

Health Reform Update – Weeks of June 27 and July 4, 2011

CONGRESS

Bipartisan appeals panel upholds federal mandate that everyone buy health insurance

A three-judge panel for the Sixth U.S. Circuit Court of Appeals in Ohio became the first federal appellate court last week to uphold the constitutionality of the Affordable Care Act mandate that all Americans purchase health insurance coverage.

The 2-1 decision is particularly significant as it was joined by Judge Jeffrey Sutton, a conservative jurist appointed by President George W. Bush who has previously stoked controversy for rulings that narrowed federal protections available to persons with disabilities. Judge Sutton rejected the argument that the purchase of health insurance constitutes “inactivity” that cannot be regulated by the federal government. Instead, he became the first Republican-appointed federal judge to conclude that self-insuring is economic activity that is within the bounds of Congress’ historically-broad power to regulate interstate commerce.

Judge Sutton’s opinion followed the decision written by Judge Boyce Martin, who was appointed by President Carter. The majority decision held that “the unique aspects of health care...make all individuals active in this market” and that an individual mandate was a constitutional mechanism to prevent “free riders” who can afford to purchase health insurance but instead force taxpayers to subsidize their health care when they inevitably get sick or injured. However, Judge Sutton included the caveat that the court could revisit the issue once the full impact of the individual mandate becomes clear after its 2014 implementation.

Judge Michael Graham, a Reagan appointee, was the lone dissenter. He argued that upholding the individual mandate would effectively make Congress’ interstate commerce power boundless.

The case was brought by the conservative Thomas More Law Center and four individuals, who can now appeal to the full Sixth Circuit and ultimately the U.S. Supreme Court. Three-judge panels for the Fourth and 11th Circuits are expected to render decisions in July.

A lower court followed later in the week by dismissing an individual mandate challenge, ruling that it was bound by the decision of the Sixth Circuit (see Ohio article below).

President proposes more entitlement cuts to help resolve debt ceiling impasse

Congressional Democrats and advocacy groups like AARP were angered this week at proposed concessions by the Obama Administration to help resolve the impasse over whether to raise the federal debt ceiling before the government potentially defaults on the debt after August 2nd.

President Obama met directly with Republican and Democratic leadership and indicated that both sides were nearing a deal before his July 22nd deadline. The President specifically proposed larger savings from entitlement programs, which including using a different inflation measure to reduce cost-of-living adjustments for Social Security, applying a blended rate to reduce the amount of Medicaid matching funds to states, and greater than expected cuts to Medicare provider reimbursement. In exchange, he has sought Republican concessions on ending certain corporate tax breaks.

Republican leaders still refuse to include tax increases as part of any debt ceiling compromise, but did indicate this week a willingness to consider extending Medicaid drug rebates to the nine million

“dual eligibles” who currently are disqualified from rebates because they receive Medicare. Democrats recently resurrected legislation to restore rebates for “dual eligibles” which were staunchly opposed by the pharmaceutical industry and removed by Republicans as part of the law creating Medicare Part D (see Update for Week of June 13th). However, Republican allegiance to pharmaceuticals has frayed somewhat after the industry supported passage of the Affordable Care Act. The Congressional Budget Office estimates that the expanded rebates could save \$112 billion over ten years.

The President’s proposal was promptly blasted by Democrats for conceding too much to Republican demands for entitlement cuts and not insisting on greater tax revenue from the wealthiest Americans. Washington Governor Christine Gregoire (D), chair of the National Governors Association, also warned that states would have a “huge problem” with the President’s plan to save \$100 billion by cutting Medicaid matching funds, even if it was a better alternative than the Republican plan to “block grant” Medicaid.

House Republicans will likely need the support of “dozens” of Democrats to pass any bill raising the debt ceiling, as the most conservative members remain opposed to any increase. As a result, House Democrats are urging the President to use this leverage and refrain from any deal that cuts entitlement benefits, instead of “restructuring” these programs to improve payment efficiency.

