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Health Reform Weekly

A weekly compilation from Aetna of health care-related developments in Washington, D.C. and state legislatures across the country

Week of March 29, 2010

After more than a year of often contentious political debate, historic health care reform legislation was passed and signed into law last week. But the ink was not yet dry on the bill before 14 states (see below) filed a lawsuit challenging the new law, and everyone else began poring over provisions to determine exactly what it would mean for them. Time magazine concluded that health insurance premiums will continue to rise under the new law, and with more predictability. In a BusinessWeek magazine interview last week, Aetna Chairman and CEO Ron Williams agreed that premiums will continue to rise because health care costs were not adequately addressed. He added, however, that the nation still can get back to meaningfully taking on the drivers of rising health care costs in the next several years during the new law's implementation period. As stated in an Aetna news release issued last week, Aetna stands ready to help if that happens.

Federal

The President's signature on health care reform legislation March 23 and his signing on March 30 of the Reconciliation measure to "fix" the March 23 version starts the clock ticking for implementation of the biggest change to American health care in 45 years. Irrespective of policy position or political persuasion, two truths emerge from its passage: 1) Health care reform is now President Obama's health care reform, and he and the Democratic Party will have to defend it going forward for many years to come; and 2) The entire country (starting with health plans and insurers) needs to fasten its seat belt tightly and get ready for the most massive regulatory and implementation process since Medicare.

For the past three months, the House and Senate have been unable to agree on either a long-term "doc fix" (to permanently eliminate the 21 percent cut to Medicare doctors in 2010) or a COBRA fix (to provide a full 2010 calendar year extension of the right for certain COBRA recipients to receive a 65 percent government subsidy). The impasse has resulted in month-to-month extensions as neither Chamber has been able to get the other to agree to its version of a permanent extension. Just before the two-week recess (March 25 to April 12) the House once again did its part and passed an extension through April for each item. The Senate refused to play ping-pong this time and went home for recess without agreeing to the same month-long extension. This could prove both costly and administratively messy. CMS has already ordered a temporary halt on processing claims for the first days in April hoping to stave off the problems associated with letting a 21 percent cut go into place early in April only to retroactively unwind the cut within weeks. Whether Congress can figure out what to do and then do the right thing is at best a 50-50 proposition

States

HEALTH CARE REFORM: On March 23, attorneys general from 13 states (Alabama, Colorado, Florida, Idaho, Louisiana, Michigan, Nebraska, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington) filed a lawsuit in the U.S. District Court for the Northern District of Florida challenging the Patient Protection and Affordable Care Act, minutes after President Barack Obama signed the comprehensive health reform legislation into law. The attorneys general's argument centers on two elements: 1) the Act's individual mandate is an unconstitutional expansion of Congress' ability to regulate interstate commerce; and 2) the penalties for non-

compliance with the individual mandate violate the taxation powers provided to Congress under the U.S. Constitution. Additionally, the states are challenging provisions of the new law that will impose dramatic Medicaid spending increases on the states. The lawsuit names as defendants U.S. Secretary of Health and Human Services Kathleen Sebelius, Secretary of Treasury Timothy Giethner, and Secretary of Labor Hilda Solis.

ARIZONA: The oral chemotherapy parity bill is dead for this year's legislative session, due to the inability of proponents to craft an amendment for consideration before the applicable deadline. No supporting evidence had been offered to support the contention that health plans maintained an undisclosed fourth tier in their pharmacy benefits that imposed extremely high out-of-pocket costs on members. Also, Governor Jan Brewer announced her support for a legal challenge to the federal health care reform law, bolstered by a November 2010 ballot initiative to amend the state constitution to prohibit the mandatory coverage requirements. Terry Goddard, the attorney general and presumptive Democratic gubernatorial nominee, will not contest the federal law and suggested that she use any additional funds to reinstate the KidsCare program, which was cut due to the budget deficit, eliminating coverage for more than 35,000 children.

CALIFORNIA: The Assembly Health Committee voted along party lines (11 to 3) to approve a bill that would require health insurers to seek approval from state agencies for any premium increases exceeding 7 percent a year. A similar bill was passed by the Assembly in 2007 but failed to pass in the state Senate. Opposition is expected to come not only from the insurance industry -- in the past, the state medical society, hospital association and business community also opposed the measure. The Governor has also raised objections to the concept of rate regulations and has stated a preference for requiring carriers to meet a standard medical benefit ratio (MBR).

CONNECTICUT: The Appropriations Committee voted out a budget restoring the majority of the cuts previously recommended by the Governor, but **proposing a number of new cost savings measures that directly impact the health insurance industry and its customers.** Most significantly, the Appropriations Committee voted to transfer numerous accounts from the Department of Public Health to the Insurance Fund that is financed by the industry. The total Insurance Fund would be increased by about $20 million to $47.9 million. It also proposes re-establishing the gross receipts tax on hospitals and would levy a 5.5 percent provider tax on hospital rates, in an attempt to draw down the federal match. The Committee also concurs with the Governor on moving the state's Medicaid program, known as HUSKY, to an ASO model. But it recommends that the program continue to use the networks and billing processes of the current managed care organizations. It also would require that new ASO contracts include performance incentives. Both the industry and employers continue to oppose new taxes and assessments that would make insurance less affordable and impede the ability of employers to grow in Connecticut.

