MARCH 2014

March 31 marked the end of the first open enrollment period for the health insurance exchanges created by the 2010 Patient Protection and Affordable Care Act, and with sign-ups topping 6 million, the Obama administration claimed success after a dismal launch in October. The end of the month was also the deadline for action on Medicare's sustainable growth rate formula, and lawmakers, who not long ago appeared ready to pass a bipartisan permanent solution, fell back on the same approach they have used since 2003 – a short-term fix that means the issue will return at the end of the year.

ISSUES AND EVENTS

House Passes Short-Term Doc Fix, Senate Expected to Do Same

The House of Representatives on March 27 approved a short-term fix to Medicare's sustainable growth rate (SGR) formula, and the Senate was expected to do the same on March 31.

The SGR, which was intended by Congress to automatically set Medicare's physician payment rates, annually threatens to slash the federal government's payments to doctors for services provided to Medicare patients. Congress has overridden the SGR calculations every year since 2003 in order to avoid payment cuts that, it has been feared, would drive doctors out of the Medicare program. Frustration has grown with the annual nature of the "doc fix," though, and momentum for enacting a permanent solution grew in 2013. Before leaving Washington for its winter recess in December, Congress approved a three-month SGR fix that blocked a 24 percent rate cut that was scheduled to go into effect the first of the year, giving lawmakers until March 31 to pass additional legislation.

Plans to enact a permanent fix fell apart in mid-March when the House passed a bill (H.R. 4015) that contains a bipartisan reform model, but amended to postpone the implementation of the individual mandate for five years. That amendment all but eliminated the bipartisanship that had formed around the issue, with just 12 Democrats supporting the bill in the 238-181 vote. Senate Majority Leader Harry Reid, D-Nev., has said that the amended bill has "no credibility," and President Obama has promised to veto it if it reaches his desk.
The legislation (H.R. 4302) approved by voice vote on March 27 would block the payment

cuts through the end of 2014 and make funding adjustments to certain other Medicare and Medicaid programs. It would also delay implementation of the ICD-10 diagnostic codes until October 1, 2015; delay until March 2015 enforcement of the "two midnight rule," under which hospital stays spanning at least two midnights qualify for Medicare Part A payments while those of shorter duration are treated as outpatient services; and repeal a provision of the 2010 Patient Protection and Affordable Care Act that caps deductibles in small group health insurance plans.

The SGR fix, itself, would cost $15.8 billion, according to the Congressional Budget Office (CBO).

"While we wait for the Senate to join us, it is important for us to keep the promises we have made to seniors who depend on the Medicare program," House Energy and Commerce Committee Chairman Fred Upton, R-Mich., said. "Our work is far from done, but today we restore some certainty to our seniors that their trusted doctor will be available when they are in need of care."

Some Democrats expressed frustration at having to pass another short-term bill.

"This is a Band-Aid," House Minority Leader Nancy Pelosi, D-Calif., said on the House floor before the vote. "There are so many things that are wrong with this bill, but the simple fact is that the clock is ticking and, on March 31, it's bad news for our seniors and the doctors that treat them."

Senate Finance Committee Chairman Ron Wyden, D-Ore., who has proposed a bill to replace the SGR (S. 2110), said, "there is no reason to wait" to enact a permanent fix.

"We can end the budget fiction that is the SGR, provide certainty to seniors and their doctors, and get the ball moving on bipartisan Medicare reforms – paying for value, managing chronic illness, increasing data transparency, and finally moving away from fee-for-service payments that got us into this mess," Wyden said.

That option, though, appeared highly unlikely to happen by midnight on March 31.

The American Medical Association released a statement that said it is "extremely disappointed in today's House action to give up on SGR repeal."

"There was bipartisan, bicameral support for reform this year, yet too many in Congress lacked the courage and wherewithal to permanently fix Medicare to improve care for patients and provide greater certainty for physician practices," the organization stated.

Exchange Enrollments Exceed 6 Million

Enrollments in the health insurance exchanges have exceeded 6 million as this year's sign-up period nears its end, the Obama administration announced on March 27.

