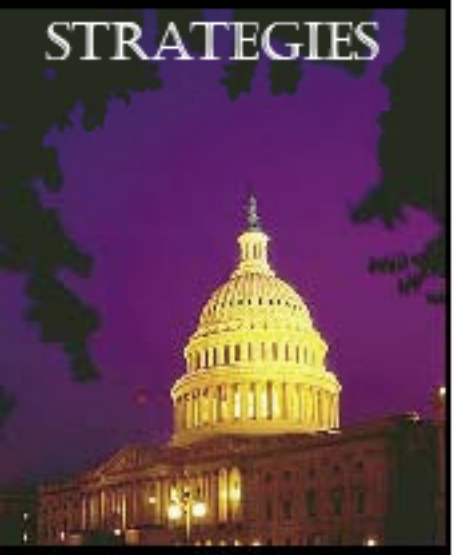
HART HEALTH HH STRATEGIES



Health Policy Briefing

March 19, 2012

House Returns to FY 2013 Budget Debate and Repeal of PPACA's IPAB

House Budget Committee Report Expected this Week

House Republicans return from their week-long recess this week to discuss various budget options in an attempt to develop an FY 2013 budget resolution blueprint which Republicans could use to push through budget cuts under the reconciliation process. However, the Senate is not expected to bring a budget resolution to the Senate floor for a vote, given that last year's debt increase legislation already provides for a $1.047 trillion discretionary spending limit for FY 2013. Whether the legislated limit is reduced by $19 billion, as some budget hawks desire, remains to be seen. **House Budget Committee Chairman Paul Ryan** is not expected to back away from producing a plan which includes Medicare spending reductions and in this effort may move to advance the so-called Ryan-Wyden Medicare reform plan (which provides Medicare beneficiaries with subsidies to purchase private health coverage as an option). House Republicans also want to avoid the sequestration of defense spending beginning in the next calendar year as dictated by the debt ceiling legislation, but are unlikely to do this by increasing taxes as proposed by House Democrats. The lack of an agreement between the House and Senate will necessarily set up another showdown over FY 2013 spending only a few weeks before the November election.

House to Vote on Repealing IPAB

The House is scheduled to meet this Wednesday to vote to repeal the PPACA Independent Payment Advisory Board (IPAB). Although the House Energy and Commerce Committee and Ways and Means Committee reports do not include a provision paying for the cost of the legislation, H.R. 452 (the Medicare Decisions Accountability Act), the House Rules Committee will package this bill with H.R. 5, the Protecting Access to Healthcare Act, as reported by the House Judiciary and Energy and Commerce committees, as a means to offset such costs. H.R. 5 is estimated to more than offset the $3.1 billion ten-year cost of the repeal by providing for medical malpractice reforms that would: provide a three-year statute of limitations for

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malpractice claims beginning at the time of discovery of an injury; limit punitive damages and attorney contingency fees; and create a safe harbor from punitive damages for medical product manufacturers and distributors in certain cases, such as when such products are FDA approved.

Senate Passes Measure Increasing Unpaid Tax Penalties for Medicare Providers

The Senate voted 74-22 to pass a transportation funding bill, S. 1813, that includes a provision to increase the IRS levy from up to 15-100% on payments to Medicare providers having tax delinquencies. CBO estimates the provision would raise revenues by $841 million over 10 years. The House is also expected to take up similar legislation to reauthorize highway, transit and safety programs through FY 2013.

Final Rules on PPACA State Health Insurance Exchanges

The final rules (with parts issued as interim final rules with a 45 day comment period) released by HHS implementing the PPACA provisions creating state health insurance exchanges includes standards for: creating so-called one-stop marketplaces; the health insurance plans participating in the exchanges; determinations of individual and small business enrollment eligibility and related subsidies; and health plan participation in such exchanges. The rules would allow states to determine how health insurance agents, brokers (including online brokers) are included in the enrollment process. In addition, the rule allows states to adopt the PPACA's American Health Benefit Exchanges for individuals and Small Business Health Options Program (SHOP) for small businesses, or a combination. Of note, the rules do not set out the final timelines for states to receive federal certification for their exchanges (many states have yet to even begin the process in light of the Supreme Court case questioning the PPACA's constitutionality). HHS said that the rules for the establishment of federal exchanges in states which do not seek certification will be issued later. Another final rule (Standards Related to Reinsurance, Risk Corridors and Risk Adjustment) defines the circumstances under which HHS, rather than state exchanges, will set the standards for programs designed to eliminate health insurance company anti-selection. Also, CMS issued a final rule defining how states are to make eligibility determinations for Medicaid enrollees beginning in 2014. The federal matching rate (FMAP) starts at 100% from 2014-2016 and gradually decreases to 90% by 2020.

ANPR on PPACA Contraceptive Services

The Departments of Labor, HHS and Treasury will publish this week an Advance Notice of Proposed Rulemaking regarding the HHS PPACA-related rule requiring religious-based organizations to provide certain women's contraceptive coverage under their fully-insured and self-insured health plans. Under the ANPR, it is anticipated that women working for religious affiliates, such as colleges and hospitals, would have access to contraceptive services without having to make out-of-pocket payments for them and organizations that object to contraception would not have to pay for such coverage (but such costs could be offset through drug rebates, reinsurance credits and other means). In a related final rule for student health plans, only fully-insured health plans sponsored by nonprofit, religious institutions of higher education would be treated in the same way as health plans for their employees. In general, insured student health plans would be subject to the PPACA minimum loss ratio and coverage rules.

