



House to Consider Medicare MD Payment/ COBRA Extension; Budget Unresolved

Budget Resolution Still Up in the Air

House Democrats say they are continuing negotiations within their caucus to agree on a FY 2011 budget resolution, but House Republicans say otherwise. In a colloquy in the House last week, **House Minority Whip Eric Cantor** asked **House Majority Leader Steny Hoyer** about budget resolution scheduling and **Rep. Hoyer** said “I am certainly hopeful that we will deal with the issue of spending levels by the time we bring appropriation bills to the floor. We are working on that.” Even without a budget resolution, the majority will have to come up with spending limits for all FY 2011 appropriations bills. One approach is for the House to consider a “deeming resolution” which would set discretionary spending levels needed to complete the appropriations process. Although the Senate Budget Committee has reported a resolution, **Chairman Kent Conrad** is apparently readying an alternative legislative strategy that would consolidate all must-pass tax legislation and the Medicare physician payment fix into an omnibus bill to be passed in an effort to allow Congress to go home in time to campaign.

Medicare MD Fix/ COBRA Extension

The temporary extender package freezing Medicare physician payments and extending COBRA subsidies

passed by Congress on April 15, H.R. 4851, ends on May 31st. In an attempt to meet the deadline and provide a “more generous” MD fix, according to **House E&C Chairman Henry Waxman**, the House will attempt to take up a “jobs” bill that would not only address the Medicare payment and COBRA issues, but extend unemployment benefits and state Medicaid funding and provide tax benefits designed to create jobs. It remains to be seen whether H.R. 4213, which the House and Senate have already approved in different versions, will be fully paid for in this ping-pong legislative maneuver. House Blue Dogs have earlier reached agreement with leadership to support a five-year \$89 billion Medicare physician payment fix.

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Health Reform Update

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Senate Finance Chairman Max Baucus has also noted that a five-year doc fix is “probably what we’re going to do.”

DOL Notice on Subsidized COBRA Coverage

Last week the Department of Labor Employee Benefits Security Administration released updated model notices of subsidized continuing health care

coverage under COBRA. The model notices are to be used by group health plans which are required to provide notices of the availability of premium reductions and additional election periods for continuing health care coverage. The ARRA and Continuing Extension Act COBRA subsidies end in May, unless the above jobs/extender bill or another extension is enacted.

Yeh and Nay to Health Reform

Last week the President touted the various provisions of the PPACA which benefit Americans this year; e.g. coverage for “children” up to age 26 on their parents coverage, tax credits for small businesses to buy health coverage for their employees, a \$250 rebate for seniors who fall into the so-called Medicare Part D doughnut hole, etc. However, Republicans continue to gear up to “repeal and replace” the major provisions of health reform. In particular, the Senate Republican leadership is instituting a strategy, “A Second Opinion,” to publicize the consequences of PPACA that the White House hopes people will miss. They plan to get their message across by means of the web, radio and TV appearances and the press. In this connection, Republican appropriators cite CBO’s latest analysis that the PPACA would add at least \$115 billion in discretionary spending over a 10-year period to the legislation’s cost and eliminate what the President said is a deficit reduction measure. The discretionary

spending falls into three categories: implementation costs for federal agencies; explicit authorizations for grants and program spending with specified funding levels; and explicit authorizations for grants and program spending without specified funding levels. The IRS and HHS implementation costs are expected to be \$5-10 billion from 2010-2019 and explicit authorizations with specified funding levels for trauma care centers, community health centers grants and workforce development grants, etc., are expected to total around \$105 billion over the same period. HHS Secretary Kathleen Sebelius said her department will not seek additional appropriations, thus leaving these additional spending items for Congress to work out. Not to be left behind, in the House, the Minority Leader John Boehner opined that “We’re going to do everything we can to make sure this law never, ever goes into effect... We’re going to rip out every possible mandate and increase, tax increase, that they’ve got contained in this bill.”

VA Program Deemed “Essential Benefits”

Last week the House passed H.R. 5014, legislation designed to ensure that the Department of Veterans Affairs “Spina Bifida Health Care

Program” (established in 1996 to cover children with spina bifida and other birth defects connected to their mothers’ service in Vietnam or Korea between 1967 and 1971)

meets minimum essential coverage requirements set out under the PPACA.

Other Implementation Issues

HHHS has informed Congress on the various PPACA implementation efforts underway, including HHS and IRS regulatory actions and letters to insurers requesting a speed up in effective dates for children's coverage, blasting them for rate increases, etc. Following the HIPAA precedent, a multi-agency PPACA regulatory drafting group has convened with members from the Treasury, DOL, HHS and the IRS. After agency coordination, last week Treasury/HHS/DOL released an interim final rule that details how health insurers and plans that offer dependent coverage must implement the

new requirement that will allow young adults to stay on a parent's insurance policy until they turn 26 years old. The requirement takes effect for plan years beginning on or after September 23, 2010 and applies regardless of factors such as a young adult's marital status, student status, the financial dependence on the primary enrollee or eligibility for other coverage. The next set of guidance to be released is expected to define grandfathered plans and clarify how the new law will affect collectively bargained plans. CMS also got into the PPACA act by advising providers who submit claims to Medicare contractors that

the maximum period for submitting claims has been reduced to one calendar year. In a letter to HHS and the National Association of Insurance Commissioners (NAIC), **Senator John D. Rockefeller IV** has urged regulators to guard against attempts by health insurers to weaken the medical loss ratio (MLR) provision under the PPACA, arguing that insurers are "mounting an all-out effort" to make it easier for them to meet the ratios called for in the law. The NAIC is to provide guidance to HHS by June 1 about how to structure the medical loss ratio provision and comments are due May 14.

