The U.S. Health Care Highway—2012

Medical Practice in an Era of Economic and Health Care Reform Challenges

THE PHYSICIANS FOUNDATION
Empowering Physicians
Improving Healthcare

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Medical Practice in an Era of Economic and Health Care Reform Challenges

Prepared by:

Bostrom

and

Old Creekside Consulting

Prepared on Behalf of

THE PHYSICIANS FOUNDATION

Physicians Committed to a Better Health Care System for All Americans

About the Physicians Foundation

The Physicians Foundation is a nonprofit 501(c)(3) organization that seeks to advance the work of practicing physicians and to help facilitate the delivery of healthcare for all Americans. It pursues its mission through a variety of activities including grant-making, research and policy impact studies. Since 2005, The Foundation has awarded numerous multi-year grants totaling more than $28 million. In addition, The Foundation focuses on the following core areas: health system reform, health information technology, physician leadership, workforce needs and pilot projects. As the health system in America continues to evolve, The Physicians Foundation is steadfast in its determination to foster the physician/patient relationship and assist physicians in sustaining their medical practices during this evolution.

LEAD AUTHORS

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Kathy Means, Lead Author

Ms. Means is a nationally recognized expert on Medicare, Medicaid and health care reform, and manages Old Creekside Consulting, an independent health care consultancy located in Fredericksburg, VA. For more information on Old Creekside Consulting you may contact Kathy Means at meanskathleen@msn.com.

Ken Monroe, Author/Editor

Ken Monroe is a recognized expert in the management of not-for-profit associations including the American Medical Association where he was COO for ten years. He now serves as the Chairman and CEO of Bostrom, a leading association management and professional services company providing comprehensive management, consulting and outsourcing services to professional societies, trade associations and charitable organizations. For more information about Bostrom visit www.bostrom.com.

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Executive Summary

The Physicians Foundation is committed to educating and assisting physicians throughout the country by providing them with comprehensive, yet focused, resources regarding health care reform. The United States is in the midst of the second full year of a vast reworking of the American health care system. Changes already underway in the health care system were accelerated by the enactment on March 23, 2010 of the landmark Patient Protection and Affordable Care Act (i.e., the ACA). There are major, ongoing, federal and state dynamics that we expect to reshape the ACA sooner rather than later.

We examine these forces through the prism of what they portend for the practice of medicine. Recently, physicians were referred to in a Wall Street Journal opinion piece as the "Lost Tribe," implying physicians were becoming lost in the maze of change. We vigorously refute that suggestion, and believe that physicians must and will be leaders in shaping these changes, on behalf of their patients, their profession, and their communities.

The Physicians Foundation is acutely attuned to the pressures building against the private practice of medicine. In other recent publications, we have highlighted physicians' perspectives about the decline in private practice, and separately described options for practice models and strategies. We refer you to our website (www.physiciansfoundation.org/reports), where you will find several timely publications.

The Health Care Highway—2012

This report, titled **The U.S. Health Care Highway—2012** (i.e., **HCH-2012**), builds upon a preceding report issued by the Physicians Foundation in May of 2011 and titled "**A Roadmap for Physicians to Health Care Reform**." The latter report is a foundational document that outlined the systemic issues leading to

enactment of the ACA. It summarized in detail the final budget scoring, legal framework and key provisions of the law, focusing on the changes that would most directly affect physicians and the private practice of medicine.

The **HCH-2012** report builds on that foundation, shifting the focus to examination of intensifying federal fiscal, legal and political drivers in health care policy, and related state pressures. **HCH-2012** also takes a closer look at five signal areas under the ACA and in Medicare for physician attention. These include:

I. Immediate "Watch-Out" Topics for Physicians
   - Independent Payment Advisory Board
   - Accountable Care Organizations
   - Medicare Physician Fee Schedule

II. Broader "Transformational" Topics for Physicians
   - Health Insurance Exchanges
   - Health Information Technology and Quality

Despite the pervasive presence of the ACA percolating through every level of health care, change continues at a rapid pace. Newly emergent, as well as more subtle, major forces are certain harbingers of further change to the ACA and to health entitlement programs.

The Supreme Court has ruled on the ACA and upheld its constitutionality, with some caveats. Beyond the Court's dramatic verdict, the U.S. economic, budgetary and political environment is under intense stress. These issues are being brought into particularly sharp focus due to the country being in the midst of a Presidential election year, with the election occurring in November 2012. These forces and the 2012 election outcomes will act to reshape the health care environment.

Further, research shows that the composition of the U.S. Congress has been changing for over three decades with worrisome implications for that "governing middle" our democracy needs to function effectively. These forces are certain to reshape the ACA, to reshape Medicare and Medicaid, and to embroil the entire health care system in deepening change. As such, it is important to consider the implications for legislative and regulatory efforts, and what those imply for physicians' medical practice and advocacy in the near-term.

Our goal is to help physicians consider these major forces and what direction such changes could take with respect to health care. Just as participation by an informed citizenry is vital to a healthy democracy, an informed medical profession is vital to the "health" of our health care system. Following are selected highlights from the **HCH--2012** report.

Selected Highlights

1 ➤ ACA SCAFFOLDING FOR COVERAGE IS SHAKY: The ACA's prime purpose for coming into being was extending access to health insurance coverage to a large majority of Americans. Despite the channeling of significant federal resources under the ACA, the actual legal scaffolding supporting the goal of near universal coverage was placed, presumptively, on the shoulders of the states. Unexpectedly, today, that scaffolding is being deeply rocked by two unfolding events—widespread state resistance to expanding coverage under Medicaid and reluctance to operate state-run health insurance exchanges. We examine these questions in detail.

2 ➤ SUPREME COURT VERDICT ROCKS WASHINGTON POLICY CIRCLES: Led by Chief Justice John Roberts, who in a stunning course of events for many Court observers wrote and delivered the ruling opinion, the U.S. Supreme Court upheld the Affordable Care Act (ACA) in large part, including the individual mandate, by a 5 to 4 vote. The exception to upholding the ACA in its entirety was to bar the Department of Health and Human Services (HHS) from denying *all* Medicaid funding to states that decline to participate in the ACA's Medicaid expansion. The immediate practical effect of the Supreme Court's ruling on the ACA is to largely turn the future of the law back to the elected officials in Congress and the Administration, and on the Medicaid expansion, to the States.

The most intense political and media focus has been on the fate of the individual mandate and its associated penalty as the lynchpin of coverage expansion under the ACA. However, as the full ACA-related dimensions and coverage consequences of the Court's ruling unfold, we examine the Chief Justice's "compass" and the possibility that the Medicaid portion of the verdict may have struck a more profound blow to the aspirations of the ACA legislation. We examine this and other implications of the Court's verdict.

3 ➤ THE FEDERAL FISCAL DILEMMA: There are four signal fiscal events closing in upon the U.S. over the next several months, and action on them could have serious implications for our economy and for health care programs. These include the FY 2013 budget package failure and temporary "kick-the-can" agreement, the debt ceiling limit, the Budget Control Act sequesters scheduled for January, and expiring tax provisions. We look at the facts and dynamics of these issues.

4 ➤ THE COSTS OF MODIFYING OR REPEALING THE ACA: On July 24, the Congressional Budget Office (CBO) released two major documents that are material to the determination of the future of the ACA. The complex cost and spending algorithms of the ACA revealed in these documents have serious legislative implications for any proposed changes to the ACA, and to existing entitlement programs due to the extensive ways in which Medicare, Medicaid and CHIP were affected by ACA provisions. We take a look behind the headline numbers.

5 ➤ THE STATE OF THE STATES: Medicaid spending growth and structural issues are at the top of the list of the six major threats to fiscal sustainability discussed in the new report of the State Budget Crisis Task Force. We take a brief look at those findings and others to understand the possible actions of states on Medicaid and Health Insurance Exchanges implementation.

6 ➤ SIGNAL TOPICS FOR PHYSICIANS: We examine the five topics identified in the introduction. Three are immediate "watch-outs" and two are transformational in the broader system sense. Although the genesis of this report was primarily to inform physicians of emergent forces affecting the ACA, we decided to give special attention to the Medicare physician fee schedule (MPFS). Given the fiscal environment, we think the issues of the sustainable growth rate formula may prompt Congress to act sooner than many anticipate. We highlight new CBO so-called cliff, clawback, and other SGR "fix" options and the scoring implications.

7 ➤ THE CHANGING COMPOSITION OF THE U.S. CONGRESS: Ongoing social science research, examining detailed voting patterns of Members of Congress and the frequency with which they cross party lines and on what issues, sheds new light on the deeper dynamics behind simple party affiliations. We conclude the report with what these data reveal about the weakening of the "governing middle" in the Congress, and the implications for governance. This sets the stage for assessing the changes that will occur in the upcoming election and what the new Congress might be poised to do.

Perspectives for Physicians

In the Roadmap report last year, we made four predictions concerning medical practice as it could be affected by ACA passage. They were:

- Physicians will assume greater responsibility for the health of populations, not just individuals,
- Significant numbers of physicians may feel compelled to relinquish private practice autonomy in favor of networks and group formations,
- Physicians' care decisions are coming under increased payer scrutiny and, therefore, physicians are steadily losing the "private" in private practice, and finally,

- Physicians can form a nexus for risk-bearing arrangements, thereby assuming significant shared financial risks and quasi-insurance roles in health care delivery.

These forecasts are generally being borne out by regulatory events. Regardless of your point of view, ACA-channeled funds (in the billions), reform initiatives and regulatory requirements are penetrating every corner of health care. Physicians, regardless of practice model, are confronted daily with ACA-driven elements in payment, electronic health records, quality measures, data reporting, insurance system changes, and changed relationships with hospitals, colleagues and other health personnel, and more. There is a growing loss of the 'private" in private practice as the demands for reporting and accountability grow, even for physicians seeking to maintain maximum practice autonomy.

Separately, and this may be a sign of physicians seeking to empower themselves in this environment, many are joining or affiliating with health care systems or enabling the formation of accountable care organizations (ACOs). For instance, the Centers for Medicare and Medicaid Services reported recently that over 153 ACOs have been approved to date, serving over 2.4 million Medicare beneficiaries. We have concluded that the ACO model, with its joint emphasis on quality metrics and shared financial risk, may be the most significant of the ACA provisions driving "value-based purchasing."

We further conclude that the genie(s) are out of the bottle. There is no turning back. Indeed, many physicians are at the forefront in the development of quality measures, new clinical algorithms, and other tools that will greatly improve the diagnosis and treatment of disease. This is a highly positive development. However, these tools, plus new payment models for services, are also disruptive technologies affecting patient care and how physicians practice medicine.

Conclusion

We invite you to stay on the lookout for our next Health Care Highway report, scheduled for release early in 2013. That report will examine the results of the 2012 Presidential and Congressional elections. Our focus will be on the changed political environment, and the near-term prospects for consensus and action on major health care reform or entitlement program changes important to physicians.

Any significant tax or budget agreement will open the door to ACA, Medicare and Medicaid program agreements, the scope of which cannot be judged at this time. In assessing the new environment, and in the hope that our current political impasse will ease after the election, we will propose timely targets for physician advocacy calibrated to the new environment. In closing, the Board of the Physicians Foundation thanks you for your time and attention. We trust you will find these materials of continuing interest and value as you manage your professional lives. ■

Introduction

The United States is in the midst of the second full year of a vast reworking of the American health care system. The changes were precipitated by the enactment on March 23, 2010 of the landmark Patient Protection and Affordable Care Act (i.e., the ACA, P.L. 111-148, as amended). And what a year it has been! In the midst of pervasive efforts on the part of health care providers to adapt to immense federal and state regulatory changes, the very foundations of the law were challenged. In rare dramatic fashion, the U.S. Supreme Court issued its verdict. The consequences of that verdict are slowly mushrooming and could threaten the central goals of the law in unexpected ways. We will cover those matters, but first, we turn to the purpose and content of this report.

The Physicians Foundation is committed to educating and assisting physicians throughout the country by providing them with comprehensive, yet focused, information regarding major, ongoing federal and state dynamics. We examine these forces through the prism of what they portend for the practice of medicine.

The **U.S. Health Care Highway—2012** (i.e., **HCH-2012**) report builds upon a preceding report issued by the Physicians Foundation in May of 2011 and titled "**A Roadmap for Physicians to Health Care Reform**." The latter report is a foundational document that outlined the systemic issues leading to enactment of the ACA. It summarizes the final budget scoring, legal framework and key provisions of the law, focusing on the changes that would most directly affect physicians and the private practice of medicine. As with the Roadmap report, we hope you will find this report to be helpful in the following ways:

1. As a continuing touchstone on why the ACA was enacted and what will be driving Congressional modifications to the two-plus-year old law,
2. As a springboard to surveying what you need to know, as the ACA proceeds and changes, to help you shape your professional and practice future,
3. As a source of a "curated" library of documents and links to a carefully selected array of governmental and private sector websites and resources that will allow you to take a deeper look at the areas most important to you,
4. As a catalyst for considering how best to work individually, and collectively, with colleagues and professional societies to help facilitate the delivery of healthcare and the professional practice experience of physicians, and
5. As a basis for participating in the evolving implementation of the ACA (however modified), addressing issues and seeking opportunities, while working to reshape the law where changes are needed.

Since publication of the Roadmap report, the Supreme Court has ruled on the ACA and upheld its constitutionality, with some caveats, the implications of which will be discussed in Chapter I. Beyond the Court's dramatic verdict, the U.S. economic, budgetary and political environment is under continuing change and numerous stresses. These issues are being brought into particularly sharp focus due to the country being in the midst of

a Presidential election year, with the election occurring in November 2012. These forces and the 2012 election outcomes will act to reshape the health care environment even further. Our goal is to help you consider what direction such changes could take.

Despite ongoing litigation, major regulatory actions have proceeded as implementation of the ACA has unfolded over the last two-plus years since enactment. Those regulatory actions, paired with complex responses and recalibrations of the private health care sector, are reaching into every corner of the delivery system.

The ACA's prime purpose for coming into being was extending access to health insurance coverage to a larger majority of Americans. Despite the channeling of significant federal resources under the ACA, the actual legal scaffolding supporting the goal of near universal coverage was placed, presumptively, on the shoulders of the states. Unexpectedly, today, that scaffolding is being deeply rocked by two unfolding events—widespread state resistance to expanding coverage under Medicaid and reluctance to operate state-run health insurance exchanges.

However, the ACA's prime purpose for coming into being was extending access to health insurance coverage to a larger majority of Americans. Despite the channeling of significant federal resources under the ACA, the actual legal scaffolding supporting the goal of near universal coverage was placed, presumptively, on the shoulders of the states. Unexpectedly, today, that scaffolding is being deeply rocked by two unfolding events—widespread state resistance to expanding coverage under Medicaid and reluctance to operate state-run health insurance exchanges. The exchanges are intended to improve access to private health plans for individuals and small businesses. The situation begs the political question—where were those states when the law was being shaped in the Congress over many long months of effort?

Finally, on the ground, physicians are central to both the direct provision and overall management of patient care. Physicians are equally central to the effective functioning of high-quality medical care delivery systems. This is the case whether medical care occurs in the physician office setting, in hospitals, in nursing homes, or in any other setting requiring direct physician care and physician management. Medical training and clinical expertise are also central to development of valid content in and effectiveness of quality measures, electronic health records and other developing health information technologies.

As noted in the Roadmap report, we predicted:

- Physicians will assume greater responsibility for the health of populations, not just individuals,
- Significant numbers of physicians may feel compelled to relinquish private practice autonomy in favor of networks and group formations,
- Physicians care decisions are coming under increased payer scrutiny and, therefore, physicians are steadily losing the "private" in private practice, and finally,
- Physicians can form a nexus for risk-bearing arrangements, thereby assuming significant shared financial risks and quasi-insurance roles in health care delivery.

It is our view that these forecasts have been borne out by regulatory events and market changes, and continue to be valid. Separately, despite many years of short-term legislative fixes and experts' advocacy for more permanent structural reforms, the Medicare physician payment system has continued without fundamental alteration in over a decade. Budgetary pressures and evolving policy ideas are likely to alter that landscape sooner than many think possible.

In closing, the balance of the **HCH-2012** report is divided into four broad areas. Our perspectives on what all this may mean systemically for medical practice and for physician advocacy are summarized in the Executive Summary accompanying this report. Following is a snapshot of how the report is organized:

CHAPTER I Drama in the Courtroom—The U.S. Supreme Court Verdict on the ACA

- Reviews the Supreme Court verdict and its immediate impact, and
- Assesses the resulting structural and policy implications for the ACA.

CHAPTER II The Fiscal Disorder in the Governments' House(s)

STATE OF THE UNION AND THE FISCAL DILEMMA— Reviews the state of the federal fiscal and economic landscape, which portends rocky shoals ahead for the ACA and the health care system.

STATE OF THE STATES—Reviews the broad economic status of the states, and selected issues in Medicaid, deeply affected by fiscal issues and the Supreme Court decision.

CBO'S RE-SCORING OF THE ACA—On July 24, CBO released two major documents that are material to the determination of the future of the ACA. We discuss that information and note that the complex cost and spending algorithms of the ACA revealed in these documents have serious implications for *any* contemplated legislated changes to existing entitlement programs. This is due to the extensive ways in which Medicare, Medicaid and CHIP were affected by ACA provisions.

CHAPTER III Seismic Rumblings in the Health Care Marketplace

TOP OF THE HEALTHCARE MARKET—Examines broad forces in the health care sector as noted recently by the Medicare Payment Advisory Commission.

SEISMIC POLICY FORCES IN THE ACA—We take a look at five signal policies under the ACA broadly affecting physicians' practice environment and payments. Three are more immediate "watch-out" topics, and two are "transformational" in the broader system sense.

CHAPTER IV Setting the Stage for 2013—Election 2012 and the Search for the Governing Middle in the U.S. Congress

PERSPECTIVES ON THE CHANGING COMPOSITION OF THE U.S. CONGRESS: The U.S. Congress is undergoing significant shifts in political orientation and voting patterns. These go well beyond the simplistic matrix of whether Members identify as Democrat or Republican. The changes affecting the "governing middle" have implications which stakeholders in health care need to consider strategically and in advocacy development. This information sets the foundation for evaluating the election results and composition of the new Congress to be sworn-in January 2013.

PREVIEW OF PART II OF THE HEALTH CARE HIGHWAY SERIES SCHEDULED FOR RELEASE IN EARLY 2013: That upcoming report will assess the implications of the Presidential and Congressional elections, as well as any major late-2012 developments on the federal budgetary, legislative or regulatory fronts affecting the status of the ACA or health care entitlement programs.

Finally, please note that the factual portions of this report have been prepared under principles of "open-source architecture" with attribution to those sources. In other words, our extensive research relies entirely on information that has been released into the public realm, whether it originates from governmental or private sector sources, as opposed to proprietary information and materials. Our underlying research is extensive, sources are carefully cited and all underlying materials are available for review at greater length should you choose to learn more about a covered topic. Please refer to the Bibliography at the end of the report for further information.

In closing, turning to Chapter I, we first review the verdict of the Supreme Court on the legal issues relating to the constitutionality of the ACA, and the verdict's immediate implications for health care reform. ■

The Medicare physician payment system has continued without fundamental alteration in over a decade. Budgetary pressures and evolving policy ideas are likely to alter that landscape sooner than many think possible.

CHAPTER I: Drama in the Courtroom

The U.S. Supreme Court Ruling on the ACA

Overview — The litigation over the ACA has been covered extensively in the media for many months. For purposes of this report, we provide a brief summary of the four key questions considered by the Court and the verdict for context purposes only. Our primary focus is on a) the implications of the verdict for the structure and continued implementation of the ACA, b) the prospects for subsequent legislative modifications, and c) the potential impact on health care.

And yes, it's a bit of a slog, but speaks volumes about the ACA as a law, the balance of power at the top reaches of American government, and the very human consequences for health care of such power struggles. We think the ramifications, still unfolding, are shaking the foundations of the ACA in unexpected ways that are important to consider and understand. We profile what was so unusual about this decision and examine implications in some detail. We also agree that pictures help. To the right are simplified snapshots of the timeframe, legal process sequence, and protagonists.

In brief, several lawsuits in multiple federal court jurisdictions were filed rapidly upon enactment of the ACA in March of 2010. Plaintiffs included 26 states as well as private parties. Dozens of briefs were filed by interested parties and encompassed a wide array of political, policy and business interests pursued in multiple federal court jurisdictions. These cases moved rapidly through the federal district court and appellate review levels, and ultimately were accepted for review by the Supreme Court in the process graphed on the opposite page.

March to the Supreme Court

TIMELINE

March 2010 — ACA enacted, Florida v. HHS filed

January 2011 — Florida District Court decision

August 2011 — 11th Circuit Court decision

November 2011 — Supreme Court accepts case

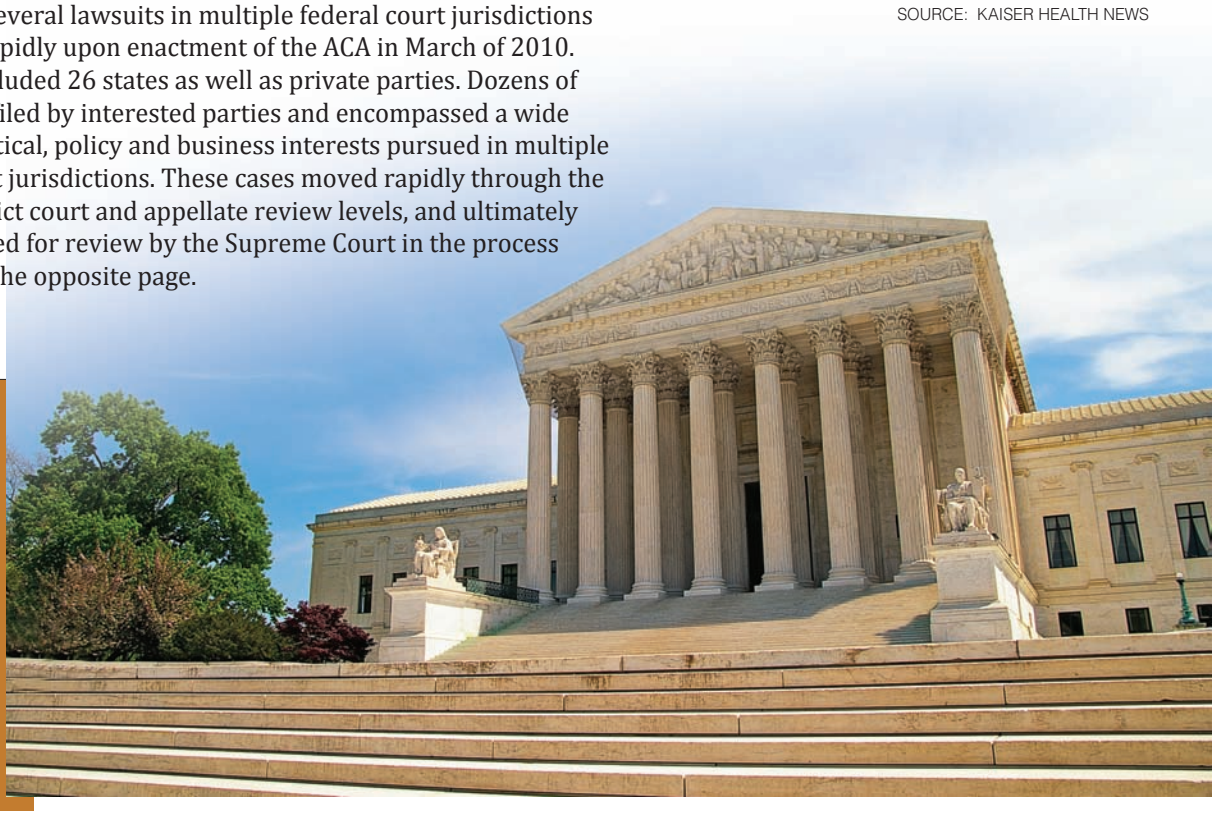
March 2012 — Supreme Court oral arguments

June 2012 — Supreme Court decision

PARTIES

- 26 states, led by Florida, plus the National Federation of Independent
- Businesses and individual plaintiffs
- US Departments of Health and Human Services, Labor and Treasury

SOURCE: KAISER HEALTH NEWS



In preparation for its review, the Supreme Court itself commissioned briefs on aspects of select issues that were raised to ensure that competing legal theories and interpretations of case-law were well-represented for their consideration. Three days of oral arguments were conducted at the Supreme Court in Washington, D.C. on March 26th, 27th and 28th. The Court considered: 1) the authority under the U.S. Constitution for the "individual mandate", 2) whether the Anti-Injunction Act precluded consideration of the case at this time because the mandate and it's associated penalties are not effective until 2014 (jurisdictional question), 3) whether the individual mandate, if found to be unconstitutional, could be severed from the rest of the ACA, and lastly, 4) whether other ACA provisions providing for expansion of the Medicaid program were unconstitutional because they effectively "coerced" states into compliance with federal requirements.

