



## The U.S. Health Care Highway—2012

*Part II: Crossing the Election Divide  
Health Care Reform Gateway To 2013*



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Health Care Reform Gateway To 2013

### **Prepared by:**

Bostrom

and

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### **Prepared on Behalf of**

THE PHYSICIANS FOUNDATION

Physicians Committed to a Better Health Care System for All Americans

### **About the Physicians Foundation**

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and to help facilitate the delivery of healthcare for all Americans. It pursues its mission through a variety of activities including grant-making, research and policy impact studies. Since 2005, The Foundation has awarded numerous multi-year grants totaling more than \$28 million. In addition, The Foundation focuses on the following core areas: health system reform, health information technology, physician leadership, workforce needs and pilot projects. As the health system in America continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician/patient relationship and assist physicians in sustaining their medical practices during this evolution.

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## PREFACE

The Physicians Foundation is committed to providing physicians with up-to-date and factual information on the intricacies of health care reform in the United States. The Foundation is acutely attuned to the transformational forces sweeping through the private practice of medicine and the U.S. health care system. These change agents are both specific to implementation of the Patient Protection and Affordable Care Act of 2010 (ACA), and more sweeping as the nation grapples with broader federal deficit and entitlement program issues. Regardless of the catalysts, physicians are experiencing extraordinary changes in the dynamics and requirements of medical practice.

The current “Crossing the Election Divide” report is the third in a series of reports that began with publication in May 2011 of “A Roadmap for Physicians to Health Care Reform” which outlined the overall structure and key elements of the ACA, with a focus on physician-centric statutory provisions. The second report, “The U.S. Healthcare Highway –2012: Part I”, published in August 2012, focused more deeply on select areas of the ACA and Medicare of particularly high impact on medical practice.

This report, Part II of the Health Care Highway series initiated in 2012, serves as a summary “wrap-up” report. It highlights select key events occurring primarily in the final quarter of 2012, political, legislative and regulatory. These events, unfolding literally as we write, are setting the stage for what promise to be deeply fought battles in 2013. Washington political leadership is galvanized over the re-shaped landscape following the 2012 elections. New thinking and strategies are emerging on the federal budget, the debt ceiling, ACA implementation and mid-course modifications, health care entitlement programs and federal tax policies. The road ahead is unclear.

As the New Year’s Day fiscal cliff drama’s twists and turns illustrated, 2013 will be another unpredictable and challenging year for physicians and others deeply engaged in the health care system. Like it or not, this is the platform upon which we currently stand and must step forward from. We provide perspective in this report looking forward to the challenges facing the President and the newly seated 113th Congress. And, of course, we examine specific ongoing legislative and regulatory issues facing physicians in this roiled environment. We trust our perspectives will be helpful to you as you shape the direction of your medical practice.





# Executive Summary

## Introduction

Focusing on the final quarter of 2012, the central event regarding the near-term course of the United States was the re-election of President Barack Obama. Further, the Democrats in the U.S. Senate and the Republicans in the U.S. House of Representatives retained their respective Majorities, albeit with some modest change in numbers. Among other things, these results ensure continued Executive Branch support for and implementation of the Patient Protection and Affordable Care Act of 2010, i.e., the ACA. It also ensures continued challenges in the internal dynamics of the Congress, and between the Congress and the Administration.

Of course, the President's re-election does not diminish opposition in some quarters to major aspects of the ACA and the health care reforms it embodies. But, it does imply a significant shift in Congressional approaches to modification of the law, at least in the near-term. Despite the re-affirmed power

(and responsibility) of the Administration to implement the law passed by the Congress in 2010, there is as strong an undercurrent of resistance as ever in some quarters to notable issues in the ACA. For instance, bills have already been introduced in the House to repeal the Independent Payment Advisory Board (IPAB) and the individual mandate to buy health insurance, despite the Supreme Court's ruling upholding the latter.

In fact, the ACA has already experienced some "nicks", such as not repealing the IPAB, but reviewing steps in the House to strengthen the Congress's procedural hand in reviewing and modifying the force and effect of IPAB recommendations. A second example is the American Taxpayer Relief Act of 2012, which removed funds intended to support CO-OPS under the insurance provisions of the ACA. The Congress had already raided by \$5 billion the ACA's \$15 billion Prevention and Public Health Fund early in 2012, when additional economic legislation was enacted



to extend payroll tax reductions and related stimulus measures.

Separately from the ACA, House Ways and Means Committee leadership has announced a strong interest in repealing and replacing the sustainable growth rate (SGR) formula in the Medicare physician fee schedule, and is beginning to circulate draft ideas. As we noted in our August 2012 report, this is a technically challenging and very expensive thing to accomplish. If the SGR formula were an easy problem to solve, it would have been solved already. However, in its February 5 release of *The Budget and Economic Outlook: Fiscal Years 2013 – 2023*, the Congressional Budget Office (CBO) may have provided some assistance on the SGR issues, by lowering its 10-year cost of freezing payment rates through 2023 at 2013 levels, to about \$14 billion in 2014 and \$138 billion through 2023. The lowered estimates derive in part from lowered growth in physician service-related expenditures and slowing Medicare spending overall.

### **CBO Perspectives on the ACA Implementation**

In its documents released on February 5 and cited above, CBO notes the following points for the 2013–2023 baseline period estimates, relative to its August 2012 estimates (see pages 59–61):

- Lower projected costs for Medicaid and the Children’s Health Insurance Program,
- Higher enrollment in and subsidies for coverage through health insurance exchanges, primarily due to higher projected enrollment in the exchanges,
- Fewer people (7 million) with employment-based coverage, with the largest factor being the reduction in marginal tax rates, which reduces the tax benefits of health insurance provided by employers,
- Increased revenues from penalty payments to be paid by employers due to reduced offering of HI benefits, and
- Reduced revenues from individual penalties associated with the individual

mandate because more will be exempt or expected to pay a smaller flat-rate, rather than income-related, penalty.

CBO and the Joint Committee on Taxation (JCT) anticipate slightly reduced rates at which people will secure coverage through exchanges and Medicaid as the expansion of coverage is implemented due to a combination of factors, such as state readiness and people’s responses to the availability of new sources of coverage. As the first weeks of the 113th Congress proceed, and Members digest CBO’s updated economic and baseline forecasts, more and more budget and policy markers will be laid down, shaping the political parties’ positions and actions in the post-election era.

### **The “Perfect Storm” — Budgetarily Speaking**

Separately, there is a perfect storm of budget deadlines looming, each an action-forcing event to varying degrees:

- 1 ➤ the debt ceiling limit, now postponed until May 19 by new legislation,
- 2 ➤ the pushed-back sequester now scheduled to take effect in March, requiring deep cuts to federal spending in the final months of fiscal year 2013, and
- 3 ➤ the expiring fiscal year 2013 continuing resolution (CR) that is keeping the government running, temporarily, until March 27.

Each major budget clash deepens budget uncertainties, raises U.S. federal governance issues and challenges the political leadership to act in a way that does not de-stabilize our still fragile economy. These matters are even more compelling in the face of economic data reported in January 2013 revealing a slow-down in economic activity in the final quarter of 2012, and an upward tick in the unemployment rate from 7.8% to 7.9%. Indeed, in the same report cited above, CBO predicts “the unemployment rate will remain above 7 1/2 percent through next year; if that happens, 2014 will be the sixth consecutive year with unemployment

**Each major budget clash deepens budget uncertainties, raises U.S. federal governance issues and challenges the political leadership to act in a way that does not de-stabilize our still fragile economy.**

...both parties have effectively violated orthodoxies of their parties, moves that may reflect deeper tectonic shifts in the landscape.

exceeding 7 1/2 percent—the longest such period in the past 70 years” (page 1).

### Some Questions to Ponder About Washington Politics

Despite the nominally same balance of power as existed prior to the election, things are a little less the same than they may appear on the surface. The election results mattered, and are bringing subtle shifts in policies and strategies as the White House and the Congress absorb what happened. For instance, what should we make of the year-end ATRA legislation as a harbinger of further actions in 2013? Who expected expedient tax increase avoidance legislation passed at 2:00 in the morning on a national holiday would include a package of twenty-nine significant health provisions totaling about \$49 billion in new spending and offsets? Of course, physicians were the major beneficiaries due to the Medicare fee schedule fix (up \$25 billion), but our colleagues in health care whose services provided the “offsets” (down \$23+ billion) were less than happy with their start to the New Year. And while physicians can be thankful over the fix, it does not solve the structural problems in Medicare that are repeatedly patched over.

...when it comes to politics, it is more important than ever to “*Consider what is done, discount what is said.*”

Turn the prism a little more. How (and why) did a Democratic President charged with “tax-and-spend” liberalism position himself to engineer a *permanently lowered* tax revenue framework, perhaps starving the financial resources for the entitlement benefits many believe he was re-elected to protect? And why would Republicans be in such initial disarray over a vote (ATRA) that overwhelmingly accomplished what has been a driving tenet of their party since the election of Ronald Reagan, a *permanently lowered* tax revenue framework? Yes, there were compromise

tax increases on high-income families, but the permanently lower rate of taxes on the majority of Americans was a goal that eluded even former President George Bush.

Separately, why did the Republican Party, after strongly advocating for four years regarding the imperative for deficit reduction, agree to add nearly \$4.0 trillion to the deficit in the passage of ATRA? Finally, both parties ignored the need for deeper tax reforms that both had indicated they thought were essential. In interesting ways, totally ignoring the rhetorical spin each used to explain their actions, both parties have effectively violated orthodoxies of their parties, moves that may reflect deeper tectonic shifts in the landscape.

So what really could happen in 2013 budget negotiations? Will both parties come together around a significant tax loophole-closing package raising new tax revenues? Will Democrats accept initial re-structuring changes to Medicare or Medicaid? Will revenue be raised by changes to the ACA, such as delaying the 2014 effective date of the health insurance exchanges by one or two years, lowering the generosity of premium subsidies, or other, deeper changes? These are interesting and provocative questions. We don’t have answers to offer, but we think it is important to consider these and similar questions as the political fray renews. In a take on actions speak louder than words, when it comes to politics, it is more important than ever to “*Consider what is done, discount what is said.*”

### Shifting Emphases in ACA Objectives

Important as such considerations are, they are just one small piece of what is unfolding now under the ACA. Several far-reaching ACA implementing regulations were released over the last two months, with more to come. These include Medicaid requirements and flexibility, major rules governing health plans, new proposals to address constitutionally sensitive matters of required preventive health services for women, including contraception, and more.

These are in addition to the traditional ongoing regulations promulgated under the



**The ACA's key, twin objectives are: 1) to expand and support health insurance coverage and its affordability throughout the U.S., and 2) to incent, even require, systemic improvements in medical care quality, patient outcomes, and cost containment throughout the health care system.**

Medicare program to annually update policies in major provider payment systems. Major ACA deadlines are imminent and the loci of activity are centered on the states, employers and a triumvirate of federal agencies, namely the Departments of Health and Human Services, Labor and Treasury.

The ACA can best be understood through grasp of its two broad health care reform objectives, which are proceeding simultaneously under the multi-year timeline of the law's implementation schedule. The ACA's key, twin objectives are: 1) to expand and support health insurance coverage and its affordability throughout the U.S., and 2) to incent, even require, systemic improvements in medical care quality, patient outcomes, and cost containment throughout the health care system.

Arguably, during the years 2013 and 2014, the insurance expansion objectives are temporarily in the ascendancy as a centerpiece of the law, health insurance exchanges (or marketplaces), go into effect in every state. The Administration has said it is switching to the term "marketplaces" as being more understandable to most Americans, and more readily translatable into Spanish. The challenge

of getting some version of these marketplaces up and running in each state, using diverse models, will consume considerable federal and state resources and attention.

Meanwhile, as every practicing physician can attest, an equally complex set of clinical pressures and transactional obligations wrought by the law are proceeding, as well, and must be understood and attended to. Underlying all is a knowledge and technology revolution deeply permeating academia, government and healthcare that is outside the scope of this report, but which is omnipresent.

### **Continuing Search for the Governing Middle in the U.S. Congress**

Separately, there are important lessons embedded in the details underlying the election that will shape the political parties' future legislative and campaign behaviors for months, and perhaps years, to come. Select findings underlying the election results, and



Political leaders' abilities to bridge their differences will drive the future of the ACA, Medicare and Medicaid.

the fiscal cliff year-end debacle, discussed respectively in Chapter 1 and in Chapter 2, affirm the significance of the closing section of our August 2012 report.

That section, titled "Election 2012 and the Search for the Governing Middle in the U.S. Congress," highlighted research in American values and in structural changes in the composition and voting patterns of the Congress. It illustrated the steady dissolution over the last two decades of the "governing middle" of the Congress consisting of Members willing on key issues to cross party lines to forge consensus legislation.

The Physicians Foundation cautioned that political divergences shown in research data do not automatically lead to a failure of governance. However, we stated "what is critical to effective leadership is whether, despite differing views, Members of Congress (and the President) accept the responsibility to reconcile their disagreements and find the common ground necessary to properly discharge their responsibilities on behalf of the nation." Now that the election has been decided, our political leaders' abilities to responsibly bridge their differences to solve our major fiscal issues, of which health care spending is a large and critical component, will materially drive the future of the ACA, and of the Medicare and Medicaid programs.

Unfortunately, political dysfunction was on full display to the nation in the days leading up to passage on New Year's Day of the contentious American Taxpayer Relief Act (ATRA). We briefly discuss that process and legislation in Chapter II, and provide a summary of the major tax and health provisions.

While our focus is on the larger political and fiscal backdrop, the balance of the report provides snapshots of the status of select ACA implementation actions and physician-focused policies. These include:

#### PHYSICIAN-FOCUSED POLICY SNAPSHOTS

- 1 ► Medicare Physician Fee Schedule; Sustainable Growth Rate Formula
- 2 ► Value-based Payments and Quality
- 3 ► ACO Growth and New Cautions Regarding the Medicare Shared Savings Program

#### ACA STRUCTURAL FRAMEWORK SNAPSHOTS

- 4 ► Health insurance market reforms, including health insurance exchanges, informally renamed marketplaces,
- 5 ► Medicaid program expansions post-Supreme Court decision affirming the voluntary character of States' expansion decisions
- 6 ► Essential health benefits requirements for plans (including mental health, and preventive (and contraceptive) services for women
- 7 ► Internal Revenue Service (IRS) year-end summary of numerous ACA-related tax provisions, including for ACOs (Appendix to Chapter III)





## Conclusion—Gateway to 2013 and Medicare As A Primary Instrument of Medical Practice Reform

As noted in our preface, the purpose of this report is to provide a recap of select health care-related events in the final quarter of 2012 to inform physicians as we move forward into an equally challenging year in 2013. However, looking forward is equally crucial in these times. In closing, we'd like to draw your attention to a future objective. For the reasons discussed below, the Physicians Foundation has concluded that the Medicare program merits much deeper attention going forward.

To a major degree, the Medicare program, due to its sheer size and its nationally centralized policy-making structure, is the primary instrument by which many of the ACA's tools for changes in *medical care*, as opposed to health insurance coverage improvements, are being wielded. The Medicaid program also contributes to these objectives, but is more diverse across States, diluting its overall thrust nationwide.

Medicare policies deeply shape areas such as adoption of electronic health records, quality measures and reporting, accountable care initiatives, bundled payment programs, medical home concepts, value-based payments, and others. Medicare also is highly influential in policies related to the financing of graduate medical education, support for medically underserved areas and similar societal objectives. Indeed, with respect to payment methods for provider services, for good or ill, Medicare has been the dominant force in the U.S. since 1965 through its creation and adoption of new provider payment methods and systems. Medicare is an "Alpha Force" and prime mover in the health care system. Should further reforms to the program occur in 2013, the effects would ripple significantly throughout the nation's health care system.

