Future Uncertain as Health Plan Settlements Expire

BY ALICIA AULT
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WASHINGTON — With health care expenses accounting for the single largest expense in their budget, states are increasingly looking for solutions from within, not from the federal government, according to an annual accounting of state legislative trends compiled by the Blue Cross and Blue Shield Association.

"Health care spending represented nearly one-third of total state expenditures last fiscal year," said Susan Laudicina, BCBSA director for state research and policy at a briefing for reporters. And, she noted, as the economyweakens, health care costs will continue to rise, while tax revenues will fall. That will increase the pressure to find creative solutions, she said.

"The challenge for state lawmakers is how to avoid cutting existing programs like Medicaid and the State Children’s Health Insurance Program while also finding new ways to cover the uninsured and contain costs," said Ms. Laudicina.

The most significant trend observed in the states: an attempt to expand coverage. About half of the state legislatures debated universal coverage or expansion programs for children in fiscal 2007. State mandates requiring individuals to buy insurance were introduced in 12 states. All failed, largely because they are controversial, Ms. Laudicina said.

Connecticut and New York expanded eligibility for SCHIP to 400% of the federal poverty level and seven other states raised eligibility to 300%, but those efforts are threatened by a rule change issued by the Department of Health and Human Services last August that ostensibly caps eligibility at 250% of the federal poverty level. Eight states have sued to challenge that ruling.

Eight states—Connecticut, Indiana, Kansas, Louisiana, Maryland, New York, Texas and Washington—created programs in which public funds are used to subsidize the cost of private employer-sponsored health insurance to Medicaid-eligible workers. Oklahoma expanded its subsidy program, making more workers eligible. So-called "transparency" initiatives are gaining ground, also. These proposals are require hospitals—and in some cases, physicians—to publicly share information on infections and other adverse events, and also other quality data and pricing. Twenty-one states debated proposals that would require transparency on some level. Transparency bills were enacted in 10 states: Arkansas, Delaware, Georgia, Indiana, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington.

In Texas, for instance, the state is now requiring hospitals and physicians to provide patients with estimates of charges if requested. Hospitals also will be required to tell patients if there is the possibility that an out-of-network provider will also be working in an in-network facility, and to inform them there may be costs to the patient as a result.

The Texas law reflects a growing concern that patients aren’t aware that they may be balance-billed, Ms. Laudicina said. Eleven states will take up transparency measures in 2008.

The annual State Legislative Health Care and Insurance Issues report compiles information from the BCBSA’s survey of 39 independent Blue Cross and Blue Shield plans.

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Health Care Spending Projected To Reach $4.3 Trillion by 2017

BY MARY ELLEN SCHNEIDER
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Health care spending in the United States is projected to consume nearly 20% of the gross domestic product by 2017, according to estimates from economists at the Centers for Medicare and Medicaid Services.

Health care spending growth is expected to remain steady at about 6.7% a year through 2017, with spending estimated to nearly double to $4.3 trillion by 2017, the CMS analysts said in a report published online in the journal Health Affairs.

The 10-year projections come from the National Health Statistics Group, part of the CMS Office of the Actuary, and are based on historical trends, projected economic conditions, and provisions of current law.

The analysts project that spending for private sector health care will slow toward the end of the projection period, while spending in the public sector, including Medicare and Medicaid, will increase. Much of the increase will be fueled by the first wave of baby boomers entering Medicare in 2011. The increase in the number of Medicare enrollees is projected to add 2.9% to growth in Medicare spending by 2017, according to the report.

The CMS economists projected that growth in spending onphysician services would average about 5.9% per year through 2017, compared with 6.6% from 1995 to 2006. These projections are based on current law, which calls for steep cuts to physician payments under Medicare over the next several years. If Congress were to provide a 0% update over the next decade, the average annual growth from 2007 to 2017 would rise to 6.2%, according to the report.

On the hospital side, growth in spending is projected to accelerate at the beginning of the projection period because of higher Medicaid payments but to slow toward the end as a result of projected lower growth in income. Home health care will likely be one of the fastest growing sectors in health care from 2007 through 2017, with an average annual spending growth rate of 7.7%, according to the report.

Growth in prescription drug spending is expected to accelerate overall through 2017, because of increased utilization, new drugs entering the market, and a leveling off of the growth in generics. The analysts projected that Medicare Part D would have "little impact on overall health spending growth" through 2017.

The American Medical Association and Aetna recently announced that they are working together to resolve outstanding complaints.

Prudential’s agreement expires in 2009, and agreements with three other insurers expire in 2010: HealthNet, Anthem/WellPoint, and Humana.

Agreements were reached with 90% of the nation’s Blue Cross and Blue Shield plans and the Blue Cross and Blue Shield Association last April, but the final settlement date was being worked out at press time. The Blues plans agreed to similar terms as did the other payers, with one exception: Anthem/WellPoint and the Blues plans refused to accept assignment of benefits. In fact, the Blues plans were willing to walk away from the settlement if they did not win that concession, said Mr. Gaines.

The court gave preliminary approval last November to a settlement with the West Virginia-based Highmark/Mountain State Blue Cross Blue Shield. Claims were paid at 99% of Medicare rates and informing patients that they are not responsible for the difference.

ACEP, the North Carolina chapter of ACEP, Wake Emergency Physicians, and the North Carolina Medical Society subsequently followed up with a legal complaint to the North Carolina insurance department in November, said Mr. Gaines. The North Carolina group is challenging bundling of 12-lead ECGs into a single bill that the two insurers are using to recoup alleged improper payments.

"If we don’t get prompt action from Aetna, we’re going back to court [to] ask for an extension of the settlement agreement term," he said.