

Health Plans Offer Proposal to Guarantee Coverage

America's Health Insurance Plans (AHIP), the national trade association representing nearly 1,300 member companies that provide health benefits to more than 200 million Americans, has released its proposal to guarantee coverage for people with pre-existing medical conditions in conjunction with an enforceable individual coverage mandate.

Under the new proposal, health plans participating in the individual health insurance market would be required to offer coverage to all applicants as part of a universal participation plan in which all individuals are required to maintain health insurance. The AHIP proposal also states that premium support for moderate-income individuals and broad spreading of risk would be necessary to promote affordability and maintain premium stability in the individual health insurance market. AHIP's proposal includes:

- guaranteeing issue of coverage with no pre-existing condition exclusions;
- establishing an individual coverage requirement with an insurance coverage verification system and automatic enrollment process and effective enforcement of the requirement that all individuals purchase and maintain coverage;
- promoting affordability by providing refundable, advanceable tax credits for moderate-income individuals and working families; and promoting tax equity whether coverage is obtained through an employer or the individual market;
- ensuring premium stability for those with existing coverage through a broadly funded reimbursement mechanism that spreads costs for the highest-risk individuals.

According to AHIP's survey of the individual market, 9 out of 10 applicants undergoing medical underwriting were offered coverage with plans that provided financial protection and a wide range of benefits, including coverage for behavioral health, prescription drugs and preventive services. However, some individuals are unable to purchase individual health insurance coverage in the private market because of their health status. One approach taken by states to address this issue has been the enactment of guarantee issue legislation requiring health plans to offer coverage to all applicants. These well-intentioned reforms have often resulted in severe unintended consequences, including significantly higher costs for all policyholders.

A report by Milliman, Inc., found that enactment of guarantee issue laws in the absence of a requirement that individuals purchase coverage may cause people to defer seeking coverage until they have health problems – a situation that unfairly penalizes those who are currently insured. According to the report, states that implemented these laws saw a rise in insurance premiums, a reduction of individual insurance enrollment and no significant decrease in the number of uninsured.

Study Confirms: Obese Children Likely At-Risk of Heart Disease

In studies presented during the American Heart Association's Scientific Sessions on November 11th, it was announced that obese children as young as 10 had the arteries of 45 year olds, that childhood obesity is tied to the abnormal enlargement of the left atrium, and that the heart in overweight or obese children had a more difficult time relaxing between beats. According to the research, all of these conditions could lead to long-term health problems for overweight children.

Health Quiz

1. **Guarantee issue of coverage encourages individuals to wait until they are sick to purchase insurance.**
(a) True
(b) False
2. **States that adopted guarantee issue laws experienced a rise in premiums and a reduction in individual enrollment.**
(a) True
(b) False
3. **Research suggests the current fee-for-service payment model rewards volume rather than quality of care.**
(a) True
(b) False
4. **Most health care leaders are satisfied with fee-for-service payment system.**
(a) True
(b) False
5. **According to a recent study, MRI scans tripled from 1997 to 2006.**
(a) True
(b) False

Rise in CT and MRI Image Tests Raising Questions

The dramatic increase in medical imaging tests is raising questions about their impact on health care costs as well as patient risks associated with increased exposure to potentially cancer-causing radiation.

According to researchers at the University of California-San Francisco (UCSF) and the Group Health Center for Health Studies in Seattle, innovative imaging tests like computed tomography (CT) and magnetic resonance imaging (MRI) rose from 260 to 478 per thousand patients from 1997-2006. The average total imaging cost per patient, per year doubled during the study period from \$229 to \$443.

The research was conducted using data from 377,000 patients enrolled in the Group Health Cooperative in Washington who combined for a total of five million radiology tests during the ten-year period. One of the most striking findings of the research was the increase in the number of newer and pricier tests such as CT and MRI scans. According to the report, in 1997, 13.5 percent of the study group had undergone a CT, MRI, or both compared to 21 percent in 2006. The study found that CT scans doubled and MRI scans tripled during the ten years reviewed.

“The goal with newer imaging tests is to use them in the most efficient and effective way possible and as a replacement for older, less accurate tests,” emphasized lead author Rebecca Smith-Bindman, M.D., an associate professor at UCSF. “But we found the newer tests are being added on top of the old tests, such as X-rays, rather than replacing them and this increases costs.”

According to Smith-Bindman, it is likely that testing is higher in fee-for-service practices because of the financial rewards for extra testing, including recouping investments in office-based scanning equipment. She concluded the study results highlighted the need to curb unnecessary imaging.

Survey Finds Widespread Dissatisfaction with Fee-For-Service Payment System

Leaders in health care and health care policy feel strongly that the way we pay for health care in the U.S. must be fundamentally reformed. The latest Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey reports that 69 percent of respondents expressed strong dissatisfaction with the current system, which is generally based on “fee-for-service” payments, saying the current system is not effective in encouraging high quality and efficient care.

The current fee-for-service system reimburses for individual services – hospital stays, physician visits, and procedures – rather than paying for the most appropriate care for the patient over the course of an illness or a time period. In doing so, it creates incentives to provide more technical and more expensive services, rather than encouraging more effective, higher-value care. Only one percent of health care leaders surveyed said they preferred the current fee-for-service payment system to alternative approaches.

There was strong support for a move away from fee-for-service payment towards the use of a payment blend that incorporates bundled approaches – that is making a single payment for all services provided to a patient during the course of an episode or time period. A bundled payment system would provide an overall payment based on the appropriate care needed for the patient rather than a separate fee for every service provided. Fifty-three percent of the health care leaders surveyed preferred a blend of modified fee-for-service and bundled per-patient payment and 23 percent chose the bundled per-patient payment alone.

Trivia answers: 1. a (True) 2. a (True) 3. a (True) 4. b (False) 5. a (True)

Birthdays

December

1 – Rep. Dan Gattis
2 – Rep. Pete Gallego
2 – Rep. Kelly Hancock
3 – Rep. Joe Deshotel
6 – Sen. Leticia Van de Putte
6 – Rep. Rob Eissler
6 – Rep. Joe Pickett
8 – Rep. Jim Murphy
12 – Rep. Jim Dunnam
14 – Sen. John Carona
17 – Sen. Tommy Williams
17 – Rep. Corbin Van Arsdale
19 – Rep. Eddie Lucio III
20 – Rep. Rob Orr
23 – Rep. Ken Paxton
25 – Rep. Roberto Alonzo
28 – Rep. Chente Quintanilla