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Weekly Health Care Reform Update

Monday, October 12, 2009

Vote on Baucus Bill Scheduled for Tuesday

The Baucus Senate Finance Committee ("SFC") health reform proposal will receive the first real litmus test on Tuesday, October 13, when the full Committee votes on the amended proposal. The bill, estimated to cost $829 billion over the next 10 years – significantly below President Obama's $900 billion ceiling – would result in a dramatic expansion of Medicaid and private insurance coverage purchased by individuals and obtained through employer-sponsored programs. According to estimates from the SFC and the Congressional Budget Office ("CBO"), as reported by Kaiser Health News, approximately 23 million Americans would buy health insurance through insurance exchanges created under the proposal.

The CBO estimated that the expansion of Medicaid coverage would be 90 percent funded by federal funds. The expansion in private insurance coverage would be paid for by premiums, federal subsidies and tax credits. The CBO analysis of costs of the SFC package did not consider as significant the coverage anticipated to be provided through proposed co-ops (community-owned, nonprofit insurance companies), primarily due to the potential complications of start-up and the lack of immediate traction for negotiating favorable rates with health care providers. Still, the CBO's assessment of the SFC proposal is that it would result in a net reduction in federal budget deficits of $81 billion over the 2010–2019 period.

Baucus Bill Expands State Insurance Regulatory Authority

The SFC health reform proposal is distinctive in that it places much of the new administrative responsibility for implementing health insurance reforms on the states and, in particular, on state insurance regulators. Speculation about implementation is the topic of debate among state insurance departments and, particularly, among the members of the National Association of Insurance Commissioners ("NAIC"). The NAIC is a nonprofit association whose members include insurance industry regulators in all 50 states, five territories and Washington, D.C. that seeks to coordinate and provide oversight of state regulation of the insurance industry. The NAIC has historically championed and supported the concept of state, not federal, regulation of insurers and their products. However, the SFC reform package could leave the job of establishing the standards, perhaps, including rates, for reformed health coverage to the NAIC.

This summer, NAIC regulators prepared a confidential memorandum for future discussion regarding the feasibility and merits of working with Congress to establish a commission of state regulators that would prepare uniform standards to be administered at the state level for health coverage under federal legislation. If this occurs, it would be the first interstate regulation of insurance, and could be seen as a compromise to federally-funded insurance initiatives. Amendments to the Baucus bill incorporate the concept of NAIC involvement, and would give the NAIC 12 months to come up with a model regulation governing the rating, issuance and marketing of health insurance coverages through state-based exchanges. States that did not adopt the NAIC model regulations would face federal pre-emption and the application of new federal standards.

Additional involvement of the NAIC was included in a provision reported in August as part of the Tri-Committee reform efforts in the House. That provision would have the NAIC draft standardized marketing guidelines for Medicare Advantage programs to replace federal marketing guidelines and provide more state oversight of insurers selling these federally funded Medicare benefit plans. In any event, it appears that the role of the NAIC is quickly evolving as the health reform legislation is being readied for SFC votes and floor debate in both the Senate and the House. Possible interstate regulation of health insurance initiatives could provide the middle ground between federally run programs and leaving the decisions to a patchwork of state standards and approaches.

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Health Reform Focuses on Wellness Initiatives

In recent weeks, there have been many actual and proposed changes to employee wellness programs and health risk assessments ("HRAs") that often accompany wellness initiatives. The SFC recently approved an amendment to the health reform proposal that would enhance financial rewards offered to program participants. Last week's final interim regulations to Title I of the Genetic Information Nondiscrimination Act of 2008 ("GINA") reveal that wellness programs that reward individuals for completing HRAs that request genetic information, including family medical history, will need to be modified to comply with GINA.

The SFC's amendment relating to workplace wellness would enhance financial incentives that could be provided to employees for participation in or for meeting certain health standards related to a wellness program. Under current law, the Health Insurance Portability and Accountability Act ("HIPAA") permits such programs to offer financial incentives to participating individuals. These incentives could include discounts or rebates of health insurance premiums, waivers of all or part of a cost-sharing mechanism under a plan (such as deductibles, co-payments or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan for those who meet a particular health standard, such as stopping the use of tobacco products. The value of the incentives is capped at 20 percent of employee-only premiums. The SFC proposes to increase this cap to 30 percent of the employee-only coverage under the plan and allows plan participants who cannot meet the applicable standard due to a medical condition or because it is medically inadvisable for them to do so to still benefit from the incentives. The SFC amendment also allows the Secretaries of Health and Human Services, Department of Labor, and Department of Treasury the discretion to increase the percentage up to 50 percent for adherence to or participation in a reasonably designed program of health promotion and disease prevention. These incentives could apply to wellness programs that reward employees solely for participation and to those programs in which rewards are based on the attainment of certain health standards, as long as certain requirements are met.

Although the amendment passed with overwhelming support from the committee (a vote of 18-4), labor unions, women's groups and patient advocacy groups such as the American Heart Association, American Diabetes Association and American Cancer Society spoke out against the amendment last week. The groups argue that the amendment would allow companies to vary their employees' premiums based on participation in these programs, which would lead to discrimination against unhealthy workers and would create opportunities to penalize those with pre-existing conditions. Some advocates argue that these workplace wellness programs provide employers with too much access to workers' personal information.

GINA prohibits group health plans and insurers from collecting genetic information for underwriting purposes or in connection with enrollment. The final interim rules implementing Title I of GINA clarify that wellness programs providing a reward for completing an HRA that collects family medical history generally will violate GINA. Limiting the ability to gather information regarding family medical history could significantly limit the way that many wellness programs are currently structured. The rules provide a number of examples illustrating how wellness programs can be designed to comply with GINA. For example, programs that provide results-based awards should not collect family medical history, and when there is a reward or penalty for completing an HRA, questionnaires should be modified to explicitly state that genetic information should not be provided. In accordance with GINA, the U.S. Department of Health and Human Services, through its Office for Civil Rights ("OCR"), recently issued a notice of proposed rulemaking updating HIPAA to prohibit health plans from using or disclosing genetic information for underwriting purposes. In combination with the new penalties for violations of the HIPAA Privacy Rule, as provided for by the American Recovery and Reinvestment Act of 2009, a use or disclosure of genetic information in violation of the HIPAA Privacy Rule could result in a fine of $100 to $50,000 or more for each violation.

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