Kaiser poll shows most Americans prefer that independent panel make Medicare cuts

A new tracking poll released last week by the Kaiser Family Foundation reveals that Americans appear to have more confidence in the ability of an independent panel to trim Medicare spending than they have in Congress, the Administration, or insurers.

Among those surveyed in the June poll, half said they would trust “a fair amount” or “a great deal” an independent panel of full-time experts with members appointed by the President and confirmed by the Senate. About 40 percent would instead place their trust in the Centers for Medicare and Medicaid Services, 34 percent in Congress and 34 percent in private health plans.

Broken down by party identification, Democrats trust an independent panel more than Republicans, who say they are more likely to trust insurers.

The Independent Payment Advisory Board (IPAB) authorized by the Affordable Care Act (ACA) would make recommendations on Medicare spending cuts whenever expenditures exceed pre-determined targets after 2014. The recommendations would automatically go into effect if Congress fails to implement them or pass appropriate offsets.

However, the panel has become a political lightning rod as House Republican efforts to repeal IPAB have been joined by seven Democrats as well as powerful advocacy groups (see Update for Week of June 20th). The Energy and Commerce Subcommittee on Health has scheduled a July 13th hearing on repeal legislation (H.R. 452).

NAIC task force backs legislation softening insurer payout rules for broker commissions

A National Association of Insurance Commissioners task force took the unusual step last week of endorsing specific legislation that would provide relief to insurance brokers from certain provisions of the Affordable Care Act (ACA).

The Department of Health and Human Services (HHS) issued regulations last year that defined fees paid to insurance brokers as administrative costs. This definition was based upon model rules approved by NAIC, which recommended what expenses HHS should consider as medical costs versus administrative costs for salaries, profits, and overhead.

Representatives for insurance brokers have strongly objected to having their fees counted as administrative costs. Since the ACA now requires that individual and small group plans spend at least 80

percent of premium revenue on direct medical care (85 percent for large groups), brokers claim that plans are cutting back on brokers fees in order to meet these higher insurer payout standards.

Fearing that these standards could impact the survival of over 500,000 brokers, the task force urged the NAIC executive committee to formally endorse H.R. 1206, a bill introduced by Congressmen Mike Rogers (R) and John Barrow (R) last March that would exempt broker fees from the calculation of administrative costs. Although NAIC does not typically endorse specific bills, NAIC's President-elect and task force chair insisted that broker survival was an issue of "critical importance" for commissioners.

H.R. 1206 has attracted some bipartisan support in the House but is strongly opposed by Senators Jay Rockefeller (D-WV) and Al Franken (D-MN) who claim it would deprive consumers of over \$1 billion in rebates mandated by the ACA. The insurance commissioner from Rockefeller's home state was one of only four commissioners to oppose endorsing the legislation, insisting that it would increase costs for consumers. North Carolina Insurance Commissioner Wayne Goodwin (D) advocated a more limited approach to preserve broker commissions.

FEDERAL AGENCIES

CMS to assume control of health plan rate reviews for up to ten "ineffective" states

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will review health insurance premium increase for ten states that currently have an "ineffective" process to determine whether rate hikes are "unreasonable."

Regulations finalized in May pursuant to the Affordable Care Act (ACA) will require all individual and small group health plans to publicly disclose actuarial data justifying any rate hike of at least ten percent, starting September 1st (see Update for Week of May 16th). However, CMS determined that seven states as of July 1st have failed to adopt a rate review mechanism that meets ACA standards for both the individual and small group markets. These seven states are Alabama, Arizona, Idaho, Louisiana, Missouri, Montana and Wyoming. Another three states (Iowa, Pennsylvania, and Virginia) lack adequate rate review for only the small group market.

The agency will continue to review premiums for deficient states until they adequately strengthen their rate review process. CMS will also review premiums for non-Blue Cross and Blue Shield plans in Alaska, but only until a new state law goes into effect this January.