For these reasons, the Medicare program will be the topic of a separate, special report by The Physicians Foundation to be released early in 2014. The exact timing of the release may be affected by the progress and timing of Medicare-related legislation, if any, enacted in 2013. It is The Physicians Foundation's goal that the report shall include information on newly enacted reforms or ACA modifications, if any occur, in the first session of the 113th Congress. Regardless of whether such actions occur, we think it is important to take a fresh look at the systemic role of Medicare in the U.S. health care system, consider how it might change in the future, and especially, assess the evolving implications for medical practice.

In the meantime, we turn to the 2012 wrap-up at hand. Thank you for your time and attention and we hope you find this report to be informative and helpful. ■

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## Chapter I: Perspectives on the Election of 2012

### The Aftermath for Health Care Reform

#### Election 2012 Results

**THE VOTE**—The nation has been inundated with election results and analyses since the dramatic denouement of November 6, 2012, plus delayed results over several days for tightly contested Congressional seats. Therefore, we confine ourselves to briefly conveying the key results and findings, and focus more on the implications for health care reform and entitlement programs in 2013 and beyond.

As we go to publication in late January, all disputed seats up for election in this cycle have been resolved. In summary, President Barack Obama, Democrat, won re-election over Mitt Romney, the Republican opponent, in the Presidential contest. President Obama won the popular vote by about 3% and, separately, the electoral vote by 332 electoral votes to Mr. Romney's 206 electoral votes. Of the nine "battleground" states, the President won eight (OH, FL, VA, WI, CO, NV, NH, and IA) to Mr. Romney's one (NC).

The incoming U.S. Senate for the 113th Congress consists of 54 Democrats and one

independent (caucusing with the Democrats) for a total of 55 seats, to Republicans' 45 seats. This represents a net loss of 2 seats for Republicans, and a net gain of one seat for Democrats. Since a plurality of 51 seats is required for control of the Senate's 100 seats, Democrats retain the Majority control of the Senate. These proportions will re-adjust, as necessary, as Members resign to join President Obama's cabinet or for any other reason, and their seats are filled.

The incoming U.S. House of Representatives consists of 232 Republican seats to Democrats' 200 seats (three seats are vacant). This represents a net loss to Republicans of nine seats, plus one later resignation (Jo Ann Emerson (R-MO.) resigned on January 21). Out of 435 total seats, 218 are required to secure the Majority; therefore, the Republicans retain Majority control of the House. Until the vacancies are resolved, the Majority can lose no more than 16 votes to pass legislation with only Republican votes. There are no registered Independents in the House.

"Democratic states are becoming more Democratic and Republican states are becoming more Republican, leaving few states where power is divided."



## The Nation's Statehouses

It's also important to note the balance of control in the nation's statehouses. The end result of the Gubernatorial races is that Republican Governors lead 30 states (gain of one seat), Democrats lead 19 states (loss of one seat), and an Independent controls one seat. In an Infographic titled "Republican Rule, Deeper Divides", released on January 21, the PEW Center for the States indicates that despite key Democratic victories at the state level in the 2012 elections, Republicans hold the majority of governorships and state legislative seats nationwide, providing a strong platform for their party's agenda.

Echoing aspects of the VoteView data we highlighted last August showing loss of the governing middle in the U.S. Congress, the PEW Center reports that the election reinforced a long-term trend: *"Democratic states are becoming more Democratic and Republican states are becoming more Republican, leaving few states where power is divided."* These suggest deep changes in our political system, our electorate and our society that merit reflection and attention as we address the issues ahead.

## Meta-Analytics in Campaigns and Health Care

The Obama Presidential campaign will be parsed for years to come if for no other reason than the unprecedented investment in and triumph of meta-analytics as employed throughout the campaign operation. These analytics contributed unprecedented insights into the characteristics and leanings of the electorate. They also provided reliable identification of the best potential sources of support for Mr. Obama, while informing campaign positions, advertising and get-out-the-vote strategies. In tribute, in its year-end double issue featuring President Obama on the cover as Person of the Year, Time Magazine provided a virtual centerfold spread (p. 70-71) of "The Geek Squad" highlighting their considerable contributions to a game-changing element in American political campaigns.

We highlight the data-driven elements

of the Presidential election because the growing focus in our society on information and data crunching on a large scale is inescapable. These same "Big Data" forces are transforming health care through avenues such as comparative effectiveness research, best clinical practices, bioinformatics, health information technology, digital technology for health, incentives for value in health and other areas. A notable resource on these matters is the Institute of Medicine's Roundtable on Value and Science-Driven Health Care and its topical Innovation Collaboratives.

**"Big Data" forces are transforming health care through avenues such as comparative effectiveness research, best clinical practices, bioinformatics, health information technology, digital technology for health, incentives for value in health and other areas.**

Returning to the election data perspective, we link the election with our focus on health care by sharing a few of the more reliable and interesting perspectives of the 2012 electorate on health care/entitlement questions. These perspectives may have influenced the 2012 election outcomes, but they are also suggestive of Americans' views as political leaders grapple over fiscal, taxation and entitlement program issues in 2013. We will discuss the country's fiscal state briefly in the next section. First, however, we turn to two interesting reports published by the non-partisan PEW Research Center.

## PEW Research Center's "A Bipartisan Nation of Beneficiaries"

The first study was published on December 18, 2012 and is titled "A Bipartisan Nation of Beneficiaries." It recognized that the issue of entitlements had moved to center stage in the election. (We expect that these issues will be central to deficit reduction efforts in 2013). The survey asked a nationally representative sample of respondents if they or a member of their household had ever received Social Security, Medicare, Medicaid, food stamps, welfare or unemployment benefits.

# REPUBLICAN RULE, DEEPER DIVIDES



Despite some key Democratic victories at the state level in the 2012 elections, **Republicans remain dominant**. Republicans hold the majority of governorships and state legislative seats nationwide and will have the opportunity to enact their party's agenda in far more places.

The election also reinforced a long-term trend: Democratic states are becoming more Democratic and Republican states are becoming more Republican, leaving **few states where power is divided**.

**POWER INDEX**

The Power Index measures the ease with which Democrats and Republicans can pass legislation. To do so, it takes into account the party of the governor, the percentage of Democrats and Republicans in each chamber of the legislature and the state's veto-override threshold.

Strong Republican

24

Strong Democrat

13

Close to even

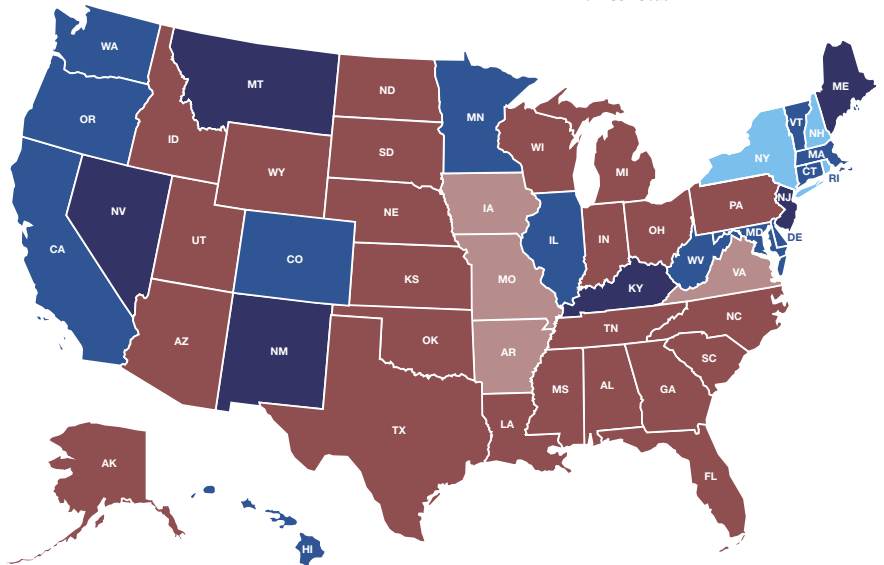
6

Leaning Republican

4

Leaning Democrat

3



States that are "strongly Democratic" or "strongly Republican" have one-party control of the legislature and governorship. Where control is divided, if one party needs far fewer votes from the opposition to pass legislation, the state "leans" toward that party.

\*While Nebraska's unicameral legislature is officially non-partisan, the *Omaha World-Herald* reported after the election that the membership will be 30 Republicans, 17 Democrats and 2 independents.

Source: National Conference of State Legislators, Stateline research. Infographic by Carla Uriona, Evan Potler, and Josh Goodman, Jan. 22, 2013.





# State Power Shifts



## Gubernatorial Reach

### 19 Governors

lead states with  
128 million people

### 30 Governors

lead states with  
184 million people



## Legislative Control



occupy 3,479  
legislative seats

occupy 3,814  
legislative seats

**hold 47% of  
legislative power**

**hold 52% of  
legislative power**



## United Control



have united control in 13  
states with 30% of the  
50-state population

have united control in  
25 states with 53% of the  
50-state population

gained united control in  
Colorado, Minnesota and Oregon

gained united control in Alaska,  
North Carolina and Wisconsin

lost united control  
in Arkansas

lost united control  
in Maine



## Since 2003



### 23 legislatures became more Democratic

New Hampshire shifted most  
toward the Democrats,  
followed by Delaware,  
Vermont, Hawaii and Nevada

in 16 of the 18 states Democrats  
carried in each of the last  
four presidential elections,  
the legislature has become  
more Democratic

### 26 legislatures became more Republican

Alabama shifted most toward  
the Republicans, followed by  
Tennessee, Arkansas,  
Oklahoma and Louisiana

in 20 of the 22 states Republicans  
carried in each of the last  
four presidential elections,  
the legislature has become  
more Republican



Notes: United control is control of the  
governorship and both houses of the  
legislature in a state.

Source: National Conference of State Legislators,  
Stateline research. Infographic by Carla Uriona,  
Evan Potler, and Josh Goodman, Jan. 22, 2013.

...these data suggest about seven-in-ten U.S. households contain at least one person who has benefitted by a major entitlement program.

In brief, the authors report that about 55% of Americans have received benefits from at least one of the major benefit programs, including a third (32%) who received help from two or more. Of those who voted for Obama, 59% have received a benefit, while of those who voted for Romney, 53% have received a benefit. There are numerous gender and demographic details in the study that are beyond the scope of our discussion. But, the following is striking.

The survey found that 16% who have not personally received a benefit reported that a member of their household has gotten help. It is reported that, collectively, *these data suggest about seven-in-ten U.S. households contain at least one person who has benefitted by a major entitlement program.* They report further that if veteran benefits and federal college loans and grants are included, the proportion of Americans who have personally received benefits rises to 70% and the share of households with at least one beneficiary rises to 86%. These are extraordinary statistics in demonstrating how deeply these programs have penetrated our society. Following is a table of the most widely received benefits in the U.S.

Budget Tradeoffs

Separately, the PEW Research Center published a second study on December 20, 2012 titled “The Big Generation Gap at the Polls Is Echoed in Attitudes on Budget Tradeoffs.” This study published an array of interesting data on views related to federal budget trade-offs and where government should focus its resources, especially parsed by age cohorts. However, we draw your attention to one finding, i.e., deficit reduction vs. maintaining entitlement benefits.

It is reported that *faced with a tradeoff of reducing the deficit vs. maintaining*

*entitlements, overall, the public favors keeping benefits as they are now by a margin of 56% to 32%.* Most experts argue this is not a sustainable position for the government. The response differences by age cohorts are striking. Young adults are closely divided, with 41% favoring deficit reduction to 48% favoring keeping Medicare and Social Security benefits as they are. Among those age 65 or older, only 21% say reducing the deficit is more important while 66% favor preserving entitlement benefits.

Interestingly, Obama ran on a platform that endorsed protection of benefits over deficit reduction, while the Romney platform emphasized deficit reduction over benefit preservation. Yet, despite the views expressed above by age cohorts, according to the PEW study, young adults voted for Obama by a 60% to 37% margin, while older Americans favored Romney by a 56% to 44% margin. This suggests caution is required in interpreting the power of budget and entitlement views to dictate the action of voters.

Revenue Increases vs. Spending Reductions

Finally, a recurring theme in the election revolved around federal personal income and corporate tax policy issues, versus spending on programs such as Social Security and Medicare, with the ballooning deficit looming

ENTITLEMENT PROGRAM RECIPIENTS

Program	Recipients
Social Security	56.7 million (Nov. 2012)
Medicaid	55.6 million (FY 2011)
Medicare	48.8 million (2011)
Food Stamps (Supplemental Nutrition Assistance Program, or SNAP)	46.6 million (FY 2012)
Welfare (Temporary Assistance for Needy Families, or TANF)	4.6 million, monthly avg. (2011)
Unemployment insurance	9.5 million new beneficiaries (2011)

(Sources: U.S. Social Security Administration, Monthly Statistical Snapshot, Oct 2012; Centers for Medicare & Medicaid Services, Fast Facts; U.S. Department of Agriculture, Monthly Data-National Level, FY 2009 through Sept 2012; U.S. Department of Health and Human Services, TANF Caseload Data (includes mostly families receiving ongoing cash welfare assistance); U.S. Department of Labor, ET Financial Data Handbook 394)

(Source: PEW RESEARCH CENTER)

over all. One narrative involved the erosion of the middle class and the distinctions that different tax treatment plays across middle income families, who rely primarily upon earned wages, versus higher income classes that are more likely to report income from investments as a source of earnings. These perspectives divided the candidates, with Mr. Obama seeking both tax increases on upper income individuals and spending reductions, and Mr. Romney seeking possible closing of corporate tax loopholes and primarily spending reductions.

We note this issue because, in spite of selected tax policy changes in ATRA, the political parties' differences on these matters continue to fester and will shape the fiscal debate in 2013. Without diving into the relative merits of those debates, the stage is set for 2013. The President's heavily thematic inaugural and State of the Union addresses, the Republican's January 2013 retreat and subsequent, revised strategy on the debt limit and increased attention on regular order budget processes, all coupled with the pending sequestration and the expiration of the 2013 continuing resolution in March, ensure an early and intense political season.

## Conclusion: A Challenge for Political Leaders

To conclude, the Pew Research Center results highlight the challenges facing political leaders as they focus on how best to constrain spending on the top benefit programs, including Medicare and Medicaid. Indeed, they show just how deeply entitlement programs and benefits have woven themselves into the fabric of ordinary Americans' lives. They also indicate that the expressed views or even personal material interests of voters don't necessarily dictate their votes.

This suggests that to achieve both effective deficit reduction and reasonable entitlement reforms, political leaders have to find the elusive balance between responsible budget management and ensuring important societal needs are met. In other words, achieve an "old-school" political accommodation that serves the broadest public interest. Despite the well-documented trends toward increasing polarization, leaders will need to find the "governing middle" we discussed in the preceding report, and unite to defend their decisions to a contradictory and divided electorate. ■

**Despite the well-documented trends toward increasing polarization, leaders will need to find the "governing middle" ...and unite to defend their decisions to a contradictory and divided electorate.**



## Chapter II: Fiscal Disorder in the Government's House—Reprised

**INTRODUCTION** Our purpose in this chapter is to review year-end federal budget actions that have set the stage for deeper, even more challenging issues immediately facing the 113th Congress in 2013. By way of background, in our preceding report of August 2012, cited earlier, we devoted a major chapter to the “Fiscal Disorder in the Governments’ House(s).” In that chapter, we took a deep dive into the overall state of the federal and state governments’ budgets. We also covered the recent, multi-year budget history and impact estimates relating to the December 31, 2012 “fiscal cliff” built into the Budget Control Act of 2011. Finally, we analyzed the implications of detailed estimates of the Congressional Budget Office

(CBO) relating to the potential coverage and budgetary impact of the June 2012 Supreme Court decision on the Medicaid program and the ACA, overall. We refer readers back to those resources, as needed.

