligible for the subsidies, which will help them purchase affordable coverage in the new state-based insurance exchanges. However, the chief actuary for the Centers for Medicare and Medicaid Services found last summer that a change in how Social Security benefits were counted under the ACA would allow married couples earning up to 400 percent of FPL to still qualify for Medicaid if they retired at age 62.

This “glitch” in the subsidy formula could cost the federal government up to \$450 billion over ten years in improper Medicaid expenses (see Update for Week of June 20th). The Congressional Budget Office estimated that fixing it through H.R. 2576 would raise \$13 billion over ten years, as up to one million fewer people would enroll in Medicaid per year (see Update for Week of July 25th).

CMS has already pledged a regulatory fix and President Obama included a similar correction in his deficit reduction plan (see Update for Week of October 10th). However, few Democrats supported the Republican-backed measure until the President announced this week that he would sign it. In the end, the measure passed with 26 Democrats voting in favor.

Report by House Republicans says that ACA subsidies will punish married couples

House Oversight Committee chair Darrell Issa (R-CA) released a report this week concluding that the Affordable Care Act (ACA) penalizes married couples by making it harder for them to be eligible for the new federal subsidies to purchase health insurance.

The ACA makes these tax credit subsidies available to those with low-to-moderate incomes so that they can comply with the federal mandate starting in 2014 requiring everyone buy health insurance.

However, the House Republican report concludes that married couples will receive only 14 percent of the tax credits while half of subsidy recipients will be unmarried individuals without dependents.

Chairman Issa claims that the data is based on a staff analysis of studies provided by the non-partisan Joint Committee on Taxation. He insists that the subsidies are skewed towards unmarried individuals because they are tied to the federal poverty level (FPL) which does not increase in direct proportion to household size. For example, FPL only increases by 35 percent for married couples, meaning their premium subsidy would also be only 35 percent higher than single individuals.

Rep. Issa also blames provisions in the new law that allows worker to receive the subsidies if their employer-based coverage is not affordable. He argues that because that proposed exchange regulations published last summer peg that affordability to individual and not family coverage, a worker's spouse and children would not have access to the subsidies.

Issa's complaints have some support among provider groups. For example, the American Academy of Pediatrics is spearheading a sign-on letter to the Centers for Medicare and Medicaid Services that decries this "family penalty" that will "negatively impact the opportunity to access quality health insurance for significant numbers of children." The letter urges Treasury Department to "use the discretion it has under the [health law]" to base tax credit eligibility on family coverage, although Treasury insists that it cannot do so with Congress amending the law.

The Center on Budget and Policy Priorities and other ACA proponents insist that it is "not unusual" for tax credits to be pegged to the federal poverty level, which assumes that people benefit from economies of scale when getting married or living in the same household as others. They also point out that Republican witnesses at a House hearing this week on the issue acknowledge that linking the subsidies to family coverage would cost the federal government an extra \$50 billion a year.

Support for Affordable Care Act wanes among Democrats

The Kaiser Family Foundation's latest monthly tracking poll found that only 34 percent of Americans surveyed have a favorable view of the Affordable Care Act (ACA). That is the lowest favorability rating recorded by Kaiser since the law passed last year.

Kaiser attributed the decline largely to "waning Democratic enthusiasm" as opposition to the law remained fairly steady while the "share of Democrats with a favorable view of the law dropped from nearly two-thirds in September to just over half in October."

Opposition to Medco and Express Scripts merger gaining steam

Fourteen House members recently sent a bipartisan letter to the Federal Trade Commission objecting to a proposed merger of two of the nation's largest drug plan administrators, joining with earlier calls from at least seven Representatives and Senators.

Congressional Community Pharmacy Caucus co-chair Rep. Cathy McMorris Rodgers (R-WA) spearheaded the letter, which calls for a "full and thorough investigation" into the proposed merger between pharmacy benefit managers Express Scripts and Medco Health Solutions. The letter follows a House Judiciary Committee hearing on the merger last month, while Senator Herb Kohl (D-WI), chair of the Senate Judiciary antitrust subcommittee, has already scheduled a hearing for next month.

Lawmakers from both parties who object to the merger argue that it would create a "behemoth" that would control more than half of specialty pharmaceutical sales and close to 60 percent of the mail-order market. Supporters insist that patients and taxpayers stand to gain as pharmacy benefit managers force pharmacies and other drug distributors to become more efficient. The merger cannot go through until ultimately approved by the FTC.