The ACA gives federal regulators the authority to determine whether double-digit rate hikes in these ten states are "unreasonable". The final CMS regulations require independent experts to assess reasonableness according to 12 specific factors including:

- Changes in medical cost trend changes;
- Changes in benefits, cost-sharing, or utilization of services;
- Changes in enrollee risk profile;
- Reserve needs;
- Administrative costs related to programs that improve healthcare quality;
- Medical loss ratios; and
- The plan's risk-based capital status relative to national standards.

Although the ACA does not allow federal regulators to block or modify rate increases in these ten states, CMS claims that public disclosure and transparency will often mitigate unreasonable rate hikes.

Missouri and Montana are the only two of the ten states lacking adequate review that do not have Republican governors. All but Montana are suing to block implementation of key provisions of the ACA.

Legislation that would provide insurance departments with greater authority to block or modify unreasonable rate hikes was recently vetoed by Republican Governors in New Mexico and Nevada, as well as the Democratic Governor of Connecticut (see below). Similar legislation failed last session in California and is facing stiff opposition from insurer and physician groups this session (see below).

ACA has saved half million Medicare Part D enrollees over \$260 million

The Administrator for the Centers for Medicare and Medicaid Services (CMS) revealed this week that number of Part D enrollees benefiting from the new prescription drug discounts has jumped 76 percent over the past month.

Nearly 500,000 enrollees have now entered the Part D coverage gap for 2011 and received the 50 percent discount on drug costs mandated by the Affordable Care Act (ACA) for a total savings of \$260.5 million or \$545 per beneficiary. Only 271,000 enrollees had benefited through April 30th (see Update for Week of May 23rd).

CMS anticipates that up to four million more Part D enrollees will eventually reach the coverage gap and benefit from the mandated discount.

According to CMS, nearly 14 percent of the discounts (or more than \$36 million) were for cancer drugs, while over eight percent went for popular drugs to control high blood pressure and cholesterol.

FEHBP to adopt new premium rating rules under ACA

The Office of Personnel Management issued an interim final rule last week that creates a new premium rating method for community-rated plans under the Federal Employees Health Benefits Program (FEHBP).

Effective July 25, 2011, community-rated FEHBP plans will apply the same premium rating rules required by the Affordable Care Act. This includes limitations on age rating and medical-loss ratios requiring large group plans spend at least 85 percent of premium revenue on medical care (80 percent for individual and small group plans).

Premiums for FEHBP plans had been compared with the rates charged to a carrier's similarly-sized subscriber groups. The new process will apply to all community-rated plans, except those under traditional community rating (TCR). It will be phased in over two years, with optional participation for non-TCR plans in the first year.

Mammoth exchange rule may not be released until next week

National Governors Association officials announced this week that proposed rules governing the state insurance exchanges required by the Affordable Care Act may be released up to a week past the July 7th target date initially announced by the Centers for Medicare and Medicaid Services (CMS).

The Office of Management and Budget was expected to issue the required paperwork clearance for the purportedly 800-page rule by July 7th (see Update for Week of June 20th). At least 14 state legislatures have yet to act on legislation authorizing the new exchanges, with most stating that they were waiting from the expected guidance from CMS on how to proceed (see Update for Week of June 6th).

Ten states have already passed laws creating an exchange, while three others (Georgia, North Dakota and Virginia) created advisory committees to begin planning an exchange. (North Dakota and Virginia began meeting this week).

CMS cuts Medicare physician payments by 29 percent, for now

The Centers for Medicare and Medicaid Services (CMS) published its Medicare Physician Fee

Schedule this week, which imposes a 29.5 percent cut in Medicare reimbursement for physicians in calendar year 2012.

The cut is not likely to go into effect. Congress has postponed similar payment cuts 11 times since the new physician payment formula was adopted under the Balanced Budget Act of 1997; including three separate delays in 2010 (see Update for Week of December 6th). CMS Administrator Donald Berwick, MD emphasized the Obama Administration has pledged to implement a “permanent and sustainable fix” in his 2012 budget that is still being negotiated with Congress (see Update for Week of February 14th).