New CBO Estimates of PPACA Costs

The CBO and Joint Tax Committee estimates that the insurance coverage provisions under the PPACA will generate a cost of about $1.083 trillion from 2012 to 2021, about $50 billion less than estimated in March 2011. Although Medicaid and SCHIP costs were estimated to increase by $168 billion and high-cost plan excise taxes were estimated to increase by $8 billion, net costs were reduced by the following: $97 billion in the costs for tax credits and other subsidies under health insurance exchanges; $20 billion in the projected costs for tax credits for small employers; and $107 billion in deficits from the projected revenue effects of changes in taxable compensation and penalty payments and from other changes. The PPACA net costs for 2012-2022 are estimated to jump to $1.252 trillion. CBO estimated that the average federal subsidy for eligible exchange enrollees would rise from $4,780 in 2014 to $7,270 in 2022. Of note, CBO estimated that while the percentage of people insured under the age of 65 would increase from 82% to 93%, the PPACA would still leave 26-27 million uninsured in 2016. Also, CBO, projected that 3 to 5 million fewer people would have employer-sponsored coverage from 2019 through 2022. House Republicans were quick to use the last point to criticize the President's promise that health reform would not cause anyone to lose their current health insurance coverage.

Final Briefs Filed by DOJ on PPACA Constitutionality

The arguments regarding the constitutionality of various aspects of the PPACA are to be heard by the U.S. Supreme Court from March 26-28. The Administration (DOJ) and opponents of the law filed their final briefs last week on whether the court should strike down some or all of the provisions of the PPACA if the court rules the individual mandate to be unconstitutional. A court appointed independent attorney said the other portions of the law should be upheld even if the individual mandate is struck down. The Administration argued that only the "guaranteed issue" (GI) and "community rating" (CR) provisions should be held severable. However, Florida and 25 other state plaintiffs argued that the independent attorney and DOJ provided no "convincing reason" for upholding the remainder of PPACA if the mandate falls. They reasoned that the mandate, GI and CR provisions were the principal motivation for the enactment of the PPACA and that, if they are ruled out, then the entire Act should be struck down. The DOJ and state plaintiffs also sparred over whether the Medicaid expansion should be held invalid because of an unreasonable coercion by the federal government to expand such coverage or lose federal matching funding. Another court appointed attorney argued that the Anti-Injunction Act (AIA) precludes court jurisdiction until the individual mandate penalty is effective in 2014.

Community Based Care Participation

CMS announced that 23 new organizations will join seven others in the Community-Based Care Transitions Program (CCTP) under the Partnership for Patients program established under the PPACA. The intent of the program is to reduce hospital readmissions; test sustainable funding streams for care transition services; maintain or improve quality of care; and document measurable savings to the Medicare program.

MedPAC Annual Report

In its annual report to Congress, the Medicare Payment Advisory Commission recommended that Congress: increase hospital inpatient and outpatient care payments by 1% in FY 2013; reduce over three years the payment rates for evaluation and management visits in hospital outpatient departments to the rates in free-standing physician offices; increase by 0.5% the payments for ambulatory surgical centers; increase by 1% the payments for outpatient dialysis services; increase by 0.5% the payments for hospice services; freeze payments for SNFs, LTC hospitals and Inpatient Rehabilitation Facilities; and restructure Medicare Part D drug low-income subsidy (LIS) copayments in an attempt to control the increasing cost of the benefit. Of note, given the expiration at the end of this year of the current level of Medicare physician payments, MedPAC recommended that the SGR formula be disbanded and replaced with a ten-year statutory fee-schedule update as follows: freezing current primary care payment levels, reducing payment levels for all other services by 5.9% annually for three years, and freezing rates for the remainder of the period. MedPAC recommended various ways to pay for the SGR repeal, such as applying an excise tax to Medigap policies and rebasing skilled-nursing facility payments.

MACPAC Annual Report

The Medicaid and CHIP Payment and Access Commission (MACPAC) also released its semiannual report to Congress, recommending: the improvement of care for Medicaid disabled persons by accelerating the advancement of targeted, efficient and innovative approaches through coordination of services; the improvement of quality measurements for Medicaid only enrollees with disabilities; that HHS ensure that its current Medicaid program integrity efforts do not place an undue burden on states or providers by eliminating existing HHS programs that are redundant, outdated or not cost-effective; and that HHS develop methods to better quantify the effectiveness of program integrity activities, including the analytic tools used to detect and deter fraud and abuse.

DEMO for Emergency Care for Low-Income Medicaid Enrollees

CMS announced that eleven states and the District of Columbia will participate in a $75 million demonstration project designed to improve emergency care for low-income patients with mental disease. The Medicaid Emergency Psychiatric Demonstration will test whether Medicaid enrollees who are experiencing a psychiatric emergency receive better care when the institutions treating them receive Medicaid reimbursement.

Initiative to Help Dual-Eligibles Avoid Hospitalization

CMS announced a $128 million "Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents" which is designed to improve care in nursing facilities for Medicare and Medicaid dual-eligibles. Interested organizations must submit their notice of intent to apply by April 30 to the CMS Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation.

Delay in HIPPA Enforcement

The Centers for Medicare & Medicaid Services Office of E-Health Standards and Services (OESS) announced that the agency will not initiate enforcement action until June 30th against any HIPPA covered entity that is not in compliance with certain electronic transaction standards.