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Health Care Issues Poised to Take Front and Center in the 113th Congress

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Health care issues dominated much of President Obama's first term. Even after Congress passed the Patient Protection and Affordable Care Act ("PPACA" or "health reform law") (Pub. L. 111-148, 111-152), the Supreme Court ruling in *National Federation of Independent Business v. Sebelius*, 567 U.S. _____, 132 S. Ct. 2566 (2012), along with the controversy over contraceptive benefits and persistent Republican efforts in Congress to repeal and defund the law, ensured that health care was never far from the spotlight.

Congress is likely to continue aggressively tackling health care issues over the next two years. To a large extent, the fiscal challenges facing the country will drive this effort by forcing lawmakers to search for ways to reduce the deficit. In addition, PPACA will continue to play a prominent role at both the federal and state levels as lawmakers and businesses work on implementing the law's provisions. Even non-health care issues like immigration reform could have a significant impact on the health care industry.

I. Fiscal Issues and Entitlement Reform

Control of the 113th Congress remains unchanged from the 112th, with Republicans retaining the majority in the House and Democrats controlling the Senate. This political environment makes it highly likely that Congress will remain entangled over fiscal issues, which could lead to entitlement reform as a way of reducing spending and raising revenue.

A. Fiscal Issues

The year-end American Taxpayer Relief Act of 2012 ("ATRA") (Pub. L. 112-240) addressed some budget issues but failed to achieve long-term deficit reduction. As a result, a slew of tax and spending issues remain on Congress's plate this year, including:

- Sequestration, which will result in across the board spending cuts of \$1.2 trillion—including \$85 billion for the remainder of 2013 alone and a 2 percent cut for Medicare providers and health plans—if it takes effect on March 1, 2013
- Appropriations for FY 2013, which are set to expire on March 27, 2013
- The FY 2014 budget, which may include significant entitlement reforms as part of an effort to reduce the deficit, and
- The debt ceiling, which Congress suspended until May through the No Budget, No Pay Act (Pub. L. 113-3)

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B. Fiscal Issues: What Does It All Mean?

The bottom line is that entitlement programs will be on the “chopping block” in the upcoming budget debates. Both parties agree on the need to address the federal deficit, and entitlement programs are widely viewed as the biggest driver of federal spending. While Republicans want to make structural changes to Medicare and Medicaid to reduce spending, the majority of Americans oppose sweeping changes to these programs. Meanwhile, Democrats have proposed a variety of small, targeted changes to the programs that would probably not reduce the growth of health care spending substantially. Ultimately, both parties will meet somewhere in the middle if a compromise is possible.

C. Entitlement Reform

1. Medicare Cuts

Medicare spending is one of the main drivers of the federal deficit, so it’s no surprise that Congress will be looking for areas of agreement that would reduce Medicare spending. Below is a list of proposals that lawmakers have raised in an effort to curb federal health care spending under the Medicare program:

- Consolidating payments for direct and indirect medical education cost and reducing federal payments for graduate medical education
- Reducing or eliminating Medicare “disproportionate share” adjustments
- “Rebasing” and “merging” the Medicare hospital wage index with the wage indices applicable to various providers
- Reducing or eliminating payment incentives to providers adopting new health information technologies
- Requiring a larger co-payment for home health episodes covered by Medicare
- Reforming cost-sharing structures for Medicare and Medigap insurance
- Reducing Medicare’s payment rates across the board in high-cost areas
- Eliminating the Medicare Critical Access Hospital, Medicare-Dependent Hospital, and Sole Community Hospital programs
- Requiring manufacturers to pay a minimum rebate on drugs covered under Medicare Part D for low-income beneficiaries
- Eliminating “quality” bonus for Medicare Advantage plans
- Developing a new payment system (such as bundling payments) for medical devices and supplies

2. Medicaid Cuts

Although President Obama has said that he will not undertake any effort to reform Medicaid during his second term, Congress may still look to cut spending under this program to reduce the deficit. Below are a few proposals that would reduce Medicaid spending and may gain traction during the 113th Congress:

- Allowing states to fully enroll a greater proportion of Medicaid recipients in managed care programs (e.g., certain disabled populations)

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- Limiting benefits to some Medicaid eligible groups (e.g., women with dependent children)
- Increasing co-payments applicable to some benefits or for some recipients — particularly for Medicaid recipients not enrolled in managed care programs
- Establishing more limited benefits (e.g., severely limit the number of covered hospital days)
- Limiting benefits to Medicaid recipients using emergency room or other high-cost services unnecessarily

D. Entitlement Reform: What Does It All Mean?

Nearly every component of Medicare and Medicaid will be under review over the next two years as lawmakers tackle the deficit. Fortunately, the legislative process gives health care providers, hospitals, businesses, and others many avenues to influence the development of public policy. Stakeholders should engage with Members of Congress as well as local officials to protect their areas of interest.