HHS provides guidance on how Medicaid can improve cost/quality for high-cost enrollees

The Department of Health and Human Services (HHS) announced three new initiatives this week to provide states with greater flexibility and resources in serving high-cost Medicaid enrollees.

The new guidance includes a demonstration that will test two prospective payment models to improve the cost and quality of care for those eligible for both Medicare and Medicaid. The agency is also creating a resource center to provide states with technical assistance on how to deliver coordinated care for high-cost Medicaid enrollees, including those with multiple chronic conditions.

High-cost patients responsible for half of all national health spending, rising premiums

The National Institute for Health Care Management (NICHM) Foundation released a new report this week concluding that roughly five percent of the U.S. population is responsible for nearly half of the nation’s total health care spending.

The non-partisan non-profit foundation relied on the 2008 Medical Expenditure Panel Survey to determine that a small group of “high-cost” patients consumed most health care resources. It found that nearly 64 percent of health spending went for ten percent of the population, while 47.5 percent was spent on only five percent and over 20 percent went for the top one percent.

While the average person incurred about \$233 in costs in 2008 for health services, those in the top half of spending cost \$7,317. However, the top one percent cost a whopping \$76,476 per person.

Adults that were at least age 55 represented the largest proportion of the high-spending group, while those in the lower spending group tended to be younger. The report also found that those with at least one chronic condition were 2-4 times more likely to have spending in the top five percent.

The report showed that private health plan premiums correlated directly with spending. From 2005 to 2009, premiums for private health insurance increased by nearly 15 percent due largely to higher hospital and physician costs.

Landmark study finds that Medicaid greatly improves health, stability of recipients

A landmark study released this week by the National Bureau of Economic Research documented that Medicaid enrollees in Oregon were far healthier, productive, and financially stable than those who were uninsured.

Researchers from the Massachusetts Institute of Technology and Harvard University examined the impact of Oregon’s “lottery” that randomly awarded Medicaid coverage in 2008 to only about 10,000 of 100,000 applicants who were eligible for the expanded program. In only the first year of data collection, they found dramatic differences between those who received Medicaid and those who remained uninsured. For example, Medicaid enrollees reported far greater health outcomes and were 35 percent more likely to be able to visit a physician, 30 percent more likely to receive hospital care, and 15 percent more likely to use prescription drugs. Those awarded greater access to care also spent more

than 25 percent less than those who remain uninsured and often relied on more costly emergency care or went without treatment until their condition become more severe.

The authors called the historic results “electrifying”, noting that the study was the first of its kind in over 25 years and provided direct evidence of the value and cost-effectiveness of Medicaid, particularly in preventing financial catastrophe for those with costly illnesses. The study specifically found that those awarded Medicaid were 25 percent less likely to have an unpaid bill sent to a collection agency and 40 percent less likely to borrow money or fail to pay other bills due to medical expenses.

STATES

Analyst finds non-profit Blues plans have huge reserves that may warrant subscriber refunds

Citi Investment Research and Analysis (CIRA) reported last week that most non-profit Blue Cross and Blue Shield (BCBS) plans have compiled huge reserves and that may translate into premium holidays or lower than expected rate increases.

The financial analyst found that 33 BCBS plans have almost \$29 billion in capital reserves, up from \$18 billion in 2008. While these reserves are intended as a cushion against unanticipated costs, CIRA concluded that such substantial reserves could more than cover any contingency and should be refunded to consumers as the utilization of health services continues to decline. CIRA notes that net profit margins for the Blues were 4.8 percent in the first quarter of 2011, the highest reported since 2005.

Blue Shield of California is the only Blues plan thus far to agree to cap profits and rebate a portion of reserves to policyholders (see Update for Week of June 20th). Blues plans in at least Arizona, North Carolina, Illinois and Texas are experiencing lower than anticipated medical cost trends that could result in subscriber refunds.

