GOVERNMENT AFFAIRS WEEKLY

AAFP Division of Government Relations — 2021 Massachusetts Avenue, NW — Washington, DC 20036

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IN THIS REPORT…

NEXT WEEK IN WASHINGTON…

* On Tuesday, March 15, the House Ways and Means will hold a hearing to receive MedPAC's Annual Report to Congress
* On Wednesday March 16, the Senate Finance Committee will hold a hearing on Health Reform: Lessons Learned
* On Thursday, March 17, the Senate Health, Education, Labor and Pensions Committee will hold a hearing on the states' implementation of Health Insurance Exchanges

1. CMS ESTIMATES 29.5 PERCENT REDUCTION IN PART B PAYMENTS

In the annual March letter from the Centers for Medicare & Medicaid Services (CMS) to the Medicare Payment Advisory Committee, CMS estimated that Medicare payments for Part B physician services will be reduced by approximately 29.5 percent on January 1, 2012 unless Congress intervenes. The AAFP will continue to urge Congress to address these cuts.

2. AAFP CALLS ON WHITE HOUSE TO NARROW PHYSICIAN PAY GAP

In a Monday, March 7 letter to President Obama, AAFP and the four academic family medicine groups called for a multi-year Medicare schedule which prevents the SGR cuts and narrows the payment differential between primary care and other physicians. The letter also praised the White House for the fiscal year 2012 budget request for increased funding for Title VII Section 747 grants and the National Health Service Corps as well as new programs such as the Teaching Health Centers Development and Rural Physician Training grants.

3. SENATE DEFEATS FY 2011 SPENDING PLANS

On Wednesday, March 9, the Senate rejected two appropriations measures which would have provided funding for the government for the remainder of FY 2011 which ends September 30,

2011. The AAFP and the Council of Academic Family Medicine sent a letter to Senators urging them to oppose the House-passed spending bill (HR 1) that would cut approximately $60 billion from the current budget — including thirty percent from Title VII. The Senate defeated that bill, 44 to 56, with all Democrats voting against it. Republican Senators Jim DeMint (SC), Mike Lee (UT) and Rand Paul (KY) also voted against HR 1. Family Medicine had urged Senators to support the Senate Democrats' alternative to HR 1, which sought $4.7 billion in cuts but was also rejected, 42 to 58. Ten Democrats and Senator Bernard Sanders (I-VT) voted against the alternative plan. The current Continuing Resolution (PL 112-4) expires March 18. The House Appropriations Committee is expected to propose a new three-week CR on Friday, March 11 for consideration next week.

4. HOUSE SUBCOMMITTEE REVIEWS HEALTH SPENDING

On Thursday, March 9, the House Energy and Commerce Subcommittee on Health held a hearing entitled "Setting Fiscal Priorities in Health Care Funding." The purpose of the hearing was to argue that certain mandatory spending included in the health reform law should have been discretionary.. Of interest to the AAFP, the hearing focused on the Teaching Health Centers, the Public Health and Prevention Trust Fund, as well as state-based exchanges, school-based health centers and a personal responsibility program for adolescents.

In opening statements, Republicans called the spending a "slush fund for the Secretary lacking Congressional oversight." Democrats pointed to the Republican prescription drug law, among others, that included large amounts of mandatory spending and criticized them for hypocrisy and using the hearing to denigrate the health law.

6. FAMMEDPAC

This year, the PAC has received $103,000 in donations from 313 AAFP members. The PAC made $116,500 in campaign contributions to 29 candidates and committees.

This week, the PAC provided opportunities for staff to attend meetings with the following legislators:

- **Rep. Jim Gerlach (R-PA)**, a member of the House Ways and Means Committee Health Subcommittee.
- **Rep. Tim Murphy (R-PA)**, a member of the House Energy and Commerce Health Subcommittee. Rep. Murphy is a psychologist.
- **Sen. Sherrod Brown (D-OH)**, a member of the Senate Appropriations Committee. Senator Brown's father was a family physician.
- **Rep. John Sullivan (R-OK)**, a member of the House Energy and Commerce Committee and the lead sponsor of legislation requiring health care practitioners to disclose the applicable license under which they are authorized to practice.
- **Delegate Donna Christensen (D-VI)**, a member of the House Energy and Commerce Committee, a family physician and a member of AAFP.
- **Rep. Steny Hoyer (D-MD)**, the Democratic Whip in the House.

