

Washington Business Health Update

From the National Business Group on Health

Vol. XXI, No. 8 May 11, 2011

IN THIS ISSUE:

- **APPEALS COURT ASKS TOUGH QUESTIONS TO CHALLENGERS OF HEALTH CARE LAW'S CONSTITUTIONALITY IN VIRGINIA CASE**
 - **HOUSE REPUBLICANS CONTINUE PUSH TO REPEAL PARTS OF THE HEALTH CARE LAW**
 - **HOUSE COMMITTEE CONTINUES TO SEEK CHANGES IN MEDICARE PHYSICIAN REIMBURSEMENTS; PHYSICIAN GROUPS CAUTION AGAINST QUICK CHANGES AND SEEK INCREASES TO MATCH MEDICAL INFLATION**
 - **SENATORS' BILL WOULD MAKE MEDICARE PROVIDERS' PAYMENT RATES PUBLIC**
-
- **APPEALS COURT ASKS TOUGH QUESTIONS TO CHALLENGERS OF HEALTH CARE LAW'S CONSTITUTIONALITY IN VIRGINIA CASE**

Yesterday, a 3-judge panel in the Fourth U.S. Circuit Court of Appeals in Virginia heard the first arguments at the appellate level on two separate Virginia-based lawsuits that question the constitutionality of the health care law's individual coverage mandate. Judges in the lower courts ruled differently in the two cases on the individual coverage mandate's constitutionality.

Democratic presidents nominated all three of the judges randomly selected by computer to hear the case. So far, judges appointed by Democrats have ruled in favor of the health care law, while judges appointed by Republicans have not.

The crux of the issue is whether or not the Constitution's Commerce Clause, which gives the federal government the right to regulate interstate economic activity, also includes the power to regulate people's choices not to purchase goods or services—or, economic inactivity, as the courts call it—namely the decision not to purchase health insurance. Alternatively, the issue facing the courts is whether the failure to have health coverage falls within the scope of economic activity because everyone needs health care at some point, and by not buying insurance, people are choosing to have other people pay for their health coverage, which the Administration has argued. Indeed, the judges' questions largely focused on this issue, and seemed to be leaning toward the government's right to require people to have coverage.

The judges also questioned Virginia's legal standing to sue because it passed a law last year that makes it illegal to require Virginians to have coverage. The judges seemed to agree with the federal government's argument that the individual coverage mandate

imposes burdens on citizens, not states, and that Virginia may have no legal standing to sue.

Two other appellate courts are scheduled to hear cases filed by Florida (which was joined by 26 other states and ruled the entire law unconstitutional) and a case in Michigan (which upheld the law) in early June.

IMPACT ON EMPLOYERS AND EMPLOYEES: If the courts find the individual mandate unconstitutional, it could threaten an important part of the law that will help to improve the functioning of the insurance market, including the future exchanges, and to assure the affordability of insurance. For private payers, like employer plans, the individual mandate promises to reduce the number of uninsured and the future potential to shift costs associated with care for the uninsured to private payers, including employer plans. In any case, the legal proceedings add to the uncertainty surrounding the implementation of the law, including the ultimate impact on employer-sponsored coverage. States too may slow down their efforts to prepare for the exchanges to await the outcome of the court cases.

OUTLOOK: *The 3-judge panel will issue a ruling in about 2-3 months followed by a likely review by the full Appeals court. The panel's decision will likely speed up the timeframe for one of the several cases to reach the Supreme Court, which will ultimately decide on the constitutionality of an individual mandate, possibly sometime in the summer of 2012.*

BACKGROUND: Congress passed and the President signed the health care law in March. Both Congress and the President, as well as the insurance industry, regard the individual mandate as a key element of the entire law.

In April, the Supreme Court announced it would not expedite consideration of Virginia's lawsuit challenging the health care law.

Forty-one states have either proposed or passed laws, filed bills or ballot measures that would prohibit implementation of the health care law or requiring people to purchase insurance.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group believes that every adult should be required to have health coverage for themselves and their dependent children. The Business Group has outlined several conditions to make this requirement possible, including changes in the payment and delivery of care to give people under age 65 access to a range of **affordable** coverage choices through multiple sources including employers, federal or state governments, insurers, or other pooling arrangements.

Link to the Business Group's Public Policy Alert on the recent court cases:

<http://www.businessgrouphealth.org/members/secureDocument.cfm?docID=3096>

➤ **HOUSE REPUBLICANS CONTINUE PUSH TO REPEAL PARTS OF THE HEALTH CARE LAW**

Last week, the House of Representatives passed a [bill](#) that would block the federal

government from continuing to issue grants to states to help them establish insurance exchanges. The health care law authorizes the Secretary of Health and Human Services (HHS) to provide grants to the states for this purpose. In analyzing the bill, the Congressional Budget Office (CBO) concluded that eliminating the grants would mean more states would need to rely on the federal government to run the exchanges. Under the law, the federal government must set up the exchanges if the states do not.