Arizona

Governor gets federal approval to freeze/cut Medicaid enrollment for childless adults

The federal government has officially given Arizona the green light to phase-in its planned elimination of Medicaid coverage for up to 250,000 childless adults.

The Affordable Care Act (ACA) and American Recovery and Reinvestment Act (ARRA) have prevented most states from cutting Medicaid eligibility in order to fill record budget deficits. However, the Obama Administration indicated last winter that it would not prevent Governor Jan Brewer (R) from eliminating coverage for childless adults previously covered through a federal demonstration waiver that expires September 30th (see Update for Week of March 14th).

Democrats and consumer advocates had hoped the Arizona Supreme Court would block the eligibility cut, as it contravened the will of the voters to expand coverage through a 2000 ballot referendum. However, the court refused to intervene last week, allowing Medicaid to save over \$200 million by freezing enrollment for childless adults starting July 1st and cutting eligibility in October.

The federal approval requires Medicaid to help those dropped from coverage find assistance from other programs.

California

Controversial rate review bill clears Senate hurdle, but changes may be needed for passage

The Senate Health Committee voted 5-3 along party lines to pass a controversial bill that would give state regulators the long-sought authority to reject or modify excessive increases in health premiums.

The bill is strongly opposed by California insurers, hospitals, and physicians who have lobbied heavily against its passage. As a result, wavering Democrats including committee Chairman Ed Hernandez (D) indicated that they may vote against full Senate passage unless the measure was weakened. These include amendments to prevent consumers or other outside parties from intervening in rate disputes and more clearly identifying the rise in medical inflation that is outside of insurer control.

A.B. 52 previously passed the full Assembly, where it was estimated to cost \$30 million per year. New Insurance Commissioner David Jones (D) was pushed forcefully for its enactment, after comparable legislation he authored last session as an Assemblyman failed to pass.

Jones has the broad support of consumer advocates outraged over repeated attempts by some of California's largest insurers to hike rates by up to 86 percent, only to withdraw them after errors were found by the Department of Insurance. The outcry has even forced Blue Shield of California to voluntarily limit increases and refund reserves (see Update for Week of June 20th).

The California Association of Health Plans and California Medical Association (CMA) are leading the charge against the bill, insisting that it will not address the underlying rise in health care costs. They insist that premium increases are on par with national averages, despite California being a high-cost state and that existing federal and state reforms already provided sufficient consumer protection against excessive rate hikes.

Consumer advocates point out that CMA's position contradicts the American Medical Association, which supports enhanced rate review. They also note that California is behind 34 other states and the District of Columbia, all of which give state regulators authority to modify excessive rate hikes.

The debate over A.B. 52 is expected to reverberate across the nation as Californians represent 11 percent of the national market for employer-sponsored insurance and 15 percent of those with individual coverage. However, industry opposition already forced bipartisan vetoes of comparable legislation in Connecticut (see below), Nevada, and New Mexico.

Governor signs on-time budget that includes steep health cuts

Governor Jerry Brown (D) signed a series of bills to finally close the state's massive budget deficit only one day before the July 1st start of the fiscal year.

The measure is only California's second on-time budget in the last 25 years and returns the state to 1970s spending levels. It was passed without any Republican support thanks to a voter referendum last fall requiring only a simple majority for budget bills (see Update for Week of November 1st). The budget includes most of the Governor's proposed health program cuts (see Update for Week of March 14th) including a ten percent drop in Medi-Cal provider reimbursement, Medi-Cal copayments of up to \$50 for emergency room visits, and strict limits on physician visits for Medi-Cal recipients. If tax revenues are less than projected, additional health cuts will automatically be enacted.

The Governor vetoed the Democrats' earlier budget in an unsuccessful effort to force the three-fifths of the Assembly to approve a voter referendum to extend certain state taxes (see Update for Week of June 13th).