The 2010 Patient Protection and Affordable Care Act (ACA) established state-level exchanges to provide marketplaces in which people who cannot get affordable group coverage can buy insurance. The federal government operates exchanges through www.healthcare.gov in 36 states that chose not to establish them, and 14 states and the District of Columbia run their own exchanges. After a dismal beginning in which technical problems with healthcare.gov limited enrollment numbers to fewer than 365,000 through the first two months after the October 1 launch, website repairs have led to dramatically increased sign-ups.

The number of enrollments stood at 4.2 million on March 1, leaving some doubt as to whether the total would reach the 6 million that had been projected by the Congressional Budget Office in February. The exchanges have experienced a surge of activity before the March 31 end of open enrollment, though.

"Signing up more than six million Americans is the latest indication that the health law is working," a White House spokesman said.

Through March 1, 25 percent of exchange consumers were between the ages of 18 and 34, well below the 40 percent that is generally regarded as the target for avoiding adverse selection issues that could drive up premium prices. The administration has been hoping to see that number increase during the final month of enrollment – and it engaged in promotional activity with that end in mind – but the final demographic information will probably not be available until mid-April.

Republicans have regularly challenged the administration's numbers, arguing that, while they represent consumers who have selected a plan, not all of those people have paid – or will pay – the premiums.

"I think those numbers are a fantasy," Rep. Michael Burgess, R-Texas, said.

On March 13, Burgess and five other GOP leaders of the House Energy and Commerce Committee, including Chairman Fred Upton of Michigan, sent letters to every insurance company that is participating in the federally-operated exchanges to request enrollment and payment information.

On March 25, the Department of Health and Human Services (HHS) announced that consumers who have started their application for coverage by March 31 but were unable to complete it will be allowed to finish it in April and have coverage effective April 1. Under the terms of the ACA's individual mandate, nearly all Americans are required to have health insurance for at least nine months of the year or they will be subject to a financial penalty.
"Just like on Election Day, if you are in line when we close, you get to enroll," an HHS spokesman said. "We're experiencing near-record volume on the site, and we're not going to turn people away who tried and couldn't complete their enrollment. This is about helping people who want to get health insurance."

Republicans characterized the move as yet another delay – of questionable legality – of what they consider to be a failed law.

"What the hell is this, a joke," Speaker of the House John Boehner, R-Ohio, asked, adding, "The law says that enrollment stops at the end of March. That's what the law says. I've got to live by the law, you've got to live by the law, the American people have got to live by the law and guess what? The president needs to live by the law as well."

The next open enrollment period is scheduled for November 15, 2014, through February 15, 2015.

Democrats Back Proposed Change to Labeling Process for Generics

A group of congressional Democrats has expressed support for a rule proposed by the Food and Drug Administration (FDA) that would loosen certain restrictions on revising safety information on the labels of generic drugs.

The FDA in November proposed allowing generic drug manufacturers "to change the product labeling to reflect certain types of newly acquired information in advance of FDA's review of the change." Currently, generic companies cannot change a label until the brand name product updates its safety information. Brand name companies are allowed to use a process similar to what is being proposed for generics and update labels while the change is under review.

Twenty three House Democrats – plus one independent who caucuses with the party – and 17 Democratic senators submitted comments to the FDA on March 5 in which they expressed their "strong support" for the proposed rule.

"The Proposed Rule achieves an important public safety goal by restoring these incentives for generic manufacturers to warn consumers of safety risks," they wrote. "Especially in light of resource constraints facing FDA, the potential for tort liability provides an important tool in incentivizing compliance with existing reporting obligations, to the benefit of American consumers."

The lawmakers noted that, when a generic drug enters the market, it typically takes a huge percentage of market share from the brand name drug.

"In such instances, generic manufacturers will have the best knowledge of adverse events; indeed, they may be the only manufacturers left in the market to monitor a product and ensure its labeling is up-to-date," they wrote. "We agree with FDA's conclusion that this factor weighs heavily in favor of allowing generic drug manufacturers to update their labeling information in the same manner available to brand-name manufacturers, to account for adverse event reports that they receive."

Many Republicans oppose the proposal, with 10 GOP senators and 18 representatives arguing in a January 22 letter to FDA Commissioner Margaret Hamburg that it "would conflict directly with the [Hatch-Waxman Act], thwart the law's purposes and objectives, and impose significant costs on the drug industry and healthcare consumers."