Medco posted a slightly higher-than-expected profit last quarter, thanks largely to a record generic dispensing rate of nearly 74 percent of all prescriptions (up 2.2 percent from last quarter).

FEDERAL AGENCIES

FTC lobbies “super committee” to ban “pay-to-delay” generic drug settlements

The Federal Trade Commission (FTC) issued its latest report this week identifying the number of “pay-to-delay” generic drug settlements last year that the agency believes are anti-competitive and greatly increases drug costs for consumers.

The FTC has sought since 2001 to ban the practice of brand-name manufacturers offering generic drugmakers generous patent litigation settlements in exchange for keeping the lower-cost generic product off the market. Previous FTC reports found that such settlements delay the introduction of generics by an average of 17 months (see Update for Week of May 2nd).

Of the 156 patent settlements tracked by the FTC in federal fiscal year 2011, brand-name manufacturers made 28 such “pay-to-delay” deals, 18 of which delay the introduction of first-time competitors. This nearly matches the 31 settlements FTC identified in fiscal year 2010, which was the highest the agency ever recorded (and a jump of 60 percent from the year prior).

President Obama, as well as Senators Herb Kohl (D-WI) and Charles Grassley (R-IA), have introduced proposals to ban “pay-to-delay” settlements. According to the Congressional Budget Office (CBO), the Senate bill (S.27) would reduce the federal deficit by at least \$2.67 billion over ten years, although the President estimates it will save up to \$8.8 billion over the decade and the FTC claims it will save \$3.5 billion per year.

The FTC presented its findings to the “super committee” struggling to develop \$1.2 trillion in deficit reduction recommendations by November 23rd (see Update for Week of October 10th).

The Generic Pharmaceutical Association has steadfastly opposed the FTC campaign to ban the settlements, claiming that 16 of the 22 first-time generics to become available in the United States this year are entering the market prior to patent expiration only because of a settlement agreement. If these deals are banned, the trade group maintains that these generics would not be available as quickly.

Despite some bipartisan support for S.27, both Republicans and Democrats from states with a heavy drug industry presence have opposed giving FTC the authority to decide when a “pay-to-delay” settlement harms competition sufficient to violate federal antitrust protections (see Update for Week of December 13th).

Medicare Part B premiums and deductible for 2012 will be lower than expected

The Centers for Medicare and Medicaid Services made the surprise announcement this week that monthly Medicare Part B premiums will be \$99.90 in 2012, or \$6.70 less than previously projected by the Medicare trustees and just \$3.50 more than the 2011 premium paid by most beneficiaries.

The agency also revealed that the Part B deductible for physician visits will be \$22 lower than 2011, while Medicare Advantage premiums should drop by 4 percent on average. However, the deductible for hospital and nursing home care will increase by \$24.

Administrator Donald Berwick attributed the lower-than-expected premium hike to historically low health care utilization rates, due partly to the Affordable Care Act’s investment in prevention and a struggling economy that forces many Americans to forgo needed medical treatment (see Update for Week of October 10th).

Due to the 3.6 percent hike in the Social Security cost-of-living adjustment for 2012 (see Update for Week of October 10th), enrollees also will not be held harmless for Medicare premium increases as they have in recent years. As a result, the Part B premium increase is lower and more evenly spread out than initially projected.

HHS steps-up rate review for association health plans

The Department of Health and Human Services (HHS) announced on its website this week that the agency will conduct at least a portion of the rate reviews for association health plans in ten states and carry out the full review in 12 other states.

The Affordable Care Act (ACA) granted HHS the authority to require health insurers publicly justify “unreasonable” rate hikes. Pursuant to HHS regulations implementing this provision, insurers had to start providing their actuarial data justifying any premium increase of at least ten percent, starting September 1st. HHS is assuming this function for ten states that do not have adequate mechanisms to do so for either the individual or small group market (see Update for Week of August 29th).

However, HHS regulations also determined that association health plans are subject to this provision. As a result, they will also assume the responsibility in those states that do not have adequate mechanisms for reviewing increases in association health plan premiums.

Treasury OIG says IRS is on track to enforce tax and penalty provisions of federal health reform

The Internal Revenue Service (IRS) appears to be meeting the technological challenges of the Affordable Care Act, according to the results of an audit published this week by the Office of the Inspector General (OIG) for the Department of Treasury.

