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- **PRESIDENT SUPPORTS STATE FLEXIBILITY TOWARD PARTS OF THE HEALTH CARE LAW**

Last week, speaking before the nation's 50 state governors, President Obama announced his support for a bill by Senators Ron Wyden (D-OR), Scott Brown (R-MA) and Mary Landrieu (D-WA) that would allow states to apply for federal waivers to opt-out of certain provisions in the federal health care law beginning on or after January 1, 2014, three years before the law currently permits in 2017.

Specifically, the bill would allow states to apply for waivers of the following:

- Individual mandate;
- Employer "free rider" assessment;
- State insurance exchanges;
- Small employer and individual tax credits,
- "Essential" health benefits and cost sharing limits for the individual, small group and exchange plans, and
- Deductible limits for the individual and small group plans.

States receiving waivers would instead receive federal funds equivalent to the small employer, individual tax credits and Medicaid funds they would have otherwise received as long as they implement reforms that would provide coverage at least as comprehensive as the exchanges, cover the same amount of people, not increase the federal deficit and provide the same out-of-pocket (OOP) limits under the law.

Senators Bernard Sanders (I-VT), Patrick Leahy (D-VT), Daniel Inouye (D-HI) and Representatives Peter Welch (D-VT) and John Conyers (D-MI) used the President's announcement to bring attention to a similar bill they previously introduced that would also move up the opt-out date to 2014 in order to allow states to implement single-payer health care systems and "public" option health care plans along the lines of what Vermont is planning at the state level and Hawaii's decades old health "reform".

Another bill by Senators John Barrasso (R-WY) and Lindsey Graham (D-SC) would permit states to opt-out of these key aspects and several other parts of the health care

law including the Medicaid expansion, lifetime and annual limit ban, prohibition on rescissions, coverage of preventive services, etc. without requiring alternative plans.

Link to the Business Group's chart comparing the federal bills allowing states to opt-out of key provisions in the new health care law:

<http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=3055>

IMPACT ON EMPLOYERS AND EMPLOYEES: In addition to the administrative problems of 50 different state rules for the exchanges, the employer mandate, and other provisions that raise complications and costs for employers and employees, state waivers MAY disrupt employer-sponsored coverage, attempt to preempt ERISA, which is essential for the future of employer-sponsored health care, or shift costs to employer plans and the employees they cover.

OUTLOOK: *State Governors will increase pressure on the Senate to pass a bill granting additional flexibility for the states to run their own health care programs or opt-out altogether from various provisions in the health care law as their budget woes and shortfalls in funding for their obligations for state employees' retiree benefits continue to mount. The Republican-run House will continue to support measures to repeal rather than modify the health care law. However, waiver bills have bipartisan support and may ultimately pass Congress.*

BACKGROUND: The health care law currently allows states to apply for waivers from the Secretary of Health and Human Services (HHS) to pass state laws to opt-out of the individual mandate, employer "free rider" assessment, "essential health benefits" and cost-sharing provisions for the individual, small group and exchange plans, and deductible limits for the individual and small group plans for up to 5 years for plan years beginning on or after January 1, 2017 as long as they implement alternative state plans equal to the law's new requirements.

Governor Mitch Daniels (R-IN) and 21 other Republican Governors recently wrote a [letter](#) to the Health and Human Services (HHS) Secretary Kathleen Sebelius that if HHS wants their states to run the exchanges then HHS must:

- Provide states with complete flexibility to operate the state exchanges and the plans offered;
- Waive the law's "essential health benefits" (mandates);
- Waive the provisions that "discriminate" against consumer-directed health plans (CHDPs) coupled with health savings accounts (HSAs);
- Allow states to move non-disabled Medicaid beneficiaries into the state exchanges without HHS approval;
- Deliver a comprehensive plan for verifying incomes and subsidy amounts for exchange participants that is fully funded by the federal government and certified by independent auditors; and

- Commission a new and objective assessment of how many people will end up in the exchanges and in Medicaid in every state, including those from employers, and the potential cost to state governments.

Secretary Sebelius responded to the Governors in a [letter](#) that the states:

- Already have broad discretion in the operation of their exchanges, including determining any additional benefits beyond the “essential health benefits” package;
- Can include CDHPs coupled with HSAs as “bronze” plans or catastrophic coverage for young adults;
- Can request waivers from many of these provisions in 2017; and
- Have the flexibility necessary to structure their Medicaid programs.

NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES: The Business Group believes that the state waivers should not:

- Disrupt the employer-sponsored coverage for over 150 million people;
- Preempt ERISA, which the health care law was careful to preserve;
- Add additional costs and burdens onto employer plans, which run efficiently under ERISA and a national, uniform set of rules; or
- Result in cost-shifting to employer plans.

➤ **BILL WOULD MAKE PUBLIC MEDICARE DOCTORS’ PAYMENT RATES**

Recently, Senate Finance Committee members Ron Wyden (D-OR) and Charles Grassley (R-IA) teamed up on a bill that would make public what Medicare pays to doctors. The bipartisan bill will likely build off the language in Senator Grassley’s larger anti-fraud [bill](#) that would require the Centers for Medicare and Medicaid Services (CMS) to make provider-level Medicare claims and payment data available to the public.

The American Medical Association (AMA) has stated that opening up the Medicare claims and payment database would violate doctors’ privacy and could lead to some physicians leaving the program. Others, including employers and consumer groups believe that publicizing government program payments to providers will improve quality and efficiency and outweighs physician privacy interests.

