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- **PRESIDENT SIGNS ONE YEAR DELAY OF MEDICARE PHYSICIAN REIMBURSEMENT CUTS**

This week, the President signed into law a 1 year (\$19 billion) delay of a required 24.9% cut in Medicare physician reimbursement rates scheduled to take effect on January 1, 2011. The law, authored by Senate Finance Committee Chair Max Baucus (D-MT) and Ranking Member Charles Grassley (R-IA), “pays” (in a budgetary sense) for the delay by increasing the amount of money the federal government will recoup from people who receive excessive tax credits for health coverage through exchanges, beginning in 2014. This change, representing the first significant modification of the new health care law, will replace the current flat repayment penalty of up to \$250 for individuals and \$400 for families who improperly receive tax credits by misstating their incomes, or whose incomes change over the course of the year, with a sliding-scale penalty ranging from \$300 - \$1,750 for individuals and \$600 - \$3,500 for families depending on their incomes. They will repay the entire subsidy if their incomes are high enough.

The law also extends the [transitional medical assistance](#) program for 1 year to allow low-income families to keep Medicaid coverage for up to 1 year as they start jobs.

IMPACT ON EMPLOYERS: Avoiding Medicare physician reimbursement cuts will reduce the pressure for physicians to shift costs to employers and other private payers to make up for the shortfall, but exacerbates the long-term threat to Medicare’s fiscal unsustainability and the threat of higher Medicare payroll taxes. Medicare should quickly move away from fee-for-service to physician payment based on performance and improved health outcomes to accelerate more effective care delivery and the program’s fiscal sustainability.

IMPACT ON EMPLOYEES: As the government reduces the pressure for physicians to shift costs to the private sector, employees avoid paying more in out-of-pocket costs, but increase their risk for Medicare payroll tax increases. As Medicare delays improving the way it pays for health care, employees do not reap the benefits of a more effective and

efficient health care system. Retirees will pay higher Part B premiums as Congress restores Medicare physician reimbursement cuts. Since more doctors are closing their practices to new Medicare patients, and would do even more so if the cuts were really enacted, not cutting doctors' fees will help stave off more defections. With baby boomers aging into Medicare, and a shrinking primary care physician pool, now would be a bad time for Congress to cut physicians' fees without considering payment reform that would improve payments for doctors providing primary and specialty care where there are shortages (e.g., general surgeons).

OUTLOOK: Congress will now turn its attention to overhauling the way Medicare reimburses physicians in January.

BACKGROUND: Recently, the President signed into law a short-term delay of the Medicare physician reimbursement cuts until January 1, 2011 that also provided a 2.2% rate increase by reducing some Medicare reimbursements for physical and occupational therapists as a temporary measure until Congress could enact a longer delay.

The 1997 Balanced Budget Act required Medicare to reduce reimbursements to physicians by 4-6% over a period of several years, beginning in 2000. Each year, however, with the exception of 2002, Congress delayed the cuts and, as a result, the amount the federal government needs to cut in future years grows. The current required cuts equal 24.9%.

Beginning in 2015, the new health care law requires the Centers for Medicare and Medicaid Services (CMS) implement a value-based, budget neutral, payment adjustment for all Medicare physician reimbursements based on the quality of care relative to cost.

NATIONAL BUSINESS GROUP ON HEALTH'S VIEW ON THESE ISSUES: The Business Group urges Congress to tie physician reimbursements to performance on quality and safety and use of health information technology in any reform of Medicare's physician payment system and along with any restoration of planned reimbursement cuts. The Business Group also supports increased physician payment for care coordination, prevention, and primary care.

➤ **REPUBLICANS BLOCK FUNDING TO IMPLEMENT THE NEW HEALTH CARE LAW**

This week, Senate Republicans blocked passage of a comprehensive "omnibus" spending bill to fund the entire federal government for the next fiscal year before the current stopgap funding expires on December 18, 2010.

The bill included millions of dollars to fund the new health care law, including the following:

- \$750 million for the new Prevention and Public Health Fund, which includes primary care funding;
- \$175.9 million to implement the law's Medicaid expansion and cuts to Medicare Advantage plans;

- An \$80.7 million increase in the Department of Health and Human Services' (HHS) to enforce new mandates and regulations; and
- \$3 million for a national health care workforce commission.

House Republicans also plan to pass a new “cut-go” rule when they re-gain control of the House in January that would mandate that Congress pay for any new spending program by eliminating an existing program of equal or greater value. It would only exempt tax cuts from the requirement and not allow Congress to offset spending increases with new taxes or fees.

