Health Care Reforms Play Central Role as Government Shuts Down Over Fiscal Debate

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The House and Senate returned in September from a month-long recess, and started negotiations on a pair of major fiscal issues: government funding and the nation’s debt limit. The current funding agreement expired on September 30th, and without a deal, a partial government shutdown commenced on October 1st — the first day of fiscal year 2014. The last shutdown occurred in 1995 and carried over into 1996, spanning 21 days.

The shutdown was the result of an impasse over funding for the Affordable Care Act (ACA), better known as “Obamacare.” The House passed three separate short-term continuing resolutions (CRs) to keep the government funded for the next several months, but attached a variety of ACA-related measures, all of which were subsequently “tabled,” or killed, by Senate Majority Leader Harry Reid (D-NV). The amendments included: (1) one year delay in ACA implementation; (2) one year delay in the ACA’s individual mandate; (3) repeal of the ACA’s 2.3 percent excise tax on medical devices; and (4) requiring Members of Congress, congressional staff, and political appointees to enroll in the ACA exchanges without an employer subsidy for coverage. With House leadership in a stand-off with Senate leadership and the administration, the funding issue could continue to dominate the D.C. landscape for the remainder of the year.

Further, the U.S. Department of the Treasury has estimated that the nation’s debt limit will be reached by October 17th at the latest, and lifting this cap will also require congressional action. There have been discussions about attaching a number of health care provisions as part of a proposal to raise the debt ceiling, although these decisions are not final and the introduction of this legislation had been put on hold as Congress turned its full attention to the government shutdown. Health care provisions that were considered included: (1) enact medical liability reform that is estimated to reduce the federal deficit; (2) increase Medicaid means-testing; (3) adjust payments to disproportionate share hospitals; and (4) defund the ACA’s Prevention and Public Health Fund.

The congressional agenda will likely continue to be centered around fiscal issues for the remainder of 2013, although Congress must eventually pivot to other end-of-year priorities, including the Medicare Sustainable Growth Rate (SGR) and other revenue measures that expire at the end of the year. However, with the focus on larger fiscal issues the House and Senate do not appear poised to finalize any other major legislative priorities, but any “grand bargain” style negotiations that are commenced between Congressional Republicans and the administration may pull in other budget issues like SGR.

CBO Releases Score of House SGR Repeal Bill

In September, the Congressional Budget Office (CBO) released its cost estimate for House SGR repeal legislation (H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013). According to the analysis, the legislation and its permanent SGR repeal will cost $175.5 billion over the next 10 years. The total cost is consistent with CBO’s most recent estimate that freezing SGR payments would cost roughly $140 billion over the next 10 years. CBO estimated that the new payment system included in the House bill will cost an additional $36 billion. The legislation updates Medicare payment rates until 2019, and is then replaced with two new payment models.

The bill was introduced by Representative Michael Burgess, MD (R-TX), and would repeal and replace the SGR with a new policy to change physician payments in two phases: (1) permanently repeal SGR and replace it with a five-year period of stable physician payments; and (2) create an Update Incentive Program that would link payments to quality of care. The legislation would also allow physicians to opt out of the fee for service (FFS) program and participate in alternative payment models (APMs). H.R. 2810 was reported unanimously from the House Energy & Commerce Committee this summer, but the legislation did not include any provisions to offset the cost of the bill.

The House Ways & Means Committee may also convene a markup on “doc fix” legislation later this year, although the timing of this effort is unclear. Given the cost of full repeal, the best opportunity for permanent SGR reform remains a congressional “grand bargain” on government funding, debt, entitlement reform, and taxes. If this kind of deal is not secured, the House and Senate will attempt to work together on another temporary SGR fix (one to two years) to prevent the 25 percent Medicare reimbursement cut set to begin on January 1st.

Congress on Track to Send Emergency Epinephrine Bill to President

On October 2nd, the Senate Health, Education, Labor, and Pensions (HELP) Committee is set to hold a markup on H.R. 2094, the School Access to Emergency Epinephrine Act. Backers of the legislation expect bipartisan support for the bill, which was already passed by the U.S. House of Representatives in July. If the legislation is reported with bipartisan support in committee, the sponsors will seek to pass the bill by Unanimous Consent (UC) in the Senate, meaning that there will be no debate or amendments to the measure. Passage in the Senate would send the bill to President Obama for his signature.

The legislation would encourage states to enact laws that require schools to plan for severe allergic reactions by allowing the Department of Health and Human Services (HHS) to give funding preference to states for asthma-treatment grants if they meet the following requirements: (1) maintain a supply of epinephrine; (2) allow trained school personnel to administer epinephrine; and (3) implement a plan to ensure that trained personnel are available during all hours of the school day. Under the legislation, states must also certify that their laws have been reviewed to ensure that liability protections are afforded to school staff who have been trained to administer epinephrine.

H.R. 2094 represents a delicate compromise on medical liability language, which has been an issue of particular contention between

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Congressional Republicans and Democrats. Last year several House Committees advanced a number of medical liability reform bills that were passed by the House but not acted on by the Senate.