The GOP letter warned, among other things, that, "Allowing generic manufacturers to unilaterally change their labeling means potentially dozens of drugs that are chemically and biologically identical might nonetheless bear different safety information, confusing patients and prescribers alike. The labeling on the generic products should be identical to the labeling on the branded product so providers and patients are comfortable with the risks and benefits of the product they are using regardless of the name of the company on the bottle or vial."

In their comments, though, the Democrats said that they "agree with FDA's conclusion that 'concerns related to temporary differences in labeling between generic drugs and their [reference listed drugs] are outweighed by the benefit to the public health that would result from'" the rule change.

The namesakes of the Hatch-Waxman Act, a landmark 1984 law that did much to promote the manufacture and sale of generic drugs, are on opposite sides of this issue, with Senate Finance Committee Ranking Republican Orrin Hatch of Utah signing on to the January 22 GOP letter and House Energy and Commerce Committee Ranking Democrat Henry Waxman of California putting his name on the March 5 Democratic comments.

The proposed rule is a response to the 2011 Supreme Court decision in Pilva v. Mensing, which shields generic manufacturers from state "failure-to-warn" lawsuits related to adverse reactions to drugs as long as the companies have complied with the FDA's labeling requirements.

"The Mensing decision alters the incentives for generic drug manufacturers to comply with current requirements to conduct robust postmarketing surveillance, evaluation, and reporting, and to ensure that the labeling for their drugs is accurate and up-to-date," the proposed rule states. It goes on to assert that the "proposal is also intended to ensure that generic drug companies actively participate with FDA in ensuring the timeliness, accuracy, and completeness of drug safety labeling in accordance with current regulatory requirements. If this proposed regulatory change is adopted, it may eliminate the preemption of certain failure-to-warn claims with respect to generic drugs."

Senior Democrats Back Proposed Medicare Advantage Cuts

Several leading Democrats are backing plans to cut spending in the Medicare Advantage program.

Medicare Advantage (MA) offers managed care plans through private companies, which receive a fixed amount of money from the federal government per beneficiary each month.

As of 2013, 14.4 million people were in MA plans, representing about 28 percent of all Medicare beneficiaries.

The 2015 Rate Announcement and Call Letter from the Centers for Medicare and Medicaid Services (CMS) proposed a spending reduction of 1.9 percent in MA for the fiscal year that begins October 1. When combined with other factors, such as local conditions, a plan's quality rating and the new tax on health insurance policies, payments to insurers could be reduced by an even larger amount. On February 27, America's Health Insurance Plans (AHIP) released a report it commissioned from Oliver Wyman that concluded that the total payment cut would average 5.9 percent. This, according to the report, could lead to premium increases of $35-75 per beneficiary per month.

Many members of Congress, particularly Republicans, have been advocating strongly against the proposed spending cut, but now some Democrats are backing the CMS proposal. Democratic staff on the House Energy and Commerce Committee on March 13 released a memo that challenged the findings in the Oliver Wyman report and asserted that AHIP has a "record of making exaggerated claims about the impacts of federal policies."

"Analyses by independent experts, financial analysts, and individual health insurance companies have reached significantly different conclusions about the Medicare Advantage reforms than the AHIP report," the memo stated. "These independent analyses have found that Medicare Advantage enrollment will continue to grow, that insurers' Medicare Advantage businesses remain highly profitable, and that many of the reforms announced by CMS will be positive for Medicare Advantage plans."

The memo also noted that per-beneficiary spending in MA plans have been significantly higher than in traditional Medicare.

"These overpayments had multiple adverse impacts," the memo stated. "Numerous independent observers including the Medicare Payment Advisory Commission, the Government Accountability Office (GAO), and the CBO have noted repeatedly that these significant overpayments increase premiums in traditional Medicare, weaken the financial health of the Medicare program, and increase the federal budget deficit. They also do not appear to improve health outcomes or the quality of care. Despite these excessive costs, numerous independent analyses demonstrated that Medicare Advantage beneficiaries did not see lower out-of-pocket costs or receive higher quality care than traditional Medicare beneficiaries."

