HHS Requires Reviews of Big Insurance Hikes

BY MARY ELLEN SCHNEIDER

FROM A PRESS BRIEFING BY THE HEALTH AND HUMAN SERVICES DEPARTMENT

Starting Sept. 1, health plans in the small group and individual markets that propose rate hikes of 10% or more must have their proposals vetted by either state or federal officials.

The mandatory review is a new requirement related to insurance premium review that has been released by the Health and Human Services Department and was required under the Affordable Care Act. The final regulation has been published in the Federal Register. The regulation does not apply to the large group insurance market or to small and individual plans that have "grandfather" status under the Affordable Care Act.

Under the regulation, states will take the lead when it comes to reviewing rate increase proposals. Federal officials will step in only when states don't have the resources or the statutory authority to review rates. Currently, insurance commissioners have differing authority based on state law, with some having the power to reject rate increases before they go into effect and others possessing more limited review powers.

Officials at HHS have encouraged states to beef up their oversight authority, and the agency has awarded about $44 million in grants to help with that process.

The final rule also includes a requirement that states give the public a chance to comment on proposed rate increases. And health plans are required to provide justification for their rate increases. HHS will post the outcome of all reviews on a rate increase of 10% or more at www.HealthCare.gov. The information will include the factors behind the rate increase and in cases where the increase was found to be "unreasonable," it will also include a justification by the insurance company. The health plan will also make the justification information available on its own website.

The new regulation does not give states or the federal government new authority to deny rate increases. But Steve Larsen, director of the Center for Consumer Information and Insurance Oversight at HHS, said that the ability to thoroughly review proposed increases and question the underlying assumptions is enough.

"Review, in and of itself, is in fact very effective in helping to ferret out reasonable and unreasonable rate increases," Mr. Larsen said at a press conference to announce the new regulation.

Elizabeth P. (Beth) Sammis, Ph.D., acting Maryland Insurance Commissioner, agreed. Maryland has prior approval authority, allowing it to reject a premium increase if state officials conclude it is too high. However, she said in practice, that authority is rarely used. Typically, health plans voluntarily withdraw the higher rate increase after discussions with state officials.

"We're confident that insurers everywhere are already thinking twice and checking their math before submitting large rate hikes," said HHS Secretary Kathleen Sebelius.

"This means millions of Americans will see savings to their own bottom lines," she noted.

But America's Health Insurance Plans (AHIP), the trade group for health insurers, said HHS is missing the point with this regulation. "Focusing on health insurance premiums while ignoring underlying medical cost drivers will not make health care coverage more affordable for families and employers," AHIP President and CEO Karen Ignagni said in a statement.

"The public policy discussion needs to be enlarged to focus on the soaring cost of medical care that threatens our economic competitiveness, our public safety net, and the affordability of health care coverage."

Ms. Ignani also criticized the 10% threshold for review, saying that creating a "de facto presumption of unreasonableness" can influence the evaluation of the proposed rate increase.

The final regulation calls for the use of state-specific thresholds in September 2012. ■

Feds Push Insurance for Pre-Existing Conditions

BY FRANCES CORREA

FROM A PRESS BRIEFING BY THE HEALTH AND HUMAN SERVICES DEPARTMENT

A 40% premium cut and simpler enrollment procedures are two changes the federal government is employing to increase enrollment in the Pre-Existing Condition Insurance Plan, Health and Human Services Secretary Kathleen Sebelius announced.

Launched in July 2010 under the Affordable Care Act (ACA), the Pre-Existing Condition Insurance Plan (PCIP) provides an insurance option for people with preexisting conditions who have been denied coverage and have been without insurance for 6 months or more.

To increase awareness for the program, HHS will offer payment for insurance brokers and agents for successfully connecting eligible enrollees with the PCIP program, said Richard Popper, deputy director of insurance programs in the Office of Consumer Information and Insurance Oversight.

People who are seeking coverage under the PCIP will no longer have to wait to receive a denial letter from their insurance company in order to enroll in the plan.

Instead, they can provide attestation of their condition from their physician, nurse practitioner, or physician assistant.

Patients with preexisting conditions still will be required to be without insurance for 6 months before they are eligible for coverage under the plan, said Mr. Popper. He added that HHS does not have the authority to waive the 6-month waiting period under the current health law.

Ms. Sebelius emphasized HHS's priority to increase PCIP's enrollment. "It's encouraging to see more people who need health insurance the most getting it, but we know that's not enough," she said.

The measures comply with the ACA provision requiring the PCIP to align premiums and benefits with the private insurance market, Mr. Popper said. However, he said there's still plenty of room for new enrollees.

"We've been enrolling people at an increasing rate, but we know we have the capacity to cover even more people," Mr. Popper said, adding that funding for the measures will fall under the original $5 billion set aside for the program through the health reform law, as well as existing member premiums.

Despite original HHS estimates that several hundred thousand people would benefit from the PCIP, 18,313 people were enrolled as of early May.

The PCIP is run by the federal government in 23 states and the District of Columbia; remaining states operate their own programs using funding from the ACA.

HHS sent letters to those 27 state programs, encouraging them to consider similar reforms to their programs. ■

Shortage of 125,000 Physicians Looming, AMA President Warns

BY MARY ELLEN SCHNEIDER

FROM THE ANNUAL MEETING OF THE SOCIETY OF HOSPITAL MEDICINE

GRAPEVINE, TEX. – The combination of the aging baby boomers, growing minority populations, and the millions of Americans who will gain coverage under the Affordable Care Act, will stress the health care system and create a "crisis of access to care" in the near future, warned Dr. Cecil B. Wilson, president of the American Medical Association.

Dr. Wilson, who recently spoke at the annual meeting of the Society of Hospital Medicine, said there is already a physician shortage in many areas and specialties, but it is likely to get worse if steps aren't taken to recruit more young people into medicine.

"The situation is serious for the patients who do not have or cannot get a physician's care," he said. "It also presents considerable challenges for those of us in medical practice as well."

Right now, the AMA estimates that there will be a shortage of at least 125,000 physicians by 2025. The problem is not just the number of the physicians but who they are and where they practice.

Some of the greatest physician shortages are in rural areas and in minority communities. Recruiting minority physicians has been a challenge, he said, in part because of the high cost of medical school, but also because there are few minority role models in the medical community. And the result is that health care disparities are increasing, Dr. Wilson said.

There has been some good news, Dr. Wilson said. The Affordable Care Act includes some provisions to address these issues, including bonuses to primary care physicians to help deal with the pay differential with specialists, loan repayment programs, and a provision to shift unused residency slots to primary care. And medical schools are expanding. In the past 3 years, nearly two dozen new medical schools have either been opened, announced, or sought accreditation, Dr. Wilson said.

But there not has been a parallel growth in residency training slots. With the cap on federally funded residency positions, it's difficult to expand training programs, he said.

One possible solution is to move to an "all-payer system" that would be financed not just by Medicare, but also by insurance companies and others with a stake in the health care system, Dr. Wilson said. ■

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