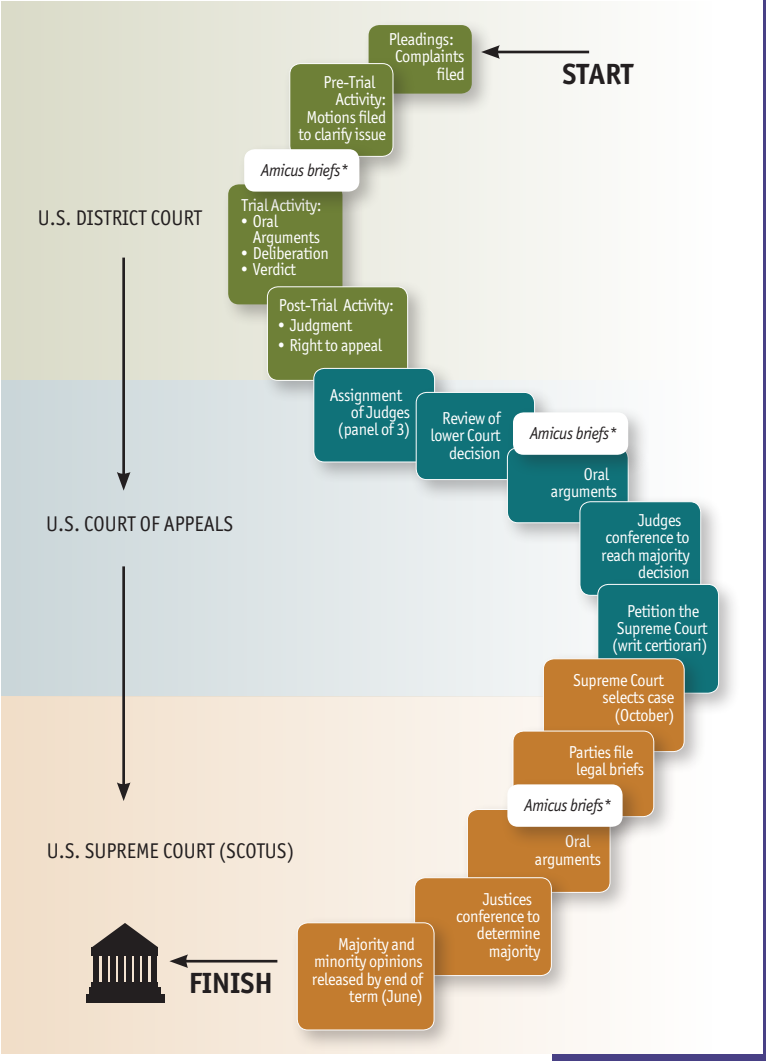
For those readers who might wish to examine actual briefs filed at various levels, lengthier "plain English" summaries, and the text of the Court's opinion, including concurring and dissenting opinions, we refer you directly to the website of the Court (www.SupremeCourt.gov). For these items, plus legal analyses, both simply descriptive and reflecting an array of legal and political interpretations, we highly recommend visiting the site known as SCOTUSBlog.com. For our purposes, following is a top-line, non-partisan summary of key issues and the opinion.

Summary of the Four Key Challenges to the ACA

The four questions considered by the Court are summarized briefly as follows.

1 ➤ Minimum Coverage Provision (aka the "individual mandate")

SHARED RESPONSIBILITY PAYMENT: Under Section 1501 of the ACA, the Congress enacted a minimum coverage provision that requires, beginning in 2014, certain individuals (including dependents) to carry a minimum level of health insurance coverage. Individuals who fail to secure such coverage face a monetary penalty (lower than the cost of purchasing a policy), which is to be enforced by the Internal Revenue Service via the federal tax code. The monetary penalty, described as a *"shared responsibility payment"* is calculated as a percentage of household income, subject to a floor of a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualified health insurance. As noted in the Court's ruling (p. 7), the penalty in 2016 "will be 2.5% of an individual's household income, but no less than $695 and no more than the average yearly premium for insurance that covers 60 percent of the cost of 10 specified services (e.g., prescription drugs and hospitalization)." There are exceptions that apply to select individuals and no amounts would be assessed for non-coverage periods that last less than three months.



SOURCE: CONTENTHEALTH LLC

REQUIREMENT TO BUY HEALTH INSURANCE: However, as was noted pre-ruling by the Congressional Research Service (CRS), "Congress has never compelled individuals to buy health insurance, and there has been significant controversy over whether the requirement is within the scope of Congress's legislative powers" (CRS Report R40725, dated April 6, 2012). Complex legal issues were argued via briefs and oral arguments focusing primarily on whether the authority behind the mandate could be construed as falling within either the Congress's legitimate taxing power or its authority to regulate interstate commerce."

WHAT IS THE CONSTITUTIONAL AUTHORITY AND STANDARD?: In the final briefs and oral arguments, both of these lines of argument drew heavily upon lengthy Constitutional analyses, case law, precedents and "what if" discussions of posited use of these authorities extended into other realms (e.g., could the government compel Americans to buy broccoli?). They also delved into questions of Congressional intent and limits on Congressional authority. As noted by many observers of the Court, the real search was for articulation of a standard that clarifies what it effectively means to exercise federal power over the regulation of interstate commerce, i.e. what is the definition of commerce and related limits on federal authority over individual behavior in the context of the health insurance market?

Separately, a key question in determining lines and scope of authority was whether the monetary penalty (described as such repeatedly in the ACA in statutory text and in so-called findings) could be construed as a tax instead, raising jurisdiction and timeliness issues under the Anti-Injunction Act. It also raised consideration of whether the penalty was a legitimate use of federal taxing power under the Constitution.

2 ➤ Anti-Injunction Act (AIA)

DID THE COURT HAVE JURISDICTION TO ACT AT THIS TIME UNDER THE AIA: If the penalty is construed to be a tax, then the question arose as to whether the Supreme Court could properly rule on the individual mandate at this time because of the requirements of the AIA. This is a long-standing federal law that effectively protects the federal government's taxing power from lawsuits "restraining the collection or assessment of any tax". The law was enacted to prevent individuals from attempting to evade taxation by virtue of challenging a tax in court in advance of the actual imposition of the tax. In other words, the AIA issue raised the issue of whether this case could even be adjudicated by the courts prior to 2014 and actual imposition of the monetary penalties on non-complying individuals. Initially, the federal government raised the AIA as a defense, but subsequently ceased raising the AIA as a defense to the challenges to the minimum coverage provisions. The position taken in lower courts was mixed, but it is clear that the fact that the administration withdrew their original argument did not negate the AIA as an issue to be dealt with.

3 ➤ Individual Mandate and Severability

SEVERABILITY DEFINED: Severability referred to the question of whether parts of a law can be voided by a court or "severed" while leaving the balance of the law intact and in force. In the CRS report cited above (p. 31), it was noted that "When a court finds a portion of a law to be unconstitutional, it may then confront the issue of whether to strike what is unconstitutional and uphold the remainder, or whether to declare the rest of a law invalid, either partially or in its entirety".

SEVERABILITY CRITERIA: The CRS further noted that current severability doctrine is based on several case-law citations that, taken together, suggest these criteria:

- Courts should refrain from invalidating more of a statute than is necessary,
- The touchstone of a court's severability analysis is Congressional intent, and

Severability is presumed "unless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law".

SEVERABILITY POSITIONS: Despite these and similar criteria expressed in additional cases, it was also clear that there was considerable room for argument both in favor of and against severability of the individual mandate provisions from the balance of the ACA. The states and private petitioners argued that the ACA should be struck down in its entirety, with support for that position gained selectively in the lower courts.

The Administration posited partial severability, indicating that if the Supreme Court struck down the individual mandate, the balance of the ACA could and should remain intact except for two provisions affecting private health insurers. The first was the "community rating" provision that prevents health insurers from charging select individuals higher premiums due to pre-existing health conditions. The second was the "guaranteed issue" provision that requires an insurer to accept all applicants and prevents an insurer from denying coverage based on health factors.

In the aftermath of the oral arguments conducted before the Supreme Court in March, it was clear that numerous competing factors would be considered by the Court in arriving at it's verdict. The pivotal decision points are discussed in the synopsis of the verdict in the next section. Finally, there was one remaining issue brought before the Court.

4 ➤ Federalism Challenge to Medicaid Expansion

MEDICAID HISTORICALLY A VOLUNTARY STATE PROGRAM: Medicaid is an entitlement program that historically has financed the provision of health care services to specified lower income populations. The Medicaid program is financed jointly by the federal government and by state governments under federal "matching" formulas. Since the inception of the Medicaid program in 1965, states have been free to choose whether or not to establish a Medicaid program in their state. Currently, all 50 states do participate. As a condition of participation, states must operate their programs within a federal framework, or obtain certain waivers to that framework in order to better tailor the program to the state's needs.

ACA MANDATORY MEDICAID EXPANSION REQUIREMENT: Significant Medicaid expansions were enacted under the ACA as part of the law's overall objective of providing access to health insurance coverage as broadly as possible across the U.S. population. Among numerous Medicaid eligibility, benefit and quality of care changes, the ACA requires states in 2014 to cover previously uncovered adults under the age of 65 with incomes up to 133% of the FPL, or federal poverty level. Importantly, many states do not currently provide Medicaid benefits to childless adults, and only provide limited benefits to parents. In fact, as noted in the Syllabus headlining the Court's ruling (p. 5), "the original program was designed to cover medical services for particular categories of vulnerable individuals"; but under the ACA, "Medicaid is transformed into a program to meet the health needs of the entire non-elderly population with income below 133 percent of the poverty level."

STATE POWERS AND FEDERAL "COERCION" ARGUMENT: One of the constitutional challenges to the ACA elevated to the Supreme Court (*Florida v. Department of Health and Human Services*) argued that states were being "coerced" into compliance with the expanded state requirements. It was argued that a state's failure to comply with the expansion raised the specter of the federal government withholding billions of dollars in Medicaid funds *for their existing Medicaid programs*, literally jeopardizing billions of dollars in current federal Medicaid payments to States. This challenge raised thorny legal issues under the Spending Clause (granting Congress the power to provide for the general welfare) and the Tenth Amendment (providing that "powers not delegated to the United States by the Constitution, nor prohibited to it by the States, are reserved to the States respectively, or to the people"). The Tenth Amendment also provides that state legislatures or executive branch officials may not be "commandeered." The Supreme Court agreed to review the federalism challenge to the Medicaid expansion in the case *Florida v. HHS*.

The Verdict of the Supreme Court

HEADLINER: Verdict day, June 28th, was a dramatic one in government and social policy circles. The nation's media in all its forms were focused on coverage and analysis of this verdict, with initially breathless and in a few cases, wildly inaccurate, reporting. And the two-part verdict in many quarters was something of a political bombshell. In brief, the Court upheld the individual mandate under the taxing power, and struck down the mandatory aspect of the Medicaid expansion. In general, the former verdict dismayed Republican Congressional leaders and conservative followers and pleased the President, Democrats and ACA advocates, while the latter verdict did the reverse.

THE INDIVIDUAL MANDATE: Led by Chief Justice John Roberts, who in a stunning course of events for many Court observers wrote and delivered the ruling opinion, the U.S. Supreme Court upheld the Affordable Care Act (ACA) in large part, including the individual mandate, by a 5 to 4 vote. First, the Court ruled that the Anti-Injunction Act did not bar consideration of the case. Regarding the power to regulate interstate commerce, the Court questioned whether the "commerce" in question underlying the mandate was the sale of health insurance or the use of health services. Regardless, the Court found that the individual mandate exceeded Congress' authority to regulate "inactivity" as commerce. However, it ruled that the penalty or "individual responsibility" payment for individuals who choose not to purchase health insurance, based on its structure and enforcement through the Internal Revenue Service, *could be construed as a tax*. Therefore, the Court ruled that the Congress has the power to impose such a penalty under the Tax and Spending Clause of the Constitution. Since the mandate was upheld, the issue of severability did not apply. In effect, this decision addressed the first three of the four major issues described earlier.

CONCURRING OPINION: It is worth noting that the concurring opinion on this issue, written by Justice Ginsburg and joined by Justices Sotomayor, Breyer and Kagan, agreed with Justice Robert's opinion that the mandate could be upheld under the taxing power, but those Justices indicated they also believed it could have been upheld under the Commerce Clause. Justice Ginsburg in particular discussed a) the unique character of the health care market, b) that everyone will inevitably participate in the market, and c) that the uninsured have an impact upon the price of health care and increase costs for the insured population.

DISSENTING OPINION: In a dissenting opinion by Justices Scalia, Kennedy, Thomas and Alito, it was argued that the health care market in question under the mandate is narrow, consisting mainly of goods and services that *younger* individuals affected by the mandate don't purchase. They argued that the mandate exceeded Congress' taxing power and its powers under the Commerce Clause. Under the former, it was argued that the ACA "penalty" is just that, and not a "tax", and that the two concepts are mutually exclusive. In their view, as a penalty, the mandate should not be upheld under the taxing power.

THE MANDATORY MEDICAID EXPANSION RULING: The exception to upholding the ACA in its entirety was to bar the Department of Health and Human Services (HHS) from denying *all* Medicaid funding to states that decline to participate in the ACA's Medicaid expansion. This latter portion of the verdict was a signal victory to the 26 states, led by Republican Governors, who had challenged the total Medicaid de-funding threat as coercive and unconstitutional. The Court agreed on the latter, while upholding the balance of the law. The ruling indicated that loss of all federal funding for Medicaid in states that fail to expand coverage under the ACA expansion overlay, essentially represented a "gun to the head", which exceeded the spending authority of the Congress.

In summary, these are top-line versions of the effective verdict(s); multiple concurring and dissenting opinions are part of the Court's overall releases on this ruling and will be

pored over for some time to come. But, these are the key decisions of import to the future of the ACA's implementation.

THE CHIEF JUSTICE'S COMPASS: Conservatives were particularly shocked that the previously "highly reliable" conservative Chief Justice Roberts, decided to not only join the Majority opinion described above, but to also assume the responsibility for writing and delivering the opinion. The shock of the verdict was heightened by the incorrect reporting of two media outlets, CNN and Fox, that the individual mandate had been struck down, an error that took several feverish minutes to correct. It was later reported in the media that the President was relying upon his viewing of CNN for the verdict and therefore, spent at least a few minutes thinking the centerpiece of the law, the individual mandate, had been struck down, before he was informed otherwise by White House staff awaiting more official confirmation of the decision.

The previously mentioned SCOTUSblog maintains statistics on the Court's rulings by term in what they call their "Stat Pack". The following charts taken from a comprehensive Stat Pack released shortly after the ACA verdict as the Court recessed for its summer break, illustrates why conservative political leaders and pundits were so surprised by the Chief Justice's actions. Chief Justice Roberts was joined in the Majority opinion by Justices Ginsburg, Sotomayor, Breyer and Kagan. The following chart suggest what an unusual alignment this was for the Chief Justice and why pre-decision betting on the outcome highly favored a different alignment of the Justices and the fall of the individual mandate.

It is outside the scope of this report to examine all of the crossing and dissenting views that accompany the verdict. However, we'd like to share with you an especially good chart summarizing those crossing points of view, prepared under the auspices of the George Washington University and Robert Wood Johnson Foundation project called Health Reform GPS.

IN THE COURT'S OWN WORDS: Given the relatively unusual alignment in the actual decision, it is helpful to view selections of the Chief Justice's own words (in italics below) appearing in the Majority opinion. They help to illustrate aspects of his thinking, or his *compass*, as follows:

1. *"The Federal Government has expanded dramatically over the past two centuries, but it still must show that a constitutional grant of power authorizes each of its actions."*(p. 3)
2. *"Resolving this controversy requires us to examine both the limits of the Government's power, and our own limited role in policing those boundaries."* (p. 6)
3. *"We do not consider whether the Act* (referring to the ACA) *embodies sound policies. That judgement is entrusted to the Nation's elected leaders. We ask only whether the Congress has the power under the Constitution to enact the challenged provisions."* (p. 2)
4. *"When a court confronts an unconstitutional statute, its endeavor must be to conserve, not destroy the legislation."* (p. 60-61)

JUSTICE AGREEMENT - HIGHS AND LOWS - 5-4 DECISIONS

The following tables list the Justice pairs with the highest, and lowest, agreement rates in *5-4 decisions* (drawn from the chart on page xx). Both tables consider the level of *agreement in full, in part, or in judgment only*.

Highest Agreement

	Pair	Average
1	Roberts - Alito	93.3%
2	Scalia - Thomas	93.3%
3	Ginsburg - Kagan	92.9%
4	Sotomayor - Kagan	92.9%
5	Roberts - Thomas	86.7%
6	Scalia - Alito	86.7%
7	Thomas - Alito	86.7%
8	Ginsburg - Breyer	86.7%
9	Ginsburg - Sotomayor	86.7%
10	Roberts - Scalia	80.0%

Lowest Agreement

	Pair	Average
1	Scalia - Ginsburg	6.7%
2	Scalia - Breyer	6.7%
3	Thomas - Ginsburg	6.7%
4	Thomas - Sotomayor	6.7%
5	Ginsburg - Alito	6.7%
6	Roberts - Kagan	7.1%
7	Alito - Kagan	7.1%
8	Roberts - Ginsburg	13.3%
9	Roberts - Sotomayor	13.3%
10	Alito - Sotomayor	13.3%

SCOTUSblog Stat Pack | Final | October Term 2011 | Saturday, June 30, 2012

HEALTH REFORM GPS

Navigating Implementation

A project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation

	Anti-Injunction Act (AIA)	Minimum coverage requirement—*Commerce Clause*	Minimum coverage requirement—*taxing power*	Medicaid expansion
John G. Roberts, Chief Justice	Does not apply	Unconstitutional	Constitutional	Constitutional, but threat to withhold all existing program funds for failure to implement the ACA eligibility expansion is unconstitutional.
Antonin Scalia	Does not apply	Unconstitutional	Does not apply	Strike entire expansion
Clarence Thomas	Does not apply	Unconstitutional	Does not apply	Strike entire expansion
Anthony M. Kennedy	Does not apply	Unconstitutional	Does not apply	Strike entire expansion
Samuel Anthony Alito	Does not apply	Unconstitutional	Does not apply	Strike entire expansion
Elena Kagan	Does not apply	Constitutional	Constitutional	Constitutional, but threat to withhold all existing program funds for failure to implement the ACA eligibility expansion is unconstitutional.
Sonia Sotomayor	Does not apply	Constitutional	Constitutional	Constitutional as is Medicaid's existing penalty scheme.
Ruth Bader Ginsberg	Does not apply	Constitutional	Constitutional	Constitutional as is Medicaid's existing penalty scheme.
Stephen G. Breyer	Does not apply	Constitutional	Constitutional	Constitutional, but threat to withhold all existing program funds for failure to implement the ACA eligibility expansion is unconstitutional.
Totals	9-0: does not apply	5-4: individual mandate is unconstitutional under the Commerce Clause	5-4: individual mandate is constitutional under the taxing power	Plurality disallows extension of existing Medicaid penalties to state's failure to implement the ACA eligibility expansion.

WWW.HEALTHREFORMGPS.ORG

This suggests a strong orientation in the verdict toward the exercise of judicial restraint, e.g., "policing the boundaries" within the Court's purview while minimizing substitution of the Court's judgement for that of lawmakers on policy, as opposed to constitutional, matters. This is a trait that conservatives have prized highly in judicial nominees in the past, as opposed to "judicial activism" where judges rule in ways that some view as overly expansive and an usurpation of the public policy role of legislators. The immediate practical effect of the Supreme Court's ruling on the ACA is to largely turn the future of the law back to the elected officials in Congress and the Administration, and on the Medicaid expansion, to the States. Coming so closely to the eve of the Presidential elections in 2012, of necessity, the opinion will reverberate through the election process, ultimately to be influenced by voters as they select who will represent them beginning in 2013.

Of course, there are diverse views on the interpretation of the Court's prerogatives and determinations. Much has been and will continue to be written over the particulars of the ACA challenges and the legal reasoning contained in the ruling. Many commentators see potential longer-term consequences (good and ill) relating to limits on and authorities for federal intervention and powers based on reasoning contained in both the Majority, concurring and dissenting opinions. There are significant issues related to federal taxing and regulation of interstate commerce powers that arise from this verdict and the legal reasoning in selected areas. Our focus, however, is

not on constitutional law and legal theory, as interesting and important as they are, but on the more foreseeable consequences for the healthcare system and ACA implementation, which we turn to now.

Short-Term Implications of the ACA Verdict

Note: Please refer to the Chapter 2 section on the states for further discussion of Medicaid and to Chapter 3 for more detailed commentary on select areas of ACA implementation affecting the environment in which physicians practice.

HEADLINER: The most intense political and media focus has been on the fate of the individual mandate and its associated penalty as the "lynchpin" of coverage expansion under the ACA. However, as the full ACA-related dimensions and coverage consequences of the Court's ruling unfold, consider the possibility that the Medicaid portion of the verdict may have struck a more profound blow to the aspirations of the legislation. Further, important technical issues, perhaps even unintended consequences, are surfacing due to the Court's Medicaid ruling. One relates to the structure of insurance premium subsidies and tax credits and whether certain poor individuals (below 133% of the FPL), in states that opt not to expand Medicaid, might be ineligible and excluded from accessing them. The Administration is working to identify areas of additional flexibility they can offer stakeholders to address issues and gain support, as well as to solve unintended consequences administratively, rather than through legislation.

General Implications

NEW LEGISLATION A PRIMARY ENGINE FOR CHANGE: As noted, one major aspect of the Supreme Court's ruling was to decline to judge the "wisdom" of the policies contained in the ACA; rather, the future of the ACA and health reforms will reside with the citizens of the U.S. and their elected officials, making the pending 2012 elections exceptionally sensitive for the future shape of health reform. As we go to print, opponents of the ACA in the House of Representatives again acted on July 11 to pass a symbolic repeal of the ACA (H.R. 6079), with no prospects for actual enactment prior to the 2012 elections. In its ACA re-scoring release on July 24, discussed below, CBO stated, on balance, that the legislation would add $109 billion to the federal deficit over the 2013-2022 period. Separately, the House has also pursued various ACA "de-funding" efforts through other legislative vehicles.