The ACA made more than 40 changes to the federal tax code that fall under IRS jurisdiction, creating \$438 billion in new taxes and fees. At least eight of these modifications are forcing the IRS to craft entirely new processes to administer the law. These include two of the most critical functions under the ACA, namely the enforcement of tax penalties against those who do not buy health insurance and the calculation of the tax credits given to those with incomes up to 400 percent of the federal poverty level so that they can purchase affordable coverage in the new health insurance exchanges.

However, the OIG praised IRS for promptly hiring additional staff, developing implementation plans on schedule, and creating an entirely new office last year just to deal with ACA implementation.

The audit did recommend that IRS more clearly articulate procedures for dealing with unresolved issues that may arise with implementation, which the agency agreed to carry out.

GAO finds that consumers are often unable to find out how much a health service will cost

A new report from the Government Accountability Office (GAO-11-791) confirmed this week that consumers are typical unable to get the pricing information from medical providers needed to make a rational purchasing decision about their treatment.

Investigators with the Congressional agency posed as potential customers and unsuccessfully tried to find out how much certain treatment would cost. None of the 19 Denver-area hospitals surveyed could identify what Medicaid beneficiary or uninsured patient would be required to pay for knee replacement surgery, and ten failed to provide any pricing information at all. The rest merely offered very broad estimates or average charges. Only four of 20 physicians were willing to even provide a complete cost estimate for a simple diabetes screening, with several refusing to respond unless the patient was first seen by a physician.

The lack of health care price transparency has frequently been cited as the primary reason why “market-based” health reforms are unsuitable for the health care marketplace. Unlike the markets for commodities like cars, computers, or toasters, consumers are simply unable to “shop around” and choose providers who offer the highest quality health care at the best price.

OIG faults CMS for failing to adequately oversee Medicaid Drug Rebate Program

Results of an audit released this week by the Health and Human Services (HHS) Office of Inspector General (OIG) found that not one of the 14 states surveyed had adequate controls in place to ensure that all of its Medicaid drug expenditures complied with federal law.

According to OIG, the lack of oversight costs state and federal taxpayer nearly \$260 million. The report specifically found that Medicaid program were paying for drugs that are ineligible for coverage, and faulted a lack of “internal controls” by the Centers for Medicare and Medicaid Services (CMS).

CMS partly agreed with some of the OIG findings and recommendations, but insisted that manufacturers participating in the Medicaid Drug Rebate Program are solely responsible for ensuring that they report only those drugs eligible for rebates. CMS said it would discuss with OIG whether to impose sanctions on offending manufacturers.

Federal judge refuses to dismiss challenge to “secret” Medicare denials for the chronically ill

A federal district court judge refused this week to grant the federal government’s request to dismiss a lawsuit seeking to ensure that Medicare beneficiaries with chronic conditions will not be denied coverage solely because their condition will not improve.

The Center for Medicare Advocacy and Vermont Legal Aid are seeking to eliminate the so-called “Improvement Standard” that is not found in federal law but has become the “rule of thumb” allowing Medicare to deny or terminate coverage to enrollees whose conditions do not improve. The Center claims that Medicare officials have relied upon this illegal “secret policy” for over 30 years, which has a “devastating effect” on anyone with chronic conditions like Multiple Sclerosis, ALS, Alzheimer’s, or Parkinson’s disease.

STATES

Kaiser surveys continue to confirm that states are greatly scaling back Medicaid

A new survey released this week by the Kaiser Family Foundation found that every state are cutting Medicaid payment or benefits in an effort to offset the loss of federal stimulus funds.

The American Recovery and Reinvestment Act (ARRA) substantially increased the federal government share of Medicaid funding for 2009 and 2010. It also brought about the only declines in state Medicaid spending in the program’s history, even as the recession sharply increased the numbers of people becoming eligible for Medicaid.

However, Congress refused to extend this emergency relief past last June 30th, forcing states to take dramatic measures to close huge budget gaps as state Medicaid spending is expected to increase by nearly 29 percent. Because both the ARRA and the Affordable Care Act (ACA) prevent states from cutting eligibility or enrollment as a condition of accepting federal assistance, states have been forced to enact a wide array of other cost containment actions, ranging from lower provider payments, eliminating optional benefits, higher beneficiary copayment, and additional restriction on high-cost prescription drugs.

The most common cost containment strategy has been simply to cut payment rates, with 39 states doing so in 2011 and 46 planning cuts in 2012. However, almost all states have made “substantial

changes” in Medicaid pharmacy programs, with several focused on controlling costs for the highest-cost specialty drugs (see Update for Week of October 10th).