IMPACT ON EMPLOYERS: Reducing funding for the implementation of the provisions of the law will add to the already considerable uncertainty surrounding the implementation of the health care law for employer plans and others.

IMPACT ON EMPLOYEES: Reducing funding for the implementation of the provisions of the law will add to the uncertainty that employees feel about the impact of the new law on their health care benefits.

OUTLOOK: Republican efforts to block the omnibus bill will likely lead to another short-term extension of current funding levels for the federal government, likely until February 18.

BACKGROUND: The federal government has already issued regulations under the new health care law (e.g., safe harbor for external reviews, allowing insured plans to change carriers without losing grandfathered status, delaying W-2 reporting, issuing waivers for “mini-med” plans, etc.). Between now and 2014, when many key provisions of the law take effect, the government will implement many more regulations on the exchanges, employer penalties, the individual coverage requirement, Medicaid expansion, federal tax credits for coverage and many Medicare payment and delivery changes.

NATIONAL BUSINESS GROUP ON HEALTH'S VIEW ON THESE ISSUES: The Business Group supports increased flexibility for the regulatory implementation of the employer provisions of the new health care law, but also would prefer to reduce the uncertainty surrounding implementation of the law.

➤ **REPRESENTATIVE JOHN CARTER (R-TX) INTRODUCES BILL TO REPEAL THE NEW HEALTH CARE LAW'S MEDICAL LOSS RATIO (MLR) REQUIREMENT**

Recently, Representative John Carter (R-TX) introduced a “resolution of disapproval” to block HHS' MLR regulation requiring all insurers selling individual health insurance policies to pay a minimum of 80% of premiums towards claims and health care services and group policies to pay a minimum of 85%. The law exempts self-funded plans and “mini-med” plans from this provision.

HHS estimates that about 45% of Americans who buy their own health insurance in the individual and small group markets are in plans that do not meet the MLR requirements.

IMPACT ON EMPLOYERS: If successful, it is unclear what the impact on premiums would be for employers who purchase insurance. The larger concern for employers on

the MLR issue is the impact of the rule on the cost or availability of some quality activities like health care professional hotlines or other services that clearly improve care and lower costs, which the MLR rule currently classifies as administrative expenses and not health care quality expenses.

IMPACT ON EMPLOYEES: If successful, it is unclear what the impact on premiums would be for employees whose employers purchase insurance. They could see fewer quality activities like health care professional hotlines or other services that clearly improve care and lower costs, which the MLR rule currently classifies as administrative expenses and not health care quality expenses.

OUTLOOK: *The House may consider the bill in January, but it will likely face substantial opposition in the Senate. The House will likely consider additional modifications to a few of the provisions in the new health care law (1099 reporting, individual mandate, flexibility for state exchanges, free rider assessment, excise tax) when Republicans re-gain control of the House.*

BACKGROUND: Under the Congressional Review Act of 1996, Congress can pass joint resolutions disapproving of federal rules, and if the resolutions become law, the rules cannot take or continue in effect. Also, the agencies may not reissue either those rules or any similar ones unless they receive new authorization under another law.

If 30 members of Congress sign a petition, it can put a disapproval resolution on the “fast track” and bring it directly to the floor for a vote if relevant committees do not act within 20 calendar days. Members of Congress must submit the disapproval resolution within 60 days after Congress receives the rule from federal agencies.

NATIONAL BUSINESS GROUP ON HEALTH’S VIEW ON THESE ISSUES: The Business Group appreciates that HHS’ MLR rule will credit many of the health plan quality activities, including health information technology, patient safety, and other quality enhancing initiatives, which are vital to improving our health care delivery and lowering costs. However, we would prefer for HHS to also include health care professional hotlines under its list of services that improve health care quality. In addition, we strongly oppose the MLR regulations that will unnecessarily increase costs and require plans to report MLRs for the large group market on a state-by-state basis, rather than on a multistate or national basis. The Business Group believes that a national MLR would be more useful for large employers. We remain concerned that requiring plans to report total costs on a state-by-state basis may disadvantage some plans like PPOs, which are popular with employees.

Link to the Business Group’s comment letter to HHS’ on the MLR rule:

<http://www.businessgrouphealth.org/pdfs/093010%20MLRFollowupLetter.pdf>

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.**

We provide this material for information purposes only and it is not a substitute for legal advice.

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