

Business News and Strategies for Health Plans, Pharma, Hospitals and Other Providers

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Debt Proposal Targets CLASS Act for Now; Longer-Term Deals May Have Wider Impact

Health care observers say it's unlikely that a bipartisan Senate proposal to resolve the nation's debt-ceiling problem will touch key health reform law provisions other than doing away with the law's long-term care insurance program. However, with suggested cuts to entitlement programs such as Medicare and Medicaid on the line, it's bound to affect how providers and payers do their business over the long run, one consultant tells *HRW*.

Most of the reform law was pre-funded, "so unless they start talking about taking structural shots at the law like eliminating any kind of state funds for exchange development...or tinkering with the subsidies, they're probably going to be looking elsewhere," consultant John Gorman, CEO of Gorman Health Group, LLC, tells *HRW*. In his view, a debt-ceiling deal would pose a great opportunity for lawmakers "to open up the penalties on the individual mandate, and to give that thing some real teeth so it compels more young invincibles to get into the program. I think it is actually a great revenue raiser that they'll be looking at."

The health care industry, including health plans that participate in government programs, needs to be watching this development very closely, Gorman cautions. Hospitals and pharmaceutical firms "already gave at the office" with respect to ACA, and so did Medicare Advantage. These providers, however, may be looking at another round of hits for debt reduction, he predicts.

The bipartisan Senate proposal to cut the deficit by nearly \$4 trillion over 10 years was devised by the so-called "Gang of Six," which includes Sens. Kent Conrad (D-N.D.), Mark Warner (D-Va.), Dick Durbin (D-Ill.), Mike Crapo (R-Idaho) and Saxby Chambliss (R-Ga.), with Sen. Tom Coburn, M.D. (R-Okla.) later rejoining the talks. The plan would be carried out in two legislative steps, the first of which would be a bill to make immediate cuts, followed by a second bill to enact comprehensive reform and put the nation back on a stable fiscal path, according to a summary of the proposal.

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As CMS Issues Draft CO-OP Rule, Actuaries Expect Start to Be Tough, Defaults Likely

When CMS issued a draft rule July 18 setting standards for new private, nonprofit, member-run health plans created under the health reform law, federal regulators said they anticipate that every state will end up with a so-called Consumer Operated and Oriented Plan (CO-OP). But insurance industry actuaries tell *HRW* this is a highly optimistic prediction since CO-OPs for individuals and small businesses face an aggressive timeline to become operational by January 2014 as planned. Also, actuaries say the challenge of lining up provider networks and managing administrative costs is especially daunting for new insurance entities setting up shop against the backdrop of newly created health insurance exchanges that start at the same time. Even CMS concedes in the proposed rule that it expects a significant portion of CO-OP sponsors to default on federal loans for startup and solvency.

continued

CMS says it soon will issue a funding opportunity announcement on loans for CO-OPs. The agency will accept public comments on the proposed rule until Sept. 16.

Of the \$3.8 billion allocated for CO-OP loans, the rule anticipates that \$600 million would be used for five-year startup loans and \$3.2 billion for 15-year solvency loans. At a July 18 news briefing, CMS officials downplayed an estimate in the draft rule that loan defaults could cost the government \$320 million. They said the estimate was "conservative" and that the default rate is unlikely to be this high since loans, which must be repaid with interest, would go only to entities demonstrating a high probability of becoming financially viable. They said CMS and outside experts will scrutinize legal, actuarial and business plans to see how viable a potential CO-OP seems.

But David Tuomala, director of actuarial consulting at OptumInsight, a unit of UnitedHealth Group, is wary of CMS's estimates on CO-OP loan defaults. "They said 65% of solvency loans and 60% of startup loans would be repaid. Arguably it could be optimistic," he tells *HRW*. "To start up a plan like this, you have to get competitive provider contracting. You have to be market competitive in terms of the administrative costs...and you're starting from scratch against longtime competitors. You could see a lot of these plans fail, so getting 60% back could be high. Also, 2014 is a brand new world, and even existing

carriers will struggle" with new exchanges and insurance rules then.

The bottom line is that "with the CO-OP, you've taken something that's hard to do and made it twice as hard," Tuomala says. For example, he says, if a CO-OP were to price too low for individuals, its infrastructure could be overwhelmed with new members through the exchanges.

