States Pursue Insurance Mandates, Transparency

BY GLENDA FAUNTLEROY
Contributing Writer

WASHINGTON — State legislation mandating health insurance will continue, with "at least 12 more states going to debate bills to expand employer participation coverage" in 2007, according to Susan Laudicina, director of state services research for the Blue Cross and Blue Shield Association.

The health care transparency debate also is heating up, with a few states, such as Colorado and Ohio, passing laws requiring provider-specific data on quality and requiring that cost information be made available publicly. At least 10 or more states will debate similar bills to promote transparency in 2007, she said.

Ms. Laudicina made her predictions when the Blue Cross and Blue Shield Association's annual "State Legislative Health Care and Insurance Issues" report was unveiled at a briefing sponsored by the association.

The report updates the top health care and insurance issues from state legislatures around the country, and the overview presented by Ms. Laudicina detailed how, despite healthy revenue growth in 2006, state governments are grappling to stem the increase in health care expenses. "Health care expenditures now account for about one-third of all state budgets, and states are in desperate need of solutions."

The report found that in 2006 states began implementing a range of initiatives including employer and individual mandates to cover the uninsured, public-private insurance partnerships to promote coverage and contain costs, and initiatives to improve quality care.

The Blue Cross and Blue Shield Association (BCBSA) reported that there was a flurry of new laws introduced around the country last year and the beginning of 2007—all aimed at providing affordable, quality coverage.

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"I read about 200 new legislations per week," Ms. Laudicina said. "That's how fast new legislation is coming in."

According to the report, employer and individual mandate legislations were pursued by three states in 2006: Maryland, Massachusetts, and Vermont. Twenty-five other states followed with introductions of similar bills last year, but none of those were enacted.

During 2006, 11 states—including Kentucky, Oklahoma, Utah, and Washington—also worked to create or expand programs to make private insurance coverage affordable for low-income workers. Seven of these states decided to use public funds to build subsidies to offset the premium costs of private employer-sponsored health plans for those eligible for Medicaid as well as for other low-income residents.

The BCBSA "State Legislative Health Care and Insurance Issues" report is compiled from a survey of each of the 39 independent Blue Cross and Blue Shield companies across the country that together provide health coverage for almost 98 million Americans. BCBSA officials were also on hand to provide an overview of the association's top health-care issues facing the 110th Congress.

"We have three priorities and the top of the list is addressing the uninsured," said Alissa Fox, the BCBSA's vice president of legislative and regulatory policy.

Ms. Fox reported that the association is urging Congress to fully support the State Children's Health Insurance Program (SCHIP) to lower the number of uninsured children, adding that Congress' "priority has to be to enroll these children."

According to the BCBSA, a surprising 74% of children without health coverage are eligible under public programs, but are not presently enrolled. Adequate funding is necessary to streamline enrollment procedures and ensure that these children get health care. In his budget submitted to Congress on Feb. 5, President Bush called for an increase in SCHIP funding of $5 billion over the next 5 years—short of the $12 billion experts say is needed to fund the program.

Another priority for the BCBSA is maintaining funding for the Medicare Advantage (MA) program that provides coverage to more than 8.3 million people. Ms. Fox explained how further budget cuts will disproportionately hurt low-income and minority Americans who rely on the program for health care.

"There's some talk in Congress about eliminating MA, and we are very concerned," Ms. Fox said. "The MA program has suffered from $13 billion in funding cuts in the past 2 years, and further cuts would put access to affordable, comprehensive coverage in jeopardy."

The BCBSA's third priority is the vision of the Bush Administration and Congress to create a nationwide health information network that will allow for the use of electronic health records in every hospital and doctor's office. Ms. Fox said the association is "very supportive of the bipartisan mission." ■

Senate Panel Expresses Doubts About Expansion of SCHIP

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — As a Senate panel opened debate on reauthorization of the State Children's Health Insurance Program, legislators had doubts about expanding coverage to an estimated 9 million children who are eligible but have not been enrolled.

SCHIP is due to expire on Sept. 30, but most states have been straining in the last few years to pay for children already covered by the program, several witnesses said at a meeting of the Senate Finance Committee.

