



## Enactment of “FMAP” Legislation Sends Congress Home until September

### *President Obama Signs Legislation to Extend Enhanced Medicaid Funding*

Last week the House voted 247-161 to pass H.R. 1586, an aviation bill revised August 5th by the Senate to provide for an extension of enhanced Medicaid funding (FMAP) first provided under the ARRA stimulus legislation. The \$26.1 billion bill signed by **President Obama** into law (P.L. 111-226) provides states with \$16.1 billion in a phase-out of the increased FMAP as follows: a 3.2% increase in the second quarter of FY 2011 and a 1.2% increase in the third quarter of FY 2011 with a slightly larger increase based on state unemployment rates. After the vote, the House again adjourned until September 13 when both chambers are expected to address jobs legislation and legislation to repeal a provision of the PPACA health reform that would expand IRS 1099 reporting for small businesses. With only two Republicans in the House voting for the legislation, **Rep. Joe Barton** said “Money is fungible and under this particular bill, while the nameplate says for Medicaid, the truth is the money can be spent for whatever purpose the state wants to spend it for. I don’t think that’s appropriate....”  
Federal District Court

### *Finding Will Narrow ERISA Preemption*

Coming on the heels

of the announcement by the DOL Employee Benefits Security Administration that it intends to withdraw a proposed regulation to define a welfare benefit plan under ERISA which would have the effect of narrowing the preemption of state law and allow state and local government laws mandating employer health benefits coverage to survive under the federal law, last week the U.S. District Court for the Northern District of California granted motions filed by San Francisco to allow the city’s play or pay health mandate ordinance to go forward based on the U.S. Court of Appeals for the Ninth Circuit determination that the ordinance did not unduly relate to matters covered exclusively by the federal ERISA law.

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## Medical Loss ratio Debate Heats Up

The health insurance industry has responded with grief over the post PACCA enactment Democrat conferee letter attempting to “clarify” the portion of the PACCA medical loss ratio provision which allows “federal and state taxes and licensing fees” to be excluded from the premium revenue number. The

congressional letter stated that that only federal taxes and fees relating specifically to revenue generated from the insurance coverage provision should be counted as medical costs-- including the annual fee on market share, the annual fee on each health policy and the tax on high-cost employer plans—but that other taxes, such

as income or payroll taxes should not be considered medical costs. Insurers claim that the clarification could harm consumers and make it more difficult for insurers to meet the 80% and 85% MLR standard for individual and group plans, respectively.

## IRS Gives Notice of PPACA Reporting Requirements

The IRS has provided information on its website that the PPACA requirement for employers to report the value of the health insurance coverage they provide employees on each employee’s annual Form W-2 is for informational purposes only

to show employees the value of their health care benefits so they can be more informed consumers. The IRS webpage also explains the therapeutic discovery project program, the small business health care tax credit, the Medicare Part D coverage gap “doughnut

hole” rebate and additional requirements for tax-exempt hospitals. Also HHS has set up a website, Healthcare.gov, to provide information on the pre-existing condition insurance plans and other insurance reforms under the PPACA.

## House Members Request CMS Data on Winning DME Bidders

Last week 136 House members wrote CMS asking the agency to reveal specific information about the durable medical equipment (DME) suppliers that are being invited to participate in the agency’s competitive bidding program scheduled to begin in 2011. The

letter said “Without knowing the identity as well as the appropriate overall qualifications of these providers, we cannot evaluate the program’s impact in terms of quality and access to care for seniors we represent... We want to ensure that qualified providers have been chosen to provide these items

and services to our constituents...” CMS had previously indicated it would offer 1,287 contracts to 364 suppliers in the nine regions of the first round of the program that requires DME suppliers to compete for Medicare business, rather than being paid based on a fee schedule.

## Final MEQC/PERM Rule

Last week CMS released a final rule that makes changes to the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs, as required by the Children’s Health Insurance Program Reauthorization Act of 2009, as well as operational changes

to Medicaid and CHIP error rate measurement. New **CMS Administrator Donald Berwick** said “Like other large federal programs, Medicare, Medicaid and CHIP are susceptible to errors or improper payments... Reducing payment errors in federal programs is a key goal of the entire Obama Administration and the rules we

are issuing today—developed with feedback and input from states and other stakeholders—allow us to implement strategies for reducing the rate of errors in Medicaid and CHIP more effectively.”

## MedPAC Urges CMS to Correct Therapy Payment System for Nursing Care

MedPAC has written CMS urging the agency to correct two major problems with its skilled nursing facility prospective payment system (SNF PPS) that affect payments for non-therapy ancillary (NTA) and therapy services. MedPAC said “.... SNF

payments are more than adequate to accommodate cost growth, and in March 2010 recommended to the Congress that the industry receive no payment update for fiscal year 2011” and that CMS needs to change the way NTA and therapy services are paid while considering group therapy minutes

in assigning patients to different case-mix groups. MedPAC said it has highlighted the shortcomings of the PPS design for years, but that CMS has yet to act on the commission’s recommendations.

### FDA Issues

***Public Meeting in September On Creating Generic Drug User Fee Program***—The FDA announced it will hold a public meeting September 17th to gather stakeholder input on the development of a generic drug user fee program. The FDA said that the number of generic drug applications and the median review time for those applications has increased in recent years and that a user fee program could provide necessary supplemental funding to allow for the timely review of such applications. However, new legislation would be required to allow the FDA to establish and collect user fees for generic drugs.