Steve Larsen, director of CMS's Center for Consumer Information and Insurance Oversight (CCIIO), hesitated at the recent news briefing when asked about the expected number of CO-OPs. "At this point we don't know exactly how many CO-OPs there are going to be," he said. "Our hope and expectation is there will be one in every state." Richard Popper, director of CCIIO's Office of Insurance Programs, added that the draft rule's impact analysis projects funding about 57 entities. But he cautioned that there are numerous variables to take into account, including CO-OPs' scope and how much risk they decide to take on.

CMS officials stressed that "the reform statute is clear, and regulations add detail" to the effect that CO-OPs must be new entities — and that any health insurer existing as of July 2009 isn't eligible. Popper said that if an existing insurer as of July 2009 wants to be a CO-OP, it would have to go out of business and reapply for insurance licensure with the state, "and it couldn't look like it did in July 2009. It would have to be a brand-new entity: consumer-driven."

Popper outlined the draft rule's proposed framework for CO-OPs, including standards that CO-OPs must meet. These include having at least two-thirds of the CO-OP's policies written in the individual or small-group markets, offering the multiple options required of all carriers participating in a health insurance exchange, and complying with state health insurance regulations.

CO-OPs Can't Convert to For-Profit Status

Under the draft rule, CO-OPs must stay true to their nonprofit mission and can't convert to for-profit status. CMS officials stressed that the draft rule calls for CO-OPs to use any profits to benefit their members by lowering premiums, increasing benefits, improving the quality of care, expanding enrollment, or otherwise contributing to the stability of coverage for their members.

Yet Tuomala notes that with other nonprofit plans, "basically any risk margin you earn would be used to contribute to your surplus first" to prevent insolvency. Nonprofit plans typically have a separate entity serving as a "backstop" — a health system may fund a plan's surplus, for example — or an organization might develop a surplus base over the course of many years that maintains the plan's solvency, he says. In any case, adds Tuomala,

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the CO-OP must generate sufficient margins to pay back loans over time and also grow its surplus. Moreover, the CO-OP must reach sufficient size to be viable, and while a statewide footprint gives the CO-OP more access to members, it also requires a statewide provider network, he asserts.

Courtney White, a principal and consulting actuary with Milliman, Inc., agrees that a CO-OP will face challenges in striking a balance between its nonprofit mission, maintaining sound insurance principles and establishing appropriate levels of surplus/reserves in order to be able to repay loans. "Management may get pressure from members and/or the government regarding the need to use profits for lowering premium, increasing benefits or for improving quality instead of building surplus/reserves," he wrote in a recent Milliman paper on CO-OPs.

White says the CO-OP concept seems to have gained traction amid ongoing private-sector efforts to set up integrated health care delivery models and accountable care organizations (ACOs), and hospitals' acquisition of physician groups. Yet he warns to expect "failures along the way" in building CO-OPs from scratch.

"Once [CO-OPs] get to critical mass and are operating in a stable environment, they can manage surplus," White says. "The big hurdle is getting operational and getting through the first couple of years. I'd be surprised if there's one [CO-OP] in every state. It's very unlikely," given the tight timeline, challenges of setting up a provider network and coping with administrative costs.

White tells *HRW* that he knows of parties interested in starting CO-OPs, "both on the provider side and the employer cooperative front," but would not identify them. He says an ACO would be "a good springboard" for the CO-OP in terms of ongoing efforts to integrate services between hospitals and physicians.

Contact White at (404) 237-7060 and Tuomala at (952) 942-3219. Find the proposed rule at http://www.ofr.gov/OFRUpload/OFRData/2011-18342_PI.pdf. ✧

Employers Lobby to Ease Coverage Mandate, Cite Huge Potential Costs

A coalition comprised of 40-plus major employers and trade groups in the retail, restaurant and hospitality industries is lobbying the Obama administration to alter critical provisions in health reform implementation, including which firms are subject to penalties if they don't offer "affordable" health coverage.

The group's first official mission was raising concerns to the IRS in June about how the agency proposes to define full-time employees, a decision that federal officials are likely to make this fall. The definition is key since employers with 50 or more "full-time" workers must either "play"

by offering "affordable" coverage through health insurance exchanges starting in January 2014 or instead "pay" a penalty.

Indeed, ongoing concerns have spawned numerous business coalitions focused on exchange rules and other aspects of reform to the point where health care lobbyist Neil Trautwein describes them to *HRW* as now "multiplying like rabbits."