Members of the committee also acknowledged that reality."Congress has simply not given [SCHIP] enough funds to meet the current demand for services," said committee chair Max Baucus (D-Mont.), who estimated that the program would need $12 billion-$15 billion over the next 5 years to maintain current coverage and $45 billion to bring all eligible children into SCHIP.

A last-minute deal signed into law at the end of 2006 allocated $271 million to cover anticipated shortfalls for a dozen or so states, but at least 14 more states will run out of SCHIP funds for fiscal 2007 if Congress does not enact another bailout by mid-May, Sen. Baucus said.

As of fiscal 2005, SCHIP had 6 million enrollees, according to a Government Accountability Office (GAO) report released at the Finance Committee hearing. Georgia Gov. Sonny Perdue testified that enrollment in his state has increased an average of 19% per month since June 2005. About 273,000 children are covered in Georgia, making it the fourth-largest SCHIP program in the country, he said. The Centers for Medicare and Medicaid Services had projected that only 130,000 children were eligible in Georgia, he said.

Some senators questioned whether states' flexibility should be reined in, saying that some initiatives might be diluting the program's intent—to cover low-income children. Federal law allows states to cover children in families with incomes up to 200% of the poverty level, but according to the GAO report, seven states were covering families with incomes at 300% of the poverty level or higher. Thirty-nine states require some cost sharing by families, but 11 states charge no premiums or copayments.

Fifteen states cover adults—generally parents of Medicaid- or SCHIP-eligible children, pregnant women, or childless adults. The Health and Human Services department has granted waivers for those states, said Kathryn G. Allen, director of health care at the GAO.

Sen. Charles Grassley (R-Iowa), ranking minority member of the Finance Committee, said he was interested in giving states more flexibility but was not happy about extending coverage to adults.

"The issue is whether SCHIP funds used to cover adults has drained resources targeted by Congress for kids," said Sen. Grassley. Sen. Orrin Hatch (R-Utah) also questioned extending SCHIP benefits to adults. ■

Sign Up Soon to Get a National Provider Identifier Number

BY MARY ELLEN SCHNEIDER
New York Bureau

The clock is ticking for physicians to sign up for a National Provider Identifier, the new 10-digit number that will be used by Medicare, Medicaid, and many private health plans to process claims.

The deadline for registering for an NPI number is May 23.

Physicians who are not using an NPI after that date could experience cash flow disruptions, according to the Centers for Medicare and Medicaid Services.

The transition to a single identifier that can be used across health plans is required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Most health plans and all health care clearinghouses must begin using NPIs to process physicians' claims in standard transactions by May 23. Small health plans have another year to become compliant.

"The NPI is the new standard identifying number for all health care billing transactions, not just for billing Medicare or Medicaid. National standards like the NPI will make electronic data exchanges a viable and preferable alternative to paper processing for healthcare providers and health plans alike," said Aaron Hase, a CMS spokesman. As of Jan. 29, more than 1.6 million NPIs had been assigned, according to CMS.

Physicians and other health care providers can apply for an NPI online or by using a paper application. In addition, organizations like hospitals or professional associations can submit applications for several physicians in an electronic file.

Officials at CMS are urging physicians who haven't yet signed up to do so soon. A physician who submits a properly completed electronic application could have his or her NPI in 10 days. However, it can take 120 days to do the remaining work to use it, Mr. Hase said. The preparation includes working on internal billing systems; coordinating with billing services, vendors, and clearinghouses; and testing the new identifier with payers, he said.

So far, the process of obtaining an NPI has been relatively easy, said Brian Whitman, senior analyst for regulatory and insurer affairs at the American College of Physicians. The application process itself takes only about 10 minutes, he said.

As the May deadline approaches and more physicians get registered, the next question is how widely CMS plans to disseminate the NPIs. CMS officials have said they are considering creating a directory of NPIs that could be available to physicians and office staff. ■

Physicians can apply for an NPI online at https://nppes.cms.hhs.gov or call 1-800-465-3203 to request a paper application.