Following, we report on the significance of regular order processes in the Congress, and the enactment of and content of the American Taxpayer Relief Act of 2012. Let the record show that ATRA passage was emphatically NOT an example of regular order, but the disorderly and emergency-style culmination of at least three years of regular order failure. We conclude with a synopsis of fiscal challenges facing the country and that Members of Congress will grapple with in 2013.

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### The Breakdown of Regular Order in the U.S. Congress

As a brief reminder to readers, we’d note that there are laws and deadlines shaping the annual U.S. federal budget process, which have been deeply disregarded over the last four years. Following is a highly abbreviated review. In a typical year, the President submits the Administration’s budget proposals for the next fiscal year by early February (already missed as of this writing). The House and Senate are expected to pass their respective budget resolutions by April 15. This sets each Chamber’s budget parameters and incorporates spending level and other instructions to key Committees charged with writing legislation affecting specific programs and activities of government.

In effect, the Congressional budget resolutions are the procedural “opening gambits” of the respective Congressional chambers on setting their political

and policy objectives for the year. The Committee processes are intended to achieve comprehensive, but differing packages of legislation within each Chamber that can pass each Chamber, preferably by about June. However, passing a budget resolution is not genuinely meaningful until those numbers have been backed-up by detailed legislation revealing the federal program changes required to meet the stated budget targets. Then, and only then, can interested parties engage in negotiations over concrete priorities with real understanding of the consequences of their decisions.

To conclude on process, the separately passed legislative packages are taken-up by a House and Senate Conference that attempts to “reconcile” policy and spending differences into a single conference agreement that could pass both Chambers and be sent to the President for signature. Ideally, this process should be completed before the October 1 beginning of the



federal fiscal year. In reality, the difficult budget reconciliation process often is not completed until late in the calendar year, requiring a short-term CR, or continuing resolution, to fund government operations pending a final budget deal.

It is this process of setting budget resolutions and voting on them, followed by conforming legislative actions within legislating Committees, including hearings, mark-ups of proposed packages and the offering of amendments and voting, that is referred to as “regular order.” It is central to our democratic processes within the Congress, yet it has been much damaged by the intensely partisan conduct of recent years in both Chambers. Many experts on the functioning of the Congress suggest it is essential to the restoration of stable governance and sound budget actions that the regular order process be healed. Regular order is a standard by which upcoming legislative actions in 2013 can be measured. It is worth keeping this in mind as the country enters a new round of crucial budget deadlines and actions.

### “Waterloo” on the Potomac

Following an earlier vote in the U.S. Senate of 89 to 8 in favor of passing a hastily assembled compromise package on taxes, health care and other provisions, the House acted about 2:00 am on New Year’s Day to pass the American Taxpayer Relief Act of 2012 (ATRA), by a vote of 257 to 167. Indeed, the House even “bent” time itself, keeping the 112th Congress in session slightly beyond the expiration of 2012 and recording this legislation as “2012” legislation. CBO estimated that ATRA would increase the deficit by \$3.97 trillion over 10 years, when compared to its current law baseline (see table).

The U.S. stock market responded positively to the deal, but it appeared to be hard for many to celebrate what was effectively the first “bipartisan” fiscal action of consequence in months. It occurred only after multiple and protracted budgetary failures over the last 2-3 years, including the:

- Bowles-Simpson Commission,
- Vice-President’s Working Group,
- Congressional Super-Committee
- Bi-lateral negotiations between President Obama and House Speaker John Boehner (twice), and
- House Speaker Boehner’s December 2012 Plan B.

**Passing a budget resolution is not genuinely meaningful until those numbers have been backed-up by detailed legislation revealing the federal program changes required to meet the stated budget targets. ...only then, can interested parties engage in negotiations over concrete priorities with real understanding of the consequences of their decisions.**

All culminated in a painful, protracted and messy election, as well as politicized post-election process, full of an exceptional degree of rancor among political leaders. Although these matters have been disheartening to many Americans, and global observers, some argue we should be cheered that at least some steps have been taken. Readers may draw their own conclusions.

Following is a summary table of the budget impact of the ATRA package, as initially passed. Please refer to the Appendix at the end of this chapter for an abbreviated summary of key ATRA provisions, focusing on health care actions.

Despite the initial public relief at some action being taken, at a minimum, ATRA left unresolved:

- **SEQUESTRATION**—resolution of the modified sequestration, postponed for 2 months.
- **DEBT CEILING LIMIT**—raising of the debt ceiling limit (technically breached around 12/31/12, with the Treasury Department taking temporary, exigent fiscal actions to delay default on obligations—see discussion below), and
- **FY 2013 CONTINUING RESOLUTION**—expiration of the temporary fiscal year 2013

**TABLE 1. IMPACT ON THE BUDGET DEFICIT OF ATRA AND OTHER "FISCAL CLIFF" POLICIES  
RELATIVE TO CURRENT LAW**

Increases or Decreases (-) in the Budget Deficit in FY2013 and in the FY2013-2022 period

Fiscal Policy Provision	Billions of Dollars of Outlays	
	FY2013	FY2013-2022
<b>Revenue Policies</b>		
Changes to Bush-era Tax Cuts, Estate and Gift Tax, and AMT Provisions*	207	3,852
Expiration of Payroll Tax Rate Reduction <sup>b</sup>	0	0
Extension of Other Expiring Tax Provisions*	74	76
Affordable Care Act (ACA) Taxes on High Income Filers <sup>b</sup>	0	0
<b>Spending Policies</b>		
Reduction and Postponement of Budget Control Act (BCA)	14	24
Automatic Spending Cuts		
Extension of Unemployment Insurance Benefits	22	30
Sustainable Growth Rate (SGR) Provisions	11	25
Extension of the Farm Bill <sup>b</sup>	0	0
<b>Net Offsets</b>		
Title VI Other Health Provisions <sup>c</sup>	2	-23
Title IX Roth IRA Provisions <sup>d</sup>	*	-12
Adjustment to Caps on Discretionary Appropriations <sup>d</sup>	-1	-10
<b>Total</b>	<b>329</b>	<b>3,961</b>

SOURCE: CONGRESSIONAL BUDGET OFFICE, *ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 8, THE AMERICAN TAXPAYER RELIEF ACT OF 2012, AS PASSED BY THE SENATE ON JANUARY 1, 2013.*

Notes: Totals may not sum due to rounding. \* indicates less than \$500 million.

continuing resolution (CR) that authorizes government spending, but only through March 27.

Stepping back, despite ATRA enactment, the most immediate subsequent issue was the December 31, 2012 threatened breach of the debt ceiling. Although the limit has now been re-extended until May 19, it must again be addressed. This places fiscal and political attention more squarely on actual budget process imperatives in the House and Senate, and on the March delayed sequestration and expiring continuing resolution problems.

Finally, ATRA did not begin to address the perceived consensus in favor of deeper tax code reforms, nor were there significant entitlement program adjustments. Some now argue that instead of helping, ATRA may have retarded the impetus to more substantive budget policy solutions, especially deeper re-structuring of the federal tax code or significant Medicare reforms. We caution that since health care spending is a major driver in federal spending, significant deficit reduction efforts could fall heavily upon the health

care sector. Even in the ATRA package, to the extent there were savings offsets, over half (\$23 billion) of the total savings came from Title VI-Other Health Care Provisions.

## The Congressional Budget Office Speaks

**THE DIRECTOR'S BLOG**—As noted earlier, on February 5, 2013, the Congressional Budget Office (CBO) released a major reassessment of the economic conditions, federal spending levels, and deficit trajectory in the U.S., in order to set the 2013- 2023 budget baselines for legislative policy and scoring purposes. These documents are jam-packed with important details. The following day, CBO summarized its views on broader budget matters and the 3-pronged “perfect storm” described earlier, in a separate statement through the Director’s Blog. Following is a major excerpt of that statement:

“Yesterday CBO released The Budget and Economic Outlook: Fiscal Years 2013 to 2023.

In that report, CBO projects that the federal deficit will drop to \$845 billion in 2013—its smallest size since 2008. Even so, under current law annual deficits and federal debt will stay at historically high levels relative to the economy through 2023, and lawmakers face key budgetary decisions this year that could have a substantial effect on that budget outlook.

### Key Budgetary Decisions Facing Lawmakers Over the Next Few Months

By changing some income tax rates and making permanent changes to the alternative minimum tax, among other things, the American Taxpayer Relief Act has reduced the uncertainty surrounding federal fiscal policy. Nevertheless, many key budget issues remain unresolved.

### Automatic Spending Reductions

The provisions of the Budget Control Act that established automatic procedures to restrain discretionary and mandatory spending are set to take effect on March 1; if fully implemented, they will reduce total funding in 2013 by \$85 billion. (The American Taxpayer Relief Act delayed the reduction by two months and reduced it by \$24 billion.) CBO estimates that, in 2013, discretionary funding (which is provided through annual appropriations) will decline by \$71 billion and funding for mandatory programs (which is not subject to annual appropriations) will be reduced by \$14 billion, as a result of those procedures.

By CBO's estimate, budgetary resources for defense (other than spending for military personnel) will be cut by around 8 percent across the board, and nondefense funding that is subject to the automatic reductions will be cut by between 5 percent and 6 percent. According to that estimate, discretionary outlays will drop by \$35 billion and mandatory spending will be reduced by \$9 billion this year as a direct result of those procedures; additional reductions in outlays attributable to the cuts in 2013 funding will occur in later years. The deficit for 2013 will depend in part on whether those cuts are allowed to take place, are canceled (in whole or in part), or are replaced with other measures designed to reduce the deficit.

If lawmakers chose to prevent those automatic cuts each year without making other changes that reduced spending by offsetting amounts, the deficit would total nearly \$900 billion in 2013, more than \$40 billion higher than under current law. Over the 2014–2023 period, total deficits would exceed \$8 trillion—over \$1 trillion more than is projected in CBO's current baseline.



### Continuing Resolution

Federal agencies are now operating under the Continuing Appropriations Resolution, 2013 (P.L. 112-175), which set discretionary funding for 2013 at an annual rate of \$1.047 trillion, the sum of the caps established by the Budget Control Act (before the American Taxpayer Relief Act reduced the caps by \$4 billion). That funding will expire on March 27, although following the rules in the Balanced Budget and Emergency Deficit Control Act of 1985, CBO's baseline incorporates the assumption that such funding will be extended at the current amount for the remainder of the fiscal year. If no additional appropriations are provided, nonessential functions of the

We caution that since health care spending is a major driver in federal spending, significant deficit reduction efforts could fall heavily upon the health care sector. Even in the ATRA package, to the extent there were savings offsets, over half (\$23 billion) of the total savings came from Title VI-Other Health Care Provisions.

**The influx of new Members sworn in for the 113th Congress, the changing composition and leadership of numerous House and Senate Committees, and the reassessment of policy strategies across the Congress and Administration, creates a great deal of uncertainty over future positions and actions.**

government will cease operations after March 27. If final appropriations differ from those provided in the continuing resolution, CBO's projections of discretionary outlays will be affected for 2013 and future years.

### **Statutory Limit on Federal Debt**

Until recently, the amount of debt that the Department of the Treasury could issue to the public and to other government accounts was capped at \$16.394 trillion; that limit was reached at the end of December 2012.

At that time, the Treasury began using what are known as extraordinary measures for managing cash and borrowing in order to continue funding the operations of the federal government. Lawmakers have recently suspended the limitation on borrowing through May 18, 2013, and on May 19, the existing debt limit will be raised by the amount of borrowing that occurred while the limitation was suspended (that is, from early February to May 18). If no further action is taken before May 19, the Treasury

will once again resort to extraordinary measures to allow the government to continue operating normally. To avoid defaulting on the federal government's obligations, including possibly defaulting on the government's debt obligations, the debt ceiling will need to be adjusted before those extraordinary measures are exhausted later in the year.

### **Other Important Budgetary Decisions**

Budgetary outcomes will also be affected by decisions about whether to continue certain policies that have been in effect in recent years. Such policies could be continued, for example, by extending some tax provisions that are scheduled to expire (and that have routinely been extended in the past) *or by preventing the 25 percent cut in Medicare's payment rates for physicians that is due to occur in 2014* (emphasis supplied).

If, for instance, lawmakers eliminated the automatic spending cuts scheduled to take effect in March (but left in place the original caps on discretionary funding set by the Budget Control Act), *prevented the sharp reduction in Medicare's payment rates for physicians* (emphasis supplied), and extended the tax provisions that are scheduled to expire at the end of calendar year 2013 (or, in some cases, in later years), budget deficits would be substantially larger over the coming decade than in CBO's baseline projections. With those changes, and no offsetting reductions in deficits, debt held by the public would rise to 87 percent of GDP by the end of 2023 rather than to 77 percent in CBO's baseline.

In addition to those decisions, lawmakers will continue to face the longer-term budgetary issues posed by the substantial federal debt and by the implications of rising health care costs and the aging of the population. Even under current law, federal debt will remain far above the average of 39 percent of GDP that the United States experienced between 1973 and 2012—and it will be trending upward by the end of the decade. Debt that is high by historical standards and heading higher will lead to rising interest costs, less domestic investment and lower incomes, less flexibility to respond to unexpected challenges, and a greater likelihood of a fiscal crisis in which the government would be unable to borrow funds at affordable interest rates. Those consequences could be mitigated if policies were enacted that reduced federal debt relative to GDP during the coming decade and beyond."

(Source: Congressional Budget Office. The CBO Blog. Douglas Elmendorf, Director. posted February 6, 2013. [www.cbo.gov](http://www.cbo.gov))

**CBO PERSPECTIVES ON THE ACA**—In its documents released on February 5 and cited above, CBO notes the following points for the 2013–2023 baseline period estimates, relative to its August 2012 estimates (see pages 59–61):

- Lower projected costs for Medicaid and the Children's Health Insurance Program,
- Higher enrollment in and subsidies for coverage through health insurance



exchanges, primarily due to higher projected enrollment in the exchanges,

- Fewer people (7 million) with employment-based coverage, with the largest factor being the reduction in marginal tax rates, which reduces the tax benefits of health insurance provided by employers,
- Increased revenues from penalty payments to be paid by employers due to reduced offering of HI benefits, and
- Reduced revenues from individual penalties associated with the individual mandate because more will be exempt or expected to pay a smaller flat-rate, rather than income-related, penalty.

In closing, CBO and the Joint Committee on Taxation (JCT) anticipate slightly reduced rates at which people will secure coverage through exchanges and Medicaid as the expansion of coverage is implemented due to a combination of factors, such as state readiness and people's responses to the availability of new sources of coverage.

## Conclusion

We opened this section by referring to the Congress's passage of ATRA as a "Waterloo" event. And why was it a "Waterloo" event? And, for whom? For Republicans, it represented the first time in over twenty years many had voted for a tax increase, albeit a fairly narrowly defined one, accompanied by select tax reductions (e.g., the AMT patch).

Whether it is a precedent that leads to future fiscal agreements that contain elements of revenue increases and significant spending reductions, remains to be seen.

Regardless, budgetary concerns mount. As our earlier CBO chart shows, ATRA, on balance, added about another \$4.0 trillion to the nation's deficit over 10 years—hardly a deficit reduction effort. Alternatively, there is room for debate over the continued sluggish economic recovery and whether an austerity package would damage the fragile recovery. The influx of new Members sworn in for the 113th Congress, the changing composition and leadership of numerous House and Senate Committees, and the reassessment of policy strategies across the Congress and Administration, creates a great deal of uncertainty over future positions and actions.