In a similar attempt to repeal parts of the health care law, Representative Charles Boustany (R-LA) introduced a [bill](#) that would repeal the employer mandate (free rider assessment) or “shared responsibility” provision that requires employers to pay a penalty if coverage is not comprehensive (they contribute at least 60%) or affordable (costs exceed employees’ household incomes by 9.5%) and employees qualify for federal tax credits for exchange coverage (below 400% of federal poverty).

IMPACT ON EMPLOYERS AND EMPLOYEES: Reducing grant funding could increase the likelihood that states will either not set up exchanges, not be ready in time, or set up exchanges that do not work as well. It could also lead to more exchanges with uniform, national standards run by the federal government instead of the states. The former would cause problems for employers and employees relying on state-run exchanges for coverage. The latter may help multistate employers and their employees who will rely on exchanges for coverage. More generally, to the extent that at least 30+ million people may have coverage through the exchanges initially and they may be a future vehicle for more people to get coverage, it is in everyone’s interest that the states and the federal government get them right.

Requiring employers to offer coverage or pay the government will cause some employers to consider paying penalties instead of offering coverage; some employers to adjust their workforce by eliminating jobs, moving more jobs offshore, keeping unfilled positions open, and foregoing future job growth; some employers to reduce wages or other benefits to comply with the mandate; and other employers to raise consumer prices.

OUTLOOK: *These bills will not pass the Senate, but there remains an outside chance that Congress may include some changes to the health care law in upcoming negotiations to raise the U.S. debt limit by August.*

BACKGROUND: The Affordable Care Act permits state-based exchanges in 2014 where eligible individuals and small businesses can buy coverage. States that want to operate exchanges must demonstrate their ability to do so and obtain certifications to that effect by January 1, 2013 or the federal government will establish exchanges in their states. States may allow large employers to participate in the exchanges in 2017.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: Exchanges present an opportunity to assure that coverage and health care delivery for the 30+ million people expected to participate in them are as efficient and effective as possible. The Business Group believes that the federal government should require and the states should set up exchanges as uniformly as possible across all states. To help assure uniformity in exchanges, so that large employers can continue to operate uniform benefit plans nationally, the Business Group submitted a model

exchange to HHS, the National Association of Insurance Commissioners (NAIC) and all 50 state governors.

This week, Helen Darling and Mike Baxter of our public policy team met with the HHS Director of the Office of Insurance Exchanges, Joel Ario, and his exchange team, by his invitation, to emphasize a number of recommendations in the Business Group's model exchange. The Business Group requested that the federal government should make all guidance; standards; uniform terms; adaptable, model administrative tools; and effective and efficient approaches to solving all of the operational issues of the exchanges available as quickly as possible in order to ensure uniformity and standardization and reduce waste, duplication and confusing variation. The states, employers, health insurers and exchanges will waste a tremendous amount of money and productivity if they have to invent the tools necessary to operate the exchanges themselves.

Link to the Business Group's follow-up letter to HHS with our additional recommendations for the exchanges:

<http://www.businessgrouphealth.org/pdfs/050911ExchangeMeetingFollowup.pdf>

Link to the Business Group's model exchange:

<http://www.businessgrouphealth.org/pdfs/042011%20National%20Business%20Group%20Exchange%20Model.pdf>

The Business Group supports the federal framework of ERISA for employer-sponsored health coverage and opposes mandating that employers offer coverage or requiring them to pay the government because it is very harmful to working families and our economy. Given the health care law, the Business Group is working with regulators to assure that implementation goes as smoothly and with as minimal a burden as possible for employers.

➤ **HOUSE COMMITTEE CONTINUES TO SEEK CHANGES IN MEDICARE PHYSICIAN REMBURSEMENTS; PHYSICIAN GROUPS CAUTION AGAINST QUICK CHANGES AND SEEK INCREASES TO MATCH MEDICAL INFLATION**

In the latest action in Congress' ongoing attempts to overhaul the way Medicare pays for care, last week, the House Energy and Commerce Committee heard a proposal from five [physician groups](#) to avoid a nearly 30% required cut, scheduled to begin in 2012. Their proposal did not recommend a permanent solution to deal with the unsustainability of Medicare's finances. The physicians want to replace Medicare's current reimbursement method with five years of stable payments from 2012-2016 that include annual bonuses that keep pace with medical practice costs while Medicare tests and transitions to new payment models. The physicians identified a number of alternative models that Medicare is currently examining as required by the new health care law, including:

- Gainsharing, where groups of providers would work together to manage care and would share in any cost savings;
- Payment bundling programs, where Medicare would provide one payment across

providers for all services for episodes of care;

- Global payments, where CMS would give provider groups defined budgets to cover the costs of providing all of their patients' care;
- Accountable Care Organizations (ACOs), where networks of doctors and hospitals and/or other provider groups would take responsibility for coordinating the care of a minimum of 5,000 Medicare beneficiaries for at least 3 years and would offer bonuses or "shared savings" if providers keep costs down and meet specific quality benchmarks; and
- Patient-centered medical homes or primary care models for improved care management and coordination.

