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Still Waiting on Senate Health Reform Bill

After the dramatic passage by the House of Representatives of the Affordable Health Care for America Act of 2009 ("H.R. 3962") on November 7, the past week has been dominated by much discussion concerning whether Congress can deliver a health reform bill to President Obama by the end of year or in early 2010. Congressional leaders in both chambers of Congress are setting schedules which require Congress to work weekends and through the final days before the Thanksgiving and Christmas holidays. Still, it is difficult to establish an end date when there is no Senate bill to move to the floor for discussion. Given the rules governing Senate proceedings, numerous amendments are expected to be offered to the Senate's health reform bill which could require weeks and weeks of debate. In view of this, there is ample concern that Congress will not be able to achieve the President's deadline.

Both Senate Democrats and Republicans eagerly anticipate the release of the Senate health reform bill secretly submitted by Senate Majority Leader Harry Reid (D-NV) to the Congressional Budget Office ("CBO") for scoring as well as the CBO's scoring of the bill. Even with no bill to discuss, this last week was filled with much clamoring and posturing about the most divisive issues weighing down the reform efforts such as abortion funding, offering of health coverage to undocumented immigrants, the public option, the cost of health reform and how the federal government will pay for the expansion of health coverage to the uninsured. The crescendo of voices from both critics and supporters of health reform will only increase once the Senate reform bill is released – which may occur later this week.

Reform Bill's Removal of Antitrust Exemption Appears to be All Smoke, No Fire

Last week's passage by the H.R. 3962 contained revisions to the federal antitrust laws designed to bring health and medical malpractice insurers fully under the anticompetitive restrictions applicable to other industries. However, the real effect of removing the current exemptions remains in doubt. The 1945 McCarran-Ferguson Act (the "Act") exempted the "business of insurance" from federal antitrust law as long as the insurers' businesses are regulated by state law and do not involve boycott, intimidation or coercion. The law codified the ability of the states to regulate insurers, including the then-current practice among property and casualty insurers to use rates developed jointly by state or regional rating organizations, a practice that might be considered to be price-fixing under federal antitrust law.

State regulators responded by passing laws to control the insurers' pricing practices and, as the years passed, collective pricing began to decline as insurers became more competitive on prices and courts continued to narrow the exemption. As noted by the *Wall Street Journal's* Scott Harrington in an Opinion article last week, the debate about the antitrust exemption primarily involved property and casualty insurers and medical malpractice liability carriers which collected and analyzed claims loss data and projections of future losses to develop future rating guidelines. The resulting information allows sharing of loss projections, subject to state regulation, among insurers to obtain more accurate rating, and can benefit small insurers by providing a level playing field for competitive pricing with larger companies.

However, in health insurance there is no joint forecasting of future medical expenses among insurers. Actuaries review actual claims experience for health insurers and conduct price modeling, taking into account benefit descriptions and variations, geographic economic indicators and other factors, including contractual pricing discounts negotiated with health care providers. Also, the current antitrust exemption does not prevent the U.S.

Department of Justice or Federal Trade Commission from reviewing other business activities of insurance companies such as mergers and acquisitions and taking action to prevent anticompetitive practices or combinations. For example, in 2005, the Department of Justice issued a consent decree requiring that PacifiCare Health Systems divest certain of its commercial health plan business in Tucson, Arizona and Boulder, Colorado as a condition to approving PacifiCare's merger with UnitedHealth Group. A recent break-up of a proposed merger between Pennsylvania's two largest health insurers occurred when state regulators declined to allow the combination on anti-competitive grounds, as well.

The House bill amendment to the Act focuses specifically on the businesses of health insurance and medical malpractice insurance, and states that nothing in the Act shall modify, impair or supersede the operation of any of the antitrust laws with respect to those businesses. It also states that it does not apply to the collecting, compiling, classifying or disseminating of historical loss data; determining a loss development factor applicable to historical loss data or performing actuarial services if doing so does not involve a restraint of trade. Thus, while the amendment effectively repeals the antitrust exemption for health and medical malpractice insurance, the insurers would still be allowed to compile historical loss data and use that data collectively, to the extent allowed by state regulators, as long as no restraint of trade is involved.

It does not appear that the repeal of the antitrust exemption would significantly affect the cost or availability of health insurance, and would have little, if any, effect on creating more competition among health insurers. The effect on medical malpractice insurers also would appear to be negligible, since repealing the Act exemption would not impact the overall medical malpractice insurance crises resulting from high jury verdicts as opposed to perceived lack of price competition among malpractice carriers. Sheryl Skolnick, an insurance industry analyst in New

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Reform Bill's Removal of Antitrust Exemption Appears to be All Smoke, No Fire (cont'd.)