Finally, it is crystal clear that neither the Congress nor the President will enjoy any respite on the unresolved fiscal issues in 2013. To achieve meaningful deficit reduction will almost assuredly require significant inroads on entitlement programs, and possible modifications to the ACA. We will be watching closely Congressional and Administration actions on these fronts. In closing, we move to Chapter III and provide current snapshots on select policies of direct importance to physicians, including the Medicare fee schedule, and progress on certain ACA structural framework implementation matters. ■

**To achieve meaningful deficit reduction will almost assuredly require significant inroads on entitlement programs, and possible modifications to the ACA.**

# Appendix

## *Overview of The American Taxpayer Relief Act of 2012*

Although extremely limited relative to the “Grand Compromise” sought earlier, ATRA contains numerous tax and health care provisions of interest. Following is a summary table of the budgetary impact, followed by select highlights, focusing primarily on the health provisions. They are ordered by tax, health spending “costers” and health savings or “offset” provisions.

### *Summary of Select ATRA Provisions*

#### **Tax Provisions**

ATRA permanently extends the reduced tax rates and other tax benefits enacted in 2001 and 2003 for most taxpayers, but allows tax rates to rise for income higher than \$400,000 for individuals and \$450,000 for couples. Tax rates for income above \$400,000 for individuals and \$450,000 for couples will rise from the current level of 35% to 39.6%. Reduced rates on capital gains and dividend income for taxable income up to those levels are extended, but rates are raised from 15% to 20% for income above that level.

It also permanently:

- extends the estate tax exemption amount at current levels but allows the maximum rate to increase to 40%;
- includes a permanent “patch” for the alternative minimum tax (AMT) to prevent many Americans from having to pay higher taxes under the alternative system;
- allows the return of the personal exemption phase-out, which phases out the value of personal exemptions of certain taxpayers in the top two income tax brackets, as well as the so-called Pease limitation, which reduces the overall value of itemized deductions of certain higher-earning taxpayers, for income levels starting at \$250,000; and,
- temporarily extends a number of expired tax credits and deductions for individuals and businesses.

The Joint Committee on Taxation (JCT) estimates that these provisions will reduce revenues, relative to the baselines that assumed expiration of the lower Bush-era tax rates, by \$3.92 trillion over 10 years.

The bill does not extend the payroll tax holiday, allowing the temporary tax cut to expire. This means an immediate 2% rise in payroll tax rates. For instance, an individual earning \$50,000.00 would pay \$1,000.00 more in annual payroll taxes.

This is a highly redacted description of the tax provisions. For detailed descriptions of those provisions, we refer readers to the Urban-Brookings Tax Policy Center ([www.taxpolicycenter.com](http://www.taxpolicycenter.com)) or to the official scoring of the new law by the Congressional Joint Committee on Taxation ([www.jct.gov/publications](http://www.jct.gov/publications)).

#### **Sequester Replacement & Other Extensions**

ATRA postpones for two months automatic cuts to government spending (sequestration) which were set to occur in January, replacing them with lower discretionary spending caps and \$12 billion in new revenue related to retirement accounts.

The measure extends by one year, through Dec. 31, 2013, eligibility for expanded unemployment insurance benefits for laid-off workers. It maintains the restructured benefit tiers enacted under last year's payroll tax agreement that reduced the maximum 99-week eligibility to 73 weeks.

#### **Health Care Provisions**

Although the principal focus was on tax policies, there were 29 separate health care provisions in the final legislation.

##### **Sustainable Growth Rate**

- The law blocks a scheduled 27% reduction in the Medicare reimbursement rate for physician services that is set to occur on Jan. 1. The measure maintains the current reimbursement rate through Dec. 31, 2013. According to CBO, the cost of the one-year extension is \$25.2 billion over 10 years.
- The law also directs the Health and Human Services Department (HHS) to work with interested parties to improve advanced clinical data registries to clarify data tracking, reporting and transparency requirements in order to identify program risks, clarify multiple-payer information and implement quality improvements for services paid for under the SGR.

##### **Outpatient Therapy Payments**

- Medicare currently sets annual per beneficiary

payment caps for non-hospital outpatient therapy services. Providers can seek an exemption if the therapy is deemed medically necessary. Exemptions from the cap were set to expire Dec. 31. The measure extends the caps through Dec. 31, 2013. It also modifies the program to cap payments for services provided during the extension, limiting the costs to the lesser of 80% of the actual costs of the service provided or 80% of the cost designated by existing fee schedules for certain services. CBO estimates that these provisions will cost roughly \$1 billion over 10 years.

### **Qualified Individual & Transitional Assistance**

- The law extends, through Dec. 31, 2013, the Qualified Individual (QI) program that allows Medicaid to pay the Medicare Part B premium for qualifying low-income individuals. The program allocates funding to state agencies responsible for administering the program. CBO estimates that this provision will cost roughly \$800 million over 10 years.
- The law also extends, through the end of 2013, the Transitional Medical Assistance program, under which individuals receiving Medicaid may continue to receive benefits as they transition to employment. According to CBO, this extension will cost about \$600 million over 10 years.

### **Medicare Work Geographic Adjustment**

- Under current law, the Medicare fee schedule is adjusted to reflect the differences in the cost of providing services in different geographic areas. This adjustment is based on three factors: physician work, practice expense and the cost of medical malpractice insurance. Medicare identifies 89 unique geographic areas. The law extends the adjustment through 2013. CBO estimates that these provisions will cost roughly \$500 million over 10 years.

### **Ambulance Add-ons**

- The law extends current Medicare reimbursement rates, including rates for "super-rural" areas, for ground ambulance services through 2013. It requires the federal Department of Health and Human Services (DHHS) to conduct a study regarding the payments for ambulance services in rural and super-rural areas. CBO estimates that these provisions will cost approximately \$100 million over 10 years.

### **Special Diabetes Program**

- The law provides early reauthorization for funding of diabetes prevention and research programs for American Indians and Alaskan Natives, which is currently set to expire at the end of FY 2013. The

measure extends the current annual authorization of \$150 million through FY 2014. CBO estimates that this provision will cost roughly \$300 million over 10 years.

### **Medicare-Dependent Hospital Program**

- The measure extends the Medicare-Dependent Hospital (MDH) Program through FY 2013. The program currently provides funding for 200 rural hospitals through special Medicare rates resulting from high populations of Medicare patients. A hospital qualifies for the MDH Program if it is located in a rural area, has 100 beds or fewer, is not a "sole community hospital" and has at least 60 percent of inpatient days or discharges covered by Medicare. CBO estimates that this extension would cost approximately \$100 million over 10 years.

### **Low-Volume Hospital Program**

- The measure extends the Low Volume Hospital program through 2013. This program provides additional Medicare funding to hospitals in rural communities that are more than 15 road miles from another comparable hospital and have fewer than 1,600 Medicare discharges per year. CBO estimates that this extension will cost roughly \$300 million over 10 years.

### **Special-Needs Medicare Advantage Plans**

- The measure extends through 2015 the availability of Medicare Advantage Plans available to individuals with special needs. According to CBO, this program will cost roughly \$300 million over 10 years.

### **Other Program Extensions**

The measure also extends a number of programs, which according to CBO will have a budgetary impact of less than \$50 million. These programs include:

- **LOW-INCOME OUTREACH PROGRAMS** — These programs are designed to increase awareness regarding available benefits for low-income individuals and families.
- **CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) EXPRESS LANE PROGRAM** — The Express Lane program streamlines the enrollment process for children eligible for health coverage under CHIP or Medicaid.
- **FAMILY-TO-FAMILY INFORMATION CENTERS** — A grant program that provides funding to nonprofit service providers that provide care to special-needs children and their families.

## Fiscal Offsets

The law includes a wide variety of offsets that reduce, rescind or eliminate funding for certain programs and adjust payment formulas for a variety of health programs.

### Inpatient Prospective Payment System

► The law modifies the payment rate adjustments for acute inpatient treatments provided to Medicare beneficiaries. The inpatient hospital benefit covers beneficiaries for 90 days of care per episode-of-illness with an additional 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted and end after they have been out of the hospital or Skilled Nursing Facility (SNF) for 60 consecutive days.

Beginning in 2007, the payment system began using Medicare severity-adjusted diagnosis-related groups (MS-DRG) in an effort to better reflect the cost differences caused by the severity of individual cases. The ACA (in 2010) further modified this payment system to require adjustments based on historical quality of care, readmission reductions and value-based purchasing. Under this program, the Centers for Medicare & Medicaid Services (CMS) was authorized to reduce payment rates for excess re-admissions, revoke eligibility for hospitals wrongly classified under the program and to recapture certain overpayments.

The law directs CMS to make additional adjustments to payment rates based on hospital and treatment discharge estimates for the FY 2014 to FY 2017 period. This adjustment would be made to offset the aggregate payment increase that occurred between FY 2008 and FY 2013, when the MS-DRG rate system took effect, but prior to the implementation of the updated payment system enacted in 2010. The measure specifies that CMS does not have the authority to recoup overpayments made in FY 2008 and FY 2009.

According to CBO, this adjustment will reduce spending by roughly \$10.5 billion.

### End-Stage Renal Disease Payment Bundling

► The law directs the Secretary of DHHS to compare patient data from 2007 with data from 2012 and make reductions to the single payment rate for renal dialysis services. The adjustment would be required to account for differences in drug and biologics utilization, but would exclude oral-only drug treatments.

A GAO investigation that tracked renal disease treatments from 2007 to 2011 discovered that drug utilization had fallen during that time and that the bundled payment rate for renal disease treatments did not reflect the difference. According to the report, between \$650 million and \$880 million could have been saved if the payment rate had been adjusted to reflect the use of non-oral drug treatments.

The law delays until 2016 the inclusion of oral-only treatments within the prospective payment system for renal disease treatments.

CBO estimates that these provisions will reduce spending by \$4.9 billion over 10 years.

### Medicaid Disproportionate Share Hospital Allotments

► The measure extends a previously enacted reduction in payments to hospitals that treat unusually large numbers of patients with little or no health insurance.

Disproportionate Share Hospital (DSH) adjustment payments provide additional funding to hospitals that serve a significantly disproportionate number of low-income patients. States receive an annual DSH allotment to cover the costs of DSH hospitals that provide care to low-income patients that are not paid by others, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or other health insurance. The allotment is calculated through a statutory formula and includes requirements to ensure that the DSH payments to individual DSH hospitals are not higher than actual uncompensated costs. The ACA modified DSH payments, reducing the rates as the availability of health insurance subsidies and state exchanges come online starting in 2014.

The law would rebase future allotments, through FY 2022, to the current law calculation, thereby reducing growth in the program. CBO estimates that this provision will reduce spending by \$4.2 billion over 10 years.

### Medicare Advantage Coding

► The law increases the rate used to reflect risk-related cost differences between certain Medicare fee-for-service plans and Medicare Advantage. There are currently two rates that are scheduled to take effect to equalize program spending — 1.3% in FY 2014 and 5.7% in 2016. The measure increases each rate by 0.2%. CBO estimates that this change will reduce spending by \$2.5 billion over 10 years.



### **Multiple Therapy Service Payments**

➤ The law increases from 25% to 50% the current mandated reduction in payments made for certain outpatient therapy treatments provided after April 1, 2013. (Under current law, when a patient receives multiple treatments at a single facility on the same day, the Medicare practice expense payments for a portion of those treatments are automatically reduced by 25%.) According to CBO, this change will reduce spending by roughly \$1.8 billion.

### **Medicare Improvement Fund**

➤ The measure eliminates funding for the Medicare Improvement Fund, reducing spending by roughly \$1.7 billion.

### **Imaging Equipment Utilization Rates**

➤ The law requires HHS to use a 90% utilization rate assumption in the average use of advanced imaging equipment in 2014. The rate is used to determine the payment rates for non-therapeutic medical equipment, including diagnostic imaging systems. CBO estimates that this provision will reduce spending roughly \$800 million over 10 years.

### **CO-OP Contingency Fund Reduction**

➤ The law creates a new CO-OP Program Contingency Fund and redirects 10% of the unobligated funds that had been provided under an earlier CO-OP Program created by the ACA. These amounts will cover loans and grants already awarded.

➤ The law rescinds the remaining funds provided under the original formulation of the CO-OP Program, effectively halting new CO-OP Program activity. The program had been intended to encourage the development of nonprofit entities to provide health insurance coverage.

### **Repeal of CLASS Program**

➤ ATRA repeals the Community Living Assistance Services and Supports (CLASS) program, which was enacted as part of the 2010 health care overhaul law (PL 111-148; PL 111-152), and replaces it with a Commission on long-term care. CBO estimates that the repeal will not have a significant budgetary effect because CBO had already incorporated into their scoring baseline the Administration's October 2011 announcement that the provisions could not be implemented, as originally enacted.

The CLASS Program had been included in the ACA to facilitate access to long-term care services. The program was intended to provide enrollees with a cash benefit that could be used to subsidize the purchase of various long-term care services and supports, such as home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home-care aides and nursing support.

The Commission is to be composed of 15 members, tasked with devising a national plan for long-term care. If a majority of the Commission members approve a plan, it is to be sent to the Congress for consideration.



## CHAPTER III: The Health Care Reform Landscape

### Post-Election ACA Implementation Updates

#### The Drive to Nationwide Coverage

After untold millions of dollars spent since 2010 in advocacy costs and legal challenges fees, both pro and con; after two and a half years of virtual trench warfare (politically speaking, of course), the ACA still stands.

Battered and nicked, but still basically the law of the land. Accordingly, our purpose is to bring some clarity to the current state of implementation, post-election 2012.

First, newly re-elected President Obama reiterated his strong commitment to the goals and continued implementation of the law. Second, Republican leaders, especially in the House, have acknowledged that full repeal is much less likely post-election, and that their strategies will focus on selective repeal, rigorous oversight and modification, including de-funding, wherever possible. Aside from overt Congressional actions, key aspects of the ACA could founder at the state level, absent determined and effective progress on federally-facilitated exchanges and other strategies within the purview of the Administration.

Separately, within the Administration, there is considerable changing of the guard in the Obama White House and in several Cabinet positions. However, it appears that at the central focal point for health care reform implementation, the Department of Health and Human Services (DHHS), the executive team will be reasonably stable.

It has been announced that Secretary Kathleen Sebelius will continue in her position, and it appears likely the most senior management posts in DHHS and the Centers for Medicare and Medicaid Services (CMS) will remain fairly stable, as well. One unresolved question is the future of Marilyn Tavenner, Acting Administrator of the Centers for Medicare and Medicaid Services. There is also a bench of long-term civil service employees who are experienced in the law's requirements and who continue to be employed in the regulatory details of the law's

implementation. While some may not view the latter as necessarily positive, it is the role of dedicated career civil servants to manage the functions of government in compliance with the law, even through changes in political direction and leadership.

This is not to suggest that all will be smooth sailing. Right now, there is a concerted drive underway within the Administration, including the Departments of Labor and Treasury (especially the Internal Revenue Service (IRS)), working with DHHS, to secure the building blocks for 2014. The final quarter of 2012, especially post-election, and January 2013, saw a flurry of policy and regulatory releases from federal agencies responsible for implementation of important tasks under tightening statutory timelines.

For instance, the regulated private insurance plan markets known as health

insurance exchanges (now referred to by the Administration as “marketplaces”), are to be up and running in all 50 states, whether under federal or state direction, or in a partnership model. Some analysts are genuinely concerned that the initial 2014 implementation of these marketplaces could be quite troubled, if not outright chaotic. In addition, in 2014, deeply enhanced Medicaid federal matching rates become available to states that voluntarily choose (per the Supreme Court’s June 2012 decision) to expand their Medicaid programs by new ACA-defined income margins. Policies governing a number of areas have been developed and announced on separate tracks via regulations, policy guidance transmittals, call letters, web postings and other notices.

