HHS Launching High-Risk Insurance Pools

BY MARY ELLEN SCHNEIDER

State-based high-risk health insurance pools are among the first programs to be implemented under health reform, Health and Human Services department officials announced in early April.

These state-based pools, designed to provide coverage to uninsured adults with preexisting conditions, are scheduled to be operational within 90 days and will operate until Jan. 1, 2014. At that time, the new state-based health insurance exchanges will open and coverage will be available to all individuals regardless of preexisting conditions.

"When it's up and running, the new high-risk pool program provides immediate relief to potentially millions of Americans with preexisting conditions like diabetes or high blood pressure who have been shut out of the insurance system," HHS Secretary Kathleen Sebelius said during a press briefing.

The same day, Ms. Sebelius sent a letter to governors and state insurance commissioners asking how they plan to participate in the temporary high-risk pool program. Under the law, HHS has $5 billion in federal funds to set up pools on its own or in collaboration with states. HHS is asking states to respond with their plans by the end of April.

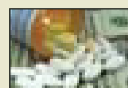
States will have a number of options for participation. For example, states that don't currently operate a high-risk insurance pool could establish one with federal help. Those that do have a pool in place could set up a companion high-risk pool that meets the new federal standards. States also could contract with an insurer to provide subsidized coverage for eligible residents. In states that choose to do nothing, HHS will operate the program on their behalf.

More than 30 states currently have high-risk insurance pools, according to HHS, with premiums 25%-100% higher than standard rates. Under the health reform law, the federal government would require new high-risk pools to set premiums at a standard rate, which would vary by state. The standard rate should be equivalent to what a typical person shopping on the individual market would be offered, according to HHS.

To be eligible for the new high-risk pools, individuals must be U.S. citizens or lawfully present here, have been uninsured for the previous 6 months, and have a preexisting condition. ■

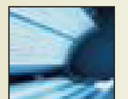
Health Reform Implementation Timeline

2010



Seniors whose prescription drug costs push them into the Medicare Part D doughnut hole receive a $250 rebate.

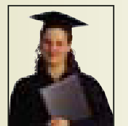
No new physician-owned hospitals may be built after Dec. 31.



Indoor tanning services are taxed at 10%, beginning as early as July.

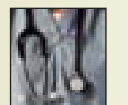
Health plans are barred from excluding children because of preexisting conditions, beginning as early as September.

Health plans are barred from dropping members because of illness.



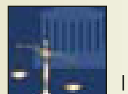
Health plans that provide dependent coverage for children must cover them up to 26 years of age.

2011

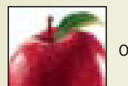


A 10% Medicare bonus payment for primary care physicians begins and runs through the end of 2015.

A 10% Medicare bonus payment for general surgeons working in shortage areas begins and runs through the end of 2015.

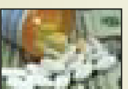


HHS awards 5-year grants to states to develop alternative medical liability reform initiatives.



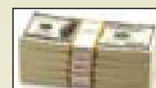
Medicare and Medicaid programs eliminate out-of-pocket costs for proven preventive services.

Unused specialty graduate medical education training slots can be used for primary care training.

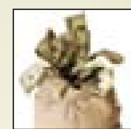


Seniors whose prescription drug costs push them into the Medicare Part D doughnut hole receive a 50% discount on all brand-name drugs.

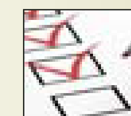
2012



Medicaid pilot tests bundled payments for episodes of care, including hospitalization.



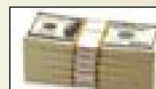
Medicare provides incentives for physicians to form accountable care organizations.



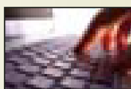
Drug makers must report drug samples given to physicians if those drugs are covered by Medicare or Medicaid.

2013

Medicaid rates for primary care services are raised to at least Medicare rates, through 2014.



National pilot program tests bundled payment.



Health plans must adopt uniform standards for electronic submission of health information.

Drug and device makers must report any payments made to physicians and hospitals.

2014

Health insurance exchanges in each state open for individuals and small employers.

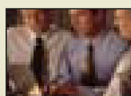
Health plans are barred from denying coverage based on preexisting conditions.

Health plans are barred from charging higher fees based on health status or gender.

Health plans are barred from imposing annual limits on coverage.

Most individuals are required to obtain health insurance coverage or pay a fine.

Medicaid eligibility expands to individuals at 133% of poverty.



Independent Payment Advisory Board created.

Elsevier Global Medical News

Medicare's PQRI Could Be The Basis of Future P4P

BY MARY ELLEN SCHNEIDER

LAS VEGAS — There's a growing interest among physicians in Medicare's Physician Quality Reporting Initiative, launched in 2007, but it isn't because of the 2% bonus payments available this year.

More likely it's the possibility that the Physician Quality Reporting Initiative (PQRI) could be the basis for pay-for-performance programs down the road, Dr. Michael A. Granovsky said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Over the last several years, CMS officials have laid out their vision for value-based purchasing. PQRI is widely seen as the first step in that transition.

And, in the near term, the Centers for Medicare and Medicaid Services, which administers the program, could begin publishing whether doctors have successfully participated in PQRI.

"I think PQRI is here to stay," said Dr. Granovsky, president of Medical Reimbursement Systems, based in Woburn, Mass. "I think this is the first leverage that CMS is developing to track quality and apply it on the reimbursement side. And I think they want a bigger and bigger stick over time."

Under the PQRI program in 2010, physicians are eligible to receive up to a 2% bonus payment based on all of their Medicare Part B charges if they report successfully 80% of the time on at least three individual quality measures in 2010. They also can report on measures groups.

This year, the program includes 179 measures and 13 measures groups. In 2008, the average individual physician who successfully reported quality data received about $1,000, Dr. Granovsky said. Payments are expected to be somewhat higher this year, because the bonus was increased from 1.5% to 2%.

Over the last several years, CMS officials have laid out their vision for value-based purchasing, emphasizing their desire to pay physicians and hospitals for quality of care, rather than simply for volume of services, and to avoid unnecessary costs. PQRI is widely seen as the first step in that transition, Dr. Granovsky said.

Although the pending federal health care reform effort would include more moves in that direction, the CMS already has the tools it needs through prior legislation to make significant progress in that direction, Dr. Granovsky said. "Medicare already has the regulatory muscle to put this in place," he said.

Medical groups that choose to participate in PQRI must commit to it, Dr. Granovsky added, because it requires a great deal of data collection and reporting. Groups also should collaborate closely with their billing company.

A regular internal auditing process will also help medical groups ensure that they are getting the most out of their reporting efforts, Dr. Granovsky said.

One of the criticisms of the PQRI program is that it takes about 18 months to get feedback reports from the CMS, making it nearly impossible to detect problems in a timely manner. However, a monthly internal audit will help alert groups if they have a data file transfer problem that could prevent their PQRI claims from being processed, he said. ■