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Health Policy Briefing

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114th Congress Convenes in New Year with More Questions than Answers

Questions Remain about Budget/Appropriations, PPACA and Other Health Legislation

When Congress reconvenes January 6th members will have more questions than answers regarding the path that the 114th Congress will take in addressing important budget and health law decisions. House and Senate Republicans will hold their party retreats in mid-January to fashion the course the House and the new Republican majority in the Senate will pursue to finish fiscal year (FY) 2015 Department of Homeland Security appropriations, the FY 2016 budget resolution and respective appropriations, as well as critical decisions involving health care. Specifically, some of the key questions are:

Budget/Appropriations:
When and how will Congress address the President's immigration executive actions and extend funding beyond February 27, 2015 for the Department of Homeland Security?

Will House Budget Committee Chairman Tom Price (R-GA) prevail in his desire to finish up the FY 2016 budget resolution on time and in regular order and gain agreement with the Senate on hard defense and non-defense spending caps (or will reconciliation caps prevail)?

Will the House and then the Senate take up FY 2016 appropriations bills individually before the new fiscal year begins on October 1, 2015 (including the always contentious Health and Human Services (HHS)/Education/Labor appropriations bill)?

Will Congress use budget reconciliation to reign in Medicare/Medicaid spending, accomplish tax reform, or repeal and replace portions of the Patient Protection and Affordable Care Act (PPACA) and which provisions would

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meet the "Byrd Rule" requiring reconciliation provisions impact the federal budget to be germane.

Repeal and Replace Obamacare:
Will the Senate follow the House agenda to vote on a straight repeal of the PPACA, thus forcing a veto by President Obama?

Will the Supreme Court agree with the U.S. Court of Appeals for the District of Columbia Circuit in King v. Burwell and overturn the Internal Revenue Service (IRS) ruling that individuals residing in states that do not establish their own health insurance exchanges still become eligible for federal tax credit premium subsidies when electing coverage under HealthCare.gov?

Will congressional Republicans respond to a decision by the high court upholding King v. Burwell with legislation retaining subsidies for individuals obtaining coverage in state-run exchanges and giving other individuals an alternative means for subsidizing coverage for low-income individuals (e.g. revised tax credits; federal grants to states providing state-based subsidies; etc.)?

Will congressional Republicans otherwise repeal and/or replace the individual mandate; the employer mandate; the medical device tax; the Independent Payment Advisory Board (IPAB); the minimum "essential health benefits"; Medicare changes; etc.?

Will congressional Republicans find or include budget offsets for any changes to Obamacare?

Other Pending Health Legislation:
Will Congress repeal the current sustainable growth rate (SGR)-based Medicare physician payment system with an alternative (with or without budget offsets)?

When and how will Congress address the continued authority for spending under the Children's Health Insurance Program (CHIP) program (and reconcile the program with Obamacare)?

When and how will Congress address the continued payment of Medicaid reimbursements at Medicare levels?

When will the House Energy and Commerce Committee consider, amend and vote on the proposed 21st Century Cures Initiative?

Will the retirement of Senator Tom Coburn (R-OK) move the Senate to vote on a new version of H.R. 5059, the Clay Hunt Suicide Prevention for American Veterans Act which he objected to saying it was duplicative of existing Veterans Administration programs?

When and how will Congress react to the various provider payment recommendations to be reported in March by the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC)?

PPACA Health Reform Update

Administration Marches Forward with Implementation of PPACA

U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell touted the advances of the operations of Heatlhcare.gov in this year's open season, reporting that 6.4 million individuals signed up with about 1.9 million of the total being new enrollees. It was also reported that another 1.1 million individuals signed up in eleven of the thirteen state-run exchanges. The Centers for Medicare and Medicaid Services (CMS) announced that five states were awarded $187 million in its last round of PPACA grants for developing state-run exchanges. During a recent hearing held by the House Committee on Oversight and Government Reform, Rep. James Lankford (R-OK) questioned CMS Administrator Marilyn Tavenner about whether permitting grant money to be used after 2014 would be contrary to the authority for the grants under the PPACA. The question remains unanswered. CMS also said that 89 new accountable care organizations (ACOs) will participate in the Medicare Shared Savings Program in January which will increase the total number of ACOs operating next year to 405. The Administration also issued a proposed rule which intends to determine whether allowing employers to offer employees "wrap-around" coverage to non-employment-based health insurance they obtain inside or outside exchanges will result in more employees electing to be insured. The IRS/HHS/DOL rule provides for a three-year pilot program that would consider such wrap-around coverage to be "excepted benefits" under the PPACA and exempt them from various requirements of the law, but require them to meet other conditions such as being non-discriminatory and low-cost. The IRS/HHS/DOL also released a proposed rule affecting group health plans and health insurers that makes changes to the summary plan description (SPD) of benefits/coverage and the uniform glossary they are required to provide employees and consumers under the PPACA. The agencies said that the changes are intended to "help people who are shopping for health insurance coverage better understand their options…." CMS also alerted health insurers subject to the PPACA that the agency will consider their plans "discriminatory" if they exclude all drugs for a certain condition or restrict access by requiring considerable copayments or prior authorization for such a drug, or place such a drug only on the highest-cost tier. Some of the conditions specifically mentioned are: bipolar disorder; diabetes; HIV/AIDS; rheumatoid arthritis and schizophrenia.