FLORIDA: A bill that would amend the current autism coverage law, and add several other developmental disabilities to the coverage requirement, is now making its way through the committee process. Aetna is continuing to educate legislators on the costs of this coverage mandate expansion, as are America's Health Insurance Plans and the Florida Association of Health Plans.

GEORGIA: Crossover day at the legislature last week, when all bills must cross from one house to the other in order to continue to be heard, marked the death or slowing down of a number of bills. **The bill that would have imposed a tax on health plans was passed out of committee, but the health plan tax language was removed** thanks to work done by trade organizations and the Chamber of Commerce to educate legislators on the impact of the proposal. The bill now would impose only a tax on hospitals, and is likely to pass. A bill requiring coverage of autism was defeated.

MICHIGAN: After more than a year of work, Senator Tom George and Representative Marc Corriveau have introduced four bills that would completely change the individual insurance market. The bills were referred to Senator George's Health Policy Committee. The bills would amend the HIPAA mechanism in Michigan from having an insurer of last resort (currently Blue Cross Blue Shield of Michigan), and would require all plans to guarantee issue a basic and an enhanced plan in the individual market with rates to be established by a new "Michigan Health Board." In addition, a separate proposal would alter the rest of the individual market whereby consumer protections would be delineated in terms of no pre-existing conditions, no rescissions except under certain circumstances, guaranteed renewal and acceptable underwriting and rating practices for policies sold. Lastly, a reinsurance pool would be established for the individual insurance market to reimburse carriers for eligible claims that are 90 percent of claims paid between

$80,000 and $800,000 in a calendar year. Once the $800,000 ceiling is reached, each carrier would assume responsibility for 100 percent of claims.

An annual assessment would be required for each carrier engaged in the individual market, based on the estimated total reimbursement to be made for claims paid plus an administration fee. The assessment would be apportioned on all carriers in the individual market in proportion to each carrier's share of covered lives in that market. There are many provisions in the four bills that do not complement changes in the federal health care reform package, i.e., the proposals do not take into account the federal high-risk pool created to provide coverage for eligible individuals, the prohibition of pre-existing condition exclusions and specific federal reform provisions on guaranteed issue. Aetna has expressed its concerns to the sponsors and will continue to monitor the issue closely.

MINNESOTA: The legislature is still working a number of bills, many of them focused on health care and insurance. Of note is a bill calling on the state legislature to join with the National Conference of Insurance Legislators in expressing opposition to creating a federal insurance charter and to any other federal legislation that would threaten the power of states to oversee, regulate, and investigate the business of insurance. That bill is still working its way through the system, as is: legislation that would extend eligibility for MinnesotaCare to single adults and households without children; a bill that would establish standards and guidelines for a health information exchange, including the creation of an oversight board; a new bill that would permit the sale of a "flexible benefit plan" that does not include all state-mandated benefits; and a bill that would establish a single-payer system for the state. Mandates dealing with prosthetic devices and coverage of routine patient care costs during cancer clinical trials are still alive, as are several bills allowing the cross border sale of insurance and several bills changing the definition of "small group" upward from a maximum of 50.

NEBRASKA: The 49 nonpartisan senators of the Nebraska unicameral legislature are at day 46 of their 60-day "short" session, eyeing an April 14 adjournment date. On the list of bills that have advanced out of committee is a **bill that would prohibit prepaid dental service plans from limiting fees for services not covered by the plan and a bill that would allow a nonrefundable income tax credit equal to 25 percent of premiums paid for a long-term care insurance policy.** Several bills are still awaiting committee action, including: a constitutional amendment to prohibit any law that restricts a person's freedom of choice of private health care systems or plans of any type, a bill that would authorize foreign insurers to offer health insurance in Nebraska, legislation that would require change notices for therapeutic alternatives (not generic substitution), a proposed prohibition on specialty medication tiers that require payment of a percentage of the cost of a drug, and proposed limits on co-pays.

NEW YORK: With the budget deadline fast approaching on March 31st and a projected revenue shortfall of $9 billion, the Senate passed its own budget resolution eliminating a number of Governor Paterson's Executive Budget cuts and proposals, and adding new ones. **It specifically rejected proposed public hearings and prior approval of all insurance rate adjustments, and an 85 percent MBR put forth by the Governor. However, the Senate added an unspecified autism mandate. Three different autism mandate bills have been introduced in the Senate**, and the version sponsored by Senate Insurance Committee Chair Neil Breslin, is likely to be the front runner. His bill includes the use of credentialed providers, medical necessity and evidenced-based therapies, but it has no age limits or caps of any kind on the benefit. Plans have met repeatedly with legislators to express real concern over the negative impact on costs to small employers. Also, **the Assembly released its own budget bills, which include a section that would require prior approval and public hearings for any requested increase over 10 percent, and an 82 percent MBR.** It does not reference an autism mandate. The next step in the process requires the Governor, the Senate and the Assembly to negotiate a budget, but it is unlikely to be done before April 1st. Absent a budget by that deadline, the Governor has proposed a two-week emergency spending bill to cover state expenses until mid-April. Despite federal activity on health care reform, there is significant election-year pressure on legislators to include prior approval, MBR and the autism mandates in the final package. Aetna will continue to address these issues with legislators.

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