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30-day budget amendments create medical liability pool
Gov. Cuomo has proposed creation of a new Excess Medical Malpractice Liability Coverage Pool as a 30-day amendment to his proposed budget. Other than this item, the governor’s budget amendments were largely silent about changes to New York’s health care system. The new pool will be overseen by the Superintendent of the Department of Financial Services and the Commissioner of Health. The Superintendent will have the authority to purchase excess medical malpractice insurance policies for physicians or dentists (or reimburse eligible hospitals that purchase these policies).

The pool has several eligibility requirements. Physicians or dentists must:
- primarily engage in the practice of medicine or be employed by a hospital;
- have privileges at an eligible hospital;
- provide emergency care at a qualifying hospital; and
- have an underlying medical malpractice insurance policy with coverage of $1.3 million for each claimant and of $3.9 million for all claimants combined.

Hospitals also must meet specific criteria to participate. They must show that the costs or unavailability of medical malpractice coverage has impaired their ability to attract or retain providers who practice in high-demand specialties as
determined by patient-physician ratios. They also must be vital access providers and have demonstrated that they are in “financial distress.”

For physicians, dentists and hospitals who meet the qualification criteria, the underlying medical malpractice policy and the additional pool coverage will combine to provide an aggregate of $2.3 million in medical malpractice coverage for each claimant and $6.9 million for all claimants under the policy for occurrences during the policy period.

Apparently, funding for this new program will be drawn from the existing excess malpractice program with no additional appropriation by the governor.

For the proposed bill:
http://publications.budget.ny.gov/eBudget1213/30day/HMHNewPartS.pdf

For the governor’s briefing book:

For the governor’s full Executive Budget Legislation:

$48 million coming to state for exchange development
New York state will receive an additional $48 million federal grant to further develop an exchange for individuals and small businesses for 2014. Nine other states were awarded $181 million in Affordable Insurance Exchange grants. Altogether, the federal government has given 33 states and the District of Columbia almost $610 million for exchange development under the federal health care reform law.

According to the federal Centers for Medicare and Medicaid Services, “New York has made significant progress under its exchange planning grant, early innovator grant, and consumer assistance program grant.” The grant will be used to bring New York to “operational readiness.” Gov. Cuomo included language in his executive budget proposal to further develop the framework for a “New York Health Benefit Exchange.”

Arkansas, Colorado, Kentucky, Massachusetts, Minnesota, Nevada, New Jersey, Pennsylvania and Tennessee also received federal funds in this round.

For an update from the state go to the 2/23/12 entry under “What’s New”
http://www.healthcarereform.ny.gov/

For a federal fact sheet on the awards:
Telemedicine: Wave of the future?
The advantages and disadvantages of telehealth and telemedicine programs were discussed at a recent Albany hearing. One of the fundamental questions raised was whether improved access to specialized care to reduce hospitalizations and unnecessary travel for patients, especially in underserved and isolated rural areas would be cost effective. Alternatively, would it just mean additional expense to an already overburdened system?

This was one of many issues raised at a roundtable discussion held by the New York State Legislative Commission on Rural Resources. The Senate and Assembly health and insurance committees are working in conjunction with the commission. Sen. Catherine Young and Assemblywoman Aileen Gunther chair the bipartisan group. On Jan. 9, they brought together state agency representatives, providers and other health care experts to discuss the benefits of and barriers to creating a statewide telemedicine network.

Dr. Frank J. Dubeck, Jr, vice president and chief medical officer for Medical Policy and Clinical Editing for Excellus BlueCross BlueShield, was the sole health plan representative to speak at the roundtable.

Dr. Dubeck testified that telemedicine was the “wave of the future” and gave examples of successful pilots that used telemedicine/telehealth to decrease hospitalizations among diabetics and ER visits among school-age children. He also cautioned that there was the potential for overuse and raised questions around how best to reimburse providers for telemedicine and telehealth services.

Other participants cited barriers to expanding the use of telehealth/telemedicine programs such as:

- limited broadband access;
- limitations in commercial and Medicaid reimbursement;
- lack of providers;
- excessive costs/lack of economies of scale for infrastructure; and
- credentialing and insurance regulations.

As a next step, the commission will draft telemedicine legislation based on testimony from the roundtable.

To view the telemedicine roundtable: http://www.nysenate.gov/video/2012/jan/10/nys-state-legislative-commission-rural-resources-joint-roundtable

Databank

What will bend the health care spending cost curve?
The winter issue of the journal INQUIRY explores the need for cost containment and addresses critical issues in anticipation of full implementation of health care reform in 2014.

Five authors explore bending the trajectory of the cost curve away from persistent escalating health spending. Today, U.S. health care spending comprises 17.6 percent of the gross domestic product. By 2020, costs are expected to grow to about 20 percent of GDP.

The key articles are summarized below:

Payment Incentives and Integrated Care Delivery: Levers for Health System Reform and Cost Containment
This literature survey finds that financial incentives and integrated delivery of care can potentially improve the value of health care.

Health Information Technology and Its Effects on Hospital Costs, Outcomes, and Patient Safety
An assessment of the potential benefits of electronic medical records based on claims data shows that EMRs do not reduce the rate of adverse patient safety events. But once an event occurs, EMRs reduce death and readmission rates, as well as spending.

The Impact of Accelerating Electronic Prescribing on Hospitals' Productivity Levels: Can Health Information Technology Bend the Curve?
Hospitals that implemented limited computerized prescriber order entry systems and moved more gradually to full implementation experienced the greatest efficiency and productivity gains, while those that introduced the technology facility-wide in a single year experienced productivity losses.