Also on March 13, Energy and Commerce Committee Ranking Democrat Henry Waxman of California and three other senior Democrats wrote to CMS Administrator Marilyn Tavenner to state that they "support many of the provisions in the Advance Notice and Draft Call

Letter, in particular those that provide greater value to beneficiaries and taxpayers," and to urge her "to reject calls to weaken this regulation."

"We continue to believe that removing plan overpayments is the right policy course for Medicare and the nation," the lawmakers wrote. "To reverse course would raise costs for taxpayers and all [Medicare] Part B beneficiaries, drain years from Trust Fund solvency, and expand beneficiary inequities that disadvantage the overwhelming majority of Medicare beneficiaries who remain in fee-for-service."

Volcker Rule Could Cost Banks as Much as $4.3 Billion: OCC

Complying with the Volcker rule could cost banks as much as $4.3 billion, or less than one-tenth of that amount, according to an analysis released by the Office of the Comptroller of the Currency (OCC).

The Volcker rule, which was included in the 2010 Dodd-Frank Act, is intended to prohibit most proprietary trading by banks. The Commodity Futures Trading Commission, the Federal Deposit Insurance Corporation, the Federal Reserve, the OCC and the Securities and Exchange Commission (SEC) approved the rule on December 10, nearly 17 months after the original deadline.

The broad range of the cost estimate, according to the report, "primarily reflects the uncertainty of the final rule's impact on the market value of banks' investments in impermissible covered funds" that they will have to divest.

"A decrease in demand may follow the imposition of the restriction on banks holding collateralized debt obligation and collateralized loan obligation assets, and we estimate the market value of this impact between zero and $3.6 billion," the report stated. "Other costs of the final rule include costs associated with compliance and reporting requirements, which we estimate at between $402 million and $541 million; costs associated with estimated capital deductions related to covered funds, which we estimate at between $147 million and $165 million; and additional costs to the OCC related to supervision, which we estimate at $10 million."

The report, which assesses the impact on 46 banks that are supervised by the OCC, also identified several "non-monetized costs," including:

- Costs associated with the exclusion of interdealer trading from reasonably expected near-term demands of clients, customers or counterparties
- Decreased liquidity
- Migration of risk
- Reduction in banks' ability to manage risk
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It also noted some "non-monetized benefits," such as:

- Benefits associated with metrics reporting
- Reduction in conflicts of interest
- Protection and improvement of core banking services

- Improved safety and soundness
- Reduction of systemic risk

The last item was a major factor in the development of the Volcker rule and other Dodd-Frank reforms that were a reaction to the financial crisis of the late 2000s.

"The restriction of trading book activities to bona fide market making, underwriting, and risk-mitigating hedging should result in restricting the total securities inventory at systemically important banks, which in turn should limit the potential losses of these systemically important banks in a stressed market, and this should add to the resiliency of the financial system," the report stated.

RELATED NATIONAL AND INDUSTRY NEWS

Senate Panel Convenes Hearing on Retirement Security

Lawmakers should "take steps to preserve existing defined benefit pensions in the public and private sector," a representative of the Economic Policy Institute told a Senate panel on March 12.

During a Senate Banking, Housing and Urban Affairs Committee Economic Policy Subcommittee hearing on "The State of U.S. Retirement Security: Can the Middle Class Afford to Retire," Monique Morrissey, an economist with the Economic Policy Institute, disagreed with critics who offer dire warnings about the financial condition of state and local pension plans.

"Contrary to the conventional wisdom, most public employee pension plans are in reasonable shape despite the effects of the financial crisis," Morrissey said. "Those that are in the worst shape got that way because elected officials neglected to make actuarially required contributions, so the focus should be on preventing this from happening in the future, not reneging on promises to workers."

Morrissey also suggested that some of the problems with 401(k)s and other defined contribution plans could be addressed "by making them more like defined benefit pensions." She noted that the "USA Retirement Funds Act" (S. 1979) proposed by Senate Health, Education, Labor and Pensions Committee Chairman Tom Harkin, D-Iowa, would "take advantage of risk pooling, economies of scale and professional investment management to provide retirees with secure lifetime incomes." She also referenced the California Secure Choice Plan, which she said "is another innovative approach to providing workers who lack access to an employer-based pension with a plan that would shield them from the high costs and risks of 401(k) plans."