Additionally, this renewed focus on entitlement reform will put the spotlight on innovation in the health care field. Innovative programs that can reduce costs while providing the same or better care will be especially attractive for lawmakers who want to cut spending without sacrificing access to quality medical care. Health care programs that can reduce costs while providing high-quality care will be much more likely to maintain current funding or avoid any detrimental effects that spending cuts would otherwise have.

II. Health Care Issues

Aside from broad efforts to curb the trajectory of entitlement spending, Congress and the Administration will focus on a variety of other health care issues this year. Most notably, 2013 will be a pivotal year for the health reform law—both for efforts to repeal or defund portions of the law, as well as the implementation of the law at the federal and state levels. Additionally, the federal government is likely to focus on addressing mental health programs, lowering health care costs attributable to “dual eligibles” who qualify for both Medicare and Medicaid, reforming the Medicare SGR through a permanent “doc fix,” and modifying the Medicare wage index.

A. Health Reform Law—Repeal/Defunding Efforts

Since President Obama signed PPACA into law in March 2010, the law has survived a Supreme Court challenge as well as the prospect of repeal if Republicans had taken control of the White House and Senate in the November 2012 elections.

In 2013, House Republicans are likely to continue in their efforts to repeal parts of the law. In particular, they are likely to focus on unpopular provisions of the law such as the Independent Payment Advisory Board (“IPAB”), a panel of non-elected officials that will make recommendations to the federal government on how to reduce Medicare spending, as well as the law’s individual mandate, which requires most Americans to maintain health insurance coverage or pay a financial penalty. Efforts to repeal the law in its entirety, while still expected to be present, will not play as significant a role in the conservative health care strategy.

Congressional Republicans will also focus on rescinding or stopping funding to certain programs under PPACA. As part of ATRA, Republicans successfully negotiated a reduction in funding to the law’s CO-OP program, which is designed to increase competition in the health insurance market by

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creating member-owned, nonprofit health insurers. Last year, Congress also voted to cut \$5 billion from PPACA's Prevention and Public Health fund. Even Democrats may be forced to consider savings from the health reform law as part of a larger effort to reduce the federal deficit.

B. Health Reform Law—Implementation

1. Federal Implementation of PPACA

The most significant provisions of PPACA are scheduled to take effect next year, but businesses, insurers, health care providers, state officials, and others have been clamoring for information about how the federal government intends to implement the law. As a result, the Administration is expected to issue guidance and regulations this year on many of the major provisions of PPACA, including:

- The individual mandate
- The employer mandate
- Disproportionate share hospital (“DSH”) payment reductions
- Health insurer tax

2. State Implementation of PPACA

Most of the PPACA implementation efforts will take place at the state level. States with Democratic governors have been more likely to take affirmative steps to implement the law ahead of PPACA's statutory deadlines; states with Republican governors, on the other hand, have been less likely.

a. Exchanges

PPACA requires states to establish health insurance exchanges (“exchanges”) to provide a marketplace for individuals to purchase health insurance, starting on January 1, 2014. If a state does not establish an exchange, the health reform law requires the federal government to set up an exchange for the state. Health plans offered on the exchange must provide a variety of health benefits and are not allowed to discriminate against individuals with pre-existing conditions, vary premium rates because of health status, and engage in other practices. Low-income individuals who purchase health benefits on the exchange are eligible for premium tax credits and reductions in cost-sharing.