Following are snapshots of select policies that we think are especially important for physicians to be aware of. Extensive resources, via federal and state governments, state medical societies and credible private organizations are available behind each item we’ve chosen. For additional resources, please consult the Bibliography provided at the end of this report. Our purpose is to ensure that, as busy, actively practicing physicians, you are alerted so that you can seek further resources from your state medical societies or other sources on those matters that are most important to your practice environment or situation. The topics are ordered as identified in the Executive Summary, beginning with physician-focus issues and followed by ACA structural framework updates.

## Physician-Focused Policy Snapshots

### 1. Medicare Physician Fee Schedule; Sustainable Growth Rate Formula

**INTRODUCTION—**For a general primer on the challenges facing the Congress in its ongoing and active consideration of reforming the Medicare physician fee schedule (MPFS), we refer you to our August 2012 Health Care Highway—2012: Part I report (p. 47-52). That write-up covered broader-scale MPFS reforms, as well as reviewing CBO scoring of multiple options modifying the way in which the sustainable growth rate (SGR) would operate to update payments every

year. As noted in the Executive Summary to this report, in its February 5 release of *The Budget and Economic Outlook: Fiscal Years 2013 – 2023*, the Congressional Budget Office (CBO) may have provided some assistance on the SGR issues, by lowering its 10-year cost of freezing payment rates through 2023 at 2013 levels, to about \$14 billion in 2014 and \$138 billion through 2023. The lowered estimates derive in part from lowered growth in physician service-related expenditures and slowing Medicare spending overall.

Separately, we also covered the views of the Medicare Payment Advisory Commission (MedPAC), in-depth, in that same section. MedPAC plays an important role in advising the Congress on Medicare matters and will continue to be a trusted resource in 2013 as the Congress grapples with Medicare financing and reform issues. We refer readers to those sections as a detailed resource behind this snapshot.

**CURRENT SGR SNAPSHOT—**A MedPAC staff presentation for the MedPAC Commissioners at their public meeting held on December 6, 2012 (available at [MedPAC.gov](http://MedPAC.gov)) contained the following updates on physician and other professional services in Medicare. In brief, Medicare outlays for such services were about \$68 billion in 2011, or 12% of total Medicare spending in that year. This measure includes office visits, surgical procedures, and a range of diagnostic and therapeutic services in all settings. It was further reported that 550,000 physicians nationwide were actively billing Medicare in 2011, as were 300,000 other health care professionals, including nurse practitioners, physical therapists and chiropractors. Finally, about 97% of fee-for-service Medicare enrollees received at least one fee schedule service in 2011. Please note that 2011 is the most recent year for which reasonably complete data are available.

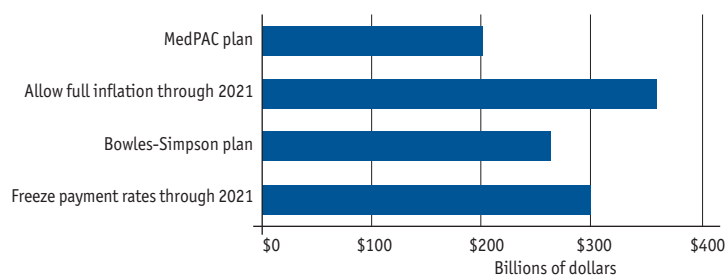
With respect to the SGR, MedPAC staff indicated the SGR is fundamentally flawed and is creating instability for providers and beneficiaries. Also, it has failed to restrain volume growth, and the link between cumulative fee schedule expenditures and annual updates is unworkable. Finally, the aggregate cost of an SGR repeal continues to

Aside from overt Congressional actions, key aspects of the ACA could founder at the state level, absent determined and effective progress on federally-facilitated exchanges and other strategies within the purview of the Administration.

increase, but potential Medicare offsets are being used for other purposes.

In short, as we noted in our August, 2012 report, we are still long on diagnostics and short on effective solutions. The short-term SGR fix passed in ATRA was more of the same, with no clear long-term solution on the table. The simplest, though still costly, option may be to replace the SGR formula with a fixed schedule of updates, perhaps modified by differential updates for “preferred” services, such as primary care. The following chart shows multiple options, scored on CBO’s 2012, not 2013, baseline.

**EXHIBIT 1: COST OF SELECTED DOC FIX OPTIONS, 2012-21**



SOURCES: CONGRESSIONAL BUDGET OFFICE; MEDICARE PAYMENT ADVISORY COMMISSION.

Notes: MedPAC plan freezes primary care rates at current levels for 10 years and cuts rates for other care by 5.9 percent annually for each of three years, then freezes them for 7 years. The Bowles-Simpson plan freezes rates through 2013, reduces rates by 1 percent in 2014, and reinstates SGR in 2015 using 2014 as the base year.

“Health Policy Brief: Medicare Payments to Physicians,” *Health Affairs*, Updated January 10, 2013. <http://www.healthaffairs.org/healthpolicybriefs/>

There is a sense of growing anger and fatigue among the medical community, their representatives, and the Congress over this collective failure to find a solution. Indeed, other health care sectors (especially hospitals) are also engaged as they have time and again been forced to accept less in order to shift Medicare financing to physician and other professional services. We expect the House Ways and Means, the House Energy and Commerce, and the Senate Finance Committees to give concerted attention to this issue this year. Members of the House Allyson Schwartz (D-PA) and Joe Heck (R-NV) are reintroducing a bill similar to last year’s. They propose to extend the current payment levels through 2014, provide for

annual updates of 2.5% for 2015 – 18 for primary care (all others would receive 0.5% annual updates), and transition to a new, CMS-tested payment model after 2018. Separately, House Ways and Means Republicans have circulated a short paper of principles and concepts for Members’ consideration. While no single, workable MPFS/SGR proposal has yet to gain wide support, it is positive that bi-partisan discussions are beginning early in the legislative cycle and within Committees that actually hold jurisdiction over the program area.

## 2. Value-Based Payments and the Physician Feedback Program Snapshot—

First, just a reminder to readers that our August 2012 report provided a detailed Appendix (p. 66-68) on the Centers for Medicare and Medicaid Services’ (CMS) 2012 regulation on the MPFS Physician Feedback/Value-Based Modifier Program. As a reminder, the ACA requires CMS to establish a value modifier that provides for differential payment to a physician or group based upon the “measured” quality of care provided to Medicare beneficiaries relative to the “measured” cost of that care during a performance period.

We are revisiting this topic not to address the regulation, per se. Rather, we think it is important to highlight a growing concern relating to the methods by which a broad array of quality measures are to be linked to physicians’ performance and payments, and whether there will be 1) excess or inappropriate levels of risk assumption for physician practices, or 2) excessive or inappropriate reductions in payments, due to methodological shortcomings.

Last year, CMS had originally proposed to apply the value modifiers to groups of physicians with 25 or more eligible professionals. In our opinion, this was too small of a base in which to proceed with such important new proposals. We were pleased when CMS stepped back from its original proposal. In the final rule, CMS would apply the value modifier in 2015 to groups of physicians with 100 or more eligible professionals. This is likely a more stable



baseline from which to calculate payment amounts at-risk in the years 2015-17 when CMS is authorized to phase-in the program. CMS also provided these larger groups an option on how the value modifier is calculated based on whether they participate in the Physician Quality Reporting System or PQRS, and encouraged physicians in smaller groups or individual practice to participate in the PQRS now since it sets the stage for payment policy changes in future rules.

**CMS REQUEST FOR INFORMATION ON THE USE OF CLINICAL QUALITY MEASURES IN REPORTING PROGRAMS**—CMS recently published an important request for information on the use of clinical quality measures, described in the Federal Register notice, as follows:

“This request for information solicits ways in which an eligible professional (EP) might use the clinical quality measures (CQM) data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the Physician Quality Reporting System (PQRS), as well as the Electronic Health Record (EHR) Incentive Program. It also solicits ways by which the entities already collecting CQM data for other reporting programs to submit this data on behalf of EPs and group practices for reporting under the PQRS and the EHR Incentive Program. It also requests information regarding section 601(b) of the American Taxpayer Relief Act of 2012, which provides for treating an EP as satisfactorily reporting data on quality measures if the EP is satisfactorily participating in a qualified clinical data registry. We are requesting information from medical specialty societies, boards, and registries, other third party registry vendors, eligible professionals using registries to report quality measures, and any other party interested in providing information on this request for information.”

CMS traces the evolving law over the last decade regarding quality reporting as it evolved from claims-based to clinical registry and other sources of data. CMS states their objectives and raises a series of policy and operational questions. We view these as important enough for practicing physicians to

abstract in their entirety, as follows:

“We are seeking input from the public on ways in which an eligible professional might use the CQM data reported to medical boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to fulfill requirements of PQRS, and, although we are not seeking to change the requirements we established for the EHR Incentive Program in 2014, the EHR Incentive Program. We are seeking input on how alignment of certain requirements present in both federal and non-federal CQM reporting programs could reduce the burden for eligible professionals and accelerate quality improvement. We are also seeking input on the amendments made by section 601(b) of the American Taxpayer Relief Act of 2012. Therefore, we are soliciting comment on the following questions:

*High-level questions:*

- 1 ➤ How are the current reporting requirements for the PQRS and the reporting requirements in 2014 for the EHR Incentive Program similar to the reporting requirements already established for the ABMS boards or to other non-federal quality reporting programs? How are they different? In what ways are these reporting requirements duplicative and can these reporting programs be integrated to reduce reporting burden on eligible professionals?
- 2 ➤ Are there examples of other non-federal programs under which eligible professionals report quality measures data?
- 3 ➤ What would be the benefits and shortcomings involved with allowing third-party entities to report quality data to CMS on behalf of physicians and other eligible professionals?
- 4 ➤ What entities have the capacity to report quality data similar to those reported under the PQRS, Value-based Payment Modifier, and/or EHR Incentive programs? If these entities were to report such data to CMS, what requirements should we include in the reporting system used by such entities, including requirements to ensure high quality data?

We support quality, improved patient outcomes and payment for efficiently rendered services. But there are large gaps between information and effective information.

**5 ➤** How should our quality reporting programs change/evolve to reduce reporting burden on eligible professionals, while still receiving robust data on clinical quality?

**6 ➤** Questions regarding reporting requirements for entities that report via a registry under the PQRS for 2014 and subsequent years or the EHR Incentive Program if registry reporting is established as a reporting method for that program in future years:

**7 ➤** What types of entities should be eligible to submit quality measures data on behalf of eligible professionals for PQRS and the EHR Incentive Program? Examples might include medical board registries, specialty society registries, regional quality collaboratives or other entities. What qualification requirements should be applicable to such entities?

**8 ➤** What functionalities should entities qualified to submit PQRS quality measures data possess? For example, for CQMs that can be electronically submitted and reported under PQRS and the EHR Incentive Program, should an entity's qualification to submit such measures be based on whether they have technology certified to ONC's certification criteria for CQM calculation and/or electronic submission?

**9 ➤** What criteria should we require of entities submitting quality measures data to us on behalf of eligible professionals? Examples might include transparency of measures available to EPs, specific frequency of feedback reports, tools to guide improvement efforts for EPs, ability to report aggregate data, agreement to data audits if requested, etc.

**10 ➤** Should reporting entities be required to publicly post performance data?

**11 ➤** Should we require an entity to submit a yearly self-nomination statement to participate in PQRS?

**12 ➤** What should be included in the data validation plan for these reporting entities?

**13 ➤** If CMS provided a reporting option for PQRS and/or the EHR Incentive

Program through such entities, what specification should CMS use to receive the quality data information (for example, Quality Reporting Document Architecture [QRDA] 1 or 3, XML, other)?

**14 ➤** Should data submission timelines for these reporting entities be modified so that the submission timeframes for these quality reporting programs are aligned? For example, PQRS qualified registries are required to submit quality measures data once, within 2 months following the reporting period. How much time are reporting entities outside of PQRS afforded to submit quality measures data? What challenges do reporting entities face in reporting data according to current timeframes?

**15 ➤** What oversight (for example, checks or audits) should be in place to ensure that data is submitted and calculated properly by entities?

*Questions regarding selection of measures related to registry reporting under PQRS for 2014 and subsequent years and for the EHR Incentive Program if registry reporting is established as a reporting method for that program in future years:*

**1 ➤** Should we require that a certain proportion of submitted measures have particular characteristics such as being NQF-endorsed or outcome-based?

**2 ➤** Should we require that the quality measures data submitted cover a certain number of the six national quality strategy domains?

**3 ➤** To what extent would third-party entities struggle to meet reporting for measures currently available under PQRS and EHR Incentive Program?

*Questions regarding registry measures reporting criteria:*

**1 ➤** If we propose revised criteria for satisfactory reporting under PQRS and for meeting the CQM component of meaningful use under the EHR Incentive Program, how many measures should an eligible professional be required to report to collect meaningful quality data? For example, for

reporting periods occurring in 2014, eligible professionals using CEHRT must report 9 measures covering at least 3 domains to meet the criteria for satisfactory reporting for the 2014 PQRS incentive and meet the CQM component of achieving meaningful use for the EHR Incentive Program. (For more information see the EHR Incentive Program Stage 2 final rule (77 FR 54058 ) and the CY 2013 Medicare PFS final rule with comment period (77 FR 69192 ).) If we were to align reporting criteria with reporting requirements for other non-federal reporting programs, in future years, should we propose to require reporting on a different number of measures than what is currently required for the PQRS in 2013 and the EHR Incentive Program under the Stage 2 final rule or should the non-federal reporting programs align with CMS criteria?

**2 ➤** For PQRS, should eligible professionals still be required to report quality measures data on a certain percentage of their applicable patients, such as 80 percent, for 2014 and subsequent years? Or, should we require that eligible professionals report on a certain minimum number of patients, such as 20, rather than a percentage?

(Source: FR Doc. 2013-02703. Filed 2-4-13; CMS-3276-NC)

The comment period on this notice closes on April 8, 2013. This notice emphasizes again the potential expansion of quality reporting concepts, data sources and potential uses in major government programs. These elements also migrate between government programs and private payers. Of course, we support the principles of quality, improved patient outcomes, and payment for efficiently rendered services. But there are large gaps between information and *effective* information, used prudently and appropriately. *Therefore, we think it is crucial for the medical profession to keep re-visiting touchstone questions and engaging with policy-makers as these health care program directions develop further.*

**BACK TO FIRST PRINCIPLES**—Our concerns relate to how clinical quality measures and their adaptation to provider profiling and payment

linkages evolve over time. What does it really mean for physicians' medical practices and compensation? In other words, are the right things being measured in the right ways, and then applied to provider profiles and payments in a sound fashion?

This is not an effort to turn-back the clock on efforts to link quality in services to provider payments. Rather, it is a caution to all of us in the medical community to remain deeply engaged on the issues of:

- which quality measures are selected,
- how many are selected,
- how well the measures themselves are supported by clinical research and data prior to integration into payment and/or performance systems,
- how well the measures *explain variations* in quality and cost differences (crucial),

**Our concerns relate to how clinical quality measures and their adaptation to provider profiling and payment linkages evolve over time. What does it really mean for physicians' medical practices and compensation? In other words, are the right things being measured in the right ways, and then applied to provider profiles and payments in a sound fashion?**

- exactly how the payment/performance linkages are computed, and importantly,
- whether there could be misleading performance profiling, leading to unsound payment results (e.g. due to measurement issues, and statistical problems in performance calculations and how they are applied to payment, or other factors).

We flag these questions in this arena because, despite different approaches, these questions underlie an emerging payment risk issue being raised in the area of accountable care organizations (ACOs). We discuss that briefly in the ACO snapshot below.