Several states like Arizona, California, Hawaii, and Tennessee are also trying to impose severe limits on benefits. Hawaii is currently seeking federal approval to limit adult Medicaid enrollees to only ten days of inpatient hospital coverage per year, the lowest in the nation.

Five states have already increased or imposed copayments, with another 14 states planning to do so next year (compared to only one in fiscal year 2010). Most copayment changes were for pharmacy and emergency room visits, although a few states like Arizona are requesting federal waivers to implement broader changes that would extend copayments beyond federal limits or to traditionally exempt populations (see Update for Week of October 17th).

The use of Medicaid managed care has greatly picked up steam with states like Florida, Kentucky, Louisiana, and Texas striving to move all or nearly all Medicaid enrollees into capitated plans. Seventeen states in FY 2011 and 24 states in FY 2012 reported expanding their managed care programs, primarily by expanding the areas and populations covered. Over two-thirds of all Medicaid enrollees were already moved into managed care by fall 2010 (see Update for Week of September 12th).

California

CMS partially approves severe cuts in Medi-Cal payment, higher copayments still pending

The Centers for Medicare and Medicaid Services (CMS) partially approved an across-the-board ten percent cut in Medi-Cal payment rates sought by Governor Jerry Brown (D).

Governor Brown put the Obama Administration in a very difficult predicament by seeking \$1.4 billion in Medi-Cal cuts in order to fill the state’s \$26.6 billion deficit. The U.S. Supreme Court is currently reviewing whether to allow previous ten percent Medi-Cal payment cuts in 2008 and 2009 that patients and providers successfully sued to block (see Update for Week of September 26th).

The Obama Administration angered consumer advocates by urging the Supreme Court to allow the cuts and deny patients and providers that statutory right to block future cuts. That made it politically untenable for them to reject all of Governor’s Browns cuts.

CMS wound up approving the ten percent reduction in Medi-Cal reimbursement for most outpatient care including pharmacy services, retroactive to June 1st. However, they rejected the ten percent cut for physician and clinic services for children, outpatient hospital care, and home health services, concluding that it would drop Medi-Cal’s lowest-in-the-nation payment to the point where it would harm access to care and thus violate federal Medicaid law.

CMS also delayed their decision on the Governor’s plan to limit most Medi-Cal enrollees to only seven physician visits per year and charge them \$5 copayments for physician visits and \$50 for emergency room visits (see Update for Week of June 27th and July 4th).

At least 12 Congressional Democrats from California had urged the CMS Administrator to reject all the cuts. The delegation, along with California’s Attorney General, also support maintaining the statutory right of patients and providers to sue Medi-Cal to enforce the access to care provision of federal Medicaid law, since CMS has traditionally been reluctant to do so (see Update for Week of May 2nd).

Georgia

Federal ADAP relief lowers nation’s second-highest waiting list by over 24 percent

At least 336 low-income Georgians will gain access to HIV/AIDS medications thanks to \$3 million in federal relief for the state’s cash-strapped AIDS Drug Assistance Program.

According to the National Association of State and Territorial AIDS Directors (NASTAD), Georgia still has 1,427 clients on their ADAP waiting list as of October 20th, which represents 21 percent of all waiting lists clients nationwide and is second only to the 3,335 on Florida's waiting list. However, this number fell by over 24 percent this month thanks to the influx of federal funds.

Waiting lists nationwide fell by 20 percent once the federal ADAP relief was released (see Update for Week of October 3rd).

Kansas

Exchange working group appears ready to allow a "federal takeover" of the exchange

The working group formed by the Insurance Commissioner to study whether to implement a health insurance exchange appeared to acknowledge this week that political realities would force the federal government to instead operate the exchange starting in 2014.

Insurance Commissioner Sandy Praeger (R) is a strong supporter of both exchanges and the ACA. Her working group composed of industry and consumer representatives has met since January to develop a plan for Kansas to create and implement its own exchange.

However, the panel was dealt a huge blow over the summer when Governor Sam Brownback (R) returned the state \$31.5 million federal "early innovator" grant (see Update for Week of August 8th). Governor Brownback initially supported the creation of a Kansas exchange, but reversed course in the face of growing "tea party" opposition to implementing anything that has to do with "Obamacare".

Praeger had pledged to press forward. However, the exchange cannot be created without legislative authorization or an executive order (as several Republican Governors have issued). As Kansas nears the 2013 deadline to certify exchange preparedness or default to the federal government, members appeared at the latest meeting to recognize that political support for an exchange is lacking.