Risk-Adjusting the Doughnut Hole to Improve Efficiency and Equity
The authors examine the spending threshold that should be applied in plans that aim to contain costs using a “doughnut hole” (a gap in coverage at a predefined spending threshold) approach. The authors contend that effective cost containment hinges on considering patient health status when defining this threshold.
What Can We Expect from the ‘Cadillac Tax’ in 2018 and Beyond
Estimates are presented of the impact of the 40 percent excise tax on high-cost private health care plans in 2018 and beyond.

A CLASS-less Act (open access article)
The demise of the Community Living Assistance Services and Support program focuses attention on the enormous financing burden and overall neglect of long term care needs.

INQUIRY is published by Excellus Health Plan, Inc.

Editor’s Note: INQUIRY is a subscription based journal. All abstracts are freely available as are a number of open access articles: http://www.inquiryjournalonline.org/toc/inqr/48/4

The remaining content is available for purchase through http://www.inquiryjournalonline.org/

News from Washington
At issue: Broker commissions under health care reform
Efforts are intensifying in Washington to support the role of insurance brokers and agents under federal health care reform. A troublesome aspect for brokers is whether their commissions will be affected by the calculation of consumer rebates.

Under debate is how broker and agent fees will be counted in an insurer’s “Medical Loss Ratio.” This provision of federal health reform requires insurers to use at least 80 percent of premium dollars (85 percent for large-employer plans) for health care expenses and quality improvement. If an insurer does not meet the MLR, it must pay rebates to consumers. Rebates based on 2011 experience will be paid by August 2012.

The National Association of (state) Insurance Commissioners adopted a resolution urging Congress and the Department of Health and Human Services to exempt insurance broker and agent compensation from medical loss ratio requirements. But when HHS released a final rule, it included broker compensation as an administrative cost for insurers.

H.R. 1206, a bill that would exempt broker commissions from the MLR calculation, is pending in the House. Five upstate members of Congress are among the 172 co-sponsors (Ann Marie Buerkle, Chris Gibson, Richard Hanna, Bill Owens and Tom Reed). A different Senate bill, S. 2068 was introduced by two Democrats and two Republicans in February to address the brokers’ concerns.
For a Kaiser Family Foundation update on the broker-and-agent issue:  


For the National Association of Insurance Commissioners statement:  

For the statement from the National Association of Health Underwriters, the national trade group representing brokers and agents:  
http://www.nahu.org/media/releases/2012/MLRSenateFinal.pdf

For the House bill, “Access to Professional Health Insurance Advisors Act of 2011”:  

For the Senate bill S. 2068:  
http://www.gpo.gov/fdsys/pkg/BILLS-112s2068is/pdf/BILLS-112s2068is.pdf

Feds request comments on employer coverage issues
Three federal departments asked for feedback on three of the employer provisions of federal health care reform. A similar technical release was issued by Labor, Treasury, and Health and Human Services addressing:
• automatic enrollment of full-time employees;
• employer shared responsibility; and
• 90-day limitation on waiting periods.

The guidance is in a question and answer format to provide direction and examples of how the law will be implemented. For example, employers could use a 12-month “look-back” period to determine if an employee has worked an average of 30 hours per week. Another potential provision is one that would allow employers to require part-time employees to complete 750 hours of service before they are eligible for coverage or begin a 90-day waiting period.

Comments can be sent electronically to: e-ohpsca-er.ebsa@dol.gov

They also can be sent in writing to:
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration,
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210.


Payroll holiday extension grows deficit
A 10-month $150 billion package will extend three significant federal provisions - the Social Security payroll tax cut holiday, federal unemployment benefits, and the Medicare physician fee “fix” through the end of the year. President Barack Obama signed the “Middle Class Tax Relief and Job Creation Act” on Feb. 22. The previous two-month extension of this bill would have expired on Feb. 29 if Congress had not met this deadline.

Despite pressure to offset expenses, no offset was agreed to for the payroll tax extension. Instead, new federal government hires will make a larger contribution to their pensions.

The law will increase the deficit by $101.1 billion in fiscal year 2012 and $89.3 billion over the 2012-2022 period according to estimates from the Congressional Budget Office and the Joint Committee on Taxation. Revenues are expected to be reduced by $77.6 billion over a 10-year period. Direct spending will increase by $11.7 billion.

The law includes offsets for the unemployment extension and Medicare “doc fix” including:
- reducing Medicare “bad debt” payments to hospitals and other providers ($6.9 billion in savings);
- decreasing the $15 billion Prevention and Public Health Fund created by the federal health care reform law ($5 billion in savings);
- rebasing funding to hospitals that treat indigent patients through the Disproportionate Share Hospital programs 2021 ($4.1 billion in savings); and
- cutting Medicare reimbursement for clinical laboratory services ($2.7 billion).

Unemployment benefit reductions will be staged and tied to the unemployment rate in a state, ranging from 99 weeks to 63.

Congress again did not fix the Medicare physician payment formula. As a result, future cuts will grow, as will the corresponding payment fixes.

For the Senate summary of the law:
http://finance.senate.gov/newsroom/chairman/release/?id=c42a8c8a-52ad-44af-86b2-4695aaff5378
For the CBO analysis of impact:
http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr3630_2.pdf

For actions on the new law choose bill number and enter H.R. 3630 in the search box:  http://thomas.loc.gov/home/thomas2.html