IRS spokesperson Eric Smith tells *HRW* that it received 200-plus responses to its notice requesting comments on "shared responsibility for employers regarding health coverage." The reform statute defines a full-time employee as a person working at least 30 hours per week on average in a given month, and requires employers to furnish "affordable" health coverage or pay a penalty of \$2,000 per worker, excluding the first 30 workers. Many employers in industries with workers who are part-time, temporary or seasonal assert that looking back one month isn't long enough. In its notice, the IRS proposes, among other things, to give employers a "look-back" period of three months to a full year in order to determine whether workers meet the full-time definition.

Retail Said to Be Seen as 'Canary in Coal Mine'

"In many ways the administration, and specifically the IRS and Treasury Department, see us as the canary in the coal mine," asserts Trautwein, vice president and employee benefits policy counsel for the National Retail Federation (NRF). Retailers and restaurants have many workers whose hours vary week to week, he says, "so measuring full-time status as 30 hours a week is not a very flexible measure and ill-fitting for our industries."

To press home the point, Employers for Flexibility in Health Care, a coalition of businesses and trade groups including large employers, NRF and the National Restaurant Association (NRA), responded to the IRS notice during the public comment period that ended June 17. It was the group's first major project since its launch this spring, says Michelle Reinke Neblett, NRA's director of labor and work-force policy.

"Because our coalition members have work forces with high turnover rates and fluctuating work schedules, it is imperative that employees become eligible for coverage only after meeting a plan's eligibility requirements, as established by the employer, including a look-back period (or probationary period), and followed by a 90-day wait period," the coalition states in its recent letter to IRS.

The reform law's proponents respond that a longer proposed "look-back" period is an attempt by employers to cover fewer workers.

Kathleen Stohl, deputy executive director and director of health policy for reform-law supporter Families USA, for instance, tells *HRW*, "Some employers who don't

offer coverage have suggested a methodology for application of the employer-responsibility provisions with long look-back periods that will weaken the employer-responsibility protections and in effect give employers a grace period before they have to provide coverage. There is no broadly applicable reason to look back at previous months' hours of work for determining penalties. We think it is straightforward and makes sense to count full-time employees — those that work an average of 30 hours per week — during each month or quarter for which employers are responsible for providing coverage or paying tax penalties."

Neblett says that such details as the definition of "full-time employee" in the reform rules are "critical" and will determine what could be a huge cost impact on the restaurant industry. Thus, she says, NRA and the coalition are urging HHS, the Treasury Department and the Department of Labor to consider the nature of seasonal workers in crafting the rules. She and others anticipate that federal regulators will issue a proposed rule this fall.

In the meantime, NRA and the coalition are "talking to the administration on an ongoing basis on what they're

thinking of next," Neblett says. "We really think the law was written with a one-size-fits-all employer model."

NRF's Trautwein cites another concern: "You can't deny the flawed math in the penalty payments. The example I use in meetings is an employer with 52 full-time employees. Its penalty payment would be \$44,000." (After subtracting the first 30 workers from the total of 52, the penalty would be calculated by multiplying 22 workers times \$2,000 apiece.) By contrast, it would cost "upwards of \$800,000" to provide full health insurance coverage to those workers, according to Kaiser Family Foundation data, he says. "So we fear even before IRS and the Department of Labor finish [working out definitions, etc., the math] will force many employers not to 'play.' It's a pretty compelling differential even for the kindest-hearted employer."

Another Coalition Seeks Maximum Plan Choices

Trautwein serves on the steering committee of the Choice & Competition Coalition, launched in April by employer, insurer, broker and provider groups working to "promote competition and preserve consumer choice" by allowing all qualified plans to participate in exchanges. The coalition wants individuals and employers to be able to purchase coverage inside and outside exchanges, and to have choices that extend beyond "a narrow set of standardized plan options."

"There are many coalitions out there: the Small Business Coalition for Affordable Healthcare, coalitions on account-based plans...the National Coalition on Benefits for ERISA employers," Trautwein says. "It's [because of] the very complexity of the health law and the need to comply and find workable solutions that these coalitions seem to be multiplying like rabbits."

Attorney Ed Fensholt, director of compliance services for Lockton Benefit Group, a unit of Lockton Companies LLC, says that some of his firm's recent actuarial analysis suggests that IRS's proposed approach will aid industries with seasonal workers. But he says the retail, restaurant and hospitality industries won't fare as well unless employers have very high turnover.