The exchanges were intended to be the centerpiece of the health reform law. However, with the exception of a few states like Vermont, Maryland, and Massachusetts, most states will not be ready to open exchanges in time to meet the law's ambitious deadlines without federal assistance. Many states with Republican governors have refused to set up exchanges altogether. Although the Department of Health and Human Services (“HHS”) has established a partnership program that allows states to share responsibility with the federal government, the federal government will be operating exchanges in more than half of states next year, and it is unclear whether the Administration will be able to set up exchanges in every state in time to meet the law's enrollment deadline.

b. Medicaid Expansion

PPACA requires states to expand their Medicaid programs to individuals with incomes up to 133 percent of the Federal Poverty Level. The assumption was that the federal government would withhold all Medicaid funding from a state if it refused to expand its Medicaid program. However, the Supreme Court ruled last year that the federal government cannot withhold *all* Medicaid funds from states that refuse to expand their programs; instead, the federal government can only withhold the *additional* funding that would have been available to the state had it expanded its Medicaid program.

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Freed by the Supreme Court from the prospect of losing billions of dollars in Medicaid funding, several states with Republican governors, including Louisiana, Kansas, and Iowa, have refused to expand their Medicaid programs. However, there has been greater willingness among Republican governors to expand Medicaid in recent months. For example, Ohio Governor John Kasich (R) and Florida Governor Rick Scott (R) announced in February 2013 that their states will expand Medicaid in accordance with the health reform law. The Administration is working with states to come up with compromise to expand their Medicaid programs, but in the face of resistance the Administration may also decide to coerce some states into expansion by withholding other funding, such as Medicaid DSH payments.

C. Mental Health

Following the mass shootings in Newtown, Connecticut and Aurora, Colorado last year, policymakers have shown a renewed interest in addressing mental health issues. On January 24, 2013, the Senate Committee on Health, Education, Labor and Pensions held its first hearing in six years focusing on mental health, and the House Appropriations Committee held a similar hearing on federal funding for mental health and substance abuse programs.

The focus on federal mental health programs has generally centered around two laws:

- The Mental Health Parity and Addictions Equity Act of 2008, which requires health insurers to treat coverage of mental health issues the same as physical health conditions
- PPACA, which includes provisions promoting increased access to mental health coverage, and requires health insurers to cover mental health conditions in order to meet “essential health benefits” requirements

Congress has asked the Administration to finalize regulations on these two laws, but there has been other action on mental health issues. In particular, federal lawmakers have pushed to protect and increase federal and state funding for mental health programs. Many states have also decided against cutting mental health funding.

D. Dual Eligibles

The high-cost group known as “dual eligibles” will be a major issue as Congress wrestles with how to reduce Medicare and Medicaid spending. Dual eligibles are individuals who are eligible for, and enrolled in, both Medicare and Medicaid. Although this group represents a small percentage of patients, it accounts for a disproportionately large share of Medicare and Medicaid spending. As a result, lawmakers frequently focus on this group when looking for ways to reduce federal health care spending.

There have been numerous proposals and demonstration programs aimed at lowering health care costs for this population. Some of these programs include:

- Accountable Care Organizations (“ACOs”), which the Affordable Care Act established to increase the coordination of health care services to populations like dual eligibles
- Medicare Advantage Special Needs Plans, which provide tailored benefits to individuals with specific diseases or characteristics
- Managed Care Organizations, including physician groups and organizations containing a broader spectrum of providers, and

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- Program of All-inclusive Care for the Elderly—also known as the “PACE Program,” which provides home-based, coordinated health care services to low-income elderly patients who would otherwise qualify for long-term nursing home care

E. Sustainable Growth Rate (“SGR”)—the “Doc Fix”

As part of ATRA, Congress voted to extend the Medicare doc fix for one year, through the end of 2013. By doing so, Congress avoided the 27% cut to Medicare reimbursement that providers would have faced without congressional action. Despite this temporary fix, the health care community continues to advocate for a permanent solution that avoids the yearly exercise of waiting for congressional action before massive cuts take effect. These efforts have gained momentum recently after the Congressional Budget Office reduced its ten-year cost estimate for the doc fix from about \$243 billion to just \$138 billion.

In response, many senior House members are determined to find a solution that provides stability to Medicare providers. Ways and Means Committee Chairman Dave Camp (R-MI), Ways and Means Health Subcommittee Chairman Kevin Brady (R-TX), Energy and Commerce Committee Chairman Fred Upton (R-MI), and others are working together towards a permanent fix.

F. Rural Floor Wage Index

Another issue that will be of continued interest is the Medicare “wage index.” By way of background, Medicare makes payments to hospitals providing inpatient care. The Center for Medicare and Medicaid Services (CMS) adjusts its base payment rate for inpatient services under Medicare based on regional differences in hospital wages. This process is called the “wage index adjustment.” In 1997, Congress established a “rural floor” for wage index adjustments and required that wage index adjustments be budget neutral. PPACA section 3141 requires CMS to make this calculation on a national basis rather than a state-by-state basis, meaning that an increase in one state’s wage index will result in a decrease in payments to other states. One result of this change is that hospitals in Massachusetts have seen a dramatic increase in payments while hospitals around the rest of the country have seen a decrease in payments.

