US Oncology
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Health Policy REPORT

Tuesday, August 2, 2011

Debt Ceiling Plan Signed Into Law

No Immediate Cancer Care Cuts

After months of debate, President Obama has signed into law a measure that will raise the debt limit and reduce the federal budget deficit. The Budget Control Act (BCA) passed the House on Monday evening and was quickly passed by the Senate and signed into law by the President today.

The BCA provides for an immediate $917 billion increase to the U.S. debt limit, allowing continued federal spending for 5 to 7 months, matched with newly established caps on discretionary (non-entitlement) spending over the next 10 years. **This portion of the legislation does not include Medicare cuts.**

A second debt limit increase would take place at the beginning of the 2012 if the Congress passes an additional $1.2 trillion in savings from the recommendations of a bipartisan joint congressional committee (Joint Committee) created by the BCA. The Joint Committee is expected to consider tax and entitlement changes along with other cuts, **including potential cuts to Medicare payments for needed cancer care services and treatments.**

The Joint Committee is required to submit a plan to the Congress prior to Thanksgiving, and the Congress must vote on the plan without amendments prior to Christmas. If the Joint Committee failed to produce a $1.2 trillion plan, or if the Congress fails to pass the Joint Committee's plan, the difference between the enacted plan and $1.2 trillion will be cut through an across-the-board spending reduction to defense and domestic spending starting in 2013. **If triggered, this provision would allow for a maximum 2% cut in all Medicare spending on providers, Medicare Advantage plans and Part D drug plans with no eligibility, premium or out of pocket changes to Medicare beneficiaries.**

The BCA also requires that the House and Senate vote on a joint resolution proposing a balanced-budget amendment (BBA) to the Constitution. The BBA is considered unlikely to pass the Senate and be sent to the states, but if it were to pass, the President could then propose an additional $1.5 trillion debt limit increase.

While the BCA does not include immediate cuts to oncology reimbursement, a significant threat remains in the near future from both the recommendations of the Select Committee, and with the development of offsets needed to fund another fix to the nearly 30% Medicare physician reimbursement cuts schedule for January 1, 2012.

Please continue to contact your Members of Congress and ask them to oppose Medicare cancer care cuts. We will continue to keep you informed as the members of the Joint Committee are named and as the situation progresses through the fall.

To read summaries of the BCA, click here.

To read a flow chart describing the BCA, click here.

To read the text of the BCA, click here.

To contact your Members of Congress (talking points provided), click here.

New Study: Medicare Patients Treated by Hospital-Based Doctors Incur Higher Costs

According to a new study by researchers from the University of Texas Medical Branch at Galveston, Medicare beneficiaries seen by hospital-based doctors were found to be discharged from the hospital more quickly than those who were followed by their primary care physician. Beneficiaries seen by hospital-based doctors were more likely to end up back in the hospital within the next month, incurring higher costs overall than the patients followed by primary care physicians.

In the study of approximately 58,000 Medicare patients who received hospital treatment between 2001 and 2006, all of the patients had a primary care physician before being admitted to the hospital, but more than one-third of the patients were cared for by hospital-based physicians.

The researchers found that the patients who were treated by a primary care physician spent about half a day more at the hospital, costing Medicare $282 more on average than patients cared for by a hospital doctor. *(Continued on page 2)*

New Study: Medicare Patients Treated by Hospital-Based Doctors Incur Higher Costs *(Cont'd)*

However, in the next month following discharge, patients who had been under hospital-based physician care incurred more expenses, averaging Medicare an extra $332.

Most of these added Medicare costs were found to have come from hospital readmissions, with another large portion of costs ascribed to patients being sent to nursing homes instead of back home.

According to the study, 76 percent of patients treated by their primary care physician were sent home following their hospital stay, while less than 71 percent of those treated by hospital physicians were sent home after their hospital care. Applied to the broader Medicare population receiving care from hospital-based doctors, these findings would equate to 120,000 patients sent to other health care facilities instead of home and $1.1 billion in additional Medicare spending.

The use of hospital-based doctors has increased in recent decades, with the goal of streamlining and improving patient care. Earlier research has indicated that this approach has contributed to shorter hospital stays; however, these new findings point out the need for more studies to examine patients' experiences after they are discharged to help ensure the provision of coordinated, high-value care.

State Health Insurance Exchanges Rule Released

In July, the Department of Health and Human Services (HHS) released a proposed rule outlining minimum standards states must meet in creating health insurance exchanges – one of the major components of the Affordable Care Act (ACA), through which individuals and small businesses can purchase health insurance.

Critics of the rule have said that it left out important details, such as whether states have the ability to control benefit levels and eligibility for Medicaid. Supporters, on the other hand, applauded the flexibility that the rule allows.

According to government estimates, as many as 11.5 million Americans are expected to use health exchanges to obtain health care coverage in the first year, and the program is expected to grow to 27 million by 2018.

HHS will set up exchanges in states that are not found to have met the requirements to operate the exchanges by 2013.

CMS officials have indicated that regulations on insurance exchange eligibility and enrollment will be issued soon. The insurance exchanges are scheduled to begin in 2014.

Lawmakers Look for Ways to Repeal IPAB

Although some Republicans and Democrats have agreed that the 15-member Independent Payment Advisory Board (IPAB) created as part of the Accountable Care Act (ACA) should be repealed, the two parties remain in disagreement over how repeal should be achieved.

The IPAB is tasked with recommending ways to control Medicare spending in the case that spending grows faster than the gross domestic product (GDP) plus 1 percent. When recommendations are made, the Department of Health and Human Services (HHS) will have the power to implement the recommendations unless Congress blocks them and replaces then with other forms of savings. Critics argue that the panel could arbitrarily cut services to Medicare patients and payments to providers with little congressional oversight.

Many Democrats feel that the Republicans' proposed repeal legislation (HR 452) is an attempt to repeal the entire health reform law. The bill does, however, have eight Democratic co-sponsors, including Rep. Allyson Schwartz of Pennsylvania, who has said that Democrats do not have to give up their support of the health care reform law in order to repeal IPAB.

If repeal efforts fail to gain traction, the IPAB is expected to begin work in 2013. While the debate over its future continues, according to HHS Secretary Kathleen Sebelius, President Obama is already in discussion with potential nominees to serve on the board.