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Health Reform Weekly

A weekly compilation from Aetna of health care-related developments in Washington, D.C. and state legislatures across the country

Week of May 26, 2008

Aetna Chairman and CEO Ron Williams is featured in a five-page article in the May 12 issue of [Fortune](#) magazine. He was interviewed by senior editor Geoff Colvin in front of an audience of more than 100 people at Fortune's New York City headquarters. This is part of a series called "C-Suite Strategies," which will feature six articles during the course of the year focused on the perspectives of business leaders on various topics. The thrust of the questions focused on health care reform and Aetna's industry leadership.

Federal

The two Democratic primaries in Oregon and Kentucky did little to change the expected inevitable result. At some point in the coming month, and likely before end of June, Hillary Clinton will find a graceful and politically meaningful way to withdraw from the race. Despite a huge 35 percent win in Kentucky, the delegate count, including pledged and super delegates, continues to pile up against her. Obama has 1,960 to Clinton's 1,776; it takes 2,026 to win the nomination. Barring a major change in the political landscape, Obama will end the primary season on June 3 with more of everything: more delegates, more super delegates; more popular vote.

Senate Finance Committee Chair Max Baucus has tried mightily for three months to craft a bipartisan Medicare bill to stave off a 10.6 percent cut in physician payments as of July 1 to be paid in part with cuts in Medicare Advantage (MA) funding. That effort came to a halt last week as the White House and enough Republicans on the committee would not agree to the chairman's plan, an \$18 billion bill taking more than half from MA. Baucus's current "Plan B" is to craft a Democratic bill, presumably a very

"skinny" bill, over the Memorial Day recess and go straight to the Senate floor in early June.

After the Senate offered a compromise on mental health parity to the House March 31, the House May 21 responded with its own counteroffer. Aetna is part of a small team of insurers, employers and mental health advocates sorting through the counteroffer with Senate staff in order to respond. But without some leadership in the House, the current stalemate may go on for some time. The health of Sen. Ted Kennedy will be a complicating factor.

President Bush last Wednesday signed into law the Genetic Information Nondiscrimination Act of 2008. Health and Human Services Secretary Mike Leavitt hosted a celebration of the signing at the HHS department, and Rep. Louise M. Slaughter praised Aetna for its leadership in getting the measure enacted, noting that Aetna had adopted its guidelines for the use of genetic information back in 2002. The new law, which takes effect in May 2009 for group health plans, prohibits discrimination against individuals on the basis of their genetic information in both employment and health care.

States

CALIFORNIA: Gov. Schwarzenegger's health care policy team and health insurance representatives discussed steps towards a comprehensive health care reform package that would include two phases over several years. The talks came after the Senate's Health Committee in January rejected a Schwarzenegger proposal, noting a growing state budget deficit. Schwarzenegger's staff outlined broad parameters of a first phase, which they said would have little impact on budget revenues. The second phase, which likely would go before voters in a ballot initiative, would be unveiled by 2010 and include increased access, coverage mandates for individuals and employers and program financing. The first phase would include cost containment with medical benefit ratio limits, quality and cost transparency, electronic medical records and electronic communications, expansion of retail clinics and e-prescribing. Schwarzenegger's staff remains weeks away from developing legislative language, but his staff says the proposals are similar to aspects of his failed comprehensive reform efforts.

MASSACHUSETTS: The state's Medical Society seeks to end the Clinical Performance Improvement initiative, a two-year-old plan in which physicians are ranked for cost and quality measures by health plans associated with the Group Insurance

Commission, the agency that oversees health insurance for thousands of public employees at state and local levels. The society recently filed suit, alleging that doctors who ranked lower have been defamed and that patients who have to pay higher co-payments based on their doctors' ranking have been defrauded. The physician rankings were first used in mid-2006. To compile them, the insurance commission uses a database of claims from six insurance companies, and applies computer analytic tools to compare the performance of physicians to one another. But the medical society said the methodology was flawed. The lawsuit also names Tufts Health Plan and UniCare Life and Health Insurance Co., two companies that offer health plans that use tiering for insurance commission members.

MINNESOTA: The House and Senate, before adjourning last week, agreed on health reform measures, which Gov. Tim Pawlenty is expected to sign after vetoing a more costly bill.

The new bill, stripped of earlier provisions, increases access to private coverage and modestly expands public programs. The bill would force providers, group purchasers, prescribers and dispensers to establish and maintain an electronic prescription drug program by 2011. In addition, the state's health commissioner would be required to develop measures to assess the quality of health care services offered by providers and develop quality incentive payments. The commissioner also would be required to create transparent prices and encourage provider innovation, as well as establish uniform definitions for "baskets of care" that must include coronary artery or heart disease, asthma, diabetes and depression. The bill also requires employers with 11 or more full-time employees to offer Section 125 plans, although opt-out provisions are included. The measure also would establish a Health Care Reform Review Council that would include provider, employer, facility and labor union representatives.

MISSOURI: The state legislature adjourned May 16, with its major health reform bills failing to make it through the session. However, a bill creating a commission on autism spectrum disorders did pass, which would advise and make recommendations on all levels of autism spectrum disorder services. But an autism mandate failed along with mandates for prosthetic devices and screenings for the sexually transmitted virus, HPV. A major piece of transparency legislation also failed to pass.

NEW JERSEY: The state Senate Budget and Appropriations Committee last week unanimously sent to the Senate a bill, which would make changes to the individual and small group markets, including reductions in the number of standard plans, and

modified community rating. But Aetna objected to parts of the bill including rate caps for existing policy holders in individual market and an increase in the medical cost ratio from 75 to 80 in individual and small group markets. Other features of the measure would expand New Jersey Family Care, creating a mandate for children's coverage. Meanwhile, lawmakers expressed concern over the cost of the measure, which would cost about \$12 million in the first year and \$48 million in its second year, according to the state Department of Human Services. Still, advocates say the program could be paid for by using surplus funds available in the Medicaid program, but Gov. Jon S. Corzine's administration has indicated that surplus funds are already spoken for.

NEW YORK: Gov. David Patterson has introduced a proposal that would require new pharmacy benefit manager (PBM) disclosures. The proposal would require PBMs to disclose to their client health plans the actual use of drugs by the health plan's participants; every policy or practice of the PBM that presents an actual or potential conflict with the health plan; any increase in the net price to the health plan for a covered drug, and the reason for the increase; and all contracts and agreements entered into by the PBM with a network pharmacy and with any pharmaceutical manufacturer. To prevent PBMs from switching patients to more costly drugs without patients' knowledge and without providing adequate information to the practitioner, the bill would require notification to patients and would provide relevant clinical and financial information to prescribers before drug switches could be made.

TEXAS: The Texas Sunset Commission last week released a long-awaited report that reviews the Department of Insurance. Its most pertinent finding to the health insurance industry was a recommendation that the insurance department requires certificates of authority over preferred provider organizations or PPOs and that the department be given increased regulatory authority. The commission also recommended that the department set new time limits for reviewing company rate filings. The limits would become part of the state's file-and-use system, under which companies could begin charging new insurance rates as soon as the companies notify the department. The commission also said the agency should set limits on how long it will review rates after they go into effect. Stakeholders have until June 9 to submit written comments in response to the report. Public hearings will be held June 24-25 in Austin, after which the commission plans to draft legislation reflecting its recommendations. That proposed legislation will go to the state House floor for debate.

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