"We put our actuaries on this issue and found that for seasonal employees...IRS's proposed methodology would really help [employers] out...and avoid a devastating cost impact," Fensholt tells *HRW*. "I thought intuitively it would have the same effect on the restaurant and other industries with low-paid workers and significant turnover. But our actuaries found unless the turnover is high — 75% — [such employers] would still fare rather poorly under the shared-responsibility construct."

Contact Fensholt at (816) 960-9775 and Trautwein at trautweinn@nrf.com. Find the IRS notice at www.irs.gov/irb/2011-21_IRB/ar07.html#d0e331. ↔

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Expatriate Plans Warn of Lost Jobs Without Relief From MLR Rules

The growth of health plans for U.S. expatriates — and the U.S. insurance jobs associated with them — could be derailed if those plans don't get a permanent exemption from the minimum medical loss ratio requirements (MLRs) in the health reform law, insurers warn. But federal regulators appear wary of using the authority the law gave them to grant such permanent relief, citing the complexity associated with these products, including their coverage of family members living in the U.S.

Until the MLR rules came out late last year (*HRW 12/6/10, p. 1*), expatriate plans attracted an increasing number of insurers in light of the more than 4 million Americans who work for extended periods in other countries. Aetna Inc. acquired an expatriate-plan company in 2007, CIGNA Corp. bought one last year, and UnitedHealth Group said it planned to enter the business this summer.

The MLR rules, however, mandate a minimum 80% ratio in the individual and small-group markets and 85% for large groups starting this year, with violators being on the hook for large rebates to customers. The insurers contend that the very nature of expatriate plans requires very high administrative costs, which have the effect of lowering the products' MLRs. And the National Association of Insurance Commissioners, in a letter to HHS Sec. Kathleen Sebelius last October, pointed out that foreign competitors offering expatriate coverage are not subject to the same requirements, and recommended either an exception or "adjustments" to the MLR rules for U.S.-based expatriate plans.

HHS responded by giving the plans a temporary exemption, in the form of allowing them to multiply their qualifying medical and quality expenses in the MLR numerator by two, but only through the end of 2011. The insurers are pushing for a permanent waiver, and CIGNA upped the ante in the debate recently by saying it might need to move the 700 jobs for its expatriate business, which now covers more than 830,000 lives, from the U.S. (mostly Delaware) to overseas since complying with the MLR requirements would drive up premiums so much as to not make the products competitive with those of foreign insurers.

The company also warned that not granting a permanent exemption could prompt some employers to hire foreign nationals rather than U.S. citizens for jobs in foreign countries.

From an actuarial standpoint, there is a "legitimate argument" to be made for treating expatriate plans differently, David Tuomala, director of actuarial consulting for OptumInsight, a unit of UnitedHealth Group, tells *HRW*. It is harder for expatriate plans to make big changes in their expense structure, he asserts, because they face "different scenarios" in each country where they operate. They may not even have provider networks in some countries, so they therefore must negotiate payments on a case-by-case situation with providers, according to Tuomala. He contends this leads to "a lot more high-touch" operations and therefore to higher administrative costs.

But while some expenses for expatriate plans need to be very high, such as for arranging emergency evacuations by air ambulance, not all of them are administrative costs that result in lowering MLRs, since some of them qualify as medical expenses, he notes. Furthermore, while insurers suggest that having to pay claims in a variety of currencies drives up costs for expatriate plans, and this indeed makes the expatriate business more risky, it may be possible to "hedge away" some of those risks if there are good data on where claims are likely to take place, Tuomala says.

If regulators don't want to waive the MLR rules for expatriate plans entirely — which is something they have done for Medicare supplement and dental plans, for instance, Tuomala points out — they could find an appropriate lower MLR level for the expatriate plans.

Asked by *HRW* about the situation at a news briefing sponsored by *Health Affairs* July 21, Steve Larsen, director of CMS's Center for Consumer Information and Insurance Oversight, said only that issuers of expatriate plans have been in contact with his office and that CCIIO must weigh their concerns with the promise that people under the reform law will be able to maintain the kind of coverage they have had. CCIIO spokesperson Bennett Blodgett added that it will need to look at another round of data from the expatriate plans before making any decisions on continuation of MLR relief beyond year's end, indicating that a decision could be at least a couple of months away.

Contact Tuomala at david.tuomala@optum.com and Blodgett at bennett.blodgett@cms.hhs.gov.