BUDGET SEQUESTERS, FISCAL CLIFF AND CBO BUDGET SCORES PRIORITY LEGISLATIVE DRIVERS IN 2013: Due to the sluggish economy, high deficits, and looming "fiscal cliff", elected leaders face continued pressure for deficit and health care spending reductions, including cost-cutting strategies in the Medicare and Medicaid programs. In the transportation bill, one of the few pieces of legislation to be successfully enacted this year, it was notable that Republican legislators accepted select "pay-fors" to offset costs that had appeared earlier in 2012 in the President's FY2013 budget submission (otherwise deemed to be "dead on arrival").

The most intense political and media focus has been on the fate of the individual mandate and its associated penalty as the "lynchpin" of coverage expansion under the ACA. However, consider the possibility that the Medicaid portion of the verdict may have struck a more profound blow to the aspirations of the legislation.

CBO RESCORING OF THE ACA'S HEALTH CARE SPENDING BASELINES: CBO's new release of updated ACA baseline scores, including the Court's ACA verdict's impact on coverage, spending and deficit trajectories over the next 10 years, is very important to the legislative debate and any future actions. They are covered in Chapter II under the Fiscal State of the Union.

MAJOR IMPLEMENTATION SCHEDULES TO PROCEED CONSISTENT WITH THE LAW'S CURRENT REQUIREMENTS: Implementation of health insurance exchanges and other major regulatory provisions, such as accountable care organizations and adoption of health information technology and other delivery system reforms, will continue on schedule according to preliminary statements after the verdict by the Department of Health and Human Services.

Note, however, that as of the date of the verdict, fewer than half of the 50 states have actively proceeded on establishment of state exchanges. The Administration has

declared its commitment to proceed on every front, including encouraging states to move apace on health insurance exchanges and voluntary adoption of Medicaid expansions. The Administration is also proceeding on its own preparations for the federal fallback exchanges to operate in those states that do not establish their own.

Despite this posture, serious questions have been raised about whether the states and the federal government can or should meet the ambitious timelines falling in 2013 and 2014. Some lawmakers have suggested large savings could be achieved by pushing some of the timelines out for an additional year or two. In the meantime, many states deferred actions pending the outcome of the constitutional challenges, leaving them lagging behind schedule even if they now move forward.

Opponents of the ACA Will Use Every "Tool in the Toolkit" to Amend or Repeal the Law

OPPONENTS OF THE ACA WILL USE EVERY "TOOL IN THE TOOLKIT" TO AMEND OR REPEAL THE LAW: Opposition to the ACA appears unabated among opponents. In the run-up to the elections, it is expected every effort will be made by ACA opponents in national, state and local races to advance their points of view. In the meantime, following is an abstract that captures clearly both the broad reach and the specificity with which Congressional opponents are proceeding.

"While the Court left most provisions of ACA intact, opponents in Congress are expected to continue to target unpopular and controversial provisions of the law for repeal or "defunding." To date, only modest changes to ACA have been enacted. Examples include: repeal of the Form 1099 filing requirement for purchases greater than $600; inclusion of Social Security benefits in Medicaid income eligibility calculations; increased recoupment of overpaid subsidies for health insurance; $5 billion in funding cuts to the Prevention and Public Health Fund; a $2.5 billion reduction in Medicaid disaster payments; a $2.2 billion decrease in budget authority for Consumer Owned and Operated Plans (CO-OPs); and a $10 million rescission of funds for the IPAB in Fiscal Year 2012.

The Republican-controlled House, with support from some Democratic Members, recently passed legislation to overturn the 2.3 percent medical device tax, to abolish the IPAB, a creation widely criticized by members of both political parties, and to repeal the Community Living Assistance Services and Supports (CLASS) Act. In this election year, the Democratic-controlled Senate is unlikely to take up any of these House-passed bills, and the White House has already announced its opposition.

House Republican Leaders immediately promised to hold a vote to repeal any ACA provisions left standing by the Court. Republicans specifically identify a number of concerns in addition to the individual mandate, including: employer and state mandates; new and higher taxes; Medicare payment cuts; higher health costs; conscience protections; government control of the patient-doctor relationship; costs of the law; and more than 150 new boards, agencies and programs. Congressional Republicans are not expected to advance alternative health reform legislation before the elections, but prior proposals have included market-based insurance reforms that would expand coverage incrementally (e.g., through high-risk and small business purchasing pools, tax credits or deductions to purchase insurance, association health plans, and other mechanisms to purchase insurance across state lines), along with more controversial proposals for tort reform, Medicaid block grants, and a Medicare premium support option.

Going forward, Republicans have many tools in their legislative toolkits that could potentially disrupt or derail ACA's successful implementation. Beyond efforts to repeal the law in its entirety, Republicans could seek to target particular initiatives (e.g., by blocking appointments to the IPAB). Consideration of the annual appropriations bills will provide an opportunity to deny federal funding for key agencies and specific implementation efforts.

Depending on the outcome of the election, the budget reconciliation process could also provide a vehicle for the next Congress to target key provisions of ACA for repeal, including a range of taxes, industry fees, and employer penalties. Regardless of the

elections' outcome, Republicans will likely seek to create new battlegrounds in state legislatures across the nation."

SOURCE: THE FUTURE OF HEALTH REFORM, P. 13-14, PATTON BOGGS LLP, JUNE 28, 2012.

ACTUAL MEDICAID EXPANSION UPTAKE BY STATES A MAJOR OPEN ISSUE: In those states that elect to opt-out of the voluntary Medicaid expansions, large numbers of low-income Americans may remain uninsured. Providers could continue to face significant uncompensated care burdens that they had expected to decline over time due to the greater prevalence of coverage, especially among lower-income Americans that have generally not been able to qualify for Medicaid. Key health industry stakeholders, e.g., hospitals, pharmaceutical and medical device manufacturers, and insurers, accepted various taxes, fees, financial limits, etc. in the original ACA negotiations on the assumption the revenues would help finance coverage expansions that may not materialize to the extent expected.

Keep in mind that the federal share of spending for the expansion is exceptionally generous, bringing billions of additional dollars into the health care systems of states that proceed with the expansion. Having said that, the expansion is not costless to states in terms of new costs for public employees, contractors, systems and medical care spending. Governors of several states are asserting they will not carry out this expansion in their states, stating that they are opposed on both ideological and state fiscal commitment grounds. Finally, several states are now examining whether there is an additional legal implication under the Court's verdict that would permit them to not only avoid the expansion, but also make further cuts to the basic Medicaid program. These issues will develop over the next several weeks and months.

OTHER LAWSUITS MAY PROCEED OR BE FILED AGAINST ACA PROVISIONS: Select cases filed against narrower provisions of the ACA were stayed in the lower federal courts while the cases challenging the broader constitutionality of the Act proceeded on an accelerated schedule to the Supreme Court. One notable example is cases filed challenging the role of the Independent Payment Advisory Board and its power to make spending and policy decisions within the framework established under the law. These cases may proceed, while additional lawsuits can be expected in other areas, such as, the ability to restrict payments to physician-owned hospitals or the requirement that religious organizations provide their employees with free preventive services, including contraception.

In those states that elect to opt-out of the voluntary Medicaid expansions, large numbers of low-income Americans may remain uninsured. Providers could continue to face significant uncompensated care burdens that they had expected to decline over time due to the greater prevalence of coverage

In closing, the ramifications of the Supreme Court's verdict on the constitutionality challenges to the ACA will take some time to be fully revealed. The legal profession is closely reviewing the implications of the verdict's reasoning on interstate commerce and taxing powers as applied to other social policy areas, such as civil rights and other forms of taxation. The immediate aftermath will be to heighten the political battleground at the federal level, and in many states among ACA supporters and detractors, health care coverage advocates, health care providers, state legislators and Governors. The 2012 election results will also shape the outcome of this debate, and provide the springboard into 2013 fiscal and legislative changes. To place that post-election landscape in perspective, we now turn to the major fiscal drivers that will compel Presidential and Congressional attention, regardless of the elections' outcome. ■

CHAPTER II: The Fiscal Disorder in the Governments' House(s)

Part I: The State of the Union

The Federal Fiscal Dilemma

Headliner —There are four signal fiscal events pending over the next six months, plus the implications of CBO's new scores for the ACA. Projected historic deficits, the anemic economic recovery, the need to address the U.S. debt ceiling, and major political disagreements on the decisions required to enact a sustainable federal budget, demand leadership and cooperation. These traits will not be much in evidence prior to the election. Add to this mix continuing efforts to repeal the ACA and to engineer tax code reform, and we have a potent and volatile political situation at the federal level, with real economic consequences at stake. While our focus is on health care, it is important for planning and strategy purposes to understand the broader fiscal issues that could determine the outcome of the 2012 elections, and deeply affect the health care system in 2013 and beyond. We start with the budget events, and cover CBO's ACA work in a following section.

FY 2013 BUDGET PACKAGE FAILURE: The federal fiscal year begins on October 1, and it is apparent that the Congress will not pass an FY 2013 budget package prior to that date, including FY 2013 appropriations, necessitating a continuing budget resolution or some other interim measure to avert a government shutdown. As of this writing, it appears House and Senate legislators may agree on a six-month continuing resolution that would fund the federal government into early 2013 at current levels consistent with the debt ceiling limit. This averts a repeat of previous fiscal showdowns around the debt ceiling and a possible government shutdown, a scenario both parties wish to avoid.

DEBT CEILING LIMIT: At some point within the next few months, the U.S. debt ceiling will be reached, necessitating an agreement as to how to handle that limit. See the scenario just described above.

BCA SEQUESTER OR AUTOMATIC CUTS SCHEDULED FOR JANUARY 2013: The $1.2 trillion sequester, or automatic cuts, already enacted under the Budget Control Act of 2011(BCA), which is effective in January 2013, could impact upon the American health care system at many levels. These automatic reductions in spending include funding levels for programs contained within the ACA, and Medicare and Medicaid entitlements, as well as for operations of federal agencies. The sequester actions also reach defense and other non-defense programs.

EXPIRING TAX AND OTHER PROVISIONS: A number of major tax provisions, initially billed as temporary, are scheduled by law to expire on December 31st. These include income tax rates, capital gains tax rates, estate and gift taxes, temporary modifications to the Alternative Minimum Tax (AMT), and numerous, recurring tax extenders.

SETTING THE FISCAL STAGE: We start with an infographic released this Spring by the Congressional Budget Office (CBO) that sets the fiscal stage beautifully, providing both a recent snapshot and a past forty years (1971-2011) perspective of total federal spending, revenues, public debt and the deficit. CBO is the non-partisan legislative "scoring" entity for the U. S. Congress and

is responsible for periodically creating and updating federal budget baselines for the Congress. These baselines inform the Congress, and the public, of the projected trajectories of mandatory and discretionary spending across all federal operations and programs.

Special attention should be given to the graphical relationships blocked out for 2011—broad federal budgetary distress is apparent on every key dimension compared to the pre-recession year of 2006—spending is higher, revenues are reduced, and the resulting deficit is higher, each by a significant order of magnitude change subsequent to what economists now call the "Great Recession".

CBO MARCH 2012 BASELINE PROJECTIONS: In March 2012, CBO released updated baseline budget projections for the period 2012-2022. These projections provide the benchmark against which the budget impact of potential federal legislation can be measured. Importantly, CBO constructs its baseline estimates of federal revenues and spending under the assumption that current law remains unchanged from its current snapshot and carried forward throughout the 10-year budget window. This means that under current law, deficits are projected to drop markedly in the next few years primarily because, absent Congressional action, revenues are scheduled to shoot-up by more than 30% over the next two years due to scheduled expiration of an array of tax provisions that have temporarily reduced tax revenues over the last decade.

CBO attributes the revenue increases primarily to scheduled expirations of recent temporary reductions in 1) income tax (i.e., the temporary tax cuts enacted under President Bush and extensions of those initial cuts) and payroll tax rates, 2) limits on the effect of the alternative minimum tax (AMT), and 3) tax extenders (over 100 special corporate concessions), plus 4) the imposition of new taxes, fees and penalties scheduled to go into effect. In addition, outlays for stimulus spending, unemployment compensation and other federal benefits that increased significantly during the depths of the economic downturn are estimated to decline gradually as special provisions expire and the economy improves, albeit slowly.

Finally, CBO separately updated its baseline projections for the ACA to take into account the effects of the Supreme Court ruling, especially the impact of the Medicaid expansion being ruled voluntary rather than mandatory. Key numbers follow in a later section; but, while CBO estimated reduced spending under the ACA and net deficit reduction effects, we flag that certain spending effects are higher and the deficit reduction effects are lower, on balance, than previous estimates—a troubling direction in this fiscal environment.

FAILED OPPORTUNITIES AND THE BCA OF 2011: The period since the 2010 elections has seen intensified partisanship over ideological differences on taxation and spending priorities that has contributed to repeated budgetary impasses. These failed opportunities reflect:

- **Breakdown** of the annual, bicameral, regular order budget processes in the Congress that would ordinarily lead to enactment of reconciled, adjusted tax and spending priorities in the federal budget,
- **Rancorous** debate around necessary raising of the federal debt limit (multiple times),
- **Rejection** of the Simpson-Bowles deficit reduction plan (meant to be a high-level, bi-partisan effort that included senior political figures of both parties and budget experts)
- **The failure** of an attempted "grand compromise" by the Administration negotiating most extensively with House, as opposed to Senate, Republican leaders, leading to enactment of the Budget Control Act of 2011 (the BCA), and
- **The failure** of an agreed-upon Joint Select Committee on Deficit Reduction (popularly, the "SuperCommittee"), formed under the auspices of the BCA. This has led to recent warnings of potential new shocks to the nation's economic system stemming from the *default budget rules* enacted under the BCA, as the "fail-safe" to failure of the Special Committee. It is interesting to note that the BCA passed with substantial majorities: in the House on a 269-161 vote and in the Senate on a 74-26 vote.

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THE U.S. FEDERAL BUDGET

The United States is facing significant and fundamental budgetary challenges. The federal government's budget deficit for fiscal year 2011 was $1.3 trillion; at 8.7% of gross domestic product (GDP), that deficit was the third-largest shortfall in the past 40 years. (GDP is the sum of all income earned in the domestic production of goods and services. In 2011, it totaled $15.0 trillion.)

In 2011, federal spending (outlays) exceeded 24% of GDP, the third-highest level in the past 40 years, while federal revenues were just over 15% of GDP, the third-lowest level during that period. If economic conditions improve, spending will decline relative to GDP and revenues will rise. But even so, under current policies, a large gap between spending and revenues will persist.

Annual budget deficits occur when spending exceeds revenues; the government must borrow to cover such a shortfall. Federal debt held by the public is the total value of outstanding Treasury bills, notes, bonds, and other debt instruments (including Treasury securities held by the Federal Reserve) that have accumulated over time to finance the government's activities.

At the end of fiscal year 2011, debt held by the public amounted to $10.1 trillion, or 67% of GDP. Another $4.6 trillion in Treasury securities were held by other federal government accounts, representing amounts that one part of the government (mostly the Social Security Administration) had lent to another (the Treasury).

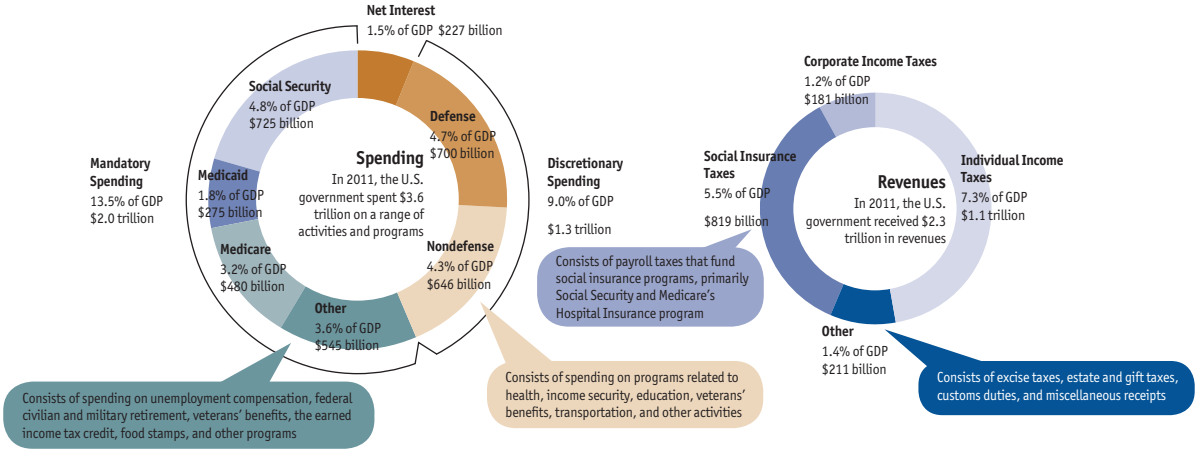
For more information, see these CBO publications:

The Budget and Economic Outlook: An Update
http://go.usa.gov/5H0

CBO's 2011 Long-Term Budget Outlook
http://go.usa.gov/5H7

Reducing the Deficit: Spending and Revenue Options
http://go.usa.gov/5HA

An Analysis of the President's Budgetary Proposals for Fiscal Year 2012
http://go.usa.gov/5Ho



FACTS ABOUT THE BUDGET

$3.6 trillion
Amount of spending by the federal government in fiscal year 2011

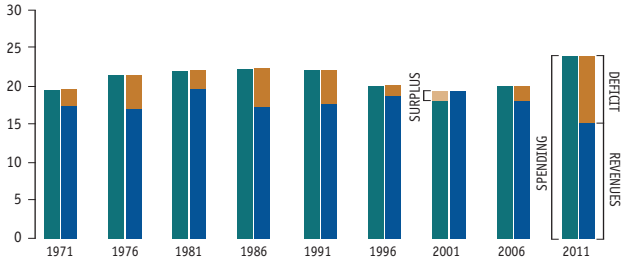
$2.3 trillion
Amount of revenues received by the federal government in fiscal year 2011

Mandatory spending
Consists primarily of benefit programs for which the Congress sets eligibility rules and benefit formulas

Discretionary spending
Consists of spending that lawmakers control through annual appropriation acts

Net Interest
Consists of the government's interest payments on debt held by the public, offset by interest income the government receives

Revenues
Funds collected from the public that arise from the government's exercise of its sovereign or governmental powers



THE FEDERAL BUDGET 1971–2011
(Percentage of GDP)

Annual Deficit or Surplus = Revenues – Outlays

To fund government spending in years of deficits, the government borrows from individuals, businesses, or other countries by selling them Treasury securities.

DEFICITS AND THE DEBT

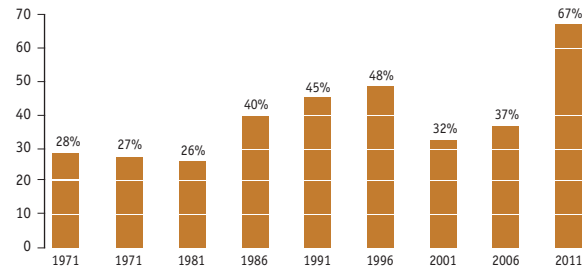
21%
Spending as a share of GDP, on average, over the past 40 years

18%
Revenues as a share of GDP, on average, over the past 40 years

8.7%
Annual deficit in 2011 as a share of GDP, the third-highest level in the past 40 years

38%
Debt held by the public as a share of GDP, on average, over the past 40 years

67%
Debt held by the public as a share of GDP at the end of 2011, the highest level in the past 40 years



THE U.S. DEBT 1971–2011
(Percentage of GDP)

Debt

Debt held by the public is roughly equal to the sum of annual deficits and surpluses. Other factors, such as borrowing to fund student loans and other federal credit programs, can also affect debt held by the public.

All of the numbers in this figure are for federal fiscal years, which run from October 1 to September 30.

AUTHORS: JONATHAN SCHWABISH AND COURTNEY GRIFFITH
SOURCE: CONGRESSIONAL BUDGET OFFICE

THE FISCAL CLIFF AHEAD: Recently, budget watchers are warning of a "fiscal cliff" that will occur in 2013 due to the combined effect of expiring, temporary tax provisions, many enacted under the previous administration, and automatic spending reductions or "sequestration" enacted in the BCA. The fear is that these separate, major budget forces occurring on a large scale to raise taxes and decrease spending simultaneously could damage the fragile economy. It is worth noting that some commentators have suggested that the effects of the fiscal cliff would be broadly diffused and that the longer-term benefits in deficit reduction due to reduced spending and improved revenues would be worth any short-term effects. But that does not seem to be the mainstream view, based on recent analyses of the CBO and testimony on Capitol Hill by economist Ben Bernanke, the Chairman of the Federal Reserve, raising concerns about the magnitude of the economic impact.

BUDGET CONTROL ACT OF 2011: The BCA (P.L. 112-25) had two major components that could result in automatic sequestration of funds:

- Establishment of discretionary spending limits, or caps, for each of the years FY2012-FY2021. Sequestration rules permit automatic, often across-the-board spending reductions under which budgetary resources are permanently reduced or canceled to enforce select budget policy goals. If Congress were to appropriate more than allowed under these spending limits in any given year, the automatic process of sequestration would cancel these amounts.
- Failure of the SuperCommittee to enact legislation by January 1, 2012 to reduce the federal deficit by $1.2 trillion over the budget window. Since the SuperCommittee failed in its charge, the BCA provides for a one-year sequestration of discretionary spending in FY 2013, and lower limits in FY2014-FY2021. The first automatic cuts are scheduled to take effect on January 2, 2013. *The automatic cuts under the BCA are designed to automatically achieve a $1.2 trillion target in deficit reduction over 10 years.*
- There are numerous rules within the BCA governing which federal budget accounts will be either exempted from or subject to the automatic cuts. According to CRS, "the automatic procedures triggered by failure of the Joint Committee process will affect both mandatory and discretionary spending, and will result in the security and nonsecurity categories being reduced by an equal amount of spending in each of FY2013 through FY2021. Because the definition of "security" is revised to mean primarily the Department of Defense, this means that half of the necessary spending reductions will come from that department while the other half will come from the rest of the federal budget. In addition to lowering the discretionary spending limits, these automatic procedures maintain separate spending limits for security and nonsecurity, as those terms have been revised, for each year through FY2021." (CRS. *Budget "Sequestration" and Selected Program Exemptions and Special Rules*. R42050. April 27, 2012.)