### 3. Accountable Care Organization Growth and New Cautions Regarding the Medicare Shared Savings Program

**INTRODUCTION**—In this discussion, we assume a general awareness on the part of physicians about the ACO concept and shared savings models. The accountable care program has generated widespread interest in the medical community and other health partners. As of January 10, 2013, CMS indicates there are 106 new ACOs in Medicare covering over 4 million Medicare beneficiaries. The ACO organizations include 15 Advance Payment Model ACOs, and the recently launched Pioneer Model ACOs. The current application period for new organizations wishing to participate in the ACO program, effective in January 2014, is open until summer of 2013. Given the rapid growth in the ACO program, it is particularly important to share some fresh research insights into statistical uncertainty in the Medicare Shared Savings Program (MSSP) methodologies that could lead to inappropriate reward for savings, payment denials, or undeserved penalties for increased spending.

**INSURANCE ELEMENTS IN ACO CONCEPTS**—To begin, the Physicians Foundation provided a detailed summary of the ACO program in its initial Roadmap Report referenced in our Preface and published in April 2011. In that report, we cautioned that the ACO model has elements of risk-assumption for the costs of patient care that closely resemble elements of the Medicare Advantage (MA) program. The difference is that MA plans are major health insurance carriers regulated by state insurance laws, as well as federal contracting requirements, and must set premium levels and maintain capital reserves adequate to cover significant fluctuations in claims liabilities related to patient care.

Insurance regulators, and health plans' actuarial practices in premium setting and in the purchase of reinsurance to protect against outside losses, recognize average fluctuations in service utilization and costs, as well as risks associated with unexpected, high-cost events, relative to average claims costs. For these reasons, we advised physicians entering ACO arrangements to seek legal, financial, and

insurance/actuarial expertise if they were interested in pursuing this practice model in the Medicare program. This is important for the reasons just cited, as well as risks associated with the need to recover high start-up/investment costs in a new ACO.

However, it is equally important for ACOs to understand and continually reassess CMS's MSSP methodology. The following section highlights why this continual reassessment is so critical to the future success of the ACO program.

**NEW STUDY: "STATISTICAL UNCERTAINTY IN THE MEDICARE SHARED SAVINGS PROGRAM"**—Our focus is on the MSSP and recent work examining those formulas published by researchers at Rutgers University. Their work raises important questions about whether CMS's current ACO regulations and arrangements adequately address issues around the appropriateness, and degree, of performance and financial risk that physicians in an ACO model could incur (as well as, the extent to which the government is adequately protected). Detailed analysis of their findings and methods is outside the scope of this report. However, we'd like to highlight their findings and refer readers to the source material cited below for personal reading and evaluation. In fact, CMS has recognized the sensitive nature of their study results, and has set-up a collaborative research group involving the Rutgers team and interested external parties to consider and interact on the significance of these findings.

*(Source: Statistical Uncertainty in the Medicare Shared Savings Program. Derek DeLia, Donald Hoover, and Joel C. Cantor. Rutgers University. Published in Medicare and Medicaid Research Review, 2012: Volume 2, Number 4).*

#### **SELECT HIGHLIGHTS OF RUTGER'S MSSP**

**METHODOLOGICAL REVIEW STUDY**—The researchers examined the probabilities that the formulas in the 1-sided and 2-sided payment models could lead to inappropriate payment, payment denial, and/or financial penalties. In particular, the authors considered the extent to which random factors beyond the control of an ACO can influence health care spending. They also examined the MSSP formulas and whether they appear to properly balance the competing risks to the



government and to providers with respect to payments and shared risk. In our opinion, it appears the researchers took care to balance the competing, as well as shared, interests of providers and the government in the future of the ACO program, and they anticipate there will be methodological improvements over time. However, the following highlights indicate providers must take an active role in understanding the formulas and in initiating necessary improvements.

**RUTGER'S STUDY KEY FINDINGS**—In brief, the study findings indicated that “there may be greater statistical uncertainty in the MSSP than previously recognized.” The statistical modeling and framework suggests the formula is fairly well designed to protect the government from paying, inappropriately, for savings that are due solely to normal variations in spending, and that risk declines rapidly as ACOs grow beyond the level of 20,000 enrollees.

However, the Rutgers’ team stated that the MSSP formula does not appear to offer the same level of protection to ACOs regarding inappropriately denied payment under certain scenarios, and that this risk is especially acute for smaller ACOs and those that generate relatively modest savings. In the 2-sided model, some ACOs saving money could face “a non-trivial risk” of penalties for spending increases that are actually due to normal variation. Finally, these risks to the ACOs could greatly reduce the expected income to ACOs and their ability to recover initial investment and operating costs.

In closing, the first few years of ACO program results and interim CMS adjustments to methodologies will play a crucial role in the future success of ACO models. This study indicates that MSSP issues and uncertainties must be part of CMS’s and ACOs’ financial, administrative and care management planning. **In our opinion, the future of the ACO program depends upon rapid detection and correction of MSSP formula problems.** We strongly advise current or prospective ACO participants to examine this and related MSSP work carefully, and to engage actively with CMS on needed improvements.

## ACA Structural Framework Snapshots

### 3. Health Insurance Exchanges (HIEs) and Plan Requirements

**INTRODUCTION**—For a general primer on HIEs and the transformational impact of the ACA on the private health insurance market in the U.S., we refer you to our August 2012 Health Care Highway—2012: Part I report (p. 52-55). The key target date is January 1, 2014, whereby millions of Americans (qualified individuals and small employers (less than 100 employees)) are expected to be able to purchase health insurance from qualified health plans (QHPs). Until all HIEs, whether

**...the Rutgers’ team stated that the MSSP formula does not appear to offer the same level of protection to ACOs regarding inappropriately denied payment under certain scenarios, and that this risk is especially acute for smaller ACOs and those that generate relatively modest savings. In the 2-sided model, some ACOs saving money could face “a non-trivial risk” of penalties for spending increases that are actually due to normal variation. Finally, these risks to the ACOs could greatly reduce the expected income to ACOs and their ability to recover initial investment and operating costs.**

under the federally facilitated, federal-state partnership, or state-run models, are fully operational in 2014, it is not known how many insurers will elect to participate, nor is it known how many individuals will both qualify and participate by obtaining coverage through health insurance exchanges.

**EXCHANGE FUNCTIONS**—What has been largely flying below the radar of public discussion is the full array of functions that government at state and federal levels must carry out in order for HIEs to function well. These tasks include, but are not limited to:

- Conduct of plan eligibility and oversight, including review of compliance with essential health benefits, cost-sharing, and level of plan generosity, premium review, reserves, appeals processes, and other requirements,

- Determination of eligibility of individuals for enrollment and financial assistance (both for premium and cost-sharing obligations), including complex coordination with Medicaid and employer coverage,
- Financial risk and instability mitigation due to adverse selection in plans via reinsurance, risk corridors and risk adjustment strategies,
- Counseling services and other assistance for individuals trying to navigate the new marketplaces, and
- Creation of complex website and electronic databases supporting several functions.

For readers following action within specific states, a good starting point is to examine state entries at an aggregator site known as StateReForum ([www.statereforum.org](http://www.statereforum.org)), which will also guide you to state sites, describing executive and legislative actions, if any, and state operational policies and decisions.

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**STATE OPTIONS**—States may choose from 3 options, a) a state-operated exchange, b) a partnership model with areas of collaboration with the federal government, or c) to default entirely to a federally-facilitated exchange. The deadlines for States for notifying DHHS of their choice of model differ by model. Those states choosing to operate their own

exchanges had a deadline of December 14, 2012 to file their letters of intent and accompanying blueprints. States that seek the partnership model have until February 15, 2013 to declare their intentions and to describe in which areas they seek to partner with the federal government. As of December 31, 2012 18 states and the District of Columbia had declared their intent to operate their own exchanges.

Early in January Secretary Sebelius announced states would be given a little more time to make a final decision on how they will proceed. It will not be until later in the Spring of 2013 that we will know how many of the remaining states will default completely to federally-run HIEs in their states.

Keep in mind a health insurance exchange must be prepared to be operational and able to begin enrollment in each state as of October 1, 2013, in order for coverage to begin effective January 1, 2014.

**STATE EXCHANGES UNDERWAY**—As of mid-January, 2013, the following 17 states and the District of Columbia will operate State-based exchanges. The list is: CA, CO, CT, DC, HI, ID, KY, MA, MD, MN, NM, NV, NY, OR, RI, UT, VT, and WA. The states of AR, DE, IA, IL, MI, NH, and WV will operate state-partnership exchanges. The remaining states will default to federally-facilitated exchanges.

**MULTI-STATE PLANS**—Private insurers are not required to participate in HIEs. However, significant premium subsidies are made available to individuals for coverage secured from a QHP via the exchange operating in their state. This is an inducement to insurers to participate, but it does not guarantee adequate insurer participation. Therefore, the ACA authorized multi-state plans to promote coverage and competition in all markets. These will be overseen in accordance with rules promulgated by the federal Office of Personnel Management (OPM), the entity that runs the national Federal Employees Health Benefit Program (FEHBP). Proposed rules were published recently by OPM outlining contract standards and other requirements for multi-state plans.

To add to the array of choices, the law

also provides for Child-Only, Consumer-Operated and Oriented Plans (CO-OPs), Catastrophic, and Dental-Service Only plans. Each has unique conditions that must be met to qualify for participation in an exchange. Note, however, that ATRA eliminated future support funds for CO-OP models as described in Chapter II.

**MARKET REFORMS**—As noted in our August 2012 report, there are a number of private insurance market reforms established in the ACA that are federally binding, although states continue to have primacy over the direct regulation of carriers licensed to sell insurance in their state. These include certification of provider network adequacy, plan marketing rules, adequacy of financial reserves, and policy offerings, pricing, and issuance requirements.

On November 20, 2012, the Center for Medicare and Medicaid Services issued proposed rules on the implementation of market reforms and rate reviews. These include such matters as market oversight, guaranteed issue and renewability of policies, prohibitions against using gender, medical history, and industry of employment to set rates. Age-rating bands affecting premium levels are limited, among other matters. Note that despite historical state primacy over the regulation of insurance, the federal proposed rule states that CMS has the authority to enforce ACA matters in states that choose not to enforce ACA market reform requirements.

**MEDICAID PROPOSED RULES AND EXCHANGES**—DHHS is making a broad attempt to respond to states' expressed concerns about the cost and lack of program flexibility in the Medicaid program. This is viewed by DHHS as important to encouraging states to voluntarily expand their Medicaid programs under the new ACA matching formulas and income eligibility expansion provisions (up to 138% of the federal poverty level) going into effect in 2014. While perhaps not going far enough to fully meet states' concerns or to materially affect their expansion decisions, CMS announced a major (474 page) notice of proposed rule-making (NPRM) on January 14 outlining many possible programmatic

adjustments. The proposal also attempts to clarify structural interactions between Medicaid programs and exchanges.

In brief, under the NPRM, state officials would be able to charge Medicaid patients higher cost-sharing for some services than current regulations permit. The NPRM also affects a wide range of other Medicaid provisions, including appeals of eligibility determinations; coordination between Medicaid and the ACA's insurance exchanges; the role of counselors to assist people with their coverage applications; procedures to verify employer-sponsored coverage; and the use of updated Medicaid eligibility categories. The NPRM would also increase the amount that states could charge patients for non-preferred drugs, non-emergency care in emergency departments and some other services. States will be able to charge \$8.00 copays for non-preferred drugs and \$8.00 copays for non-emergency use of the emergency department for people with income equal to or less than 150 percent of the poverty level, or who have been exempted from cost-sharing. The NPRM retains current rules that *don't* have a limit on the cost-sharing that may be imposed for non-emergency use of the emergency department for those above certain income limits.

The proposed rule also would allow states to offer benefit packages to the group of people who would gain eligibility in 2014 under the ACA, that would differ from what is currently allowed for Medicaid patients under the traditional program.

Finally, the NPRM seeks to streamline appeals decisions so that people who are denied coverage don't have to file separate appeals with exchange officials and Medicaid officials. States that run their own exchanges could choose to have the exchange take the lead in deciding Medicaid appeals.

The public comment period has been extended by CMS and is open through February 21, 2013.

**Note that despite historical state primacy over the regulation of insurance, the federal proposed rule states that CMS has the authority to enforce ACA matters in states that choose not to enforce ACA market reform requirements.**

The voluntary Medicaid expansion issue has recently been resolved by DHHS against partial expansion, a position supported by the Justice Department and conveyed by Secretary Sebelius to State Governors. In other words, the voluntary Medicaid expansion is an all-or-nothing proposition for states.

#### 4. Medicaid Program Expansions Post-Supreme Court Decision

Our August 2012 report provides extensive coverage of the important ACA legal challenges decided by the Supreme Court in June 2012, and the implications for coverage under the Medicaid expansion provisions effective in 2014. In that decision, the Court ruled that states' decisions regarding Medicaid program expansions under the ACA are voluntary, not mandatory.

However, in its 2012 ACA ruling, the Supreme Court left open the crucial question of whether states could access the ACA's enhanced federal matching payments even if they expanded their Medicaid programs only partway to the ACA-specified income target. The voluntary Medicaid expansion issue has recently been resolved by DHHS against partial expansion, a position supported by the Justice Department and conveyed by Secretary Sebelius to State Governors. In other words, the voluntary Medicaid expansion is an all-or-nothing proposition for states.

Following is a summary of the government's position as abbreviated by HealthReform GPS:

"On December 10, 2012, the Centers for Medicare and Medicaid Services (CMS) released a long-awaited set of frequently asked questions on Exchanges, market reforms, and Medicaid. *We will post a further analysis of these FAQs in the near future*, but we rush to post one question and answer because of its significance in relation to the Medicaid expansion.

Chief among the questions CMS addressed was a series that were designed to address the major questions left open by the United States Supreme Court's ruling in *NFIB v Sebelius*, namely, whether enhanced federal funding is available under the ACA in states that desire to expand to cover less than all persons not otherwise eligible for Medicaid on a mandatory basis, who are under age 65, and whose MAGI-level income falls below 133% of the federal poverty level (138% with the ACA's additional 5 percentage point income disregard). The answer from CMS is "no," not as a state option, and not as a §1115 demonstration.

Specifically, Question 26 asks:

"Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?"