Providers Say 'Wellness Visit' Is Burdensome, Confusing to Patients

It was designed to detect health problems early on and help cut Medicare costs, but some provider groups say the health reform law's "annual wellness visit" is too prescriptive and in various instances is not meeting patient expectations.

The wellness visit has received pushback from physicians in part because it requires meeting a more than 15-step "checklist" of screenings, medical history and patient advice. If the physician misses one thing, "then you can't bill that service. It's very frustrating," Glen Stream, M.D., Spokane, Wash.-based president-elect of the American Academy of Family Physicians (AAFP), tells *HRW*.

This payment hurdle is part of the larger reimbursement issues Medicare physicians face, Stream observes. "We're on an approach to a cliff of a 25% pay cut at the end of the year for Medicare physician services if they don't fix the [Sustainable Growth Rate] thing again.... That whole cloud sits over everything that has to do with Medicare."

The wellness visit started in January and is part of the series of "free" preventive benefits the reform law offers under fee-for-service Medicare. As part of that visit, beneficiaries and their physicians review the patient's health and then develop a personalized wellness plan. Based on recent CMS data, however, it seems that only a small portion of the 46 million Medicare patients have had such a visit. Based on claims processed by June 29, Medicare has paid for just more than 950,000 annual wellness visits.

Overall, about 5 million Medicare patients have taken advantage of the free preventive benefits under the reform statute, HHS reported in June. These include services such as mammograms, bone-density screenings and screenings for prostate cancer. CMS also launched a public-outreach campaign to raise awareness about the free benefits, including the wellness visit. Skeptics, however, doubt that more preventive services will result in lowered costs or in more freedom of choice for patients (*HRW* 6/30/11, p. 1).

Visit Is 'Not Like a Typical Exam'

The wellness visit, in particular, is throwing patients off because it's not like a typical checkup exam, Stream explains. In fact, its very terminology creates confusion for both patients and doctors, he says. For example, it's often mistaken for the "Welcome to Medicare" visit, which suffered its own growing pains when it was introduced in 2005, Stream says.

Pam DeVisser, a family nurse practitioner in Portland, Ore., who works with Providence Medical Group, a group of clinics in Oregon, says that patients are used to having a complete physical, a head-to-toe

exam, and are perplexed that the "annual wellness visit" is more about developing a plan of preventive care. "You may have to talk to the patient for five to 10 minutes, explaining why this is different" from a regular physical, she tells *HRW*.

While Medicare's copayment is waived for the annual wellness visit, any subsequent visits in which the provider starts implementing the plan of care do require a copayment, DeVisser adds.

Providers who spoke with *HRW* say the long "checklist" of services that need to be addressed during the wellness visit makes it a challenge to get adequately reimbursed under Medicare. "If you don't cross all your t's and dot all your i's, and don't document everything, it's been kind of an all-or-none thing," in terms of getting reimbursed by Medicare, Conrad L. Flick, M.D., a family physician in Raleigh, N.C., who sits on the board of directors of AAFP, tells *HRW*.

Some odd things also were incorporated into the guidelines for the wellness visit, Stream continues. "If you have a 65-year-old patient who's otherwise in good health, you still have to do dementia screening," which begs the question of whether this actually adds value to that patient's health. "Probably not," Stream says. Physicians would prefer having the flexibility to exercise their own professional medical judgment about what things should be included in their specific examination for patients they know well rather than abiding by a prescriptive checklist, he says.

Physicians also are not supposed to talk about anything outside of the prescribed processes of the wellness visit. For patients who have multiple, chronic problems, says Flick, "I'm not so convinced that it's going to be helpful," as it is difficult to separate preventive issues from ongoing chronic problems. "Physicians are taught to take care of the whole person."

EHRs Can Facilitate Visit

At least in her practice, DeVisser says, electronic health records (EHRs) have made it easier to administer the visit and manage its prescriptive checklist.

Her electronic record devised a form that lays out a step-by-step process for the practitioner to follow, DeVisser says. "It's like doing an OB-GYN form for a woman. It's devised so that it could be a Welcome to Medicare visit, an initial annual wellness visit or a subsequent annual wellness visit."

She says a medical assistant first comes in and gets the patient's vital signs, "and then we go in and we review patients' medications and medical history and go through and update all their medical problems."