Effect of PPACA on Medicare Advantage Premium Rates

The Medicare Payment Advisory Commission (MedPAC) reported that Medicare Advantage (MA) plans will, on average, be paid 2% above traditional Medicare fee-for-serve (FFS), despite the PPACA provision designed to bring down the rate of payments to Medicare Advantage plans. MedPAC said that payments varied by plan type and ranged from 100% of FFS for regional preferred provider organizations (PPOs) to 111% for private FFS plans with health maintenance organizations (HMOs) getting about 101% of FFS.

Supreme Court and PPACA

The U.S. Supreme Court will hold oral arguments on March 4th on the above-mentioned King v. Burwell case which could result in a decision being released sometime this summer. In related news, the Competitive Enterprise Institute (CEI) filed suit in federal court against HHS which alleges that the agency has failed to respond to Freedom of Information requests the organization has made that would shed some light on the decisions made by the Administration in connection with the issues to be taken up by the high court in King v. Burwell and Halbig v. Burwell.

Medicare/Medicaid/PHSA Corner

Meaningful Use Penalties Announced

Reps. Renee Ellmers (R-NC), Jim Matheson (D-UT) and 28 other House members sent a letter to the HHS Secretary which demands that the agency reduce the 2015 meaningful use program reporting period from twelve months to three months. They said that "Our constituents remain concerned that the pace and scope of change has outstripped the capacity of our nation's hospitals and doctors to comply with program requirements…." CMS announced that over 257,000 providers and 200 hospitals will have their 2015 Medicare reimbursements cut by 1-2% for failing to adopt an electronic health record and meet the requirements of the meaningful use program.

Senate HELP Committee Urges Action on Drug Abuse

More than twelve members of the Senate Health, Education, Labor and Pensions (HELP) Committee sent a letter to the HHS Secretary urging the agency to take further action to stop drug misuse. They said "With our shared goal of preventing and reducing prescription drug abuse in this country -- a crisis that demands continued action, we expect that your activities in this area will continue, and we stand ready to assist you….We request that you provide updates to us early next year about your ongoing work, as we continue to explore potential solutions to this problem…." They also requested help form the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the National Governors Association (NGA), and the National Association of County and City Health Officials (NACCHO).

Health Care Compare Postings

CMS has posted quality of care data for Medicare providers, including ACOs, and hospitals as follows: 2015 payment adjustments associated with the hospital value-based purchasing program; and 2013 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) measures for 139 group practices, 214 Shared Savings Program ACOs and 23 Pioneer ACOs on Physician Compare.

MedPAC on IRF, SNF, ASC and HHA Payments

At its December meeting, MedPAC commissioners appeared likely to recommend that Congress lower Medicare payment rates to inpatient rehabilitation facilities (IRFs) to the levels paid to skilled nursing facilities (SNFs) while leaving the decision on what medical conditions would be affected up to CMS regulations. It was estimated that the change could save Medicare about $500 million per year. For SNFs, it appeared the commission will recommend that there be no payment update for 2016 and that for 2017 there would be a payment rebasing accompanied by a 4% reduction in payments. For ambulatory surgical centers (ASCs), it appeared the commission will recommend that there be no payment update for 2016 and that such entities report certain cost data to CMS. MedPAC also appears set to recommend that outpatient dialysis facilities receive no payment update for 2016. For home health agencies (HHAs), the commission also indicated it will recommend: no update to payment rates; a reduction of payments through a full rebasing that adequately addresses excessive payments; a rebalancing of payments so agencies don't favor therapy services over non-therapy services; an expansion of fraud and abuse efforts to address regions with aberrant patterns of home health utilization; and the establishment of copayments for certain episodes to encourage appropriate utilization. MedPAC will vote on final recommendations to be included in its March 2015 report to Congress at its January 15-16, 2015 meeting.