**ACA Implementation Continues; Enrollment Begins October 1st**

On October 1st open enrollment began for the ACA’s health insurance exchanges. As expected, there were a number of glitches associated with the roll-out, with Democrats claiming success and Republicans citing access problems and delays.

The Administration made a number of high-profile announcements regarding implementation of the ACA in advance of October 1st. The U.S. Department of Health & Human Services (HHS) announced a delay in online enrollment for small businesses seeking to participate in the Small Business Health Options Program (SHOP) exchanges. HHS officials indicated that small businesses can begin enrolling online in November. Meanwhile, reports surfaced that the website designed for Spanish-language speakers to enroll in the health insurance exchanges would also not be ready by October 1st. A number of Congressional Republicans have said these reports are further evidence that the ACA should be delayed for a year, as part of the government funding measure or legislation to increase the debt ceiling.

The Centers for Medicaid and Medicare Services (CMS) announced that it had granted a waiver for Arkansas’ Medicaid expansion proposal. With this waiver, Arkansas will be allowed to use funding to purchase private health insurance plans for Medicaid enrollees under the Medicaid expansion. Iowa has submitted a proposal to CMS that would allow for similar coverage under the state’s Medicaid expansion, and Pennsylvania has also had discussions with CMS about this type of plan.

At the end of August the Internal Revenue Service (IRS) released the final rule on the ACA’s individual mandate, entitled “Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage.” The rule provides guidance to individual taxpayers on their liability under section 5000A of the Internal Revenue Code, for a penalty for failing to maintain minimum essential coverage. The rule provides clarity on the monetary fine that non-exempt individuals must pay if they do not obtain health insurance. In year one, the penalty is $95 or one percent of household income, and gradually increases to $695 or 2.5 percent of household income in 2016. After 2016, individuals are penalized based on a cost-of-living formula applied for that calendar year.

The rule also finalizes a number of exemptions for individuals that do not have to pay the penalty. Exempt individuals include those that have their health coverage lapse on a temporary basis between jobs. Many of these exemptions were previously outlined in proposed rule published earlier this year. Notably, the rule also exempts Medicaid-eligible individuals that live in states that have not participated in the ACA’s Medicaid expansion. Michigan became the 25th state to approve the Medicaid expansion, while 21 states have decided not to approve the expansion. The penalty for individuals who do not maintain minimum essential health coverage goes into effect on January 1, 2014.

**Key House Committees Release Medicare Reform Paper**

Republicans on the House Ways & Means Committee and House Energy & Commerce Committee released a joint white paper entitled, “Modernizing Medicare for the 21st Century.” The document, which is subtitled, “Why Medicare is Outdated and Beneficiaries Deserve Better,” is the first in a series of Medicare policy papers to be released by the two committees. The paper reviews: “(1) the traditional Medicare cost-sharing framework and the impact current thresholds have on beneficiaries — often leaving them unprotected against catastrophic costs; (2) the impact of supplemental coverage with low cost-sharing requirements that reduce incentives to seek cost-effective care; and (3) how modernizing the traditional cost-sharing features could better align beneficiary incentives, ensure beneficiaries greater out-of-pocket predictability and reduce overall Medicare costs.” The document recommends that structural reforms to Medicare should make the program easier to navigate, protect seniors, and reduce costs. It includes several potential changes to the traditional Medicare benefit structure, including the establishment of a single combined annual deductible for Medicare Parts A and B and a simplified coinsurance rate that is applicable to spending above the unified deductible. The paper discusses at length the need to enact reforms that protect Medicare beneficiaries from catastrophic costs.

According to the committees, the additional policy proposals that will be released over the next several months will identify flaws in the existing traditional Medicare framework and propose and seek public feedback on additional Medicare reform concepts.

**CMS Requests Comments on Potential Release of Medicare Physician Data**

In August, CMS reached out to stakeholders in the physician community to request public comment on policies with respect to the disclosure of individual physician payment data. The document cited CMS’s commitment to data transparency, including the release of information on hospital charges for common inpatient services, which received considerable news coverage earlier this year. It also noted a recent legal development in which a Florida court lifted a permanent injunction issued in 1979, which prevented the agency that preceded HHS from disclosing annual Medicare reimbursement payments in a way that was identifiable at the individual physician level.

AAEM submitted a comment letter that highlighted its mission to support fair and equitable practice environments for emergency physicians, including the principal of “open books.” As part of the release of this data, AAEM strongly encouraged CMS to produce a separate document that goes directly to the individual physician that discloses how much the physician received from Medicare during the reporting period. The physician can then compare this data with reports from the contract management group or billing company. AAEM cited the benefits of a transparent system that will result in better patient outcomes and more efficient Federal health care programs. AAEM also asked that CMS consider including several disclosure statements to accompany the release of this data, including a note that the monies listed may not be paid directly to the physician, and that the data does not represent the final amount of money earned by physicians in exchange for their services — but is reimbursement before malpractice insurance, billing, and numerous other costs inherent to the expensive practice of medicine.