Contact Stream and Flick via Amanda Holt at aholt@afafp.org and DeVisser at pamdv1@comcast.net. ♦

How Will Debt Plan Affect Reform?

continued from p. 1

Elements of this plan have been targeted as a longer-term solution to the nation's debt crisis (*HRW 7/18/11, p. 1*). At press time, lawmakers and President Obama were mulling the possibility of a shorter-term solution that Congress could pass to meet an Aug. 2 deadline for increasing the nation's borrowing limit to avoid defaults. An alternative plan approved along party lines in the House July 19 to slice the nation's debt and create a balanced-budget requirement was not expected to pass in the Senate, nor does it have Obama's endorsement.

With a few exceptions, however, the details about which health reform provisions would be affected are not yet known. The Gang of Six plan proposes to spend health care dollars "more efficiently in order to strengthen Medicare and Medicaid while maintaining the basic structure of these programs," but offers no specifics on how it would accomplish this goal.

CLASS Act Would Be Repealed

As part of its first legislative effort to save \$500 billion and enact cuts to secure immediate deficit savings, the Gang of Six plan calls for repealing the Community Living Assistance Services and Supports (CLASS) Act in the reform law. It sets up a national, voluntary program that would be available after October 2012 to help people plan ahead to pay for long-term care services and support.

Chip Kerby, an employee benefits attorney at Washington, D.C.-based benefits consulting firm Liberté Group LLC, sees this as a minor blip in the health reform radar screen. CLASS, first off, "is still a voluntary program, meaning that individuals can choose whether to participate or not. It's also voluntary from the employer perspective, [meaning] employers could choose to opt out of the program...and wouldn't have to perform any kind of payroll-withholding functions."

The program has experienced a great deal of push-back from Republican lawmakers and from the president's own fiscal commission (*HRW 12/6/10, p. 1*). CLASS would cost \$76 billion through 2020 and over time would require premium hikes and a reduction of benefits to sustain it, according to the commission. Even HHS Sec. Kathleen Sebelius has acknowledged that CLASS in its current form is unsustainable, suggesting specific changes to its employment and minimum-earnings requirements (*HRW 2/14/11, p. 3*).

"Actuaries I have talked to are highly critical of the notion of CLASS being self-financing," so it's a logical target, Kerby says. Outside of CLASS, he says, the short-term implications of the debt-ceiling proposal on reform are less clear. Kerby adds that he didn't see anything else in the Senate proposal that specifically focused on other reform

provisions, "so it's hard to tell at this point what they're thinking of doing in terms of making further changes [to the law]," he says.

Other Health Cuts Are Not Specific

To achieve more longer-term savings, the proposal instructs various Senate committees to develop legislation within six months that would "deliver real deficit savings in entitlement programs over 10 years."

The Senate Budget Committee would have to come up with legislation that would review total federal health care spending starting in 2020, "with a target of holding growth to the [Gross Domestic Product] plus 1% per beneficiary." The proposal would require action by Congress and the president if the target is exceeded.

The Senate Finance Committee would have to find a way to permanently reform or replace Medicare's troubled Sustainable Growth Rate or SGR formula, which is tied to the health of the economy and has been threatening payment cuts to physicians since 2003. Doing away with the SGR formula would cost nearly \$300 billion, although the Gang of Six plan, in a rather confusing recommendation, directs Finance to find further "health savings" of \$85 billion to \$202 billion, while maintaining essential health care services to the poor and elderly.

The senators are essentially offering "two different numbers to pay for an SGR fix," Paul Van de Water, senior fellow at the nonpartisan Center on Budget and Policy Priorities (CBPP), tells *HRW*. The apparent reason for the \$202 billion versus the \$85 billion figure is "not all six members of the gang could agree on what the numbers should be," he says.

In other health provisions, the plan would require the Senate Judiciary Committee to identify savings through medical malpractice reform, and fight fraud, abuse and waste in entitlement programs "to the tune of \$28 billion," according to an Oppenheimer & Co., Inc. analysis of the Gang of Six plan released July 19. If none of the committees identifies savings within six months, sweeping cuts would be imposed on programs (except for low-income initiatives) under those committees, Oppenheimer said.

Gorman says he is encouraged about the SGR fix. "If we can make some progress on that issue under the guise of budget reform, it's great. It's the annual exercise of kicking that can down the road, and now they've finally found a big enough box to put the can in," he says.