Both Republican and Democratic committee members expressed support for a bipartisan solution to avoid future cuts to physicians' Medicare reimbursements and for the alternative payment models listed above. The Congressional Budget Office (CBO) estimated that simply freezing Medicare's payment rates for physicians at the current level through 2021 would cost nearly \$300 billion.

IMPACT ON EMPLOYERS AND EMPLOYEES: Avoiding Medicare physician reimbursement cuts will reduce the pressure for physicians to shift costs to employers, employees and other private payers to make up for the shortfall, but merely paying more under the current fee-for-service approach exacerbates the long-term threat to Medicare's fiscal unsustainability and the threat of higher Medicare payroll taxes. 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 payment cuts.

OUTLOOK: *The House Energy and Commerce Committee plans to pass a bill with a transition period changing the current system Medicare reimburses physicians before the end of summer. The House Ways and Means Committee will hold its hearing on this topic tomorrow. The Senate may pass a House bill to change Medicare's payment system for physicians if the effort remains bipartisan.*

BACKGROUND: In March, Energy and Commerce Committee Chair Fred Upton (R-MI) and Ranking Member Henry Waxman (D-CA) sent a bipartisan [letter](#) to physician groups seeking proposals on a long-term solution to changing the way that Medicare reimburses physicians that the committee could pass this year.

In December, the President signed into law a 1 year (\$19 billion) delay of a required 24.9% cut in Medicare physician reimbursement rates until January 1, 2012 that "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.

The President's 2012 budget proposal also includes a provision that would delay the cuts to phased Medicare physician reimbursements for 2 years.

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.

Beginning in 2015, the Affordable Care Act requires that 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 VIEW AND ACTION ON THESE ISSUES: The Business Group urges Congress to move rapidly away from paying for volume and 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.

On Monday, Steve Wojcik spoke at a Federal Trade Commission (FTC) meeting on ACOs and antitrust issues to support the delivery system changes that ACOs would bring about and the FTC and Department of Justice's plans for maintaining active scrutiny of ACOs to assure that they do not engage in anti-competitive behavior or shift costs to private payers, including employer plans.

Link to the Business Group's position statement on ACOs:

http://www.businessgrouphealth.org/pdfs/Position%20Statement%20-%20National%20Business%20Group%20on%20Health%20Position%20Statement%20Accountable%20Care%20Organizations%20_ACOs_%20Final%20Draft.pdf

➤ **SENATORS' BILL WOULD MAKE MEDICARE PROVIDERS' PAYMENT RATES PUBLIC**

Recently, Senate Finance Committee members Ron Wyden (D-OR) and Charles Grassley (R-IA) introduced a [bill](#) that would make what Medicare pays to individual providers (hospitals and doctors) public beginning in 2013. It would make public the amounts paid, items paid for and providers' locations in a publicly searchable database organized by unique identifier, specialty and the type of providers. The bill would also ensure that the federal government no longer exempts providers' Medicare claims data from Freedom of Information Act (FOIA) requests. The bill also includes a disclaimer, favored by the physicians, that the aggregate data in the Medicare database does not reflect the quality of the providers or services.

The American Medical Association (AMA) believes that opening up the Medicare claims and payment database would violate doctors' privacy and could lead some physicians to leave 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.

<p>IMPACT ON EMPLOYERS AND EMPLOYEES: Employers and employees' access to CMS' Medicare provider claims and payment data will help them and all Americans to identify efficient, effective providers. Public reporting will also help providers identify</p>
--

areas of improvement and help them refer consumers to high-value physicians and services, thereby raising the bar for all.

OUTLOOK: *The Senate may pass a bill to make Medicare providers' payments public this year. However, it is uncertain if it would pass the House.*

BACKGROUND: The bipartisan bill builds 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 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.

Beginning in 2006, CMS required every Medicare provider to receive unique National Provider Identifier.

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 support letter for the Grassley-Wyden bill.

Link to the support letter:

<http://www.businessgrouphealth.org/pdfs/05511%20Medicare%20Provider%20Data%20Claims%20Support%20Letter.pdf>

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

Link to the comment letter:

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

The Business Group also filed a joint friend of the court (Amicus) brief to support release of provider-level Medicare claims data by CMS to the public.

Link to the Amicus brief:

<http://www.businessgrouphealth.org/pdfs/Checkbook%20Amici%20Curiae%20Brief.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.**

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

Steven Wojcik
Vice President, Public Policy
National Business Group on Health
202-558-3012
wojcik@businessgrouphealth.org

Michael Baxter
Policy Analyst, Public Policy
National Business Group on Health
202-558-3013
baxter@businessgrouphealth.org