Finally, she said that "we should reconsider our reliance on tax incentives for retirement saving."

"This approach is inherently inefficient, because there is no way to guarantee that tax subsidies encourage people to save more as opposed to simply shifting funds to tax-favored accounts," she said. "Nevertheless, a refundable tax credit is a more efficient way to encourage voluntary saving than the current system, which actually provides a tax break on investment income."

Robert Hiltonsmith, policy analyst with Demos, also identified many shortcomings with defined contribution plans.

"The 401(k)'s plethora of risks and excessive fees make a convincing case for what many critics have been saying for decades: this national experiment in 401(k)-based 'do-it-yourself retirement' has been, and will continue to be, a failure," Hiltonsmith said. "A new system to replace 401(k)s is urgently needed. All hardworking Americans need a safe, low-cost secure account to save for retirement, one that can also provide a lifetime stream of income when they retire; in other words, an account that protects workers from the severe risks and high costs of 401(k)-type plans."

Kristi Mitchem, executive vice president of State Street Global Advisors, said that there is a "great divide" between the retirement accounts of people who work for large employers and those who work for small employers.

"Large employers are much more likely to provide a retirement plan," Mitchem said. "And, when they do, the plan produces better results for those employees that participate in it. ... The largest plan sponsors are clearly outpacing small employers in the race to provide a viable replacement for DB plans."

Mitchem said that the difference results from larger plans "leveraging changes in public policy and incorporating insights from behavioral finance to drive real improvements in retirement readiness." She identified several actions that "automate good behaviors, simplify choices and enhance transparency":

- Automatically enrolling new employees
- Automatically increasing contribution rates for participants over time
- Offering participants a more streamlined and simplified menu of investment choices to help them make better investment choices
- Embracing well-diversified target date funds as default investment options to aid participants in managing key investment risks
- Negotiating lower investment fees on behalf of participants across all types of investments and asset classes
- Utilizing high-quality, low-fee index-based investments where appropriate on retirement plan investment menus

She suggested that, since "small businesses often do not have the time, resources and expertise to administer a retirement plan," they be encouraged to participate in "well-structured, multiple-employer DC plans."

"These well-structured [multi-employer plans] should mimic the largest plans in the U.S. by leveraging automation and simplification to drive better participant outcomes," Mitchem said.

Oregon Treasurer Ted Wheeler stressed the importance of Social Security and said that states should develop approaches to enhancing retirement security that are unique to their populations.

"Those innovations and conversations can help to guide your conversations about federal policy," Wheeler told lawmakers.

CALIFORNIA CONGRESSIONAL DELEGATION NEWS

House Panel Wants More Documents Regarding Employer Mandate Delay

A California lawmaker is pressing the Treasury Department for more information about the employer mandate delay.

The 2010 Patient Protection and Affordable Care Act (ACA) requires employers with at least 50 employees to offer affordable health coverage that meets certain benefits standards or pay a penalty. The employer mandate originally was to have gone into effect at the start of this year, but the administration announced in July that it would delay enforcement until 2015. On February 10, Treasury and the IRS released a rule that delays enforcement until 2016 for mid-size employers (those with 50-99 employees) and phases it in next year for large employers (those with at least 100 employees). All employers with at least 50 employees will have to start reporting to the federal government on their workers' insurance status in 2015.

The House Oversight and Government Reform Committee, which is chaired by Rep. Darrell Issa, R-Calif., has conducted multiple investigations and hearings into ACA topics, and on March 18, Issa and two subcommittee chairmen wrote to Treasury Secretary Jacob Lew to express their concern that "the Department of the Treasury is intentionally disregarding core statutory requirements of the law."

While Republican lawmakers unanimously oppose the ACA, Issa and others have nonetheless criticized – and investigated – the administration for not implementing its provisions according to the dates contained in the law, challenging the legality of such delays in the absence of congressional action.

In the March 18 letter, they stated that their inquiries indicate that "there was no serious legal review" of the employer mandate delay and have raised "serious questions about whether the White House directed the delay of the employer mandate for political reasons."

They asked Lew to provide the committee with certain written communications related to the issue between the Treasury Department and the Obama administration by April 1.