While the plan lacks specifics, Gorman and other observers expect it will dovetail with the 60-page proposal that Erskine Bowles, a White House chief of staff under President Clinton, and former Wyoming Sen. Alan Simpson (R) submitted to the National Commission on Fiscal Responsibility and Reform last December to address the looming fiscal crisis. "What

Finance will likely do is look at the Bowles-Simpson recommendations and then [find] whatever else they could get the votes for," Gorman says. While CLASS is the biggest reform target at the moment, "the one thing we have to cross our fingers on is that they don't touch the \$10 billion that went to the CMS Innovation Center. That's a big target."

The Independent Payment Advisory Board (IPAB) has been one of the Republicans' favorite punching bags. But Gorman says, "I don't think you can touch IPAB without changing some of the [Congressional Budget Office] scoring from the ACA. I don't think that eliminating IPAB would score favorably at all." Obama is the ultimate compromiser, he continues, and "for now, if they're just nipping around the edges of ACA without touching structural stuff like exchanges or the subsidies, I think he could hold his nose and support it."

It's also been speculated that a bill (S. 1376) introduced by Sen. Mike Enzi (R-Wyo.) July 18 that seeks to fix a supposed "glitch" in the law's Medicaid enrollment requirements could get into a final debt-ceiling deal. Not yet released CBO numbers state the bill could save \$13 billion from 2014 to 2021, but "that's small potatoes," Van de Water says.

Enzi's bill says the "glitch" pertains to certain middle-class early retirees being able to qualify for Medicaid coverage, although CBPP claims the law's provision is neither unintended nor very costly.

While the direct implications for health reform are still unknown, any long-term solution to the debt-ceiling problem is going to have significant impact for stakeholders in government health programs, observers say. "This is going to reach deep into Medicare and Medicaid, almost certainly," Gorman says.

Ian Spatz, a senior adviser in the national health care practice of Manatt, Phelps & Phillips, LLP and Manatt Health Solutions, observes that Medicare and Medicaid account for at least 40% to 50% of the health reform law. "This proposal would also have a lot to do with Medicare, not only the reform of SGR but for additional cuts in Medicare funding. So there's clearly changes envisioned in that part of it." Although the Senate's proposal doesn't appear to get directly at things like the health insurance exchanges and subsidies, "it would certainly affect other things in the legislation," such as Medicare, Spatz says.

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HEALTH REFORM BRIEFS

◆ **The Institute of Medicine on July 19 recommended that health plans cover eight additional free preventive health services for women**, including birth-control methods and counseling, under the health reform law. IOM in its report also suggested that health plans cover screening for gestational diabetes, human papilloma virus testing as part of cervical cancer screening for women over age 30, and counseling on sexually transmitted infections, among other things. In response to IOM's recommendations, Robert Zirkelbach, spokesperson for trade group America's Health Insurance Plans, tells *HRW* that "broadening the scope of mandated preventive services that go beyond or conflict with the current evidence-based guidelines will increase the cost of coverage for individuals, families and employers." View the report at <http://tinyurl.com/3d48eey>.

◆ **Bipartisan legislation introduced in the House and Senate July 14 seeks to repeal a provision in the reform law** that prohibits individuals from using funds from medical savings accounts to buy over-the-counter medications. The House legislation (H.R. 2529) was introduced by Reps. Lynn Jenkins (R-Kan.) and Shelly Berkley (D-Nev.), while the Senate version (S. 1368) is

sponsored by Sen. Pat Roberts (R-Kan.). "Our legislation allows Americans who utilize a health care account to use money they've set aside to purchase over-the-counter medications without a prescription," said Berkley in a prepared statement. To view the bills, visit <http://thomas.loc.gov/cgi-bin/thomas>.

◆ **Lawmakers from both sides of the political aisle told the House Energy and Commerce Committee's health panel July 13 that the reform law's Independent Payment Advisory Board (IPAB)** was a step in the wrong direction and needed to be repealed. IPAB is not a "death panel"; it's simply the wrong approach to rein in Medicare spending, Rep. Allyson Schwartz (D-Pa.) testified before the Health Subcommittee. Schwartz said IPAB was structured to impose cuts "on a narrow sector of the health care system," which now is mainly physicians, "ignoring the need for broader changes." Rep. David Roe, M.D. (R-Tenn.), who introduced legislation (H.R. 452) Jan. 26 to kill IPAB (*HRW* 4/25/11, p. 1), testified that the board would be empowered to make Medicare payment recommendations without input from Congress. View Roe's bill at <http://thomas.loc.gov/cgi-bin/thomas>.

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