CBO'S LONG-TERM BUDGET OUTLOOK: Early this June, CBO released a report that has gained considerable attention (CBO. *The 2012 Long-Term Budget Outlook*. June 2012). All major scoring and estimation exercises carried out by CBO are highly influential in legislative discussions. This report gained particular attention because it poses two broad scenarios that embody different assumptions about future policies governing federal revenues and spending, and *CBO has raised cautions about the potentially negative effects on a struggling economy of increased taxes and deep sequestration cuts occurring simultaneously.* Political leaders in both parties have seized on CBO's analysis to reposition themselves in various ways, especially on income taxes and defense cuts. See the CBO infographic below illustrating the estimated effects of the alternative scenarios:

- **Scenario 1—**The *extended baseline scenario*, which reflects the assumption that current laws generally remain unchanged; that assumption implies that lawmakers will allow changes that are scheduled under current law to occur, forgoing adjustments routinely made in the past that have boosted

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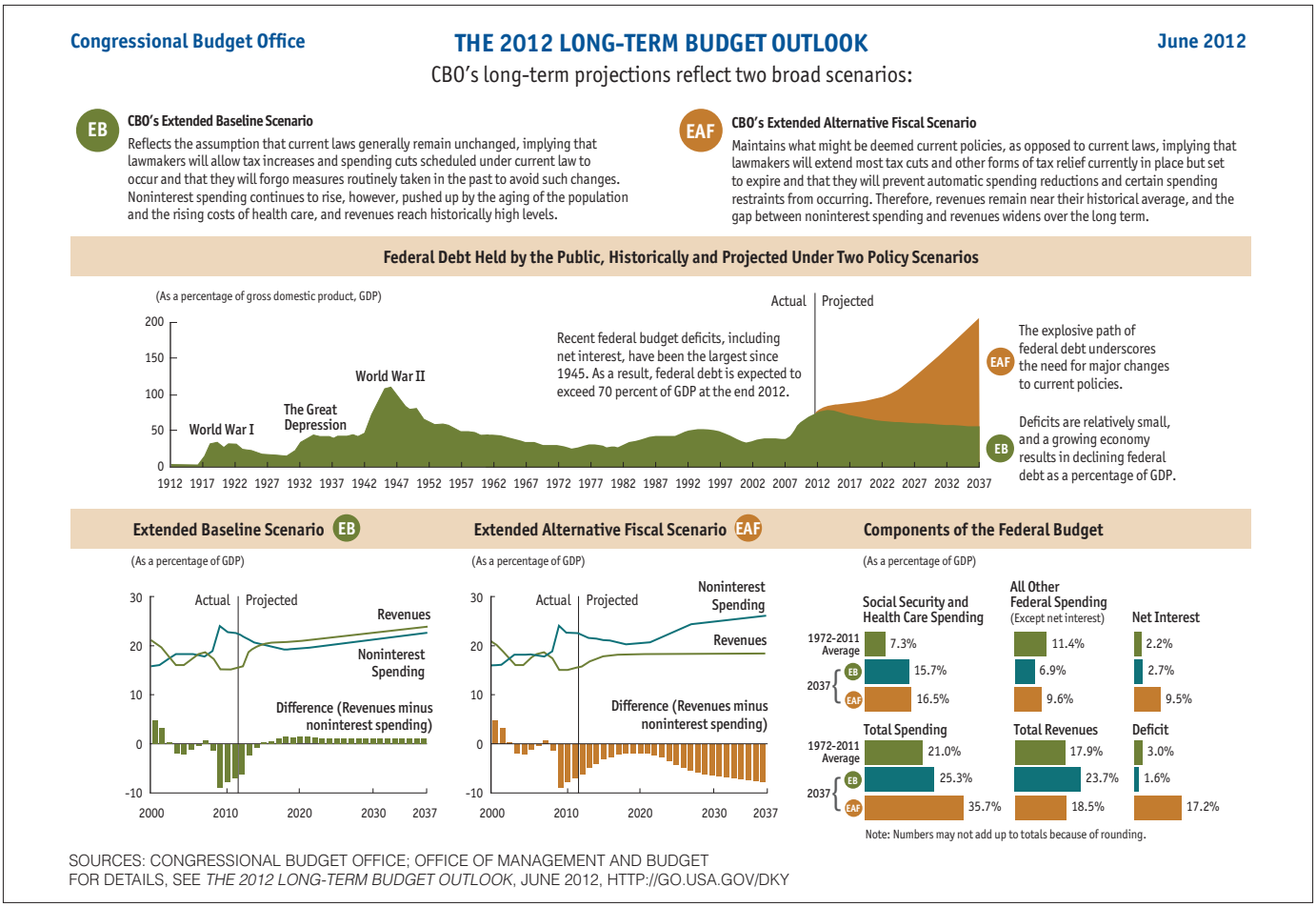


SOURCES: CONGRESSIONAL BUDGET OFFICE; OFFICE OF MANAGEMENT AND BUDGET
FOR DETAILS, SEE *THE 2012 LONG-TERM BUDGET OUTLOOK*, JUNE 2012, HTTP://GO.USA.GOV/DKY

deficits (this would allow expiring tax cuts to expire, sequestration cuts to occur, and would not assume actions such as a Medicare physician fee schedule fix).

➤ **Scenario 2—**The *extended alternative fiscal scenario*, which incorporates the assumptions that certain policies that have been in place for a number of years will be continued and that some provisions of law that might be difficult to sustain for a long period will be modified, thus maintaining what some analysts might consider "current policies," as opposed to current laws.

Alternatively, it may be helpful to view the two scenarios as presented in a short-hand format and appearing in the Wall Street Journal.

COMMENTARY: While cautioning about the economic impact of simply allowing the combined expiring provisions, which raise federal revenues, and the BCA spending reductions to occur, *CBO also shows the dire fiscal consequences of maintaining the temporarily reduced tax levels currently in place and canceling the scheduled BCA spending reductions*. This is the proverbial "being between a rock and a hard place", which suggests the need for some combination of policies.

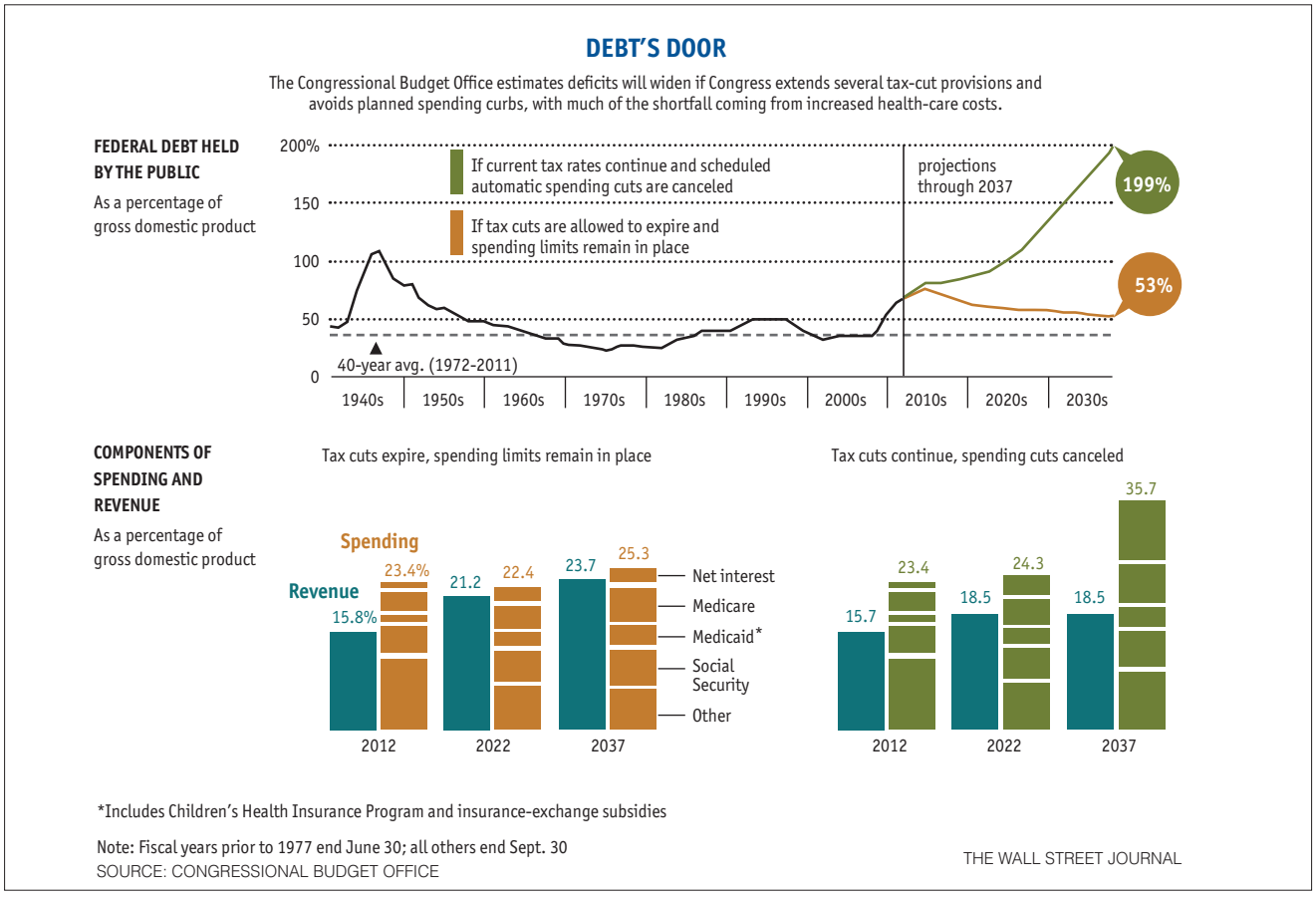
Further, these scenarios do not reflect any potential impact of CBO's estimates of the recent Supreme Court decision on the ACA. CBO has just released its ACA spending projections (see below) subsequent to the Court's verdict. These affect the above deficit calculations, but not the validity of CBO's illustration of the fundamental budget alternatives. Unfortunately, there is only modest potential for balanced political collaboration within the Congress and between the Congress and the Administration until after the 2012 election, discussed briefly in the next section.

The government "kick-the-can" maneuvers described above on current government operations do not address resolution of the deeply serious sequester and expiring

provisions impact after the first of the year. That effort addresses only about $1 trillion in appropriations measures for current operations and would likely extend into next March. It is now expected that some kind of second temporary agreement may be needed to address the sequester and expiring provisions impact, to grant time for newly reconfigured, post-election leadership to act on a deeper accord. In this mix, budget leaders must now also grapple with deep legislative scoring implications for taxes and spending attributable to CBO's re-estimation of the impact of the ACA provisions upon revenue and spending baselines, and upon the deficit.

CBO'S RE-SCORING OF THE ACA: On July 24, CBO released two major documents that are material to the determination of the future of the ACA. The complex cost and spending algorithms of the ACA revealed in these documents also have serious implications for any legislated changes to existing entitlement programs due to the extensive ways in which Medicare, Medicaid and CHIP were affected by ACA provisions. The foundational baseline updating document is the second one below, which informed the results on the recent House vote to repeal the ACA in its entirety, without attempting to navigate through provisions and make selections as to what to keep or discard. We show that discussion first to highlight the health care program complications of undiscriminating legislating.

1 ➤ **SCORING OF H.R. 6079—AN ACA REPEAL BILL:** The first was a letter to the Speaker of the House, John Boehner, which provided scoring for H.R. 6079, an ACA repeal bill passed by the House on July 11. Although the headline number was the net deficit increasing impact of $109 billion cited above, the scoring information is much more complex than that number suggests. Without attempting to be exhaustive, it is important to look behind the headline numbers to gain a clearer picture of what's at stake for the Congress,



CBO and the Joint Tax Committee of the Congress (JCT) estimated that repeal of the ACA as legislated in H.R. 6079 (full ACA repeal) would reduce direct spending by $890 billion and reduce federal revenues by $1 trillion over the 2013-2022 period, leading to the net deficit increase figure of $109 billion cited as the headline figure.

at least fiscally speaking.

On broad coverage effects, CBO stated about 30 million fewer nonelderly people would have health insurance in 2022 than under current law, leaving a total of about 60 million nonelderly people uninsured, leading to about 81 percent of legal nonelderly residents with insurance coverage in 2022, compared with 92 percent projected under current law (and 82 percent currently). Notably, repealing the coverage and insurance provisions would result in a net decrease in federal deficits of $1.1 trillion in 2022, including a reduction of $643 billion in net federal outlays for Medicaid and CHIP. State spending would drop about $41 billion over the budget period.

However, within these savings, the offsetting spending consequences are significant in Medicare, Medicaid and CHIP. CBO estimates that:

"Within Medicare, net increases in spending for the services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) would total $517 billion and $247 billion, respectively. Those increases would be partially offset by a $48 billion reduction in net spending for Part D. The provisions whose repeal would result in the largest increases in federal deficits include the following (all estimates are for the 2013–2022 period):

- "Repeal of the reductions in the annual updates to Medicare's payment rates for most services in the fee-for-service sector (other than physicians' services) would increase Medicare outlays by $415 billion. (That figure excludes interactions between those provisions and others—namely, the effects of those changes on payments to Medicare Advantage plans and collections of Part B premiums.) Of that amount, higher payments for hospital services account for $260 billion; for skilled nursing services, $39 billion; for hospice services, $17 billion; for home health services, $66 billion; and for all other services, $33 billion.
- Repeal of the new mechanism for setting payment rates in the Medicare Advantage program would increase Medicare outlays by $156 billion (before considering interactions with other provisions).
- Repeal of the reductions in Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH), would increase federal spending by $56 billion.
- Repeal of other provisions pertaining to Medicare, Medicaid, and CHIP (other than the coverage-related provisions discussed earlier) would increase federal spending by $114 billion. That figure includes a $3 billion increase in spending from eliminating the Independent Payment Advisory Board (IPAB). Under current law, the IPAB will be required, under certain circumstances, to recommend changes to the Medicare program to reduce that program's spending; such changes will go into effect automatically."

(Source: Letter to the Honorable John Boehner on H.R. 6079, the Repeal of the Obamacare Act. Douglas W. Elmendorf. CBO. July 24, 2012.) (p. 14).

To summarize, CBO and the Joint Tax Committee of the Congress (JCT) estimated that repeal of the ACA as legislated in H.R. 6079 (full ACA repeal) would reduce direct spending by $890 billion and reduce federal revenues by $1 trillion over the 2013-2022 period, leading to the net deficit increase figure of $109 billion cited as the headline figure.

COMMENTARY: CBO's analysis is much richer and more complex than we can do justice to in this report. CBO's re-scoring of the House ACA repeal bill makes abundantly clear that there are confounding cost, spending and entitlement program implications for any effort to disentangle, repeal or even "reform the reform". The House-passed bill was a blunt political instrument that did not attempt at this stage to navigate those minefields. But that suggests, in the right political circumstances, a well-crafted, more targeted bill in the future could succeed.

2 ➤ CBO'S "ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE ACA UPDATED FOR THE RECENT SUPREME COURT DECISION": A large portion of the named report describes the technical approach and general assumptions made by CBO and JCT in arriving at their

estimates for such matters as the uptake by States of the now voluntary Medicaid expansion, the numbers of individuals expected to access subsidies and gain coverage through the exchanges in the future, and how their estimates differ compared to previous estimates. It was also emphasized that CBO and JCT seek advice and input from highly qualified technical panels in economics and health care.

In fact, in a CBO Director's Blog post released on July 27 (www.cbo.gov), CBO released the names of those advisers and provided answers to most frequently asked questions about how they develop estimates. As an unusual, defensive move, this action suggests that CBO has been fielding an exceptional number of questions and certainly, criticism regarding its ACA estimates. This is not an unusual position for CBO to be in on sensitive legislative matters, where they have to thread the needle on protecting the technical integrity of their work, while understanding the political conduct of their "bosses", the U.S. Congress. CBO indicated in the report under review that the ACA estimates are both highly uncertain and fall in the middle range of possible projections. With those caveats, following are select excerpts from the report:

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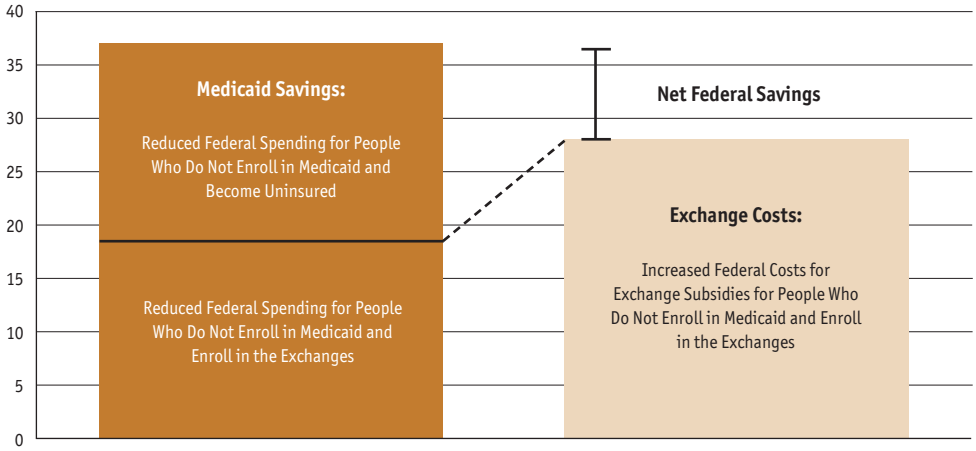
- The insurance coverage provisions will have a net cost of $1,168 billion over the 2012-2022 period—this is a net reduction of $84 billion from CBO's previous cost estimate (p. 2).

MAJOR EFFECTS ON THE FEDERAL BUDGET IN 2022 OF CHANGES IN MEDICAID ENROLLMENT DUE TO THE RECENT SUPREME COURT DECISION

(Billions of dollars)



SOURCES: CONGRESSIONAL BUDGET OFFICE AND THE STAFF OF THE JOINT COMMITTEE ON TAXATION.

Notes: The effects shown in the figure reflect the major changes in enrollment and do not include smaller shifts in coverage. For example, relative to prior estimates, not all of the increases in enrollment in exchanges and in the uninsured are among people who would have been newly eligible for Medicaid.

See the Supreme Court's opinion issued on June 28, 2012 (*National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 [2012]).

- Post-Supreme Court decision, lower Medicaid enrollment savings will more than offset the increase in costs from greater participation in exchanges, because the additional number of people entering the exchanges (albeit at a higher per capita cost than Medicaid) is projected to be about half the number who will not be obtaining Medicaid coverage. Many of the latter will not be eligible to participate in the exchanges (p. 2). See the chart below (p. 5).
- In its decision, the Supreme Court upheld the constitutionality of the ACA's provision requiring most individuals to obtain insurance coverage or pay a penalty tax. The Court viewed that arrangement as a valid exercise of the Congress's constitutional power to levy taxes. That ruling has not caused CBO and JCT to change their estimate of the impact of the coverage requirement and the associated penalty on people's decisions about whether to obtain insurance coverage (p. 3).
- In 2022, for example, Medicaid and the Children's Health Insurance Program (CHIP) are expected to cover about 6 million fewer people than previously estimated, about 3 million more people will be enrolled in exchanges, and about 3 million more people will be uninsured (see Table 1, at the end of this report). Although the estimates discussed here are dominated by the movements of people losing eligibility for Medicaid, other smaller shifts in coverage are expected to occur as well. See the chart below on the long-term, estimated effects on the federal budget of these estimates (p. 5).
- CBO and JCT project that the coverage expansions will unfold according to the following rough timetable:
- About one-third of the people who will ultimately become newly eligible for Medicaid reside in states that will expand their program beginning in 2014.
- About one-third of newly eligible people will reside in states that will delay their coverage expansion until 2015.
- The remaining one-third will reside in states that will delay longer than one year—expanding coverage in 2016, 2017, or 2018.
- CBO and JCT project that the newly eligible people living in states more likely to expand coverage to 138 percent of the FPL are also more likely to see the expansion begin in 2014, while those newly eligible people living in states that are more likely to choose lower income eligibility thresholds or other options to limit their costs are more likely to see expansion occurring later (p.12).
- According to CBO and JCT's updated estimates, the subsidies to be provided through the insurance exchanges over the 2012–2022 period are $210 billion higher than the previous estimates—$178 billion more in projected tax credits for health insurance premiums and $31 billion more in projected cost-sharing subsidies and related spending.
- The average subsidy for the additional enrollees resulting from the Supreme Court's decision is expected to be higher than the average subsidy for all exchange enrollees for two reasons:
- The additional enrollees will have lower average income than those previously expected to purchase insurance through the exchanges, so they will qualify for higher federal subsidies for premiums and cost sharing.
- The additional enrollees are likely to spend more on health care, on average, than those previously expected to purchase insurance through the exchanges because people with lower income generally have somewhat poorer health. As a result, CBO and JCT now estimate that the premiums for health insurance offered through the exchanges, along with premiums in the individual market, will be 2- percent higher than those estimated in March 2012 (p. 15).

(Source: Estimates for the Insurance coverage Provisions of the ACA Updated for the Recent Supreme Court Decision. Douglas W. Elmendorf. CBO. July 24, 2012.)

CONCLUSION: In closing, there is much more to pore over in the reports, but in our view, these are major highlights. The estimates and

reasoning behind them indicate important systemic impacts will unfold as a result of the Court's decision relative to the original access goals of the ACA. You will note that CBO projects much higher levels of uninsured relative to the original law. On an average, per capita basis, individuals will cost more to cover through the exchanges than if they had been reached by the Medicaid expansion. Perversely, many who would have been covered by the mandatory Medicaid expansion will not be eligible for the exchanges precisely because they are lower income and were expected to be Medicaid-eligible when the law was written. Now, large numbers may not be depending on where they reside. We say "perversely" because the result is that much more affluent individuals will be eligible for subsidies, which many lower-income individuals cannot qualify for under current ACA provisions. Coverage levels will remain highly uneven across states.

Finally, CBO estimates premium costs will increase by about 2% over previous estimates in the exchanges and individual markets, affecting everyone accessing those markets. This is entirely speculative, but as we noted earlier, the Court's decision on Medicaid may have a more profoundly negative impact on the coverage aspirations of the ACA than if the mandate had fallen.

There is one other aspect of CBO's ACA estimates that should not be ignored, even and perhaps, especially, by ACA supporters. That is, these estimates draw new attention to the sheer scale of the ACA: 1) as a source of significant new federal and state spending in the health care system, 2) as a source of new taxes, penalties and health system "pay-fors", and 3) as a legislative and regulatory driver of change in our health care system. In our current economic climate, such renewed attention will almost inevitably prompt changes to the original law sooner rather than later.

CBO's scoring of the ACA draws new attention to the cost and complexity of the ACA.

Part II: The State of the States

STATE FISCAL STATUS: The Supreme Court's recent decision regarding the ACA placed a fresh spotlight on the nature of the constitutional relationships in our democracy between the federal government and the states. And, as was made clear in our earlier Roadmap report, the ACA builds upon not only existing Medicaid interconnections between these separately constituted levels of government, but creates major new ones in the now *voluntary* Medicaid expansion, health insurance exchanges and numerous other health system areas. Although states led by Republican Governors have led in challenging the responsibilities and costs for states created by an array of ACA provisions, all states are evaluating the real risks and opportunities created under the law.

WHAT'S REALLY OPERATIVE?: What is most difficult to discern in the politics around the ACA is a) how much is truly a matter of differing principles about the role of government, b) how much is political opportunism as the major parties jockey for greater power at national and local levels following the 2012 elections, and c) how much is driven by the prolonged fiscal distress afflicting every corner of our economy? For instance, focusing on governmental fiscal capacity, both the federal government and states are struggling over major questions of revenues versus spending obligations. We've discussed the fiscal cliff and general deficit issues at the federal level. For similar recessionary reasons, and for fiscal reasons unique to state obligations and practices, states are equally challenged. At both the federal and state levels of government, the aspirations of the ACA are being tested due to divergent social principles, strained fiscal resources, and competing funding priorities.

The Supreme Court's recent decision regarding the ACA placed a fresh spotlight on the nature of the constitutional relationships in our democracy between the federal government and the states.

One major effect of the low federal interest rates is to dramatically reduce the debt service costs to the federal government of financing the federal deficit by hundreds of billions of dollars.

TWO BROAD FISCAL ASSESSMENTS OF THE STATES: As at the federal level, it is important for stakeholders in the health care system to have a realistic grasp of the fiscal situation facing states. Understanding these facts helps shape more realistic and effective advocacy approaches. Therefore, focusing briefly on the fiscal "state of the states", we take a look at two perspectives.

The first comes from the National Governor's Association (NGA) and the National Association of State Budget Officers (NASBO) and is contained in the bi-annual Fiscal Survey of the States—Spring 2012 (available at NASBO.org). In brief, the take-away is that while states faced wrenching budgetary pressures related to the Great Recession, states have come to grips with fiscal reality and their budgets are slowly on the mend. There is more on this survey of states to follow.