York, stated that there is no love lost among CEOs of publicly-traded insurers, who did not need the antitrust exemption to be competitive. And, she stated, removing the exemption is "not going to have any effect on the bottom line" of insurers. As noted by Mr. Harrington of the *Wall Street Journal*, "the insurance industry's antitrust exemption is inconsequential to the health-care reform

debate. It just distracts attention from important issues and further demonizes private health insurance."

While the removal of the antitrust exemption in the House reform bill and similar well-publicized efforts in the Senate have drawn considerable attention and media hype, the real impact appears to be all smoke and no fire.

Health Reform Transforming Medicare

The H.R. 3962 imposes changes on the Medicare system to both fund health care coverage for millions of uninsured Americans and as a mechanism to change how health care is delivered and paid for under federal programs. According to the CBO analysis and the Congressional Research Service Report to Congress, under the House health reform bill, the largest opportunities for Medicare savings come from three areas: (1) reducing annual increases for Medicare fee-for-service providers, estimated to save **\$228 billion** over 10 years; (2) changing the way Medicare Advantage plans are paid, estimated to save **\$170 billion** over 10 years; and (3) changes to the Medicare Part D prescription drug program, estimated to save **\$50 billion** over 10 years.

Reduction in Spending on Medicare FFS Providers

Traditional Medicare typically pays for covered services on a fee-for-service ("FFS") basis. Medicare Part A covers inpatient hospital services, skilled nursing facility ("SNF") services, home health services and hospice care. The House reform bill is expected to achieve cost savings by lowering the annual increases to which Part A providers would be entitled under current law and, starting in 2017, reducing hospitals' disproportionate share ("DSH") payments attributed to their low income patients. The reduction in DSH payments is contingent upon reducing the number of uninsured by at least eight percent from 2012 to 2014. Although the "physician fix" to prevent deep cuts in Medicare reimbursement to physicians has been removed from the House reform bill, the bill would implement various changes to how physician services would be compensated under Medicare Part B. Under the House bill, physician reimbursement would be adjusted based upon increased productivity, reporting and bonus programs, re-evaluation of codes under the physician fee schedule, geographic variations and imbalances caused by uneven economic growth in particular localities. A CMS actuarial report released over the weekend has now caused quite a stir by speculating that cuts to Medicare FFS providers may cause them to end their participation in Medicare, possibly jeopardizing access to care by Medicare beneficiaries.

Changing How Medicare Advantage Plans are Paid

The House reform bill would reduce over time the maximum amount paid to private health plans which participate in the Part C Medicare Advantage program. Today, CMS pays Medicare Advantage health plans by comparing the plan's cost of providing the *required* Medicare benefits (*i.e.*, the bid amount) to the maximum amount which Medicare pays for those benefits on a FFS basis in each geographic area (*i.e.*, the benchmark amount). Congress has been increas-

ing the benchmark amount over the years to encourage plan participation in various geographies. As a result, in some areas, the benchmark amount is now higher than the government's average cost of providing FFS Medicare benefits. In 2009, CMS is projected to pay Medicare Advantage plans an average of 14% more per enrolled beneficiary than the average costs associated with such beneficiaries enrolled in traditional Medicare.

Under the House health reform bill, starting in 2011, CMS would begin to phase in Medicare Advantage benchmarks that are equal to Medicare's FFS spending in each county and, by 2013, these benchmarks would equal the FFS spending by county. As a counter to these reductions, starting in 2011, the House reform bill also would *increase* benchmarks for Medicare Advantage plans that provide quality health care in qualifying areas. Still, the greater impact of the reductions may result in Medicare Advantage plans scaling back on optional supplemental offerings to their enrollees, increasing cost-sharing to their enrollees and, perhaps, the withdrawal altogether from the Medicare Advantage program.

Medicare Prescription Drug Program Changes

The House health reform bill gradually phases out the coverage gap during which Medicare beneficiaries enrolled in private health plans offering Medicare Part D prescription coverage are responsible for 100 percent of the cost of their drugs. Until the coverage gap is phased out, drug manufacturers would provide Medicare Part D plan enrollees with a 50 percent discount off the price of *brand* name drugs dispensed to them while in the coverage gap. However, an enrollee's out-of-pocket costs would be calculated at the actual cost of the drug (without reduction due to the discount) so as not to impede an enrollee from reaching the next threshold for Medicare Part D insurance coverage. Even as the coverage gap is being eliminated, the discounts would continue to accrue to the Medicare program.

The House reform bill also requires the Secretary of Health and Human Services to negotiate directly with drug manufacturers for rebates, discounts and other price concessions which may be charged to Medicare Part D prescription drug plans. The government's negotiations would include a new program for drug manufacturers to provide rebates directly to Medicare for drugs dispensed to certain low income beneficiaries. From the perspective of the Medicare beneficiary, CBO predicts that the elimination of the coverage gap would likely increase the drug plan premiums which they pay, but that the eventual elimination of cost-sharing in the coverage gap should more than offset these premium increases.