CMS answers as follows:

No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100% matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purpose of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

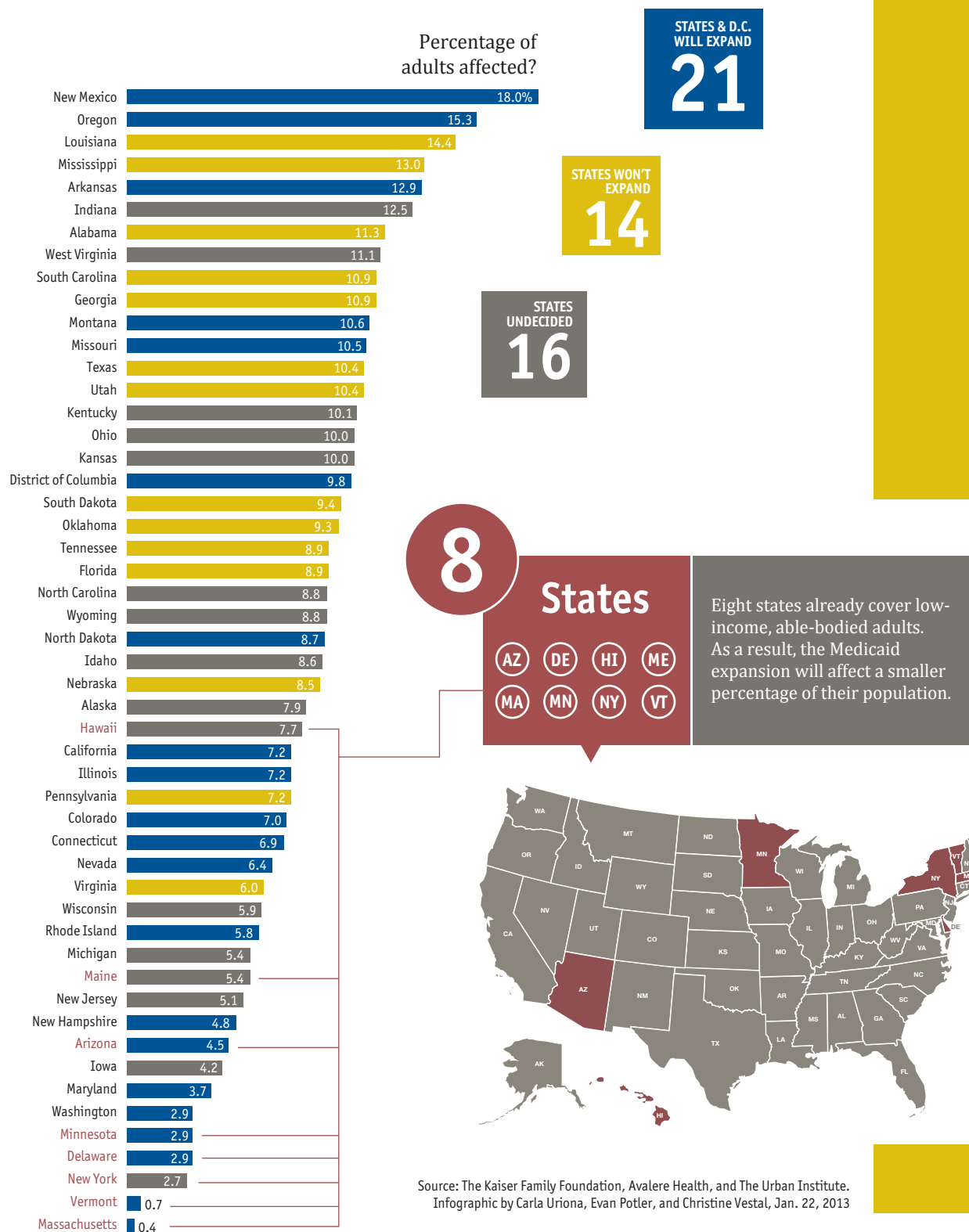
In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges. The law contemplates that such demonstrations may be coupled with §1115 Medicaid demonstrations, with the enhanced federal matching rates in the context of these overall system demonstrations.

CMS also clarifies (Q. 24) that states face no deadline in letting CMS know their intentions regarding whether they will adopt the Medicaid expansion. In addition, CMS clarifies (Q. 25) that a state that chooses to expand coverage for the newly eligible population of nonelderly adults also can decide later to drop the coverage, and that such decisions are separate and apart from state Exchange decision-making. CMS also reminds states (Q. 24) that by law, the enhanced federal matching rates for newly eligible populations follow a specific schedule tied to specific calendar years (e.g., 100% in 2014, 2015, and 2016, declining to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter."



## HOW MANY PEOPLE WOULD MEDICAID EXPANSION COVER?

States must decide whether to expand their Medicaid programs to low-income, able-bodied adults. The percentage of the population potentially affected by these decisions varies widely among states.



(Source: "Update: CMS's Frequently Asked Questions on Market Reforms and Medicaid—Can States Cover Less than all Newly Eligible Individuals under the ACA 2014 Medicaid Eligibility Expansion and Still Receive Enhanced Federal Funding?" Sara Rosenbaum, Health Reform GPS, George Washington University).

**STATE MEDICAID EXPANSION STATUS**—At present, it is unclear how many states will expand their Medicaid programs in 2014 or later under the ACA-specified conditions. As of this writing, according to Stateline, part of the PEW Center for the States, it appears that 21 states, plus the District of Columbia, have declared their intent to expand their Medicaid programs. Fourteen states have declared their intention to not expand Medicaid, and 15 states are undecided.

Some object on ideological and/or programmatic grounds; others are concerned about out-year issues, flexibility and costs for states if they proceed now. We would note that States that decline to participate in the Medicaid expansion option are leaving substantial health care funds on the table, in most cases billions over a multi-year period. As is displayed below, the percentage of some states' population in the eligibility range is substantial. This is setting up a tough dynamic in many states between health care leaders, advocates, state legislators and Governors. Indeed, in a surprise announcement early in February, the Republican Governors of Ohio and Michigan, John Kasich and Rick Snyder, expressed support for the first time for acting on the Medicaid expansion opportunity.

**ARIZONA AND MISSISSIPPI ILLUSTRATE CHALLENGES**—In a closing note on the dynamics still to play through in many states, we can look to Arizona and Mississippi to appreciate the difficult dynamics. In another surprise announcement, Republican Governor Jan Brewer of Arizona reversed her prior opposition (AZ was a party to the Supreme Court challenge to the ACA), and declared that she would like Arizona to take advantage of the generous fiscal terms for the ACA-defined Medicaid expansion. It was indicated that Arizona could receive about \$7.9 billion in federal funds over 4 years to expand the program to over 300,000 low-income residents. However, so far, the State stands firm against operating a health insurance exchange, intending to default to a federally-facilitated exchange.

In Mississippi, despite Republican Governor Phil Bryant's opposition, the Republican State Insurance Commissioner, Mike Chaney, sought approval of an exchange plan. He had the support of the State's Attorney General, a Democrat, but DHHS in Washington declined approval due to the Governor's lack of support. We can expect to see more of such cross-cutting dynamics over the next few months as undecided states finalize their positions for 2014 expansion.

## 5. Essential Health Benefits Requirements for Plans

**BACKGROUND**—Starting on January 1, 2014, non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover an ACA-established package of essential health benefits. Note that self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

The ACA directed the Secretary of DHHS (the Secretary) to define essential health benefits (EHB). It also required that EHBs include items and services within the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

There are significant other requirements in the ACA that make EHBs an important, but challenging provision to implement, and that may even add real costs to plans subject to the EHB requirements, raising premium affordability issues. The law added other requirements, also. In brief:

- the scope of EHBs shall equal the scope of benefits provided under a typical employer plan,

- an appropriate balance must be ensured among the benefit categories,
- the Secretary must not make coverage decisions, determine reimbursement rates, or establish incentive programs,
- benefits must not be designed in ways that discriminate based on age, disability, or expected length of life, but must consider the health care needs of diverse segments of the population, and
- States must defray the cost of any benefits required by State law to be covered by qualified health plans beyond the EHB

Finally, the law distinguishes between a plan's covered services and the plan's cost-sharing features, such as deductibles, copayments, and coinsurance. The cost-sharing features determine the level of actuarial value of the plan, expressed as a "metal level" as specified in the statute: bronze at 60 percent actuarial value, silver at 70 percent actuarial value, gold at 80 percent actuarial value, and platinum at 90 percent actuarial value. These are simply referred to as the **"Metals."**

**CURRENT STATUS**—In a highly complex undertaking, extensive federal, state, insurer, employer and health care stakeholders have participated in a multi-year effort (still underway) to define essential health benefits. The Secretary of DHHS sought early input from the Institute of Medicine, asking them to focus on criteria and policy foundations for establishing and periodically updating EHBs. The Institute's report, titled "Essential Health Benefits, Balancing Coverage and Cost", released on October 7, 2011, is an enduring resource on the topic. In addition, the Department of Labor contributed by conducting and reporting on a major survey of employer-sponsored health coverage.

At the end of this initial effort, DHHS published a December 2011 bulletin laying out a proposed approach that has pleased states and the business community, but which has dismayed some health care leaders and patient advocates. Simply put, DHHS decided against taking a nationally uniform approach of defining one standard set of EHBs, and instead

decided to allow states to choose from a set of plans to serve as the benchmark plan for determining EHBs in their state. For good or ill, this has thrown the concept of EHBs open to widely varying interpretations across states. In addition, initially some questioned the legality of the DHHS approach because it was not originally promulgated under a notice of proposed rulemaking, with a public comment period, as would be customary. That has been rectified.

At present, there are many unanswered questions around EHBs and DHHS's state flexibility-oriented approach. From a patient and provider standpoint, it is unclear in many instances what will govern:

- 1 ➤ medical necessity determinations,
- 2 ➤ the scope and duration of covered services, and
- 3 ➤ the treatment of costs that arise from state benefit mandates that exceed the value of the EHB.

On November 26, 2012 DHHS published a series of proposed rules on ACA matters, including one on Standards Related to Essential Health Benefits, Actuarial Value and Accreditation (77 Fed. Reg. 70644). These rules have some bearing on the above questions. Please note the public comment period closed in December.

Unfortunately, a detailed summary and discussion of this complex rule is outside of the scope of this report. Therefore, we refer readers seeking more details to an excellent summary prepared by Sara Rosenbaum and published on the jointly sponsored George Washington University-Robert Wood Johnson Foundation [www.HealthReformGPS.org](http://www.HealthReformGPS.org) website. The document is titled, "Essential Health Benefits Update: Proposed Regulations Implementing the ACA; and Applications of the Proposed EHB Regulations to Medicaid Benchmark Plans."

In brief, the NPRM aims to ensure that state benchmark plans and plans governed by the EHB standards reflect typical employer plans and that they will provide consumers with familiar products and minimize disruption in local health insurance markets. The proposed rule also describes the steps by which plans

DHHS decided against taking a nationally uniform approach of defining one standard set of EHBs, and instead decided to allow states to choose from a set of plans to serve as the benchmark plan for determining EHBs in their state. For good or ill, this has thrown the concept of EHBs open to widely varying interpretations across states.

will be brought into conformance with EHB requirements. It permits some diversity within and among plans provided certain standards, including actuarial equivalence, are met. There are also standards governing cost-sharing limits and updating of cost-sharing over time.

**MENTAL HEALTH PARITY**—Finally, CMS also issued a State Medicaid Director Letter (SMD Letter 12-003, ACA #21) detailing the relationship between the EHB rule and the Medicaid benchmark statute, which authorizes the use of Alternative Benefit Plans or ABPs. All ABP plans must be brought into conformity with the EHB requirements. It is important to note under CMS's guidance, that mental health parity requirements must be maintained, and that EPSDT remains the coverage standard for individuals under age 21.

Separately, multiple, tragic, mass shootings in the U.S. carried out by mentally ill individuals over the last two years has brought renewed attention to mental health benefits in the EHB concept and to variations in how they are being defined within states' benchmark plans. **Medicaid is the largest single payer of mental health benefits in the U.S. and this role will grow as the program expands.** The Administration has yet to issue final regulations under the mental health parity law passed in 2008, but CMS has indicated it intends to publish the final rule on these matters in either February or March. There are challenges in reconciling the requirements of the mental health parity law provisions with Medicaid and health insurance exchanges. We will reserve judgment until that rule is published and available for public comment.

Physicians should be aware that the scope of coverage of plans, under the governance of the EHB alignment rules, will affect many patients, starting in 2014. It may be helpful to coordinate with state medical societies and other trusted sources on exactly how these plans are being implemented within your home state.

**PREVENTION BENEFITS FOR WOMEN, INCLUDING CONTRACEPTIVE SERVICES**—Most physicians are likely aware that the coverage of contraceptive services, under the preventive

services portion of the ACA's essential health benefits requirements, has been a source of controversy with religiously-affiliated employers, leading to multiple litigation actions around the nation. These lawsuits, brought by organizations with differing characteristics and claims, leading to differing decisions in federal court venues, are expected by many legal professionals to rise to Supreme Court level review due to the nature of the Constitutional challenges.

In brief, under Section 1001(5) of the ACA, non-grandfathered group health plans must cover certain preventive services without cost-sharing. These include various preventive services for women as provided in guidelines issued by the Health Resources Services Administration (HRSA), an organization within DHHS. HRSA's guidelines in this instance require coverage for "all Food and Drug Administration...approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed by a provider." 77 Fed. Reg. 8725 (Feb. 15, 2012).

Separately, the Administration has issued multiple proposals over the last two years under which the ACA requirements could be met, attempting to balance women's health rights, the requirements of the ACA and religious liberty. Initially, early in 2012, the Administration would have required religiously affiliated entities to cover contraceptive care without any cost-sharing requirements. A second rulemaking attempt stated that nonprofit organizations affiliated with religious institutions for which contraceptives coverage was not offered on the basis of it being a violation of their beliefs, would not have to include it in their coverage under a worship institution exemption. However, health insurers would have been required to offer separate insurance policy "riders" that cover contraceptive services at no additional cost. This rule continued to attract deep opposition in some religious-affiliated organizations, as well as secular employers owned by individuals asserting that their personal religious beliefs obviated against provision of such coverage to their employees, leading to a spate of lawsuits



against the February, 2012 final rule.

On February 1, 2013, the Administration issued a new proposed rule, attempting to find a new solution to the continuing issues. Based on the fact sheet released by the Administration, their objectives are to:

- Provide women with coverage for recommended preventive care, including contraceptive services, without cost sharing, while also ensuring that non-profit organizations with religious objections won't have to contract, arrange, pay, or refer for insurance coverage for these services to their employees or students,
- Exempt group health plans of “religious employers” from having to provide contraceptive coverage, if they have religious objections to contraception,
- Simplify the existing definition of a “religious employer” as it relates to contraceptive coverage, by following a section of the Internal Revenue Code that would primarily include churches, other houses of worship, and their affiliated organizations and would eliminate criteria that a religious employer:
  - 1 ➤ have the inculcation of religious values as its purpose;
  - 2 ➤ primarily employ persons who share its religious tenets; and
  - 3 ➤ primarily serve persons who share its religious tenets.
- Create “accommodations” for non-profit religious organizations (definitions are crucial), such that eligible organizations would not have to contract, arrange, pay or refer for any contraceptive coverage to which they object on religious grounds.

Finally, under the proposed accommodations, plan participants would receive contraceptive coverage through separate individual health insurance policies, without cost sharing or additional premiums under administrative processes described in the proposed rule. It was posited that the costs of both the health insurance issuer and third party administrator would be offset by

adjustments in Federally-facilitated Exchange user fees that insurers pay.

This is an important “watch and wait” essential health benefits issue. The Administration seeks to finalize the proposed rule as soon as possible after the comment period closes. As noted, litigation conceivably will elevate these issues to the Supreme Court for a potential ruling.

## Conclusion

In closing, the year 2012 was a challenging one for the medical profession and the entire health care sector. The challenges continue to grow and change as we enter 2013, and the pace of ACA implementation accelerates. Further, the Physicians Foundation expects the major health care entitlement programs and portions of the ACA to come under deep scrutiny during this year’s federal budget process. State actions will also be exceptionally important from a health care policy standpoint. We will be carefully tracking these ongoing debates and actions, and examining how best to utilize our resources to assist practicing physicians. And, as we noted at the beginning of this report, we will be taking a particularly close look this year at the impact of the Medicare program on medical practice.

In the meantime, please refer to the Appendix at the end of this chapter for a summary of ACA tax provisions as posted at years-end by the Internal Revenue Service. We sincerely hope that you find it and the other information in this report to be interesting and worthwhile. As always, thank you for your time and attention. ■





# Appendix

## *Affordable Care Act Tax Provisions Summary*

Posted by the Internal Revenue Service on 12/28/12

### Major Health Care Tax Provisions—

The Internal Revenue Service published the following materials as of December 28, 2012. We provide the information in its entirety for those physicians to whom it is of personal or business tax interest, without editing or commentary, as tax analyses are outside the scope of this report. Please note that there are sections further into the list on ACO provisions, among others, that merit attention. Should any of this information raise questions, we recommend physicians contact the IRS directly and/or seek professional tax services from a reputable source. Finally, this list does not reflect tax changes, if any, enacted after 12/28/12.

*Información en Español: Disposiciones del Acta del Cuidado de Salud de Bajo Precio*

“The Affordable Care Act was enacted on March 23, 2010. It contains some tax provisions that are in effect and more that will be implemented during the next several years. The following is a list of provisions for which the IRS has issued proposed and/or final guidance; additional information will be added to this page as it becomes available.