7 GRASSROOTS REACH OUT TO NEW MEMBERS OF CONGRESS

This week, AAFP Key Contact **Karen Mitchell, MD** met with the district staff of Representative Gary Peters (D-MI). They discussed what family medicine is and what Dr. Mitchell does as well as a number of AAFP issues including: Medicare Physician Payment, GME, Title VII funding, and the Patient-Centered Medical Home. The meeting was a successful introduction to family medicine and a meeting with Representative Peters is in the works.

8. REGULATORY SUMMARY

- On March 7, CMS issued a proposed consumer disclosure notice in an effort to increase pricing transparency in the health insurance market. As required by the *Affordable Care Act* and effective on July 1, the notice requires insurers to report online when they propose a rate increase over 10 percent. Such increases are then subject to a rate review by either the state or the U.S. Department of Health & Human Services.
- On March 8, the U.S. Department of Health & Human Services highlighted a Health Affairs report of recent studies that indicates the benefits of using health information technology. The report notes that 92 percent of studies of health information technology yielded results showing positive effects, including improved quality and increased efficiency of health care.
- On March 10, the U.S. Department of Health & Human Services and U.S. Department of Treasury released a proposed regulation of how states can apply for a State Innovation Waiver. The *Affordable Care Act* provides these waivers in 2017 and the administration recently indicated support for legislation to make waivers available to states beginning in 2014. Comments on the proposed regulation will be accepted until May 13, 2011.

9. WEST VIRGINIA RX BILL DEFEATED

State legislation (HB 2946), which was endorsed by the **West Virginia Academy of Family Physicians**, would have required a prescription for individuals to purchase cold medication containing pseudoephedrine. Although the House approved the measure 77-23, the Senate rejected it with a 16-16 vote. However, because two Senators were absent, there may be a retake of the vote before the legislature adjourns on March 12.

10. CONNECTICUT AFP TESTIFIES AGAINST MOST FAVORED NATION CLAUSES

During a March 3 hearing held by the Connecticut Joint Committee on Insurance and Real Estate, the **Connecticut Academy of Family Physicians** testified in favor of a bill (HB 6471) to prohibit managed care organizations and preferred provider networks from including most favored nation clauses in contracts with health care providers. The Connecticut Chapter testified that such clauses are unfair and discourage competitive markets by requiring providers to give payors the lowest rate provided to any comparable payor including public payors. Although physicians can choose whether to accept such clauses or to sign such contracts, because managed care organizations have such strong market power in the state and anti-trust laws prevent physicians from collectively negotiating, physicians have little say in the matter. The Joint Committee approved the measure, which will be considered by the full House.

11. SUMMARY OF STATE ISSUES…

- **Maine First to Receive Approval for Medical Loss Ratio Waiver**
  Steven Larson, CMS's Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversigh, sent a letter to Maine's Insurance Superintendent, granting approval for the state's waiver request concerning a new medical loss rule (MLR) rule. Under the *Affordable Care Act* (ACA), for policies written or renewed in the individual and small group market in 2011, insurers must spend at least 80 percent of premium dollars on reimbursement for clinical services and for activities that improve enrollee's health care quality—or provide rebates to enrollees. However, a state can seek exemption from this requirement only if there is a reasonable likelihood this standard "may destabilize the individual market in [the] state."

- **South Carolina Cuts Medicaid Provider Payment by 3 Percent**
  Medicaid providers in South Carolina were recently notified of a three percent cut in reimbursement beginning April 4. This reduction is expected to save the state about $7.5 million.