Not surprisingly, this change has drawn the ire of hospitals around the country outside of Massachusetts. There has been a renewed interest in fixing the wage index formula, and Congress’s effort to reduce the deficit may provide a vehicle to change the Medicare reimbursement system—including the rural floor wage index. Hospitals should expect a continued focus on this issue throughout the year.

G. Health Care Issues: What Does It All Mean?

Putting these issues together, several themes emerge.

- **This year will play a large role in determining how the health reform law is implemented.** Although the law has survived a Supreme Court challenge and the November 2012 elections, the debate over some significant portions of the law continues. There are ample opportunities for stakeholders to shape the implementation of PPACA through the regulatory process. HHS, Treasury, the Department of Labor, and other agencies continue to solicit feedback from businesses, health plans, health care providers, and others.
- **The states will play a major role in implementing the law.** As the old adage goes, “All politics is local.” Stakeholders can use this cliché to their advantage by engaging with state and local officials.

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- **Care coordination will be key to health care savings.** Aside from cutting payments to providers, some of the most popular proposals to reduce health care spending revolve around coordinating care for high-cost populations—especially low-income elderly populations. This emphasis on care coordination highlights the importance of programs such as PACE that replace long-term care settings with comprehensive home-based care coordinated by a dedicated health care provider.
- **The partisan atmosphere in Congress will impede the implementation of the health reform law.** The November 2012 election did not dramatically alter the composition of Congress. As a result, the President and Senate Democrats are expected to beat back any efforts to repeal significant portions of the health reform law. However, the House is likely to exercise its oversight duties to undercut the Administration’s implementation of PPACA wherever it can. The Energy and Commerce Committee and the Committee on Oversight and Government Reform will play large roles in this effort.
- **Possibility of new funding for mental health.** The mass shootings of recent years have drawn attention to the diagnosis and treatment of mental health issues. The spotlight on this issue has caused many Democrats to push for additional funding for mental health. This wave of popular sentiment has the possibility to bring some Republican support for mental health programs.
- **Possibility of a “grand bargain” on the doc fix and wage index.** Both parties have shown an interest in finding long-term solutions to the Medicare SGR and wage index. However, any efforts to achieve an agreement may be impeded by the need to find offsets to fund these initiatives.

III. Immigration Reform

A. Reform Efforts

In the wake of the 2012 elections, Republicans and Democrats alike have made immigration reform a priority for the next two years. There is general agreement on the need for bipartisan legislation to increase visas for skilled foreign-born workers, and Republicans are more open to comprehensive immigration reform efforts that would provide a pathway to citizenship for undocumented individuals living in America. Illustrating this growing consensus, a bipartisan group of senators recently released their framework for comprehensive immigration reform.

Immigration reform could have a significant impact on the health care industry. A recent report from the HHS Office of the Inspector General found that Medicare improperly paid over \$120 million for services delivered to undocumented immigrants and incarcerated residents between 2009 and 2011. This figure shows the economic impact of illegal immigrants on the country’s health care system. Undocumented immigrants tend to have lower incomes than others and are much more likely to be uninsured. As a result, this population accounts for a large share of the uncompensated care that hospitals provide each year.

B. Immigration Reform: What Does It All Mean?

Comprehensive immigration reform could include a pathway to citizenship for undocumented immigrants. This could lead to an increase in the number of individuals enrolled in Medicaid, which could, in turn, lead to a decrease in uncompensated care provided by hospitals.

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IV. Conclusion

After the Supreme Court upheld PPACA in *NFIB v. Sebelius* and President Obama won re-election, it would have been reasonable to assume that there would be little interest in tackling health care issues in the 113th Congress. However, the fiscal challenges facing the country and the ongoing implementation of PPACA mean that a variety of health care issues are on the table this year, including the possibility of entitlement reform, state efforts to establish insurance exchanges, mental health programs, and even immigration reform. Hospitals, health plans, health care providers, businesses, and others need to actively engage with lawmakers to ensure that Congress does not cut federal programs that benefit them and their industries.

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