Health Law and Policy Update:
October 5, 2012

Please join us on Friday, October 19th, 2012 for the Colorado 2019 Summit , hosted by The Economic Opportunity Poverty Reduction Task Force of the Colorado General Assembly. Register here.

This week's updates

- New report finds there's not much interest in proposals to sell health insurance across state lines
- Newly insured under PPACA likely healthier than expected, but face unique challenges
- Medicare readmission penalties now in effect

What's New

New report finds there's not much interest in proposals to sell health insurance across state lines

One hot debate in Colorado in recent years has been whether or not the state legislature ought to authorize the purchase of private health insurance across state lines. Proponents have claimed that buying insurance across state lines would increase competition and open up more affordable opportunities for those seeking to purchase health insurance, in part by by-passing state mandates. Opponents, CCLP among them, have said that the purchase and sale of insurance across state lines would put consumers at risk and result in a regulatory "race to the bottom" in terms of benefits and consumer protections.

Only six states so far have enacted laws that "require, encourage or study the feasibility of allowing the sale of health insurance across state lines or form compacts with other states" A study, entitled Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage, released this week by The Center on Health Insurance Reforms examines what happened in those states. The bottom line, according to the report, is that "across state lines proposals have been unsuccessful at meeting their stated goals." Those goals included increasing the availability and affordability of health insurance, exempting coverage from state benefit mandates, and taking advantage of lower rates negotiated in other states.

Among the key findings of the report:

- Two states chose not to proceed after a feasibility study (Kentucky and Washington). Maine is due to implement in January 2014.
- Two states have implemented proposals but are encountering problems (Georgia and Wyoming) and no out of state insurers have entered the market or are contemplating entering the market as a result of implementation.
- Across state lines proposals have been largely unsuccessful because of the local nature of health care. People don't want to leave their state to see an in-network provider and it's very difficult for out of state insurance companies to build adequate network s in a new state.
- The cost of care is largely driven by provider costs, and provider rates can differ dramatically between states. One quote from the study: "You can go out and purchase something that looks cheaper in south Alabama, but when you actually deliver the health care in Atlanta, Georgia, it's much more expensive."
- Health insurance is far more complicated than life insurance or long term care insurance. It is network driven and care is delivered locally. In addition, each state has its own regulatory structure and mandates. This makes it difficult to work out satisfactory cooperative relationships between states, particularly given states' interests in protecting their own residents.
- The six states exploring interstate purchasing reported difficulty finding other states to negotiate with, whether because they were busy with other priorities, lacked resources, or were concerned about state mandates and jurisdictional issues.
- There was little insurer interest in using the laws as vehicles for entering new markets or selling new products.

Ultimately, the report concludes that proponents of across state lines insurance purchasing generally were elected officials and think tanks seeking to "do something" about the cost of health insurance. But barriers to implementation are high and there seems to be little interest in the actual product among insurers or consumers.

For more, see a recent blog by one of the report's author's, Sabrina Corlette, of the Georgetown University Health Policy Institute's blog.

Newly insured under PPACA likely healthier than expected, but face unique challenges

Starting in January 2014, a central feature of the Patient Protection and Affordable Care Act--the newly established health insurance exchanges--will go live. It is expected that by 2021 an estimated 29 million individuals will be enrolled in exchanges across the country. A new report from PricewaterhouseCoopers suggests that this newly insured population will be in relatively good health but may face significantly more challenges navigating the healthcare system than today's insured population.

The report concludes that the newly insured will be "unlikely to overwhelm the health care system or substantially drive up costs immediately after gaining coverage," largely because they are young, healthy and in good shape. However, this group will likely face a group of unique challenges as they become covered, many of them for the first time. For example, newly insured individuals are more likely to be less educated, more diverse and unemployed or underemployed. Approximately 30 percent will speak a language other than English.

The cultural, education and employment characteristics of the newly insured will likely present unique challenges to understanding and obtaining health coverage and navigating the complex health care system. They will face complex choices when purchasing insurance, requiring them to understand premiums, co-payments, deductibles, co-insurance, etc. In addition, given the variability of income common among lower income persons, many will have to understand and navigate the transition between commercial coverage and Medicaid.

The Navigator program--a program that will provide culturally competent outreach, education and enrollment assistance for coverage through the exchange--will provide critical assistance to this population. Addressing the unique challenges of the newly insured population, however, requires more than a successful Navigator program. The Exchange itself, health plans, providers, and Medicaid agency, must all develop policies to ensure that the newly insured population receives the assistance they need to understand and navigate the complex health care system.

Medicare readmission penalties now in effect

CMS is now penalizing hospitals for Medicare patient readmission rates. The new CMS action results from the Hospital Readmissions Reduction Program included in the Affordable Care Act, which penalizes or rewards hospitals based on performance. A Kaiser Healthnews story outline the CMS changes. Currently, one out of five Medicare patients is readmitted within 30 days of discharge, costing an extra $17.5 billion in hospital bills. Readmission penalties, which go into effect this month, were calculated using heart failure, heart attack, and pneumonia patient readmissions within 30 days of discharge between July 2008 and June 2011. Two-thirds of reviewed hospitals (2,211 facilities) will face varying penalty degrees at a maximum rate of 1% of their base Medicare payments. For example, a hospital with a 1% penalty will be reimbursed below regular payment rates at $19,800 instead of $20,000 for a claim filed to CMS throughout the entire year. The maximum penalty increases with time, moving to 2% beginning in October of 2013 and increasing to 3% in 2014.

The hardest hit areas include New Jersey, New York, the District of Columbia, Arkansas, Kentucky, Mississippi, Illinois and Massachusetts. Idaho is the only state without any penalties. Another Kaiser News report on readmission penalties explains Maryland is exempt from readmission penalties due to a state CMS waiver that governs Medicare payments.

According to the CMS Readmissions Reduction Program website, some adjustments were made in calculations; "the excess readmission ratio includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty." However, many hospital insiders are upset with the increased burden readmission rate penalties have on hospitals serving large numbers of low-income patients. Kaiser Health noted that CMS adjustments did not account for racial or socio-economic background, and furthermore, that 76 percent of the hospitals serving a large number of low-income Medicare patients are being penalized compared to 55 percent of hospitals treating less low-income patients. Kaiser Health also reported Medicare disagrees with these claims, pointing out that many hospitals serving low-income Medicare patients, including Denver Health, are not facing any penalties.

The readmission penalty program has already started encouraging broader communication as hospitals try to better coordinate care once patients are discharged to avoid penalties. CMS is currently giving out grants to help hospitals and other community organizations work towards better care coordination models. As the Denver Post recentlyreported, words from Nancy Foster of the American Hospital Association highlight the current impact of the readmission penalties, "we are...spreading our wings a little and reaching outside the hospital, to the extent that we can, to make sure patients are getting the ongoing treatment they need."