Justice Department Responds to Constitutional Challenge to Individual Mandate

In a brief filed in federal district court in Detroit, the Department of Justice argued as invalid the claims made in a lawsuit filed by the Ann Arbor, Michigan-based Thomas More Law Center which challenges the constitutionality of the individual mandate. The brief said that Congress acted well within its power to approve comprehensive legislation that would help to fix a health care system that "is in crisis, spawning public expense and public tragedy." It also said that the "minimum coverage provision is vital to that comprehensive scheme...Enjoining it would thwart this reform and reignite the crisis that the elected branches of government acted to forestall...[and that the plaintiffs] bring this suit four years before the provision they challenge takes effect, demonstrate no current injury and merely speculate whether the law will harm them once it is in force..." In related news, the NFIB has joined the lawsuit filed by the Florida Attorney General and 13 other states challenging the individual mandate and other elements of the PPACA. Many other states are ramping up state constitution and referendums challenging the individual mandate and provisions forcing the states to pay more for the Medicaid expansion under PPACA. In addition, the CRS has released a report, *Requiring Individuals to Obtain Health Insurance: A*

Constitutional Analysis, analyzing the constitutionality of the individual mandate. Looking at whether Congress had the authority to require individuals to purchase health insurance, the report found no specific enumerated power but said that Congress' other broad enumerated powers have been used to justify social programs of the past. It said that the Constitution provides that Congress has the power to tax and spend for the general welfare and that this power affords the basis for a number of government health programs that include Medicare and Medicaid. It also said that use of the Commerce Clause of the Constitution, in order to require individuals to purchase health insurance, is a novel issue, although "there is plenty of evidence that the purchase of health insurance has an effect on the commerce of the nation." Examining whether the requirement to have health insurance might violate certain protections found under the Fifth and Tenth Amendments of the Constitution, the report said that it seems unlikely that a challenge to the individual responsibility requirement would be successful under those provisions. The report also examined religious exemptions to individual responsibility requirements, and it concluded that the question of the constitutionality of exemptions based on religion appears not to be settled yet.

Enhanced Medicaid FMAP Promoted

Last week over 200 House members sent the Speaker and Minority Leader a letter urging them to act quickly to extend for six months the AARA enhanced federal

Medicaid matching funding that ends December 31st. They said “Without this funding, our states will be forced to make severe cuts to Medicaid providers and benefits, and the ensuing

budget shortfall would have grave consequences for school funding and other essential state programs....”

Potential “Medically Unnecessary” Home Visits

Last week **Senate Finance Committee Chairman Max Baucus** and **ranking member Chuck Grassley** sent letters to the four largest for-profit home health agencies expressing concern over potentially medically unnecessary home health visits linked to receiving higher Medicare reimbursement rates. They said “We need to make sure care is provided based on patients’ best interests, not profit margins. So far, it appears that either the home health care reimbursement policy is flawed, some companies are gaming the system, or both.”

CMS Nominee Berwick under Fire

Last week **Senator Pat Roberts** said the President’s nominee for **CMS Administrator, Donald Berwick**, “is the wrong man, wrong time, [for the] wrong job....” He has charged that Berwick supports rationing patient care at the end of life. The White House denounced the remarks as a distortion of Berwick’s record and an effort to rehash unsuccessful arguments about the health care overhaul.

FDA Issues

FDA to Examine Genetic Testing Kits--Last week the FDA said it is considering requiring a genetic testing company to seek agency approval for personal genetic testing kits that are marketed directly to the public. Currently, the FDA regulates diagnostic tests only if they are developed and sold by device manufacturers as diagnostic kits, regardless of whether they were developed by clinical laboratory companies for in-house testing or by manufacturers for use in kits.

S. 3330 (VETERANS' HEALTH), to amend Title 38, United States Code, to make certain improvements in the administration of medical facilities of the Department of Veterans Affairs, and for other purposes; CASEY; to the Committee on Veterans' Affairs, May 7.

H.R. 5279 (TAX POLICY), to amend the Internal Revenue Code of 1986 to provide for active qualified public safety employees to elect to be covered under the hospital insurance tax, and for other purposes; GENE GREEN of Texas; to the Committee on Ways and Means, May 12.

H.R. 5290 (MEDICARE), to permit physicians and suppliers a new election to become Medicare participating physicians and suppliers if Medicare physician fee schedule rates are extended; GIFFORDS; jointly,

to the committees on Energy and Commerce and Ways and Means, May 12.

S. 3356 (MILITARY HEALTH), to amend Title 38, United States Code, to increase the maximum age for children eligible for medical care under the CHAMPVA program, and for other purposes; FEINGOLD; to the Committee on Veterans' Affairs, May 13.

S. 3357 (PHARMACIES), to establish certain duties for pharmacies to ensure provision of Food and Drug Administration-approved contraception, and for other purposes; LAUTENBERG; to the Committee on Health, Education, Labor, and Pensions, May 13.

S. 3371 (MILITARY HEALTH), to amend Title 10, United States Code, to improve access to mental health care counselors under

TRICARE, and for other purposes; McCASKILL; to the Committee on Armed Services, May 13.

H.R. 5295 (QUALITY), to ensure that patients receive accurate health care information by prohibiting misleading and deceptive advertising or representation in the provision of health care services, and to require the identification of the license of health care professionals; SULLIVAN; to the Committee on Energy and Commerce, May 13.

H.R. 5309 (PHARMACIES), to establish certain duties for pharmacies to ensure provision of Food and Drug Administration-approved contraception, and for other purposes; MALONEY; to the Committee on Energy and Commerce, May 13.