Colorado

Hemophilia advocate appointed to new health insurance exchange board

Governor John Hickenlooper (D) announced the new appointments to the Colorado Health Benefits Exchange Board last week.

Colorado became the ninth state to pass legislation authorizing the creation of a health insurance exchange; thanks largely to the support of the state's insurers and business community (see Update for Week of May 30th). However, due to tea party opposition that nearly derailed S.B. 200, the exchange will be an independent public entity not affiliated with an existing state agency or department and initially funded only by gifts, grants and donations.

The nine members appointed by the Governor, Senate and House Majority and Minority leadership include four representatives from the state's largest insurers, a potential conflict of interest that has engendered intense controversy in other states (see Update for Week of May 23rd). According to *The Denver Post*, a fifth board member is an executive of a large health-technology company that previously had vendor contracts with at least three of the four insurers.

The two consumer representatives on the board include the Executive Director for the Colorado Coalition for the Medically Underserved and hemophilia advocate Nathan Wilkes.

Connecticut

Governor issues surprise veto of bill requiring hearings for double-digit rate hikes

Consumer advocates and physician groups were shocked this week when Governor Daniel Malloy (D) vetoed legislation that required a public hearing be held for any double-digit rate hike.

The Governor's veto of S.B. 11 was particularly surprising given that he campaigned last fall for greater transparency in the rate approval process after the outcry over "rubber-stamped" rate hikes under his predecessor's Administration. Former Insurance Commissioner Sullivan (R) was forced to resign last fall after an investigation by U.S. Senator and then Attorney General Richard Blumenthal (D) revealed he had blindly approved rate hikes of up to 46 percent without review or public hearing, even though Anthem had erroneously blamed them on the Affordable Care Act (see Update for Week of November 1st).

However, the Governor determined that S.B. 11 was a knee-jerk reaction to the controversy that would impose over \$181,000 in unnecessary costs on the Department of Insurance and not reduce health insurance premiums. He noted that the Department already performs an "objective actuarial analysis of each and every rate increase request" and "fully protects Connecticut's residents from excessive and discriminatory rate increases."

While the Department currently has the authority to reject or modify rate hikes, the bill would have for the first time defined in law the terms "excessive," "unfairly discriminatory" and "inadequate" and automatically required a public hearing at the same ten percent "unreasonable" threshold defined by the U.S. Department of Health and Human Services under the Affordable Care Act.

Consumer advocates accused the Governor of caving into pressure from insurers, many of whom are headquartered in Connecticut.

Louisiana

Health department to announce winning Medicaid managed care plans later this month

Twelve companies have applied to participate in the Governor's new coordinated care network (CCN) initiative, which will steer nearly 900,000 Medicaid recipients into private managed-care plans starting early next year

The Department of Health and Hospitals plans to announce the winners by July 25th. A maximum of six winners can be chosen in each of the three geographic regions where the program will be launched, starting with a planned rollout in the New Orleans area and the north shore.

Governor Bobby Jindal (R) has been at odds with Republican lawmakers over his signature health reform strategy. Upset that he developed the plan without legislative input or oversight, they passed S.B. 207 imposing strict reporting requirements and allowing the legislature to terminate the program in savings targets are not met (see Update for Week of June 13th). The Governor has yet to decide whether to veto the bill.

Louisiana Medicaid currently operates solely on a fee-for-service model, but has sought for several years to transition to a capitated model like Florida's five-county Medicaid managed care demonstration.

Minnesota

Dispute over Medicaid expansion, spending at heart of government shutdown

The impasse between Governor Mark Dayton (D) and the Republican-controlled Legislature over spending for the Department of Health and Human Services (HHS) resulted in a statewide government shutdown on the July 1st start of the fiscal year.