A second, more urgent summons, sounded by the State Budget Crisis Task Force (SBCTF), an independent group, assesses conditions more bluntly. As noted in their recent report:

"*The United States Constitution leaves to states the responsibility for most domestic governmental functions: states and their localities finance and build public infrastructure, educate our children, maintain public safety, and implement the social safety net. State and local governments spend $2.5 trillion annually and employ over 19 million workers—15 percent of the national total and 6 times as many workers as the federal government. State governments are coping with unprecedented challenges in attempting to provide established levels of service with uncertain and constrained resources.*" (p. 1).

Source: Report of the State Budget Crisis Task Force—Full Report. July 2012.

This report identifies six major fiscal threats, of which Medicaid growth rates received top billing. However, it is helpful to turn first to how states and their representative organizations characterize the current state of affairs.

THE FISCAL SURVEY OF THE STATES—SPRING 2012: Following are perspectives from the Fiscal Survey.

"*Budgets are being squeezed by constrained revenues and increased expenditure pressures, reductions in federal funding, replenishing reserves and providing resources for critical areas that were cut during the recession. Due to the severity of the economic contraction as well as the lag time between tax collections and changes in the national economy, states have been slow to recover from the recession. The fiscal fallout from the unprecedented budgetary declines in fiscal 2009 and 2010 puts states well below historical growth trends in general fund spending and revenue.*

With the expiration of federal funding support provided by the American Recovery and Reinvestment Act of 2009 (ARRA), states continue to realign spending plans with fiscal reality. States also face significant uncertainty surrounding traditional federal funds because of potential political gridlock over federal spending decisions. In addition, states will face particularly intense budgetary challenges in education and health care in fiscal 2013, putting pressure on all budget areas – including corrections and infrastructure. As budgets face strain from slow revenue growth and expenditure pressures, states will likely confront tough budgetary choices in the next fiscal year (excerpt, page vii)."

To grasp current fiscal concerns of states, it is important to understand that for over two years (October 2008 – June 2011), states were assisted significantly by ARRA's (more commonly referred to as the Recovery Act) flexible emergency funding under enhanced Medicaid matching rates and the State Fiscal Stabilization Fund. It is estimated the Recovery Act channeled about $112.8 billion in funds to the States during the height of the recessionary period and immediate aftermath. States have been forced to adjust to the now rapid phase-down in availability of those funds, which are estimated to decline to about $500 million in fiscal 2013.

Most states, excepting Vermont, are required to balance their budgets. In some cases, it's alleged, the methods by which they achieve this measure are questionable, involving definitional and accounting strategies rather than more enduring policy or structural changes affecting revenue or spending trajectories. The federal government, of course, is not required to

balance its budget and is able to run deficits, which present other long-term problems if not addressed responsibly.

At the federal level, the Federal Reserve has employed a number of strategies to keep interest rates low in the home mortgage and other markets, including federal treasuries, to help stimulate economic recovery, which is proceeding more slowly than the government would wish. *One major effect of the low federal interest rates is to dramatically reduce the debt service costs to the federal government of financing the federal deficit by hundreds of billions of dollars.* (Indeed, at least one Member of Congress recently characterized the Federal Reserve Chairman, Ben Bernanke, as an "enabler" of government excess by holding down the costs of deficit financing to artificially low levels, thereby allowing political leaders to avoid action on the deficit).

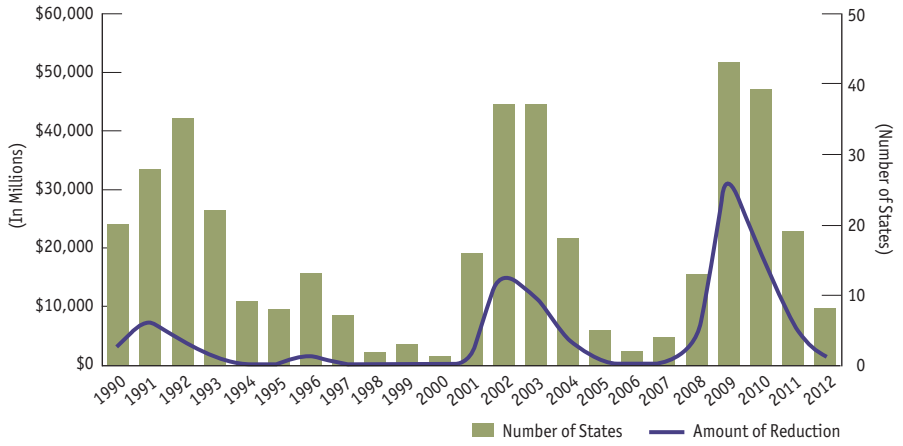
States, however, do not have as great a range of fiscal tools available to them. According to the Fiscal Survey, states reported a broad array of strategies ranging from state employee and programmatic spending reductions, to enactment of taxes and fee increases, to balance their budgets. States often make mid-year adjustments to ensure their spending will be in balance with appropriated funding and actual revenues. Following is a graphical representation both of the severe impact of the recession and of the sheer magnitude of states' actions to adjust their budgets to the severe conditions of the last several years, with historical perspective.

Looking at the period of 2008 – 2011, the steep budget cuts taken by states to effectuate mid-course corrections to existing budgets are stunning. *States have a very high stake in maintaining an excellent credit rating with lenders and in the bond markets, because it deeply affects their costs of borrowing funds in the open market to fund government operations.* Despite enormous pressures, with a few exceptions, states have been reasonably successful in maintaining acceptable to excellent credit ratings. It is worth noting, though, that several states have had ongoing issues with Moody's and other rating organizations in their efforts to maintain high level ratings over this period.

THE MEDICAID OUTLOOK: According to the Fiscal Survey, Medicaid spending in fiscal 2011 (State budget year-ends vary) accounted for approximately 23.6 percent of total spending, or the single largest portion of total state spending (including federal funds). When measured as a percentage of state general funds spending, Medicaid was 17.4 percent, the second largest share and eclipsed only by spending on elementary and secondary education.

Aside from absolute Medicaid spending levels, many state executives and lawmakers are even more concerned about the rates of increase in Medicaid spending, the declines in federal matching payments, insufficient flexibility for states in program design, and the impact of the economic downturn and high unemployment on state general revenues (stabilizing), and Medicaid enrollment (moderating). Medicaid enrollment and spending fluctuates with changes in the economy, often counter-cyclically, meaning that they rise as economic conditions worsen, and ease as conditions improve. For instance, approximately six million people entered Medicaid in the two-year period of December 2007 – December 2009, an influx rivaled only in the start-up period following Medicaid enactment. As

BUDGET CUTS MADE AFTER THE BUDGET PASSED, FISCAL 1990 TO FISCAL 2012 (MILLIONS)



SOURCE: THE FISCAL SURVEY OF STATES, SPRING 2012. NGA AND NASBO. (p.15)

Source: The Fiscal Survey of States, Spring 2012. NGA and NASBO. (p.15)

States have a very high stake in maintaining an excellent credit rating with lenders and in the bond markets, because it deeply affects their costs of borrowing funds in the open market to fund government operations.

ANNUAL PERCENTAGE MEDICAID GROWTH RATE

	Fiscal 2011 (Actual)			Fiscal 2012 (Estimated)			Fiscal 2013 (Recommended)		
	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds
Alabama	7.5	-5.1	-1.7	11.7	15.9	14.6	-2.7	-2.8	-2.8
Alaska	15.2	8.0	10.3	36.8	-1.3	11.6	8.9	8.6	8.7
Arizona	13.8	4.8	6.9	7.9	-23.9	-15.9	4.3	4.9	4.7
Arkansas	19.2	3.8	6.8	40.5	-3.8	5.8	8.5	4.8	5.9
California*	93.0	10.0	34.0	-12.0	3.0	-3.0	14.0	9.0	11.0
Colorado	23.7	10.8	15.8	30.5	-8.7	7.5	8.2	8.1	8.1
Connecticut*	16.0	0.0	16.0	2.9	0.0	2.9	2.2	0.0	2.2
Delaware*	6.3	8.2	7.5	31.5	-7.3	7.4	1.1	7.6	4.6
Florida	17.1	1.5	6.8	27.6	-9.4	4.4	2.5	9.6	6.4
Georgia	8.5	-0.9	1.5	33.1	-13.3	-0.7	1.7	2.9	2.4
Hawaii	41.0	29.0	33.0	43.0	-22.0	0.0	7.0	6.0	6.0
Idaho	-6.4	28.0	34.2	42.4	-14.8	-9.3	21.1	13.3	10.8
Illinois	20.9	7.3	12.7	2.8	-30.7	-16.2	-3.0	5.1	0.8
Indiana	17.3	-1.4	2.5	30.9	-6.7	2.3	8.8	12.5	11.3
Iowa	13.4	2.7	5.8	33.0	-7.3	5.3	3.2	-1.4	0.4
Kansas	12.8	6.8	8.6	40.4	-16.6	0.7	4.8	5.7	5.3
Kentucky	6.2	1.0	2.1	35.3	-7.9	1.2	-2.6	-5.5	-4.7
Louisiana	35.0	-6.5	1.7	17.9	-9.3	-0.3	7.5	12.5	11.0
Maine	11.8	-6.6	-1.4	25.0	1.0	9.2	-26.3	-14.3	-15.4
Maryland	18.8	6.3	11.0	29.6	-10.8	5.6	5.5	6.1	5.8
Massachusetts*	14.6	7.1	10.0	33.0	-19.3	1.9	5.4	3.0	4.3
Michigan	9.8	2.4	4.4	13.1	-4.7	1.1	-1.2	8.1	4.3
Minnesota	8.2	1.8	4.6	28.1	-4.9	9.4	-0.6	-0.5	-0.7
Mississippi	19.7	5.3	7.5	55.0	-7.9	2.8	14.3	10.2	11.3
Missouri	7.6	0.0	3.4	5.0	11.2	8.3	3.6	-1.5	0.8
Montana	18.9	2.7	6.2	29.6	-12.1	-2.0	5.1	3.6	4.1
Nebraska*	0.9	-0.6	-0.2	40.8	-5.0	8.5	4.5	2.8	3.5
Nevada	12.3	3.2	6.3	27.0	0.5	10.0	-10.2	4.8	-1.5
New Hampshire	14.6	2.5	7.5	9.4	-17.8	-5.8	2.6	1.8	2.3
New Jersey	8.6	-0.7	4.1	25.8	-11.2	1.7	-4.3	4.4	0.3
New Mexico	5.2	-4.7	-2.7	36.1	-10.4	-0.5	8.4	2.7	4.4
New York	1.4	4.4	4.0	31.9	-12.9	4.0	4.6	-1.6	-0.4
North Carolina	4.2	-3.6	-1.2	19.4	-13.9	-3.4	-1.1	0.5	-0.1
North Dakota	12.3	0.6	4.0	45.3	-8.7	8.5	11.7	-2.2	3.7
Ohio	9.0	12.3	11.4	23.7	-4.0	6.0	2.8	5.5	4.8
Oklahoma	16.3	2.7	6.1	51.1	1.6	13.0	5.7	5.7	5.7
Oregon	21.6	12.2	14.9	-12.2	-35.1	-28.2	-13.0	-13.0	-13.0
Pennsylvania	8.5	11.7	10.6	25.7	-10.6	2.1	3.2	-5.3	-2.0
Rhode Island	10.7	-1.6	3.4	19.5	-16.8	-1.8	1.6	-0.7	0.6
South Carolina	2.5	0.1	10.0	7.8	-5.5	1.2	-3.3	-4.1	-4.0
South Dakota	3.3	-6.1	-3.6	24.6	4.2	10.1	8.3	-1.8	1.5
Tennessee	14.4	2.6	9.3	49.5	-8.1	-0.7	1.7	-0.6	0.0
Texas	17.6	1.2	6.2	30.7	-3.8	7.8	2.3	5.3	4.1
Utah	17.2	0.3	4.5	23.4	-1.8	5.2	6.9	3.7	4.8
Vermont	12.1	-0.9	2.9	37.1	-9.3	5.2	8.9	1.4	4.5
Virginia	14.5	5.9	9.2	18.7	-18.1	-3.3	6.5	7.0	6.8
Washington	8.6	2.8	5.1	29.4	-12.0	4.4	0.9	0.7	0.7
West Virginia	14.5	5.1	19.1	51.2	-1.4	8.7	5.1	1.7	2.6
Wisconsin	8.1	6.3	6.8	25.7	-14.2	-2.1	-0.7	0.0	-0.3
Wyoming	-1.3	2.0	-3.5	3.7	23.2	-15.2	0.0	0.0	0.0
TERRITORIES									
Puerto Rico	26.4	15.0	23.0	-32.6	71.5	-4.0	10.6	12.0	11.3
Average**	**23.1**	**4.6**	**10.6**	**20.4**	**-8.2**	**1.1**	**3.9**	**3.4**	**3.4**

SOURCE: THE FISCAL SURVEY OF STATES – SPRING 2012. NGA AND NASBO. (P. 56). NOTE: PLEASE REFER TO PAGE 64 OF SOURCE DOCUMENT FOR TECHNICAL NOTES ON CA., CT., DE., MA., AND NE.

the previous chart shows, examining funding levels, not enrollment figures, per se, growth rates are moderating and states are adjusting to the downward shift in temporary federal financing increases, at least in the short-run.

Having stated this, such short-term moderation is likely just that, i.e., short-term. Medicaid spending growth and structural issues are at the top of the list of the six major threats to fiscal sustainability discussed in the new report of the State Budget Crisis Task Force. Following, we take a brief look at those findings.

FINDINGS OF THE STATE BUDGET CRISIS TASK FORCE (SBCTF): The SBCTF was founded over two years ago as a non-partisan, responsible government-oriented effort, co-chaired by former New York Lieutenant Governor Richard Ravitch and former Reserve Board Chair Paul Volcker. Other talented and highly reputable public figures joined the Board of the SBCTF, such as George Schultz and Alice Rivlin. The work was supported by state partners and financed by a cross-section of foundations supportive of best practices in public policy and government. The express motivation for forming the Task Force was their growing concern about persistent structural imbalances in state budgets and the long-term fiscal sustainability of the states, especially after the financial collapse of 2008. Finally, for feasibility reasons, they targeted six states—California, Illinois, New Jersey, New York, Texas and Virginia—for study purposes, but their findings are of import across all states.

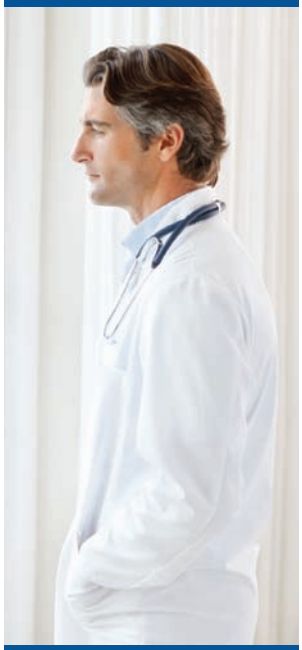
Notwithstanding acknowledged differences across states, including politics, policies, economies, and demographics, the SBCTF identified six major fiscal threats to states:

- Medicaid spending growth is crowding out other needs
- Federal deficit reduction threatens state economies and budgets
- Underfunded retirement promises create risks for future budgets
- Narrow, eroding tax bases and volatile tax revenues undermine state finances
- Local government fiscal stress poses challenges for states
- State budget laws and practices hinder fiscal instability and mask imbalances

We commend interested readers to the full report—our focus is primarily on the health spending issue, which is dominated by the first issue above, namely Medicaid. But it is important to be aware of the following points:

- Federal actions to manage the fiscal cliff, reduce the federal deficit, and reduce spending across many sources of health spending (Medicare, Medicaid, public health programs, etc.) could reduce the flow of funds to states, adversely affecting their budgets.
- Alternatively, the voluntary Medicaid expansion originally mandated to begin in 2014, due to its generous federal funding schedule, could distribute billions of dollars to cover an additional 6 million uninsured individuals. However, despite the exceptionally generous federal financing incentives, expansion is not costless to states, leading now to challenging fiscal and social policy debates in many states.
- Federal actions on individual and corporate taxes can impair state sources of revenues.
- Not all states have income taxes and some states that do have attempted historically to keep the rates low. Many states are challenged regarding sources and levels of revenue, and experience great volatility in revenues as economic conditions change.
- Revenue and social priority issues are creating divisiveness over the Medicaid expansion option, as many states consider the wisdom of embarking on such an expansion absent structural reforms granting greater state control over the design and management of their programs.

With this backdrop, the SBCTF found that Medicaid costs have been growing faster than the economy since the program's inception, and generally faster than state revenue, absorbing steadily growing shares of state's resources. As noted in the Fiscal Survey above, Medicaid is now the second highest share of state dollars, exceeded only by education. Medicaid is the highest share of total spending within states when federal matching payments are counted in.



In the past, Medicare and Medicaid (pre-ACA expansion model) have been considered to be the country's major health entitlement programs. From a legal framework standpoint, Medicare is actually the genuine "entitlement" program. Medicaid, until the ACA was passed, became an "entitlement" (highly caveated) only to the extent a state chose to offer benefits. States have had the option since the program's inception as to whether or not to participate. That essentially voluntary character has been re-affirmed by the Supreme Court, at least so far as the mandatory expansion. It is conceivable that some states will attempt to retreat even from the scope of their base Medicaid programs regarding the offering of optional benefits, or even of coverage to some optional groups, going forward under the existing program. The Governor of the State of Maine has declared that intention, possibly coming into legal conflict with certain "maintenance-of-effort (MOE)" requirements. The federal government is holding firm to the position that states are bound by ACA MOE requirements affecting their existing programs.

This fiscal and political period is a critical juncture for the future of the ACA. The shape of that future depends heavily upon the outcome of the 2012 elections. It also depends on the ultimate willingness of political leaders to create a "governing middle" with participants from both major parties to collaborate on revamping federal fiscal and health care entitlement policies. And, it depends on the economic and political realities on the ground at the state level.

Other Governors are signaling an unwillingness to add to the base Medicaid programs they have in place now. A number of states have indicated to the federal government a commitment to proceed with the optional Medicaid expansion. Some may choose to add some expansions but not the entire amount. Others are potentially willing to, but may hold that decision hostage to demands for changes in the program that would permit them greater control, changes up to and including outright conversion of the program to block grants. It will take some period of time before the full dimensions of Medicaid's future emerge clearly.

STATES' POSTURE CAUTIOUS IN A DYNAMIC FEDERAL FISCAL ENVIRONMENT: This fiscal and political period is a critical juncture for the future of the ACA. The shape of that future depends heavily upon the outcome of the 2012 elections. It also depends on the ultimate willingness of political leaders to create a "governing middle" with participants from both major parties to collaborate on revamping federal fiscal and health care entitlement policies. And, it depends on the economic and political realities on the ground at the state level. As noted, states have a wide range of societal obligations towards their residents unrelated to health care. In their report, the SBCTF noted that the federal government makes grants of federal funds to states for many important purposes (see their chart: *Federal Grants to States (estimated)*.)

Even setting the ACA and Medicaid issues aside, states have a major stake in upcoming federal deficit reduction and tax reform negotiations. Medicaid is by far the largest category of federal grants to states. However, to scale the implications for states of federal spending reductions, according to the SBCTF report:

"Overall, cuts in federal grants, when they come, will have a profound impact. If these

FEDERAL GRANTS TO STATES IN FFY 2012 (ESTIMATED)

	Federal Grants ($ billions)	Share (%)
Grants to state & local governments	**$612.4**	**100%**
Payments for individuals	368.5	60.2
Medicaid & Child Health Insurance Program (CHIP)	265.0	43.3
Public assistance, nutrition & other payments for individuals	103.5	16.9
Grants for education & training	**105.2**	**17.2**
Elementary, secondary & vocational education	85.1	13.9
Other grants for education & training	20.1	3.3
Grant for physical capital investment	**96.4**	**15.7**
Highway capital grants	41.7	6.8
Transit, airports & other transportation capital grants	23.8	3.9
Community & regional development capital grants	11.5	1.9
Housing assistance capital grants	6.3	1.0
Pollution control & other capital grants	13.1	2.1
All other grants to state & local governments	42.2	6.9

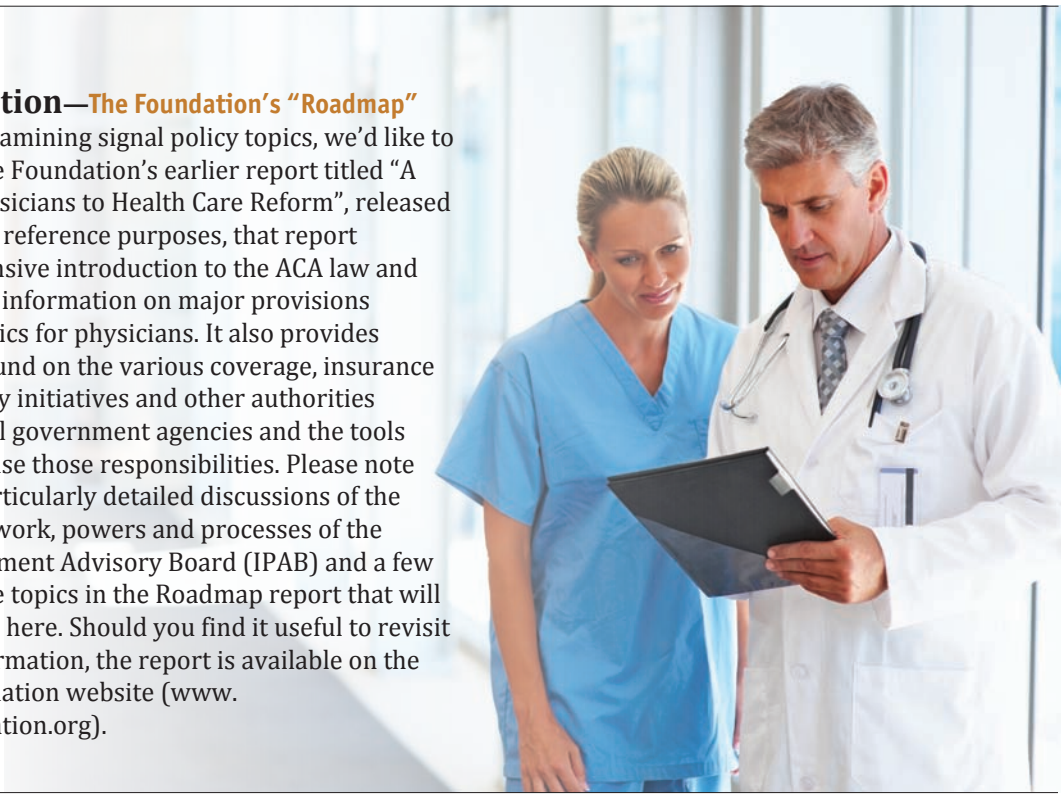
SOURCES: FEDERAL BUDGET FOR FFY 2013, HISTORICAL TABLES 8.1, 8.5, 8.7, 9.6, 11.3, 12.1 AND PUBLIC BUDGET DATABASE OUTLAYS SPREADSHEET.

grants were cut by 10 percent, the loss to state and local government budgets would be more than $60 billion annually. That is nearly twice the size of the combined tax increases that states enacted for 2008 through 2011 in response to their deepest crisis in more than 50 years." (p. 24).

In closing, the nation is far from out of the woods, economically speaking. The funds displayed above are deeply significant to state economies and budgets, funding many types of activities and stimulating employment. Health care services are a major component of local economic activity and the sector is competing with other important sectors and functions.