### Net Investment Income Tax

A new Net Investment Income Tax goes into effect starting in 2013. The 3.8 percent Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above certain threshold amounts. The IRS and the Treasury Department have issued proposed regulations on the Net Investment Income Tax. Comments may be submitted electronically, by mail or hand delivered to the IRS. For additional information on the Net Investment Income Tax, see our questions and answers.

### Additional Medicare Tax

A new Additional Medicare Tax goes into effect starting in 2013. The 0.9 percent Additional Medicare Tax applies to an individual’s wages, Railroad Retirement Tax Act compensation, and self-employment income that exceeds a threshold amount based on the individual’s filing status. The threshold amounts are \$250,000 for married taxpayers who

file jointly, \$125,000 for married taxpayers who file separately, and \$200,000 for all other taxpayers. An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of \$200,000 in a calendar year. The IRS and the Treasury Department have issued proposed regulations on the Additional Medicare Tax. Comments may be submitted electronically, by mail or hand delivered to the IRS. For additional information on the Additional Medicare Tax, see our questions and answers.

### Minimum Value

On April 26, 2012, the Department of the Treasury and IRS issued Notice 2012-31, which provides information and requested public comment on an approach to determining whether an eligible employer-sponsored health plan provides minimum value. Starting in 2014, whether such a plan provides minimum value will be relevant to eligibility for the premium tax credit and application of the employer shared responsibility payment.

### Information Reporting on Health Insurance Coverage

On April 26, 2012, the Department of the Treasury and IRS issued Notices 2012-32 and 2012-33, which invited comments to help inform the development of guidance on annual information reporting related to health insurance coverage. The information reporting is to be provided by health insurance issuers, certain employers that sponsor self-insured plans, government agencies and certain other parties that provide health insurance coverage.

### Disclosure of Return Information

On April 27, 2012, the Department of the Treasury and the IRS issued proposed regulations with rules for disclosure of return information to be used to carry out eligibility determinations for advance payments of the premium tax credit, Medicaid and other health insurance affordability programs. The proposed regulations solicit public comments.

### Small Business Health Care Tax Credit

This new credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees and is specifically targeted for those with low- and moderate-income workers. The credit is designed to encourage small employers to offer health insurance coverage for the first time or

maintain coverage they already have. In general, the credit is available to small employers that pay at least half the cost of single coverage for their employees. Learn more by browsing our page on the Small Business Health Care Tax Credit for Small Employers and our news release.

## Health Flexible Spending Arrangements

Effective Jan. 1, 2011, the cost of an over-the-counter medicine or drug cannot be reimbursed from Flexible Spending Arrangements (FSAs) or health reimbursement arrangements unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. This standard applies only to purchases made on or after Jan. 1, 2011. A similar rule went into effect on Jan. 1, 2011, for Health Savings Accounts (HSAs), and Archer Medical Savings Accounts (Archer MSAs). Employers and employees should take these changes into account as they make health benefit decisions. For more information, see news release IR-2010-95, Notice 2010-59, Revenue Ruling 2010-23 and our questions and answers. FSA and HRA participants can continue using debit cards to buy prescribed over-the-counter medicines, if requirements are met. For more information, see news release IR-2010-128 and Notice 2011-5.

In addition, starting in 2013, there are new rules about the amount that can be contributed to an FSA. Notice 2012-40 provides information about these rules and flexibility for employers applying the new rules and requests comments about other possible administrative changes to the rules on FSA contributions. The Notice provides instructions on how to submit comments.

## Medical Device Excise Tax

On Dec. 5, 2012, the IRS and the Treasury Department issued final regulations on the new 2.3-percent medical device excise tax (IRC §4191) that manufacturers and importers will pay on their sales of certain medical devices starting in 2013. On Dec. 5, 2012, the IRS and the Treasury Department also issued Notice 2012-77, which provides interim guidance on certain issues related to the medical device excise tax. Additional information is available on the Medical Device Excise Tax page and Medical Device Excise Tax FAQs on IRS.gov.

## Health Insurance Premium Tax Credit

Starting in 2014, individuals and families can take a new premium tax credit to help them afford health insurance coverage purchased through an Affordable Insurance Exchange. Exchanges will operate in every state and the District of Columbia. The premium tax credit is refundable so taxpayers who have little or no income tax liability can still benefit. The credit also can be paid in advance to a taxpayer's insurance company to help cover the cost of premiums. On May 18, 2012, the IRS issued final regulations which provide guidance for individuals who enroll in qualified health plans through Exchanges and claim the premium tax credit, and for Exchanges that make qualified health plans available to individuals and employers.

The portion of the law that will allow eligible individuals to use tax credits to purchase health coverage through an Exchange is not effective until 2014.

Exchanges will offer individuals a choice of health plans that meet certain benefit and cost standards. The Department of Health and Human Services (HHS) administers the requirements for the Exchanges and the health plans they offer. Additional information about the Exchange can be found at [www.healthcare.gov](http://www.healthcare.gov) and in IRS REG-131491-10 issued on Aug. 12, 2011.

## Health Coverage for Older Children

Health coverage for an employee's children under 27 years of age is now generally tax-free to the employee. This expanded health care tax benefit applies to various work place and retiree health plans. These changes immediately allow employers with cafeteria plans -- plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits -- to permit employees to begin making pre-tax contributions to pay for this expanded benefit. This also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return. Learn more by reading our news release or this notice.

## Excise Tax on Indoor Tanning Services

A 10-percent excise tax on indoor UV tanning services went into effect on July 1, 2010. Payments are made along with Form 720, Quarterly Federal Excise Tax Return. The tax doesn't apply to phototherapy services performed by a licensed medical professional on his or her premises. There's also an exception for certain physical fitness facilities that offer tanning



as an incidental service to members without a separately identifiable fee. For more information on the tax and how it is administered, see the Indoor Tanning Services Tax Center.

## **Reporting Employer Provided Health Coverage in Form W-2**

The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan on an employee's Form W-2, Wage and Tax Statement, in Box 12, using Code DD. Many employers are eligible for transition relief for tax-year 2012 and beyond, until the IRS issues final guidance for this reporting requirement.

The amount reported does not affect tax liability, as the value of the employer excludible contribution to health coverage continues to be excludible from an employee's income, and it is not taxable. This reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers.

More information about the reporting can be found on Form W-2 Reporting of Employer-Sponsored Health Coverage.

## **Adoption Credit**

The Affordable Care Act raises the maximum adoption credit to \$13,360 per child, up from \$13,170 in 2010 and \$12,150 in 2009. The adoption tax credit is refundable for tax year 2011, meaning that eligible taxpayers can get it even if they owe no tax for that year. In general, the credit is based on the reasonable and necessary expenses related to a legal adoption, including adoption fees, court costs, attorney's fees and travel expenses. Income limits and other special rules apply. In addition to attaching Form 8839, Qualified Adoption Expenses (see instructions), eligible taxpayers must include with their 2011 paper tax return one or more adoption-related documents to avoid delaying their refund. Taxpayers may also be asked, after filing their returns, to substantiate any qualified adoption expenses they paid.

For other information, see our news release, tax tip, questions and answers, flyer, Notice 2010-66, Revenue Procedure 2010-31, Revenue Procedure 2010-35 and Revenue Procedure 2011-52.

## **Transitional Reinsurance Program**

The ACA requires all health insurance issuers and self-insured group health plans to make contributions under the transitional Reinsurance Program to support payments to individual market issuers that cover high-cost individuals. For information on the tax treatment of contributions made under the Reinsurance Program, see our frequently asked questions.

## **Medicare Shared Savings Program**

The Affordable Care Act establishes a Medicare shared savings program (MSSP) which encourages Accountable Care Organizations (ACOs) to facilitate cooperation among providers to improve the quality of care provided to Medicare beneficiaries and reduce unnecessary costs. More information can be found in Notice 2011-20, which solicited written comments regarding what additional guidance, if any, is needed for tax-exempt organizations participating in the MSSP through an ACO. This guidance also addresses the participation of tax-exempt organizations in non-MSSP activities through ACOs. Additional information on the MSSP is available on the Department of Health and Human Services website.

The Centers for Medicare and Medicaid Services has released final regulations describing the rules for the Shared Savings Program and accountable care organizations. Fact Sheet 2011-11 confirms that Notice 2011-20 continues to reflect IRS expectations regarding the Shared Savings Program and ACOs, and provides additional information for charitable organizations that may wish to participate.

## **Qualified Therapeutic Discovery Project Program**

This program was designed to provide tax credits and grants to small firms that show significant potential to produce new and cost-saving therapies, support U.S. jobs and increase U.S. competitiveness. Applicants were required to have their research projects certified as eligible for the credit or grant. IRS guidance describes the application process. Submission of certification applications began June 21, 2010, and applications had to be postmarked no later than July 21, 2010, to be considered for the program. Applications that were postmarked by July 21, 2010, were reviewed by both the Department of Health and Human Services (HHS) and the IRS. All applicants were notified by letter dated October 29, 2010, advising whether or not the application for certification was approved. For those

applications that were approved, the letter also provided the amount of the grant to be awarded or the tax credit the applicant was eligible to take.

The IRS published the names of the applicants whose projects were approved as required by law. Listings of results are available by state.

Learn more by reading the IRS news release, the news release issued by the U.S. Department of the Treasury, the page on the HHS website and our questions and answers.

## **Group Health Plan Requirements**

The Affordable Care Act establishes a number of new requirements for group health plans. Interim guidance on changes to the nondiscrimination requirements for group health plans can be found in Notice 2011-1, which provides that employers will not be subject to penalties until after additional guidance is issued. Additionally, TD 9575 and REG-4003810, issued by DOL, HHS and IRS, provide information on the summary of benefits and coverage and the uniform glossary. Notice 2012-59 provides guidance to group health plans on the waiting periods they may apply before coverage starts. Other information on group health plan requirements is available on the websites of the Departments of Health and Human Services and Labor and in additional guidance.

## **Tax-Exempt 501(c)(29) Qualified Nonprofit Health Insurance Issuers**

The Affordable Care Act requires the Department of Health and Human Services (HHS) to establish the Consumer Operated and Oriented Plan program (CO-OP program). It also provides for tax exemption for recipients of CO-OP program grants and loans that meet additional requirements under section 501(c)(29). IRS Notice 2011-23 outlined the requirements for tax exemption under section 501(c)(29) and solicited written comments regarding these requirements as well as the application process. Revenue Procedure 2012-11, issued in conjunction with temporary regulations and a notice of proposed rulemaking, sets out the procedures for issuing determination letters and rulings on the exempt status of organizations applying for recognition of exemption under 501(c)(29).

An overview of the CO-OP program is available on the Department of Health and Human Services website.

## **Medicare Part D Coverage Gap “donut hole” Rebate**

The Affordable Care Act provides a one-time \$250 rebate in 2010 to assist Medicare Part D recipients who have reached their Medicare drug plan’s coverage gap. This payment is not taxable. This payment is not made by the IRS. More information can be found at [www.medicare.gov](http://www.medicare.gov).

## **Additional Requirements for Tax-Exempt Hospitals**

The Affordable Care Act added new requirements for charitable hospitals. (See Notice 2010-39 and Notice 2011-52.) On June 22, 2012, the IRS issued proposed regulations which provide information on the requirements for charitable hospitals relating to financial assistance and emergency medical care policies, charges for emergency or medically necessary care provided to individuals eligible for financial assistance, and billing and collections. Comments on the proposed regulations are requested by Sept. 24, 2012.

Form 990, Schedule H, for tax year 2010 was revised to include a new Part V, Section B, to gather information on hospitals’ compliance with the new requirements and on related policies and practices. To give the hospital community time to familiarize itself with the types of information the IRS is requesting, Part V, Section B of Schedule H was made optional for the 2010 tax year (see Announcement 2011-37).

The IRS considered public input and made revisions to Part V, Section B for tax year 2011 (see the Form 990, Schedule H and instructions). Hospitals are required to complete all parts and sections of Schedule H for tax year 2011, with the exception of lines 1-7 of Part V, Section B, which relate to community health needs assessments (see Notice 2012-4). These lines are optional for 2011. The IRS continues to welcome public input on the new requirements for charitable hospitals under the Affordable Care Act.

## **Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers**

The Affordable Care Act created an annual fee payable beginning in 2011 by certain manufacturers and importers of brand name pharmaceuticals. On Aug. 15, 2011, the IRS issued temporary regulations and a notice of proposed rulemaking on the branded

prescription drug fee. The temporary regulations describe the rules related to the fee, including how it is computed and how it is paid.

On Nov. 4, 2011, the IRS issued Notice 2011-92 which provides additional guidance on the branded prescription drug fee for the 2012 fee year. On Nov. 29, 2012, the IRS issued Notice 2012-74 providing similar guidance for the 2013 fee year.

### **Modification of Section 833 Treatment of Certain Health Organizations**

The Affordable Care Act amended section 833 of the Code, which provides special rules for the taxation of Blue Cross and Blue Shield organizations and certain other organizations that provide health insurance. IRS Notice 2010-79 provides transitional relief and interim guidance on the computation of an organization's taxpayer's Medical Loss Ratio for purposes of section 833, the consequences of nonapplication and changes in accounting method. Notice 2011-04 provides additional information and the procedures for qualifying organizations to obtain automatic consent to change its method of accounting for unearned premiums. Notice 2011-51 extends the transitional relief and interim guidance provided in Notice 2010-79 for another year to any taxable year beginning in 2010 and the first taxable year beginning after Dec. 31, 2010. Notice 2012-37 extends the transitional relief and interim guidance provided in Notice 2010-79 for another year to any taxable year beginning in 2012 and the first taxable year beginning after Dec. 31, 2012.

### **Medical Loss Ratio (MLR)**

Beginning in 2011, insurance companies are required to spend a specified percentage of premium dollars on medical care and quality improvement activities, meeting a medical loss ratio (MLR) standard. Insurance companies that are not meeting the MLR standard will be required to provide rebates to their consumers beginning in 2012. For information on the federal tax consequences to an insurance company that pays a MLR rebate and an individual policyholder who receives a MLR rebate, as well as information on the federal tax consequences to employees if a MLR rebate stems from a group health insurance policy, see our frequently asked questions.

### **Limitation on Deduction for Compensation Paid by Certain Health Insurance Providers**

The Affordable Care Act amended section 162(m) of the Code to limit the compensation deduction available to certain health insurance providers. The amendment goes into effect for taxable years beginning after Dec. 31, 2012, but may affect deferred compensation attributable to services performed in a taxable year beginning after Dec. 31, 2009. Initial guidance on the application of this provision can be found in Notice 2011-2, which also solicited comments on the application of the amended provision.

### **Employer Shared Responsibility Payment**

Starting in 2014, certain employers must offer health coverage to their full-time employees or a shared responsibility payment may apply. On Dec. 28, 2012, the Treasury Department and the IRS issued proposed regulations on the Employer Shared Responsibility provisions. Comments may be submitted electronically, by mail or hand delivered to the IRS. For additional information on the Employer Shared Responsibility provisions and the proposed regulations, see our questions and answers. Other information, much of which has been incorporated into the proposed regulations, may be found in news releases IR-2011-92 and IR-2011-50 and Notices 2011-73, 2011-36, 2012-17 and 2012-58. Additionally, Notice 2012-59 provides related guidance for group health plans on the waiting periods they may apply before starting coverage.

### **Patient-Centered Outcomes Research Institute**

The Affordable Care Act establishes the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing clinical effectiveness research. The trust fund will be funded in part by fees paid by issuers of certain health insurance policies and sponsors of certain self-insured health plans. The IRS and the Treasury Department have issued final regulations on this fee."

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[www.physiciansfoundation.org](http://www.physiciansfoundation.org).