Health Reform Bulletin

Week of September 17, 2012

The U.S. Census Bureau released a report last week that shows the number of Americans without insurance in 2011 fell for the first time since 2007. About 48.6 million Americans were uninsured last year compared to 49.9 million in 2010 – a drop that has been widely attributed to a provision of the Affordable Care Act (ACA) that requires plans offering dependent coverage to extend coverage to dependents up to age 26. The number of uninsured young adults declined by about 540,000 in 2011. The percentage of Americans covered by private health insurance in 2011 was 63.9 percent, virtually unchanged from 2010. It was the first time in the last 10 years that the rate of private health insurance coverage did note decrease. The percentage of Americans covered by government health insurance increased from 31.2 percent to 32.2.

In other business, the White House late last week released a report that outlines the severity of automatic cuts scheduled to be made to Medicare, implementation of the ACA, defense and numerous other programs if Republicans and Democrats do not agree on a compromise deficit reduction plan.

Federal

By a bipartisan vote of 329 to 91, the House approved legislation last week that would provide appropriations for federal programs and agencies in the first half of fiscal year 2013 at the levels agreed to in the Budget Control Act of 2011. This measure was approved with support from 165 Republicans and 164 Democrats. This "continuing resolution" will cover the six-month period beginning on October 1, 2012. It provides funding for most programs and agencies within the Department of Health and Human Services (HHS), with the exception of Medicare and Medicaid, which are not funded through the annual appropriations process. The Senate is expected to approve the continuing resolution this week. The White House issued a statement expressing support for the measure. Enactment of this legislation ensures that there will not be a government shutdown before the election.

The House Ways and Means Subcommittee on Health held a hearing last week on the implementation of the ACA's health insurance exchanges and other related issues. America's Health Insurance Plans (AHIP) was among those testifying, emphasizing the urgent need for clear regulatory guidance on a number of key provisions of the law. In its written testimony, AHIP recommended minimizing disruptions during the transition to exchanges, ensuring workable exchange operations and state flexibility, maximizing coordination to prevent redundant regulations and data collections, maximizing choice and competition, and addressing specific ACA provisions to make health coverage more affordable. On the issue of affordability, AHIP cautioned that provisions implementing a premium tax, minimum coverage requirements and new age-rating bands will have the unintended consequence of making coverage less affordable.

States

ARIZONA: A series of public meetings regarding the state's options for complying with the ACA kicked off last week in front of an audience that largely called for expanding Medicaid eligibility. The staff of the Arizona Health Care Cost Containment System (Medicaid) is holding the forums to help educate the public on the options facing Governor Jan Brewer in the wake of the U. S. Supreme Court's decision on the federal health reform law and to gauge stakeholder support for Medicaid expansion. Numbering about 150, the audience was composed of health advocates, physicians and residents who benefit, or have in the past benefited, from Medicaid assistance. The comments overwhelmingly favored, at a minimum, reinstating coverage levels previously in place, which included childless adults up to 100 percent of federal poverty level. But there was also support for implementing a fuller coverage expansion to make available the broadest coverage possible.

ILLINOIS: The Health Care Reform Implementation Council met last week to hear testimony on the state's essential health benefits package. The council has yet to determine a benchmark plan, but the state announced that if it cannot agree on the benchmark plan by the end of the month its default will be Blue Cross Blue Shield Blue Advantage PPO. The state also announced it will have an actuarial value of the plan and that it will not control modifying benefit categories. For example, if the plan covers prenatal care, insurers can make changes within a benefit category as long as the value is equal to the benchmark. The State has yet to put forth the analysis prepared by Wakely Consulting of the 10 Illinois plans it evaluated and the value of benefits used to create those plans. Aetna presented testimony at the hearing.

KANSAS: State insurance officials trying to develop an "essential health benefits" recommendation for the state held a public hearing on the issue last week despite calls from some quarters to delay the process until after the presidential election in November. Insurance Commissioner Sandy Praeger noted that the state will lose the opportunity to determine its own essential health benefit package if it does not do so by late September. Some stakeholders at the hearing called for coverage of pediatric services to be extended to treat disorders like autism. Others worried about the effect a more expansive set of essential health benefits might have on the cost of health insurance. The Kansas Chamber of Commerce and the Greater Kansas City Association of Health Underwriters testified against including coverage that some beneficiaries are not paying for now. Each state must settle on its plans for essential benefits by Sept. 30.

MICHIGAN: Governor Rick Snyder proposed last week that Blue Cross Blue Shield of Michigan (BCBSM) become a nonprofit mutual insurance company that is regulated under the Michigan Insurance Code rather than be regulated under a separate act. The Governor has struck a deal with the insurer that would require BCBSM to contribute about $1.5 billion over 18 years to a new nonprofit entity and eliminate their tax on small businesses and individual customers to subsidize other lines of coverage. The proposal would require changes to Michigan law, and hearings on the topic will begin September 19. The Governor's office would like to move the proposal through by year-end to ensure that BCBSM can operate in the new ACA environment. As of Jan.

1, 2014, it would no longer serve Michigan as the carrier of last resort. Substantive negotiations regarding the proposal are expected in the House.

NEBRASKA: In the first two of eight statewide meetings to discuss the development of a state health insurance exchange, representatives from three health insurers and provider groups expressed support for the creation of a state-based exchange or at least a state-federal partnership. They acknowledged, however, that there continues to be uncertainty surrounding exchanges, including how consumers will react to them and whether the federal deadlines are realistic. Governor Dave Heineman asked pointed questions of those who testified, but as the statewide meetings wrapped up it was unclear exactly where the governor stands on the question. Governor Heineman said recently that he would not make a decision until after the November elections. Regardless of what the governor decides, Insurance Director Bruce Ramge has said publicly that the state's efforts over the last two years have put Nebraska in a good position to move forward after November 16, the deadline for states to submit exchange blueprints.

WASHINGTON: Concerned that the Health Benefits Exchange could face solvency problems if enrollment does not meet expectations, the board's Operations Committee decided it would make operational recommendations to the legislature with multiple options. If the legislature takes no action on any of the recommendations, the default funding mechanism would likely be assessments only on those who are within the HBE. The HBE needs $50 million per year to operate, estimated at $13 per member per month for those served by the HBE in the early years, with the level falling to $10 per member per month in later years if enrollment grows. It is estimated that 4 percent of premiums written exclusively through the HBE would produce $51 million per year. But if the HBE only attracts 75 percent of possible enrollees, there may be solvency issues. If the HBE attracts less than 50 percent of available enrollees, and the HBE substantially reduced variable costs, the HBE may not be viable. The Operations Committee directed HBE staff to prepare an analysis in two parts: An assumption that there will be an assessment on those in the HBE; and a staff analysis of additional funding options that would require legislation.

Courtesy of Aetna Health Reform Weekly