The stage is set at the federal and state level for major battles to come over resources and priorities. Keeping this in mind, we turn to Chapter III, where we take a look at the the health care system at a macroeconomic level, and a targeted look at unfolding policy directions in select policies of most import to physicians. ■

CHAPTER III: Seismic Rumblings in the Health Care Policy Landscape



Introduction—The Foundation's "Roadmap" Report: Before examining signal policy topics, we'd like to remind you of the Foundation's earlier report titled "A Roadmap for Physicians to Health Care Reform", released in June 2012. For reference purposes, that report provides an extensive introduction to the ACA law and includes detailed information on major provisions including key topics for physicians. It also provides detailed background on the various coverage, insurance regulation, quality initiatives and other authorities granted to federal government agencies and the tools they use to exercise those responsibilities. Please note that there are particularly detailed discussions of the legislative framework, powers and processes of the Independent Payment Advisory Board (IPAB) and a few other high-profile topics in the Roadmap report that will not be duplicated here. Should you find it useful to revisit some of that information, the report is available on the Physicians Foundation website (www.physiciansfoundation.org).

This report assumes most readers will now have some basic familiarity with the law. Therefore, our focus has shifted in this report to honing in on certain signal policies that are rattling the foundation of today's health care environment, and select topics of immediate interest to practicing physicians.

To begin, we'd like to reprise one short section from the Roadmap report that continues to express the goals that the current Administration and other supporters of the ACA have for America's health care system. These are a benchmark for evaluating actions taken to implement the ACA. They also provide a basis for deciding what policies fall short, either in conception or in execution, or both. In addition, with a brief, initial look at advocates' vs. critics' points of view, we recognize that each of the topics we discuss is often seen through very different "filters."

ACA SUPPORTERS: Taking the core imperative of nationwide expansion of coverage as a given, this is what advocates also expect the ACA reforms to accomplish, despite the law's legally and politically beleaguered state.

"As we focus on health delivery system reform, rather than on all the broader aspects of the ACA, two key themes evolve. The first major theme is creation of a medical care and payer environment that fosters "value-based" provision and purchasing of health care services. Physicians' medical practices are at the heart of this effort, but it also includes hospital and other facility-based providers, and other caregivers, including those assisting in care coordination across medical settings. Value-based purchasing of health care services, to policy-makers, marries quality care with cost management and cost reduction."

The second major theme is achieving universal access to high-quality care, as closely as is possible in a country as large and

diverse as the United States. As stated by HHS in its March 2011 Report to Congress on A National Strategy for Health Care Quality, "…our goal is to ensure that all patients receive the right care, at the right time, in the right setting, every time." The unspoken subtext is "at the right price."

The tension in the ACA is between the attempts to:

- **design** successful coverage expansions through public and private sector requirements,
- **promote** delivery system changes to achieve higher quality (workforce improvements, wellness, prevention, and evidence-based services that promote optimal outcomes for patients), and
- **bend** *the cost curve down (reducing unnecessary and inappropriate medical services, improving efficiencies and rewarding cost-effective care).*"

(Source: A Roadmap for Physicians to Health Care Reform. Physicians Foundation. June 2012. (p. 36-37).

These are the objectives federal regulators would likely state they are pursuing every day as they work to meet statutory timetables and regulations issuance requirements necessary to interpret and implement the ACA in its myriad details.

ACA OPPONENTS: For opponents of the law, their prime concern is its sheer scope, public spending levels, and the regulatory and administrative intrusiveness into the private sector components of our health care system. For instance, Dr. Scott Gottlieb, a resident scholar at the American Enterprise Institute, recently wrote in an article (posted July 18, 2012 on www.realclearmarkets.com) that:

"*The progressives running Health and Human Services view "excessive" profits earned by for-profit providers as money that could have been directed instead into patient care. In recent years, "excessive" has typically meant any healthcare services ventures earning a persistent profit margin better than about ten percentage points. This kind of success invites regulation, rate cuts, and sometimes, outright penalties.*

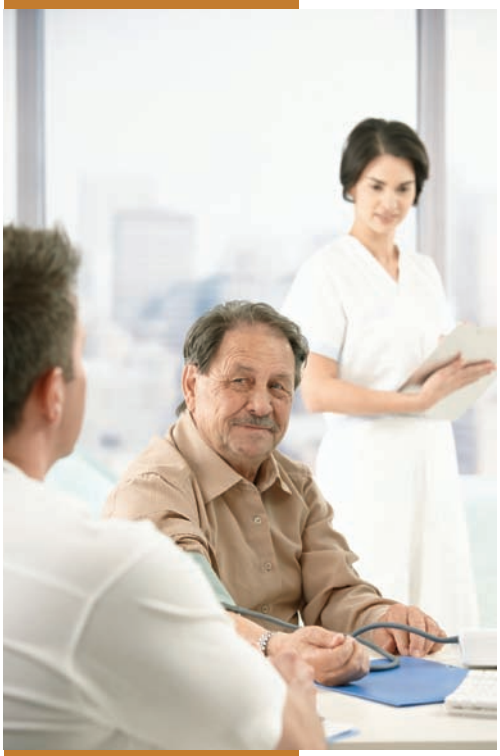
So Obamacare dictates fixed caps on margins earned by health insurers (their medical loss ratios) and arbitrarily cuts the payment rates of broad swaths of providers. The law empowers an insular agency (the Independent Payment Advisory Board) to survey the profitability of industry segments like nursing homes and hospice providers, and sand down payment schedules when any one of these provider groups enjoys profit margins that exceed some arbitrary norm…(excerpt)."

Regardless of your point of view, ACA-channeled funds (in the billions), reform initiatives and regulatory requirements are penetrating every corner of health care. Physicians, regardless of practice model, are confronted daily with ACA-driven elements in payment, medical records, quality measures, data reporting, insurance system changes, and changed relationships with hospitals, colleagues and other health personnel.

Opposition to the law comes from many other quarters, as well. The House-passed budget this year, in conjunction with an ACA repeal vote, would effectively repeal the ACA, convert Medicaid to a block-grant program and convert Medicare to a premium support system. In the interim, recently active House discretionary budget measures would slash funding to the Department of Health and Human Services, especially the Centers for Medicare and Medicaid Services (CMS), and completely de-fund the Agency for Healthcare Research and Quality (AHRQ). So the battle lines are drawn.

ACA FORCES AT WORK IN THE HEALTH CARE SYSTEM: In the meantime, regardless of your point of view, ACA-channeled funds (in the billions), reform initiatives and regulatory requirements are penetrating every corner of health care. Physicians, regardless of practice model, are confronted daily with ACA-driven elements in payment, medical records, quality measures, data reporting, insurance system changes, and changed relationships with hospitals, colleagues and other health personnel.

To add to the complexity, other major players in the system are equally challenged by ACA-driven changes. Employers face significant changes affecting employee benefits. Insur-



ers face new model benefit package, medical-loss ratio, premium rebates, and other requirements. States are grappling with Medicaid maintenance of effort, Medicaid expansion and health insurance exchange options and requirements, and more. Individuals must navigate new realms of insurance coverage options, subsidies, penalties, etc., all of which can vary according to their age, income level, employment status, immigration status, and/or insurance status. In short, nobody in America is completely immune to the changes wrought by the ACA to health care.

In closing, Dr. Scott Gottlieb, as cited above, has referred to this collectively as the "industrialization of medicine." ACA enactment is accelerating systemic change and impacting upon physicians' practice of medicine, regardless of practice model. We turn now to note briefly a few macroeconomic changes at the system level that have the government's attention, and then, examine select discussion topics that physicians should consider as they forecast where they want to be in their own practice arrangements.

Top of the Market

A Brief Scan of Health Care System Forces: A number of broad forces are generally reshaping health care delivery in the United States. They are sufficient to be the basis of a major report in their own right. We confine ourselves to noting just a few that happen to be getting attention at the federal government level as they examine the context in which Medicare operates. For instance, following are selected highlights from the Medicare Payment Advisory Commission (MedPAC). (Source: *Medicare Payment Policy*. Report to the Congress. March 2012. (p. 16-25).

HEALTH SECTOR CONSOLIDATION—There is continuing hospital system consolidation into chains often within local or across regional markets, with similar consolidation drives in other sectors, such as nursing homes, hospice and other specialized care centers. MedPAC notes that the Federal Trade Commission has intervened in several instances over the past several years due to concern over anti-competitive effects.

GROWTH IN FOR-PROFIT DOMINANCE IN MOST SECTORS—A growing dominance of for-profit ownership in most sectors; only the hospital and inpatient rehabilitation facility (hospital-linked) sectors are dominated by not-for-profit ownership (about 75%). MedPAC also cites an increase in private-equity firms moving into the hospital sector as well as studies suggesting private equity is "aggressively investing" in other health care sectors and HIT firms. (The ownership mix for provider sectors is important to policy-makers in part because they observe higher margins in for-profit facilities. This often translates into a concern that such facilities are being overpaid by Medicare or other payers, or that beneficiaries are being underserved relative to payment levels.) The growth in investment in health information technology should be viewed as a positive development.

GENERATIONAL SHIFT IN PHYSICIAN PRACTICE MODELS—There are increasing numbers of physicians exiting (or never entering) solo, private medical practice, and instead being employed by hospitals or entering group models, or configurations encouraged by models such as the rapidly emerging accountable care organizations.

Keeping these in mind, we turn now to a review of the direction unfolding in selected ACA (including Medicare) policies as implementation of the law proceeds.

Select ACA Policies of Import to Physicians

INTRODUCTION: We selected five topics for a closer look at their directional shift. We distinguish those that are of "immediate watch-out" and demonstrated high-interest to physicians, from those that are "transformational" movements in a broader system perspective. Given the sheer

scale of the ACA and its implications, we had no choice but to be selective. This does not mean that other issues aren't equally compelling. Many are, but an exhaustive topical review is outside the scope of this report. This report balances significant legal and fiscal issues shaping the future of health reform with a closer look at fewer individual topics. Note also that the Roadmap report covered virtually all of the physician-centric initiatives contained within the ACA.

Our goal is to help physicians understand directionally where regulators appear to be going by examining recent policy and political actions. For each topic, our format is simply: "What It Is" and "Where It's Going". General implications for medical practice appear in the Executive Summary accompanying this report.

SELECTED DISCUSSION TOPICS: The topics selected for discussion appear in the categories, and as numbered, below. By way of format, for each topic, we describe briefly what the topic is, followed by a status report on the where it's going based on a combination of policy and political perspectives.

I. Immediate "Watch-Out" Topics for Physicians

1. Independent Payment Advisory Board
2. Accountable Care Organizations
3. Medicare Physician Fee Schedule

II. Broader "Transformational" Topics for Physicians

1. Health Insurance Exchanges
2. Health Information Technology and Quality

Discussion Topics: Perspectives on "What It Is" and Where It's Going"

I. Immediate "Watch-Out" Topics for Physicians

1. Independent Payment Advisory Board (IPAB)

What It Is: This provision establishes an Independent Payment Advisory Board (IPAB) to develop and submit detailed proposals to Congress and the President to reduce Medicare spending. The Board is to consist of 15 members with expertise in health care financing, delivery, and organization. All members are to be appointed by the President and confirmed by the Senate. There are ex-officio members of the IPAB, namely, the Secretary of HHS, and the Administrators of CMS and the Health Resources and Services Administration (HRSA). The Chief Actuary of CMS plays a very significant technical role in supplying the cost estimates that the IPAB relies upon in triggering action.

The IPAB proposals are to primarily focus on payments to certain providers, although in later years, the IPAB is authorized to address broader-scope health care cost matters beyond the Medicare program. The law directs the Board to recommend savings for Medicare if the per capita growth in Medicare spending exceeds defined benchmark growth rates.

Certain classes of providers are exempt from mandatory IPAB recommendations due to recognition that they are already subject under the ACA to payment reductions below the level of the automatic annual productivity adjustments called for under the Act. These include inpatient and outpatient hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices until 2020. Clinical laboratories are exempt until 2016.

The sustainable growth rate (SGR) formula creates a complicated and ambiguous set of issues regarding the IPAB's purposes and any recommendations as they relate to physician payments. *It is unclear whether or to what degree the IPAB, which is appointed, not elected, is authorized to adjust physician payments.* The law specifies that the CMS Chief Actuary is to assume a zero-percent increase in the physician services baseline for IPAB spending projection purposes, not the reductions that the SGR is known to require, but which the Congress repeatedly overrides, at a scoreable legislative cost. This means that *for IPAB purposes*, physician spending is set on a no-growth or freeze trajectory that raises serious technical and policy matters.

Where It's Going: Organized medicine's opposition to the implementation of the

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IPAB has both crystallized and intensified. Concerted opposition has been expressed in letters, in testimony before Congressional Committees, and in other advocacy efforts of many of the major physician representation organizations and medical societies. Most recently, on July 11, leaders from the American Medical Association and the American College of Physicians, and several other physician witnesses expressed concerns and opposition regarding the IPAB in testimony before the Senate Finance Committee. These views have also been forcefully delivered in the House of Representatives.

LEGAL ISSUES IN IPAB STRUCTURE—Separately, the ACA provisions outlining the Board's authorities and any limits are complex, and have also become the target of detailed legal analyses and federal lawsuits. Legal issues have been raised about the unprecedented scope of the IPAB legislative charter, and whether it represents an abdication of Congressional and Administration responsibilities and authorities. For instance, a conservative think-tank, the CATO Institute, has released a detailed analysis challenging IPAB on the basis that the law empowers "IPAB's unelected government officials to propose legislation that can become law without Congressional action, meaningful congressional oversight, and without being subject to a presidential veto, administrative review, or judicial review. The Act even attempts to prevent future Congresses from repealing IPAB" (Source: Policy Analysis No. 700. *The Independent Payment Advisory Board, PPACA's Anti-Constitutional and Authoritarian Super-Legislature*. Cohen, Diane and Cannon, Michael F., June 14, 2012).

Supporters would dispute some of the characterizations of the law and its intent, but these arguments have found an audience in some important corners of the Congress, and may contribute to placing the IPAB's legal foundation and programmatic legitimacy under deeper scrutiny. For instance, the House of Representatives has included repeal of the IPAB in multiple bills, including the House-passed bill known as H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, passed in March 2012. In this bill, scored by CBO as reducing deficits by $45.5 billion over the 2013-2022 period, the provision repealing the IPAB was scored as *increasing* deficits by $3.1 billion over the same period.

CBO SCORING TIP OF REPEAL COST—The *current* $3.1 billion repeal price-tag for repeal is consistent with the CBO's more recent score for H.R. 6079 discussed earlier in this report. However, the fiscal cost of repealing the IPAB increases significantly for each year that the law remains on the books. Keep in mind that although that score covered a 10-year budget window, CBO's score was derived from savings occurring only in the 2018-2022 period, meaning that it only scored five out of the ten years due to the way the IPAB is structured to work in the beginning years. That suggests each year the IPAB authority fails to be repealed, the price tag in legislative scoring costs increases significantly, adding to the challenge of repealing the provision. In the meantime, the House has pursued an ACA de-funding strategy in a variety of budgetary venues, leading to some short-term reductions in administrative funds for IPAB functions.

PRESIDENT'S FY 2013 IPAB PROPOSAL—The President's FY2013 budget, as submitted to Congress on February 13, 2012, not only supports the IPAB, it includes a proposal to increase the potential savings associated with the IPAB targets. Beginning in the sixth year of implementation (i.e., the 2018 determination year for *2020* implementation), the proposal would lower the target growth to the growth rate in nominal GDP per capita plus 0.5 percentage point, instead of plus one percentage point. This would likely increase the savings and provider payment impacts. Further, in the short-term, the Supreme Court's general upholding of the constitutionality of the law has strengthened the Administration's position that it would veto bills repealing the ACA (or sections thereof, presumably, that it continues to support).

Finally, the National Commission on Fiscal Responsibility and Reform, known as the Simpson-Bowles Deficit Commission, proposed both to "eliminate the provider carve-outs that exempt certain providers from

any short-term changes in their payments," and suggested "expanding and strengthening the Independent Payment Advisory Board (IPAB) to allow it to make recommendations for cost-sharing and benefit design and to look beyond Medicare." In the interest of budgetary goals, these proposals would greatly expand the scope and role of the IPAB in the health care system. The Commission is disbanded, but it's proposals are being re-worked for consideration in the upcoming budget discussions over the BCA sequester and the fiscal cliff.

As with so many especially sensitive areas in the ACA, there are diametrically opposed views among policymakers and across the political spectrum. Therefore, as of this writing, the IPAB's fate is uncertain, but may be clarified post-election.

2. Accountable Care Organizations (ACOs)

What It Is: The ACO model embodies many of the themes of the ACA linking payment, quality and accountability, and that most directly begin to influence the models of physician practice. At its simplest, an ACO is a voluntary organization of health care providers who agree to be accountable for the quality and overall cost of care of those individuals that receive the bulk of their medical services from providers in the ACO.

However, there is nothing simple about the actual business model of an ACO, with its myriad regulatory, contractual, legal, patient enrollment, quality reporting, payment model and financial requirements. At present, there are a number of private arrangements and organizations that would fit within this general definition. In this report, we are focused solely on the ACO program defined in the ACA as part of the Medicare program.

The Medicare ACO program is being administered primarily by the Centers for Medicare and Medicaid Services (CMS), with narrower, but critical elements administered by other federal entities in cooperation with CMS. After receiving hundreds of comments on a proposed rule governing Medicare ACO structural and operational requirements, released on March 31, 2011, CMS posted its final rule on October 20, 2011. That rule currently governs the requirements and opportunities for ACOs to participate in the Medicare Shared Savings Program (MSSP). Since there are additional legal and operational elements to participating in an ACO under the law, other agencies issued companion rules and guidance for their areas of federal jurisdiction, as follows:

- CMS and the HHS Office of the Inspector General (waivers under anti-fraud statutes),
- Department of Justice and the Federal Trade Commission (a joint anti-trust policy statement), and
- Internal Revenue Service (fact sheet regarding the treatment of tax-exempt organizations participating in the MSSP).

Officially, CMS defined an ACO as a legal entity that is recognized and authorized under applicable state, federal, and tribal law and is composed of certified Medicare providers or suppliers. As noted by the Commonwealth Fund, in the final rule, CMS was fairly expansive in defining potentially eligible providers beyond the four categories specified in the law:

> "CMS expands the list of providers eligible to apply for the program beyond the four specified in the Affordable Care Act: 1) professionals (i.e., physicians and other clinicians) in group practice arrangements; 2) networks of individual practices; 3) joint venture arrangements between hospitals and professionals; and 4) hospitals employing professionals. In addition to these four, eligibility will be open to a subset of critical access hospitals (CAHs), rural health clinics (RHCs) and federally qualified health clinics (FQHCs).
>
> The eligibility of CAHs is limited to those that are paid by Medicare in a manner that supports the collection of cost and utilization data needed to assign patients to providers. It should also be noted that while other providers (such as home health agencies, hospice

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facilities, and dialysis centers) cannot independently participate in the ACO program, any provider can participate in the program by partnering with eligible providers. For example, a home health agency can partner with a network of individual practices. This will allow for participation from a broad range of provider configurations."

(Source: Commonwealth Fund. *The Final Rule for the Medicare Shared Savings Program*. December 2, 2011. Available at www.CWF.org).

For many physicians, the most important initial consideration regarding joining an ACO may be whether to sacrifice a significant degree of practice autonomy in order to participate in a much more group-oriented, highly structured practice model.

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Physicians, however, are central to the success of *every* ACO that is formed. There are important considerations, though. Physicians entering, or considering organizing into ACOs, must undertake a careful review of the legal, financial and medical practice risks of doing so, and with a full understanding of the regulations and sub-regulatory guidance coming out of the government on an ongoing basis.

CMS has created a framework for physicians to actively participate in new infrastructure and care delivery processes. Theoretically, the framework aligns caregiver and payer incentives to improve the quality of patient care, while reducing inefficiencies and costs. The caution for each potential participant is that there are important conditions of entry around governance and business operations, and for participation in and management of technology, care delivery, quality reporting and costs.

For many physicians, the most important initial consideration regarding joining an ACO may be whether to sacrifice a significant degree of practice autonomy in order to participate in a much more group-oriented, highly structured practice model. Although there are different opportunities for practice control and financial rewards, there are sacrifices and risks associated with entering such a model. It is also worth noting that there is little evidence yet as to how successful ACOs will be or even what elements of such organizations will most effectively contribute to success. Despite notable organizations such as the Mayo Clinic, the Kaiser Permanente Medical Group and other similarly successful group models around the U.S., the ACO model presents for many a challenging and potentially empowering alternative that has not previously existed in quite the forms now envisioned under the new law and regulations.

A detailed summary of the final rule is beyond the scope of this report. However, if you refer to our Bibliography under the Accountable Care Organizations heading, we have provided a curated set of links to several excellent documents (including the above) from highly reputable sources.

Where It's Going: In the final ACO rule, CMS created much greater flexibility in arrangements to incentivize participation. These included more flexible ways in which to participate in the Medicare Shared Savings Program, longer agreement periods, extended application and start dates, and more flexible governance requirements. CMS also made welcome adjustments to the financial model options to permit advance financing in some instances, more flexibility in timing of repayments for losses, and other incentives to participate. Most importantly, CMS has created an advanced payment model for qualified institutions that allows for multiple payment choices:

- Advance, fixed payments for services,
- Advance, variable payments based on historically assigned beneficiaries for each service performed, or
- Monthly payments that vary based on historically assigned beneficiaries.

FINANCING MODEL FLEXIBILITY—There is also increased flexibility in repayment of losses to be carried out through the contractual agreement between CMS and the ACO. Many were surprised and pleased that CMS conceived of a process in the final rule to help provide access to capital needed to invest in the infrastructure required in the ACO, a need of rural and smaller ACO aspirants. It might be of historical interest to know there is

precedent for a regulatory, advance financing mechanism in the Medicare program. Early in the program's history, shortly after enactment, there was widespread concern that hospitals would not be willing to participate in the new program unless additional funding was provided to offset early costs. This became known as the "current financing" mechanism for inpatient hospital services. Once hospital participation was widespread nationwide, the current financing policy was rescinded in 1973 through regulatory directive. There is no way to predict at this early stage, what CMS's expectations are for the future continuation of advance payment models in the ACO context.

QUALITY METRICS—From a medical care standpoint, CMS established important quality metrics for patients considered to be part of At-Risk Populations. These are organized around four quality domains and involve complex, ongoing assessments of 33 quality measures focusing on high-cost areas in the Medicare program. These data are collected via multiple sources; some relate to quality-only, others interact with resource use and cost algorithms. Selected measures are derived from the Electronic Health Record (EHR) Incentive Program data, and others from the Group Practice Reporting Program (GPRO) Web interface. The latter is currently used in the Physician Quality Reporting System. These are key examples of the growing penetration of technology into medical care providing for the capture of data, the organization of data into standardized datasets, and the means by which data can be shared within the organization and externally with payers to serve a variety of important purposes. One of the purposes is an express linkage to payment. In the final rule, CMS emphasizes the critical importance of an ACO both accurately capturing these data, and for reporting them timely under schedules established by CMS.

ACO AS VALUE-BASED PURCHASING MODEL—We point out these key elements to underscore the drive embodied in the ACO model towards accountability in medicine, and from the payer perspective, value-based purchasing. CMS has taken many steps over the last several years in the Medicare program, many pre-dating the ACA, to introduce the building blocks necessary to achieve such goals. The ACO model is the most highly specified launch to date of a value-based purchasing model in the Medicare program. As with the introduction of DRGs in the hospital sector, and of the RB-

RVS model in the physician sector, Medicare's market power behind the ACO model is likely to drive the future direction of the health care system in a significant way.