Massachusetts

Blue Cross and Blue Shield issues "symbolic" refund to quell CEO compensation controversy

Blue Cross and Blue Shield of Massachusetts (BCBSM) became the latest insurer this week to try and stem negative publicity by issuing premium refunds to subscribers.

Subscribers began receiving premium refunds last week, which were intended to exactly offset the amount of the controversial \$4.2 million severance given to its former chief executive officer. However, unlike the dramatic refunds by Blue Shield of California that reduced individual premiums by an average of \$135 (see Update for Week of October 10th), BCBSM critics were quick to point out that subscribers will only see only a "symbolic" drop in their premiums of roughly \$3.

The refunds were urged by Attorney General Martha Coakley (D) who conducted a four-month investigation in the "generous severance [that] did not serve the purposes of a nonprofit insurer." However, BCBSM will not try to recoup any of the former CEO's \$11 million total severance package.

Pennsylvania

Insurance department to send exchange recommendations to Governor in the next few weeks

The Insurance Department is waiting on a report from the consulting firm KPMG before it makes final recommendations to Governor Corbett (R) about how or whether to create the new health insurance exchange required by the Affordable Care Act (ACA).

The Department hired KPMG to study structural issues such as governance, how consumers and businesses will be able to access the exchange, financial structure, and regulatory reviews. The KPMG report will form the basis of the non-public recommendations to be sent to the Governor in the next few weeks, along with feedback from public meetings and the results of a small business survey.

The small business survey has already showed that 40 percent of Pennsylvania small businesses surveyed does not provide health insurance to their employees, with 41 percent saying it is too expensive and another 20 percent actually claiming that their employees do not need coverage.

KPMG was commissioned to perform a similar analysis for the Wisconsin insurance department (see Update for Week of August 22nd).

Virginia

Employer-based coverage in Virginia falls to lowest level in two decades

A report released this week by the Commonwealth Institute for Fiscal Analysis found that Virginia's rate of employer-sponsored health insurance has fallen to its lowest rate in nearly 20 years.

The Richmond-based think tank attributed the erosion to skyrocketing health insurance costs and a "general willingness among businesses to skimp on employee benefits." However, it concluded that the provisions in the Affordable Care Act (ACA) aimed at helping small businesses afford coverage would reverse this trend and expand employer-based coverage.

Only slightly more than 61 percent of Virginians had employer-based coverage in 2010, down more than ten percent over the past decade. The percentage of small businesses offering coverage in Virginia also fell from 48 to 40 percent over this time. The Institute found that this erosion was due largely to the fact that Virginia residents paid the third-largest share of their premiums for employer-based family coverage (32.2 percent), trailing only residents of Arkansas and Idaho.

According to estimates from the U.S. Census Bureau's American Community Survey (ACS), rates of employer-based coverage within Virginia corresponded directly to unemployment. Northern Virginia counties with the lowest unemployment had the highest rate of employer-based coverage (68 percent), while the Danville area experiencing the Commonwealth's highest unemployment also had the lowest rate of employer-based coverage (52 percent).

Wisconsin

Wisconsin becomes 17th state to seek federal waiver for new insurer payout standards

The Commissioner of Insurance submitted a request this week for a federal waiver that would allow small business and individual health plans to phase-in the new medical-loss ratios (MLRs) required by the Affordable Care Act (ACA).

The Commissioner's request would allow applicable health plans to spend only 71 percent of premium revenue on direct medical care in 2011, and gradually move up to the federally-required 80 percent threshold by 2014. He insisted that the Wisconsin small business and individual markets would be destabilized without the waiver, noting that at least six insurers representing 35 percent of the individual market currently fail to meet the 80 percent threshold.

The federal Centers for Medicare and Medicaid Services (CMS) has already granted MLR waivers to five states that were able to show that immediate compliance would could cause existing plans to go out of business or otherwise leave the market (see Update for Week of October 10th). However, Wisconsin's own market analysis ordered by former Governor Jim Doyle (D) showed that the state has a highly-concentrated and competitive health insurance marketplace with most plans already meeting or exceeding the new MLRs (see Update for Week of March 14th).

CMS has rejected waiver requests from Delaware and North Dakota, and is expected do so for Florida which also has a highly-competitive health insurance market. The Florida Office of Insurance Regulation recently surveyed health plans in attempt to bolster their application and found only two subsidiaries of American Enterprise Group who plan to leave the market as a result of the new MLRs. Both issue less than 3,000 policies in Florida.