Both sides remain over \$5 billion apart on funding for the \$24.6 billion department, the largest of all state agencies. The Governor refuses to budge on Republican demands to slash health care spending without any increase in tax revenues, as well as backtrack on his early expansion of Medicaid to receive enhanced federal funding under the Affordable Care Act (see Update for Week of January 3rd). Republicans also staunchly oppose the Governor's plan to increase taxes for the wealthy.

As a result, former Vice President Walter Mondale (D) and former Governor Arne Carlson (R) created a bipartisan independent panel to propose a "third option" that fills the budget gap with 70 percent spending cuts and 30 percent in new or temporary taxes on cigarettes, alcohol, and hospitals. However, since the panel's proposal is closer to the Governor's plan than Republican proposals, analysts do not expect a compromise without additional changes.

Republican leaders insist that no deal is possible so long as the Governor moves forward on expanding Medicaid.

New York

Assembly passes Governor's health insurance exchange bill

The Assembly has passed legislation proposed by Governor Andrew Cuomo (D) that would create a health insurance exchange subject to Affordable Care Act standards (see Update for Week of June 13th).

A.8514/S.5849 has been beset by delays and is awaiting Senate action since June 23rd. Further inaction may cause federal regulators to assume control of the exchange if the state has not made sufficient progress by January 2013, even though New York has received over \$28 million in federal grants for taking the lead in exchange planning.

New York submitted a Level One application last week for an additional \$10.6 million federal Exchange Establishment grant.

Ohio

Federal court says it is bound by Sixth Circuit decision to uphold ACA's individual mandate

A federal judge appointed by President Reagan ruled last week that he was bound by the decision of the U.S. Sixth Circuit Court of Appeals panel to uphold the new federal mandate that everyone buy health insurance (see article above).

Judge David Dowd from the Northern District of Ohio had initially dismissed all but the individual mandate claim brought last fall by an advocacy group promoting the “virtues of conservatism.” Among their “novel” arguments, the U.S. Citizens Association had alleged that the Affordable Care Act (ACA) violated their constitutional freedom of association by forcing them to see traditional instead of holistic providers.

The Judge granted the federal government summary judgment on the remaining claim, as the Sixth Circuit panel found that the individual mandate was a proper exercise of Congress’ constitutional authority under the commerce clause. The Northern District of Ohio is within the Sixth Circuit.

In so doing, Judge Dowd becomes the fourth lower court judge to declare the individual mandate constitutional, but the first appointed by a Republican president. The only two lower court judges to invalidate the mandate were appointed by Presidents Reagan and George W. Bush.

Sixth Circuit Judge Jeffrey Sutton is the first Republican-appointed appellate judge to uphold the individual mandate (see article above).

Texas

Insurance department to seek waiver from new federal insurer payout standards

The Texas Department of Insurance (TDI) announced last week that it will seek federal approval to phase-in the new insurer payout standards under the Affordable Care Act (ACA).

The Obama Administration has already granted waivers to Maine, Nevada, and New Hampshire. At least 12 other states are seeking similar waivers to phase-in the new requirements through 2014, or 2105 in the case of Indiana (see Update for Week of May 23rd).

Utah

Health department seeks federal waiver to require Medicaid cost-sharing, lump-sum payments

The Department of Health submitted a waiver request last week to the federal government that would allow Utah to increase copayments for Medicaid recipients and reimburse providers on a capitated basis.

Senator Dan Liljenquist (R), who sponsored the bill that required the waiver, insisted that the change could save the Medicaid program “hundreds of millions” of dollars once approved. It would enable the Department to pay providers a lump sum monthly payment for each patient instead of the current fee-for-service model. Providers would be required to educate Medicaid recipients about choosing a primary care physician and going to a hospital within a set network.

Recipients for the first time would be required to pay an annual \$40 deductible and \$15-25 copayment for emergency room visits. The federal government currently limits out-of-pocket expenses for Medicaid recipients to no more than five percent of their annual income.

Senator Liljenquist acknowledged that the waiver is but the first step in his plan to dramatically overhaul Medicaid.