In closing, as of July 9, 2012, CMS has announced the approval of 153 participating ACO organizations across the available models, estimated to be serving 2.4 million Medicare beneficiaries. The full, and growing, list of organizations is available on the CMS website (www.cms.gov) under the Center for Medicare and Medicaid Innovation. CMS has now established an annual cycle for ACO applications. On August 1, 2012, CMS will begin accepting applications for the next round of Advance Payment Model ACOs that would begin on January 1, 2013.

In our view, the likelihood of an important change to the Medicare Physician Fee Schedule is intensifying.

3. Medicare Physician Fee Schedule

What It Is: All practicing physicians are likely to have some working familiarity and level of frustration with the Medicare physician fee schedule (MPFS). The ACA made numerous technical adjustments to the long-standing resource-based, relative value scale (RB-RVS) fee schedule that were covered extensively in the Roadmap report cited earlier. Aside from this focus, please refer to the Appendix in this report for a summary of new CMS proposals for 2013 for value-based payments.

Our goal in this section is to look forward regarding the continuing challenges regarding

the MPFS that are likely to lead to further near-term legislation, if not outright reform. The most material target for legislation in recent years by the Congress has been the update process known as the sustainable growth rate formula, or SGR. In our view, the likelihood of an important change to the MFPS is intensifying.

Simply to frame the current configuration of the MPFS, a little history is in order. Following is a brief historical introduction prepared by the Congressional Research Service (CRS) for the Congress.

> Medicare payments for Part B services provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare. From the inception of the program until 1992 and the introduction of the resource-based relative value scale (RB-RVS) fee schedule, Medicare paid physicians based on "usual, customary, and reasonable" charges. The Omnibus Budget Reconciliation Act (OBRA 89, P.L. 101-239) created the RB-RVS-based Medicare fee schedule, which went into effect January 1, 1992. Under the RB-RVS fee schedule, the Center for Medicare & Medicaid Services (CMS) assigns relative value units (RVUs) that reflect physician work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The adjusted relative values are then multiplied by a conversion factor to derive the actual payment amount in dollars. Medicare pays providers the lesser of the actual charge for the service or the allowed amount under the fee schedule.
>
> Expenditure targets have been a factor in the calculation of Medicare physician payment updates since the current fee schedule was first implemented in 1992. In the first year, one overall conversion factor was used to calculate the update. Then, two (surgical and non-surgical services) and eventually three conversion factors were used for different categories of services (surgical, primary care, and other nonsurgical services). However, under the Medicare Volume Performance Standard (MVPS) method, targets were set (and typically exceeded) each year; there was no cumulative goal and no significant consequence to exceeding the expenditure target. The current SGR method for calculating annual updates was created partly in response to the shortcomings of the prior method.
>
> The Balanced Budget Act of 1997 (BBA97, P.L. 105-33) replaced the MVPS with the SGR, with the objective of creating a sustainable growth path for Part B expenditures. First, BBA97 added cumulative spending criteria that resulted in actual consequences for failing to meet expenditure targets; beginning with April 1, 1996, as the starting point, actual program expenditures are compared to growth targets to determine annual updates. Second, BBA 97 introduced the rate of growth in the per capita amount of the gross domestic product (GDP) into the SGR calculation and also provided for the use of a single conversion factor instead of three. By tying the expenditure targets to the growth in GDP per capita, this system attempted to hold Medicare physician expenditures to a level that would not consume an ever-increasing share of national income.
>
> The SGR system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. While the fee schedule limits the amount that Medicare will pay for each service, there are no limits on the volume or mix of services. The SGR system was intended to serve as a restraint on aggregate spending. While the SGR targets are not limits on expenditures, they represent a "sustainable" trajectory for cumulative spending on Medicare physician services from April 1996 forward. The annual fee schedule update thus reflects the success or failure in meeting the goal. If expenditures over a period are less than the cumulative spending target for the period, the update is increased. However, if spending exceeds the cumulative spending target over a certain period, the update for a future year is reduced, with the goal to bring spending

back in line with the target. Since the conversion factor applies to all services, the update to the conversion factor is the key component for determining how reimbursements change from year to year."

(Source: *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*. R40907. Congressional Research Service. February 17, 2012.)

The painful recent history of the SGR system is that it has resulted in technical calculations over the last several years that, if not annually over-ridden by the Congress, would have resulted in billions of dollars in cumulative, actual cuts in payments to physicians. Arguably, this is not what was originally intended under the concept of a "sustainable trajectory". This costly process has led to intense review of the fee schedule structure and possible models for reform.

Where It's Going: In the short-term, CMS, as usual, has published its annual notice of proposed rulemaking on the physician fee schedule, covering numerous regulatory matters. The NPRM was published on July 30, 2012 for actions to take effect on January 1, 2013. Comments are due by September 4, 2012.

The NPRM would impose a 27% across-the-board cut in MPFS payments. The resulting conversion factor in 2013 would be $24.7124, as compared to today's conversion factor of $34.0376. Although outside the scope of this report, we note that this rule is quite expansive and covers many areas of interest, for instance:

- Primary care payment boost for coordination of services in select circumstance,
- Expanded application of the multiple procedure payment reduction policy,
- Continued implementation of the value-based payment modifier, mandated by the ACA, including the payment methodology and phase-in plans, and
- Numerous other policies of importance.

Under the MPFS, physicians are forced once again into significant advocacy efforts to obtain a legislatively expensive, one-year postponement of the application of a flawed update system. This is an ever-more challenging effort in this economic and fiscal environment, and diverts advocacy resources from other priorities. To understand this fully, we briefly review how CBO scores the fiscal costs associated with options to adjust the SGR-driven formula.

LATEST CBO ESTIMATES OF SGR ADJUSTMENTS: CBO recently scored the budgetary impact of alternative policies relative to CBO's March 2012 current law spending baseline. All references in this section, unless otherwise indicated, are cited from this document.

(Source: *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies relative to CBO's March 2012 Baseline*. CBO. July 2012.)

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CBO scored three categories of adjusting the SGR update trajectory over a 5-year budget window (2013-2017) used by the House of Representatives, and a 10-year budget window (2013-2022) used by the Senate. These costs are calculated relative to simply allowing the current formula to effectuate major reductions in payment. The categories are:

1 ➤ "CLIFF" POLICIES: This assumes a temporary override of the otherwise scheduled reduction and when the override period has elapsed, reversion to the formula in the following year as if the override had never occurred. That causes a significant payment reduction or "cliff" in the following year. The size of the reduction would range from about 22–26% under CBO's estimates, and of course the SGR is not fixed.

To scale this, a 0% update in 2013 is estimated to cost $18.5 billion over 10 years.

2 ➤ "CLAWBACK" POLICIES: The "clawback" approach means that the "legislation would specify that the override of reductions to payment rates is not considered a change

in law or regulations for the purpose of the SGR." (p. 2)

Practically, this means that the additional spending would be recouped under the formula in later years, meaning the ongoing expenditure targets are larger than they otherwise would have been under current law. This is more expensive in the budget window than cliff options, but less costly over time because the larger expenditure targets are assumed to operate in the out-years.

To scale this, a 0% update in 2013 is estimated to cost $93.7 billion.

3 ➤ POLICIES THAT REPLACE OR RESTRUCTURE THE SGR: These are more complex options. For example, a straight 0% update through the year 2022 simply replaces the SGR for that period and is estimated to cost $271 billion over 10 years.

Another illustrative option would "reset the SGR". For instance, forgiving all the spending above the cumulative targets and resetting the targets and spending to zero as of 2011 would set 2012 as the new base year going forward.

To scale this, allowing the SGR formula to carry on off of the new base is estimated to cost $254.2 billion over 10 years (CBO indicates payment updates would start going negative in 2016). Alternatively, specifying an annual update by GDP + 1% in the target is estimated to cost $314 billion over 10 years.

Separately from CBO, the Administration's estimates of an *unspecified fix*, as contained in the FY 2013 budget submission to Congress, are higher at $429 billion.

CBO's latest SGR scoring options show that, literally, everything is on the table—no clearly compelling solution has yet appeared. With these options and costs in mind, we provide further perspectives on this challenge.

POLICY PERSPECTIVES: MedPAC continues to be a primary source to the Congress for analytical and policy perspectives on the Medicare program, and has made detailed proposals about how to address the MPFS design problems. A little history about that is in order, provided by an excerpt from the CRS report cited above.

According to CRS:

"The Deficit Reduction Act of 2005 (DRA) required MedPAC to submit a report to Congress on mechanisms that could be used to replace the SGR system, including "such recommendations on alternative mechanisms to replace the sustainable growth rate system as the Medicare Payment Advisory Commission determines appropriate." In its March 2007 report, MedPAC described two possible paths: one path would eliminate the SGR and emphasize the development and adoption of approaches for improving incentives for physicians and other providers to furnish lower cost and higher quality care, while the second path would add a new system of expenditure targets in addition to these approaches. Earlier reports to Congress from MedPAC have included recommendations for updating payments for physicians' services based on the estimated change in input prices for the coming year less an adjustment for savings attributable to increased productivity. Specifically, input prices would be measured using the MEI (without regard to the CMS adjustment for productivity increases). The recommended productivity adjustment would be used across all provider services.

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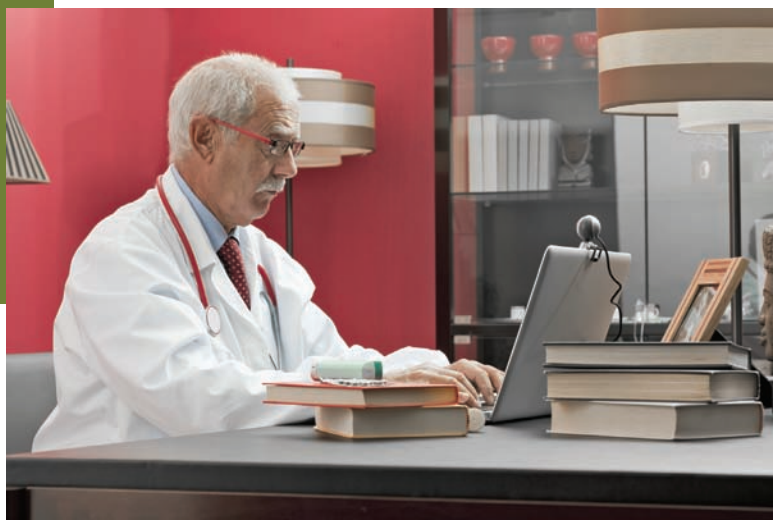

Most recently, on October 14, 2011, MedPAC sent to Congress its specific recommendations for addressing the SGR and Medicare physician payments. Among the objectives of its proposal was to replace uncertain payment updates under the SGR system with "a stable, predictable 10-year path of legislated fee-schedule updates," and to eliminate the almost 30% reduction beginning January 1, 2012, that would occur under current law. The recommendation acknowledges the criticisms of the SGR system as well as the concern that beneficiary access to providers willing to accept Medicare patients may be affected in coming years should the uncertainty about fee schedule reimbursements continue. Further, MedPAC is concerned about reducing the discrepancy in payment between primary care services (mostly cognitive, evaluation, and management activities) and specialty care and procedure-oriented services.

Specifically, MedPAC's recommendations to Congress are to (1) freeze the Medicare physician fee schedule reimbursement rates for primary care services for 10 years; (2) reduce non-primary care fee schedule reimbursements by 5.9% each year for three years, then freeze the rates at that level for 7 additional years; and (3) offset over $200 billion of the cost of the override through a combination of other modifications to the Medicare program."

CRS further observes:

"If the SGR system is abandoned, a key question becomes what is the best payment system to replace it that would lead to improvements in quality, efficiency, and care coordination, particularly for chronic conditions. As noted above, MedPAC recommended exploring the feasibility of Medicare Accountable Care Organizations (ACO) and bundling of payments. The ACA included a number of demonstrations and other efforts aimed at alternative payment models that have the potential to change fundamental aspects of how physicians organize, practice, and deliver care in the future. Some of these provisions create new structures and entities, like the CMS Center for Medicare and Medicaid Innovation or the Patient-Centered Outcomes Research Institute (PCORI), while others seek to develop alternatives to traditional fee-for-service payment, such as the National Pilot Program on Payment Bundling, the Medicare shared savings program (including the ACO, model), or the value-based payment modifier under the physician fee schedule.

Federal officials' views on systemic problems in Medicare are material to legislative and regulatory strategies not just in Medicare, but are sub-themes for on-going debates around certain, future ACA and Medicaid legislative objectives. There is a track record of adoption of such stated "on the ground" Medicare program objectives by the Congress, despite partisan differences on other matters.

The PCORI, combined with the efforts and experiences with the alternative payment models, could generate new information about how alternative treatments affect patient outcomes as well as evidence to support how different payment methods might alter the incentives for providers and the outcomes for patients. The Innovation Center would have the authority and flexibility to adopt new payment alternatives, so long as certain criteria were met—for instance, maintaining quality while reducing expenditures, or improving quality without increasing expenditures. In the long run, these various provisions have the potential to modify behavior and payments for physicians and related providers." (Ibid. p. 14-15.)

Federal officials' views on systemic problems in Medicare are material to legislative and regulatory strategies not just in Medicare, but are sub-themes for on-going debates around certain, future ACA and Medicaid legislative objectives. There is a track record of adoption of such stated "on the ground" Medi-

The emerging, value-based purchasing models of care neither "feed the bulldog" now on necessary MPFS reforms, nor might they for some years to come.

care program objectives by the Congress, despite partisan differences on other matters. Further, there is often cross-pollination across Medicare, Medicaid and private health insurers leading to wider adaptations of certain concepts, because as major payers they share the underlying concerns. For that reason, we'd like to draw physicians' attention to what federal officials are saying *now* about the Medicare program, and in particular, physician payment reform.

MEDICARE PHYSICIAN FEE SCHEDULE—THE CANARY IN THE MINE: In brief, MedPAC has indicated to the Congress (March 2012 report previously cited) that the following areas continue to be of material concern.

- There has been a noted failure to bend the cost curve in total health expenditures, across every population and every service category,
- There continues to be a mal-distribution in payments across practice areas, and, therefore,
- MedPAC argues for more effective strategies to achieve the following system goals:
  - Directly linking payments to patient characteristics and quality outcomes,
  - Penalizing inappropriate, avoidable and excessive hospital readmissions,
  - Replacement of the physician sustainable growth rate (SGR) updates with specified updates,
  - Granting primary care services "favored service" treatment, and
  - Adoption of "constant value" payment methods for the same service regardless of site of service, referred to as "site neutrality".

In closing, when it comes to Medicare payment policies, the Congress seeks great specificity for inclusion in the law. The emerging, value-based purchasing models of care neither "feed the bulldog" now on necessary MPFS reforms, nor might they for some years to come. They have merit in their own right and will make a difference in care and payment models over time. But they do not solve either physicians' or the Congress's immediate problems with the legal and fiscal imperatives of current law governing the MPFS.

Arguably, any realistic solution is likely to depart from current payment levels as the starting point. The imperative is to arrive at a solution that takes the system forward in a fiscally responsible fashion over the next decade, while other models such as bundled payments and ACOs have an opportunity develop and diffuse through the health care system. Any interim or longer-term SGR solution must be equitable to practicing physicians and bring to the MPFS much-needed stability, with a minimum of social engineering. There is sharpening focus on federal deficits and significant Congressional acceptance of MedPAC's system goals. The risk we see is that some variation of MedPAC's fee schedule proposal, flawed as it is, could be adopted in a large budget deal with some variations primarily because of the trusted source, and due to the specificity it provides at a time when specificity is sorely needed.

II. Broader "Seismic Force" Topics for Physicians to Consider

1. Health Insurance Exchanges

What It Is: The ACA authorizes and supports states' creation by 2014 of health insurance exchanges. Exchanges are not insurers, but a regulated, virtual marketplace that will provide qualified individuals and small businesses with access to private health insurance plans that meet a set of minimum benefit standards.

Why do we think Health Insurance Exchanges embody a transformational moment in American health care? We do so because of all the fundamental changes in the delivery and regulation of private health insurance in this country that is embodied in the concept. The Health Exchange concept embodies major realignments via: 1) the regulatory platform governing health insurance companies and products, 2) the relationship between states and the federal government regarding their roles in the insurance market, 3) the creation of a minimum federal floor in requirements for insurers, 4) the creation of four standardized benefit packages with actuarial value

requirements, and 5) the availability of subsidies to millions of individuals to improve affordability of coverage through the exchange. Earlier we alluded to the scaffolding supporting the coverage expansion goals of the ACA; this is the other leg, with the first one being the mandatory expansion of Medicaid coverage in 2014, now voluntary under the Supreme Court ruling.

It is first important to convey some idea of the complexity underlying the basic concept of an insurance exchange. Under the McCarran-Ferguson Act of 1945, states have the power to regulate the "business of insurance", and all states do so. In exercising that power, states license insurers and as a condition of licensure to do business in a state, insurers must meet requirements regarding matters of solvency, marketing, market conduct, benefits, and other standards. The federal government, until the ACA, has had only a tangential presence in impacting upon the private health insurance market. As a consequence of state primacy in insurance regulation, coupled with wide differences across states in the scope and manner of regulation, consumers in different states have experienced very different effects regarding such matters as premium structures across group and individual markets, and in the minimum scope of benefit packages.

That has changed in at least two crucial ways. First, the ACA establishes an array of new federal requirements that apply to private health insurance, effectively creating a floor of requirements that all plans offered in the U.S. to individuals or groups must meet (with some variations in defined circumstances). These address benefits, premiums, cost-sharing limits, and consumer protections.

Second, the exchanges created under the ACA create a federal framework within which states must operate (albeit with great latitude), and only if they choose to do so, to administer a complex new marketplace. The exchange function is, along with the now voluntary Medicaid expansion, the central means by which the ACA would achieve its objectives for increasing access to coverage for millions of Americans, and assisting in affordability through the administration of federal subsidies. Along with requirements for health plans, a key function of an exchange is to determine eligibility of individuals for advance premium credits to offset the cost of coverage. These are income-based subsidies that are payable in advance on a monthly basis directly to insurers. If an individual is eligible for Medicare, Medicaid, and or have an offer of employer coverage, they are not eligible for this assistance.

As noted in the Roadmap report, initially, exchanges would apply to the individual and small group markets, with large groups potentially permitted to enter in later years. There are many complex administrative issues for States with respect to the decision to offer or govern an exchange, and many matters and choices available concerning the internal operations of any exchange, once launched. There are also implications for Medicaid interactions and operations. In most, if not all, states, this area requires new authorizing legislation in the state and operational changes within state government.

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Within the federal framework, there is room for significant differences in insurance regulation and exchange operation across states. There is also authorization under the ACA for States to collaborate across state lines by establishing regional exchanges. Finally, state creation of an exchange is voluntary. The federal government is authorized to directly operate exchanges in states that do not establish a state exchange. We'll come back to this issue of the federal "default" exchange.

Exchanges are scheduled under the ACA to go into effect on January 1, 2014.

Where It's Going: There have been several signal events this spring with regard to progress on states' development of exchanges.

First, final federal rules for exchanges were promulgated on March 27, 2012 (77 Fed. Reg. 8310). The rules address 1) the minimum standards states must meet in order to establish and administer exchanges, 2)

Qualified Health Plan standards insurers must meet, and 3) Small Business Health Options Program (SHOP) Exchange standards for employer participation. The rules governing the functions of the exchanges are extensive, primarily because the functions are numerous and there are complex interactions across many areas, particularly relating to eligibility determinations, consumer assistance tools, rules for Navigators, and other functions.

In general, states may establish exchanges as governmental agencies (e.g., the state insurance agency) or non-profit organizations. The deadline for the Secretary of HHS's determination that a state's exchange will be operational by January 1, 2014, is January 1, 2013. States must submit an "Exchange Blueprint" to HHS to gain approval, and HHS will notify states of their decision, whether conditional or final. While the rule establishes procedures for potential modification of the Exchange Blueprint, if a state fails to submit a blueprint, or if the Secretary disapproves it, HHS will establish an exchange in the state.

The lack of widespread, concrete progress at the state level on two signature features of the ACA, state health insurance exchanges, and the expansion of Medicaid, draws in sharp relief the challenges and weaknesses of the organizational structure of the ACA. It raises deep concerns at the federal level over the scope of federal activity, resources and effort that will be required to carry out the law as effectively as possible.

Second, in addition to releasing the final rule, CMS released the Exchange Blueprint document for states. Third, on May 16, CMS released the General Guidance on Federally-facilitated Exchanges or FFE's. Both documents are available on the CMS website at www.cms.gov under the Insurance Oversight tab. The FFE guidance discusses four guiding principles for FFEs, with focus on a flexible regulatory model that to the extent possible, preserves the traditional responsibilities of state insurance departments. It anticipates entering into partnerships with states even under a federally-administered exchange, by offering State Partners primary responsibility for certain functions, such as plan management or consumer assistance. However, HHS makes it clear, by law, that under an FFE model, the federal government retains authority over the operation of the exchange. Notably, HHS said it must allow consumers to receive eligibility determinations for multiple programs using a single, streamlined application. HHS is creating a model electronic application for use in all FFE operations, but which could be used potentially by all states.

Another signal development, of course, is the Supreme Court's verdict on the ACA and its political aftermath. As noted earlier, 26 states, all led by Republican Governors, were parties to the lawsuits challenging the constitutionality of the ACA. Subsequent to the verdict, several Governors indicated they were not going to proceed with the voluntary Medicaid expansion. Several have also indicated they have no intention of operating state exchanges. Among the leadership of several states, there is an avowed effort to pursue multiple strategies for undermining or weakening the coverage goals of the ACA, based on idealogical and/or state cost objections. The Republican Governor's Association has written to the Secretary of HHS raising many issues and questions about exchanges and related matters and the Secretary has been in subsequent correspondence over those issues.

In the face of this opposition, HHS has pursued an aggressive grants program to states to encourage them to develop state exchanges by helping to defray the considerable start-up costs. HHS announced on June 29 additional resources to help states establish a state exchange, a state partnership exchange, or to prepare state systems for a federally facilitated exchange. There will be 10 additional opportunities to apply for funding to be carried out through cooperative agreements. The HHS release stated that as of June 29, over $850 million in Exchange Establishment cooperative agreement funds had been awarded to 34 states and the District of Columbia. Despite this effort, the Commonwealth Fund reported in a July issue brief that as of May 2012, only 13 states,

together with the District of Columbia, had taken legal action to establish exchanges, through legislation or executive order.

In closing, the lack of widespread, concrete progress at the state level on two signature features of the ACA, state health insurance exchanges, and the expansion of Medicaid, draws in sharp relief the challenges and weaknesses of the organizational structure of the ACA. It raises deep concerns at the federal level over the scope of federal activity, resources and effort that will be required to carry out the law as effectively as possible. It is a situation that bears continuing attention as the major implementation date of January 1, 2014 draws nearer.

2. Health Information Technology (HIT) and Quality

What It Is: Health information technology (HIT) is a broad term that encompasses an array of system-oriented technologies harnessed to supporting coordinated, accountable and patient-centered models of patient care. While most physicians are actively engaging in HIT activities to varying degrees, it is helpful to step back briefly to review the federal and state impetus in this arena in the last three years. In the "Where It's Going" section below, we look at a particularly timely, broad assessment of these major investments and initiatives.