IMPACT ON EMPLOYERS AND EMPLOYEES: Employers and employees need access to CMS’ Medicare provider claims and payment data to identify efficient, effective providers. Public reporting will help providers identify areas of improvement and consumers, referring physicians, and purchasers to select physicians providing high-quality services, thereby raising the bar for all.

OUTLOOK: *The Senate may pass a bill this year. However, it is uncertain if the bill would pass the House.*

BACKGROUND: The health care law includes a provision that would require the HHS Secretary to release provider-level Part A, B, and D Medicare claims data to “qualified

entities” for the evaluation of the performance of providers of services and suppliers. However, the provision only allows “qualified entities” to include information on provider services or suppliers in their reports to the public in an “aggregate” form.

The Florida Medical Association and the AMA successfully sued to keep the Medicare claims database private in 1978. However, the issue has resurfaced in recent months after *The Wall Street Journal* and the Center for Public Integrity sued HHS to get the information.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group supports the release of provider-specific Medicare claims data to the public and believes that all health care providers and facilities should publicly disclose, in a simple, user-friendly format, the cost, quality, safety, and efficiency of health care services they provide as well as any other data and information that may impact patients’ care decisions, such as financial arrangements and clinical guidelines for treatment. Transparency is a necessary strategy to achieve high quality care. Public reporting will help providers identify areas of improvement and consumers, referring physicians, and purchasers to select physicians providing high-quality services, thereby raising the bar for all.

The Business Group recently submitted a comment letter to CMS on the health care law’s provision to release provider-level Medicare claims data to the public.

Link to the letter:

<http://www.businessgrouphealth.org/pdfs/092410%20Medicare%20Data%20Claims%20%20Letter.pdf>

➤ **PRESIDENT SIGNS 2 WEEK DELAY OF GOVERNMENT SHUTDOWN**

Recently, the President signed into law a bill that prevented a government shutdown originally set for March 4th until March 18th unless Congress acts before then. The law cuts \$4 billion in federal funding partly by rolling back funds once intended for earmarks for lawmakers’ state pet projects.

The law will cut over \$400 million in health care funding for the Department of Health and Human Services (HHS), including:

- \$397 million from the Health Resources and Services Administration (HRSA);
- \$21 million from both the Centers for Disease Control (CDC) and the Children and Families Services program;
- \$15 million from Substance Abuse and Mental Health Services Administration (SAMHSA);
- \$6 million from Administration on Aging; and
- \$3 million from CMS' program management.

The Administration wants to sit down with Republicans in Congress to agree on funding the federal government through the end of the fiscal year (September 30). Congressional Republicans instead called on the President and Senate Democrats to

first produce their own spending reduction plan before they talk or propose an alternative.

IMPACT ON EMPLOYERS AND EMPLOYEES: The discretionary cuts in the 2-week delay only hit a small part of the larger federal budget and will have little impact on the federal government's public health programs or employer plans. However, if Congress' future funding bills include cuts for the implementation of the health care law it would only add to employers' and employees' uncertainty about whether the law will change in the future and the impact these potential changes will have on health care benefits. Congress and the President also need to come to a larger agreement on reforming our nation's expensive entitlement programs (Medicare and Social Security) and the state-federal Medicaid program to save the federal government from fiscal ruin and our economy too, before the Medicaid expansion begins in 2014, and both Medicare and Social Security run out of money, respectively in 2029 and 2037.

OUTLOOK: *Senate Republicans support a House-passed 7-month funding bill that would cut an additional \$65 billion from 2010 levels and bar funding for the health care law that is opposed by Senate Democrats. Senate Democrats and the White House will put forth their own proposal for a spending bill for the rest of the year.*

In the end, the President and the House Republicans' will likely compromise on minor funding reductions and avoid a government shutdown.

BACKGROUND: The House recently passed a 7-month funding bill that would keep the government spending at a level \$61.5 billion less than in fiscal 2010 and approximately \$100 billion less than the President requested for 2011. It includes 3 amendments to halt funding to implement the health care law, including:

- House Labor, Health and Human Services Appropriations Subcommittee Chair Danny Rehberg's (R-MT) amendment that would prohibit funding for "any employee, officer, contractor, or grantee of any department" to implement the law;
- Representative Steve King's (R-IA) amendment that would prohibit funding for any salary of any federal official to implement the law; and
- Representative Jo Ann Emerson's (R-MO) amendment prohibiting funding for the Internal Revenue Service (IRS) to enforce the individual mandate.

NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES: The Business Group believes that blocking additional funding to implement the law in the future only adds to the uncertainty about whether the law will change in the future and the impact these potential changes will have on employers' and employees' health care benefits. The Business Group also believes that we need a long term solution to the country's unsustainable entitlement spending. We need to put our government's fiscal house in order, invest in high value services and programs in order to strengthen our economy.

If you would like more details on these or other issues or would like a phone briefing on legislation, or want to express concerns about specific issues, please contact Steven Wojcik, Vice President, Public Policy at wojcik@businessgrouphealth.org or 202-558-

3012. Also, as part of our "Ask a Benefits Question" service, we are happy to respond within 24 hours to any health benefits question on policy, regulations or legislation.

This material is provided for information purposes only and is not a substitute for legal advice.

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