In general, technology investments in HIT are critical and have been growing rapidly for many important purposes in health care. For instance:

- Separate and linked health information technologies (HIT) are needed to support diagnostic and treatment algorithms, care coordination within and across health care sites (also, including laboratories and other adjunct services), electronic health records, and quality measures and assessment.
- For payers, HIT also refers to insurance benefit identification, and the coding of and billing for services. New uses are being developed and adopted by private and public payers by which to evaluate health care services in order to profile and provide feedback to hospitals and physicians to both improve care overall, and to provide patients and other consumers with comparative information about providers' performance.
- A complex set of HIT support technologies are being developed by states and the federal government investing in health insurance exchange support requirements.
- HIT also includes data collection, reporting and organization in databases and datasets to meet health services research needs

At the federal level, numerous pieces of legislation over the past decade have introduced programmatic changes and fiscal support for HIT, often through episodic provisions scattered through Medicare, Medicaid, and public health legislation. Notable recent legislation includes:

- The Health Information Technology for Economic and Clinical Health Act of 2009 (aka HITECH), which authorized up to $30 billion in funds to support investment by the private health care sector in expanded use of HIT.
- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which added annual state reporting of quality information about Medicaid and CHIP populations to HHS, development of core and comprehensive sets of quality measures, data publication, and a permanent pediatric quality measures program.
- The ACA, enacted in 2010, which built on many existing initiatives, but which added funding for major commitments to quality measurement and evaluation, provider performance assessment, feedback and profiling, new patient care models such as ACOs and medical homes, "baking" these concepts into the Medicare and Medicaid programs in various ways. The ACA also created the Center for Medicare and Medicaid Innovation, tools for alignment in payment incentives across public and private payers, and reporting requirements for private insurers on several quality improvement, health and wellness promotion, and value-based purchasing fronts. The law included

Separate and linked health information technologies (HIT) are needed to support diagnostic and treatment algorithms, care coordination within and across health care sites (also, including laboratories and other adjunct services), electronic health records, and quality measures and assessment.

financing for HIT and administrative efficiency initiatives, and promotion and implementation of a national strategy to improve the delivery of health services, patient health outcomes and population health. Finally, there were major new commitments to comparative effectiveness research through the creation of the Patient-Centered Outcomes Research Institute (PCORI), and to public reporting for hospitals, physicians, ambulatory surgical centers, nursing homes, long-term care facilities.

Regarding HIT, the first, direct challenge for physicians is how to choose and invest in the right education, training and technology to meet practice needs in light of these proliferating information demands. The second, broader challenge for physicians is how best to participate, and even lead, in the development of these technologies and applications to the daily practice of medicine in the office and at the community level.

This synopsis merely provides a snapshot of the transformations now underway in health care, that are fundamentally rooted in HIT support mechanisms. Physicians are participating in all these systemic changes in direct and indirect ways. Regarding HIT, the first, direct challenge for physicians is how to choose and invest in the right education, training and technology to meet practice needs in light of these proliferating information demands. The second, broader challenge for physicians is how best to participate, and even lead, in the development of these technologies and applications to the daily practice of medicine in the office and at the community level. This is an area in which national and state medical societies and associations are showing genuine leadership in creating mechanisms for systematic physician engagement with quality organizations and major payers, including Medicare, and with organizations directly responsible for HIT support systems.

Finally, authorized by HITECH, an Office of the National Coordinator for Health Information Technology (ONC) was established within the federal Department of Health and Human Services. One of the fundamental responsibilities of that office is to help establish the policies and standards that will facilitate nationwide the timely, secure and private exchange of health information.

In effect, to achieve the goals of quality measurement and improvement, and alignment with payment reforms, it is necessary that information follow patients timely wherever and from whomever they seek care, especially as they move across providers and settings. As noted in a recent article in Health Affairs, "timely sharing of key information when patients transition from one provider and setting to another can prevent readmissions, improve diagnoses, reduce duplicate testing, and can reduce medication errors. Transitions are a frequent occurrence—more than 40% of all outpatient visits involve a transition between different medical groups—and are especially common and risky for patients with complex and chronic conditions." (Source: Health Affairs. From the Office of the National Coordinator: The Strategy for Advancing the Exchange of Health Information. C. Williams, et al. March 2012. Vol. 31. No. 3)

Simply stated, but volumes of complexity lurk underneath that objective. We turn now to look at where HIT is going.

Where It's Going: For purposes of this report, we reviewed a number of sources for general background that appear in the Bibliography. However, we are highlighting the Health Affairs (HA) article cited above which is co-authored by Claudia Williams and several other employees of ONC, including the current Director, Farzad Mostashari. It effectively lays out ONC's challenges and workplan from the federal perspective. For a deeper dive on HIT, including clinical stories, we recommend this entire issue to your attention due to its focus on numerous aspects and findings regarding HIT. We also include material from a Bipartisan Policy Center Report and a recent review carried out by GAO of the Medicare and Medicaid electronic health record and meaningful use programs.

Starting at the top of HHS, the ONC's role is not to build exchange networks. ONC has

indicated that its role is to lead the development of technical standards, services and policies that a) solve core problems, b) reduce cost and complexity, and c) to establish governance and enforcement.

In brief, the ONC team highlights that:

- Little electronic information sharing occurs today
- Implementing information exchange has been expensive (increased standardization would help)
- Demand for exchange is growing
- Diverse models and business approaches are emerging, relying less than expected on governmental and not-for-profit models, but including local ACO models, private electronic health records vendors and services provided by national exchange networks
- Public trust throughout the system is vital.

Looking forward, ONC will be focused on the building blocks needed to support three types of exchanges:

1 ➤ **DIRECTED EXCHANGE—**For providers, the sending and receiving of health information to support care coordination, such as laboratory orders and results, patient referrals and discharge summaries.

2 ➤ **QUERY-BASED EXCHANGE—**For providers, the ability to find information when delivering unplanned care, such as cardiac history, recent radiology images or medication history.

3 ➤ **CONSUMER-MEDIATED EXCHANGE—**For consumers, tools and methods for accessing their own health information for a variety of purposes.

Finally, for 2012, ONC is focusing on closing three gaps in the advancement of exchanges. These include:

1 ➤ Specification of standards to create findable, reliable, consistent *digital provider directories* necessary for all three forms of exchanges to work.

2 ➤ Common guidelines for establishing and making findable the digital certificates necessary to establish and verify a user's identity for secure electronic transactions.

3 ➤ Similar to the process by which the Internet grew, creation of a governance approach that establishes user rules and protocols that avoid the need for specific legal agreements and negotiations among and between participants.

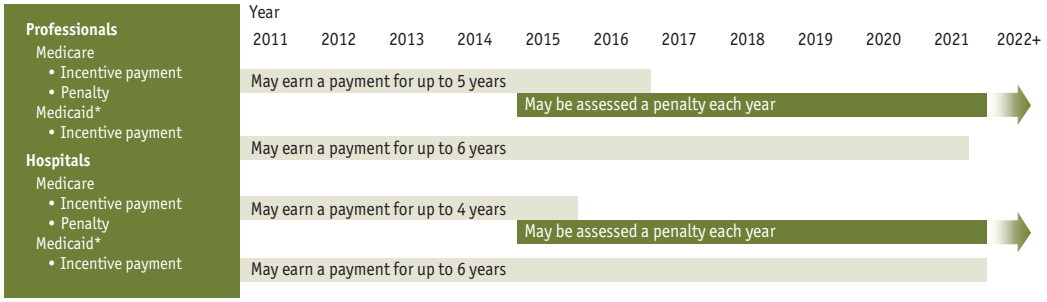
For an external assessment of the considerable work ahead of ONC and all of us in health care, we highlight a report titled "Transforming Health Care: The Role of Health IT", a product of the Bipartisan Policy Center Task Force on Delivery System Reform and Health IT, published by the Bipartisan Policy Center in Washington, D.C. in January, 2012. This report both dissects problems in HIT and proposes a number of steps needed to accelerate its development and dissemination, including linkages to payment reforms. For deeper consideration of HIT, we commend this report to your attention.

However, we do highlight their views on the types of electronically formatted and electronically accessible information that are critical in both care delivery and in improvements in the health of patient populations. Among other points, these are:

- Patient demographic information
- Diagnoses and problems
- Procedures and other services provided during visits and hospitalization
- Discharge instructions and recommendations
- Laboratory, imaging and other diagnostic test orders and results
- Medication lists
- Allergies
- Prescriptions written and filled
- Referrals and authorizations
- Cost information
- Patient preferences
- Patient experiences
- Patient functional status

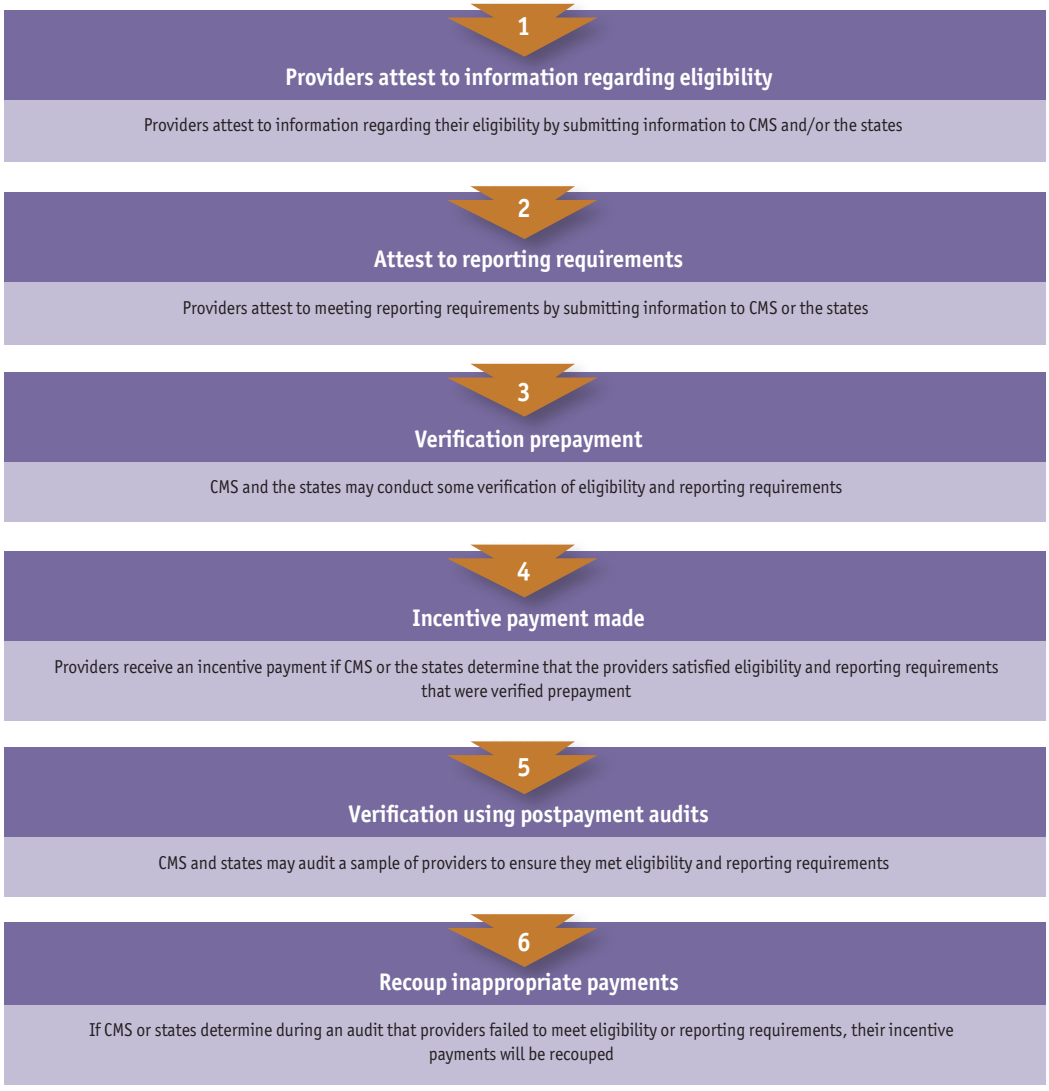
These tie closely to the meaningful use concept in electronic health records (EHRs), recently examined by the Government Accountability Office (GAO). HITECH established the Medicare and Medicaid EHR

YEARS IN WHICH INCENTIVE PAYMENTS ARE AVAILABLE AND WHEN PENALTIES WILL BE ASSESSED IN THE MEDICARE AND MEDICAID EHR PROGRAMS



(SOURCE: GAO-12-481. ELECTRONIC HEALTH RECORDS: FIRST YEAR OF CMS'S INCENTIVES PROGRAMS SHOWS OPPORTUNITIES TO IMPROVE PROCESSES TO VERIFY PROVIDERS MET REQUIREMENTS. APRIL 2012.)

OVERSIGHT PROCESS CMS AND STATES MAY USE TO VERIFY PROVIDERS MET ELIGIBILITY AND REPORTING REQUIREMENTS FOR THE MEDICARE AND MEDICAID EHR PROGRAMS



SOURCE: GAO ANALYSIS OF CMS DOCUMENTS

programs. CMS and the states administer incentives under these programs payable to hospitals, physicians and other select professionals, to promote EHR adoption and to demonstrate the "meaningful use" of an EHR system and of measures of clinical quality. GAO reports that CBO estimates spending on these programs will cost about $30 billion from 2011-2019. On the previous page is a depiction of the timelines governing the incentive payments programs.

For physicians' reference, we also provide a graphic developed by GAO of CMS's oversight and verification process.

The EHR and meaningful use concepts are valuable and important building blocks in the HIT transformation process. However, GAO's recent report highlights another unavoidable facet of the government's deepening investment in HIT and all that it promises—that is, oversight, intervention, and in some cases, enforcement and liability for penalties.

ON A LIGHTER NOTE—In closing, perhaps the deepest, most important health care transformations are occurring at the technological and scientific levels of medicine. This includes results and promises at the clinical and scientific frontier. Therefore, we commend to your attention a pending release from the National Research Council (NRC) of the National Academies titled **Toward Precision Medicine: Building a Knowledge Network for Biomedical Research and a New Taxonomy of Disease** (Prepublication copy available at www.nap.edu). As the writer Agatha Christie's character Hercule Poirot would say, the future envisioned in the Knowledge Network and New Taxonomy of Disease stimulates "the little gray cells".

The NRC is laying down organized conceptual thinking about a new taxonomy of human disease based on molecular biology. They concluded that any new taxonomy must meet the needs of the existing International Classification of Diseases (ICD) system, but could also be linked to rooting future improvements in disease classification in an "Information Commons" and "Knowledge Network" that would also play other roles. Inherent in the linking of HIT and molecular biology is the possibility of truly individualized care in the future based on rich scientific understanding arising from biomedical research linked to the Information Commons and New Taxonomy. This future would provide physicians with more accurate diagnostic and targeted treatment options, leading to improved health outcomes.

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We are not examining their report, per se, but raise it to illustrate the potential outgrowth of what may appear currently to be costly and burdensome information technologies largely pushed by payers. Although payers have different purposes, these technologies, such as electronic health records, quality measures linked to payment, etc., are harbingers of the upside of health information technology just taking root, as witness in the NRC project. In fact, the vision laid out in this report is genuinely transformational for physicians and patients. ■

CHAPTER IV: Setting the Stage for 2013

Election 2012 and the Search for the Governing Middle In the U.S. Congress

A Question of Political Leadership

It is neither the goal nor the role of this report, to wade into the partisan politics that has impaired federal governance in recent years. Indeed, we've taken care throughout to provide balanced perspectives from reliable, fact-based sources. However, it is an observed fact that the Congress has failed over the past few years to carry out an essential core function under the U.S. Constitution, which is to create and enact the federal budget. The reasons for this state of affairs are complex and debated widely. For most Americans, it is hard to assess the internal dynamics of the Congress. Yet the budgetary actions of the Congress are material to the United States economy and to the social fabric of our country, and are worthy of our attention.

We examine the situation in the Congress briefly because we find it to be material to the future of the ACA with respect to repeal or modification, and to other major health programs and initiatives. The daily practice of medicine is permeated with the effluvia of federal statutory and regulatory requirements under the ACA, Medicare and Medicaid. Physicians face challenges in their professional lives that are exacerbated by the uncertainty governing these areas, including the future of health care reform.

Therefore, we would like to share with you some interesting research perspectives on the changing composition of the U.S. Congress. To a certain extent, these may reflect underlying changes in American values, at least in select areas. These trends are reshaping how the Congress goes about its work. They also offer insight into the barriers to achieving either 1) dominance of one political party's preferred approach to enacting budget and policy priorities, or 2) bipartisan solutions stemming from the willingness of sufficient members of either party to cross party lines to form a "governing middle".

As we noted earlier, the Presidential and Congressional 2012 elections, coupled with the fiscal cliff looming in January 2013, will shape the future of health care in material ways. With respect to health care, the federal budget process is often the means by which major policy and spending priorities are established or adjusted, and signed by the President. This has been particularly true in areas of public health, regulation of food and drugs, and in the major entitlement programs of Medicare and Medicaid. We expect major adjustments in federal health care policy and spending to begin shortly after the election and to continue throughout 2013 and beyond. We trust the following "environmental scan" will set the stage for better understanding the implications of 2012 election results and help inform physicians of important Congressional dynamics that will shape the future of health care.

A DIVIDED CONGRESS—Most observers of the federal budget process over the last few years, regardless of political persuasion, would likely agree it has been a divided and unproductive process. The recent Great Recession, the costs of bank bailouts and government fiscal stimulus efforts, and the lengthy economic recovery, have resulted in serious federal spending spikes and higher deficits. For the last two years, major divisions in the Congress and tensions between primarily the

Administration and the House Republican Majority, have led to repeated failures in achieving sustainable budget agreements. The enactment of the ACA in 2010 was a particular catalyst in crystallizing differences in the major political parties. This and other factors have negatively impacted upon political discourse to no small degree. The public's perception of the impasse regarding legislative and budget responsibilities is captured in polling data.

PUBLIC RATINGS OF THE CONGRESS—The Gallup polling organization has been polling for years on a monthly basis against standardized questions regarding the U.S. public's perception of the performance of the Congress. In its monthly poll published in June 2012, the overall approval rating was a mere 17%. The disapproval rating was 79%. The highest approval rating in the last four years of monthly polls occurred in March 2009 immediately after passage of the federal economic stimulus package. The approval ratings have declined steadily since that point in time.

TRENDS IN AMERICANS' VALUES—However, stepping back from the immediate situation, it is useful to examine the trends in the changing composition of the Congress. But first, it's important to consider whether the realignment in the Congress actually reflects changes in the views of Americans. In June of this year, the Pew Research Center published data on trends in American values, examined over the period 1987-2012. The PEW Research Center Values Survey began in 1987 and has been updated 14 times since then. According to their most recent report, their questions do not measure opinions about specific policy or political questions, but instead, the values across selected broad areas that ultimately shape those opinions. While the report is rich in data, we focus on those findings that relate most directly to Americans views about the social safety net and the role of government in health care. The following select, major findings are drawn from the most recent survey, conducted April 4-15, 2012, among 3,008 adults nationwide.

- Americans values and basic beliefs are more polarized along partisan lines than at any point in the past 25 years. Unlike in 1987, when this series of surveys began, the *values* gap between Republicans and Democrats is now greater than gender, age, race or class divides.
- With regard to the broad spectrum of values, basic demographic divisions – along lines such as gender, race, ethnicity, religion and class – are no wider than they have ever been. Men and women, whites, blacks and Hispanics, the highly religious and the less religious, and those with more and less education differ in many respects. However, these differences have not grown in recent years and for the most part pale in comparison to the overwhelming partisan divide we see today.
- Overall, there has been much more stability than change across the 48 political values measures that the Pew Research Center has tracked since 1987. But the average partisan gap has nearly doubled over this 25-year period – from 10 percentage points in 1987 to 18 percentage points in the new study.
- The greatest change in American politics over the past quarter-century is not in overall public beliefs, but how these beliefs are being sorted along partisan lines. Today, the partisan bases are more homogeneous and less "cross-pressured" and hold more consistently conservative or liberal values across a wider spectrum of values.
- Both political parties have become smaller and more ideologically homogeneous. Republicans are dominated by self-described conservatives, and conservatives continue to outnumber moderates by about two-to-one. Democrats are about evenly divided between liberal and moderate Democrats.
- Republicans and Democrats are furthest apart in their opinions about the social safety net. There are partisan differences of 35 points or more in opinions about

Today, 88% of Republicans express a concern about the government becoming too involved in health care, compared with 37% of Democrats. The 51-point gap between Republicans and Democrats over the role of government in health care is the single largest partisan divide in the 79 items covered in the PEW Values Survey.

At the heart of an effective Congress resides the art of compromise—the ability of Members of Congress and their leaders to reach across party lines and seek out solutions to major problems that will secure the fiscal stability and general welfare of the country.

the government's responsibility to care for the poor and whether the government should help more needy people if it means adding to the debt. The percentage of Republicans asserting a government responsibility to aid the poor has fallen in recent years to 25-year lows.

- Just 40% of Republicans agree that "It is the responsibility of the government to take care of people who can't take care of themselves," down 18 points since 2007. In three surveys during the George W. Bush administration, no fewer than half of Republicans said the government had a responsibility to care for those unable to care for themselves. In 1987, during Ronald Reagan's second term, 62% expressed this view.
- The public remains conflicted about the government's role in the health care system. Today, 59% agree that they are concerned about the government becoming too involved in health care. In 2009, during the early stages of debate about what would become the Affordable Care Act a year later, 46% expressed concern about growing government involvement in health care. Yet, even as concern about government involvement has grown, an overwhelming majority (82%) continues to agree that the government needs to do more to make health care affordable and accessible.
- Today, 88% of Republicans express a concern about the government becoming too involved in health care, compared with 37% of Democrats. The 51-point gap between Republicans and Democrats over the role of government in health care is the single largest partisan divide in the 79 items covered in the PEW Values Survey.

(Source: *Trends inAmerican Values: 1987-2012. Partisan Polarization Surges in Bush, Obama Years.* The PEW Research Center for the People & the Press. June 4, 2012).

DISCUSSION—The findings highlighted above don't illuminate why Americans feel as they do, they are simply descriptive. However, they illustrate clearly the deep challenges facing the Administration and the Congress over the future of the ACA. The safety net questions also suggest indirectly major leadership challenges over the role of Medicaid, in particular, due to two strong partisan negatives--declining support for assistance to the needy, combined with heightened concern over the role of government in health care.

It is important to note, however, the fact that self-described Republicans and Democrats are a shrinking share of Americans. With respect to party identification, the PEW survey found that 38% of Americans identify as Independents, while Democrat affiliation stands at 32% and Republican affiliation stands at 25%. The number on Independents differs from that of swing voters, which are drawn only from registered voters. In this analysis, swing voters make up 23% of all registered voters. Although there is less party identification among Independents, they are not necessarily neutral, showing "leanings" depending on issues. This fragmentation in identification poses a challenge and an opportunity for political leaders who resolve to find the common ground necessary to resolve divisions over the federal budgetary and health care priorities. With these findings in mind, we close with a different look at the loss of the so-called "governing middle" in the Congress.

LOSS OF THE GOVERNING MIDDLE IN THE CONGRESS—At the heart of an effective Congress resides the art of compromise—the ability of Members of Congress and their leaders to reach across party lines and seek out solutions to major problems that will secure the fiscal stability and general welfare of the country. This relates to working within and across party caucuses, within the House and Senate chambers, across the Chambers, and in bipartisan negotiations with the Administration as budget and program policies are shaped. To examine the extent to which this is occurring and on what issues, we turned to a social sciences research site known as VoteView.

VoteView is a project founded initially at Carnegie Mellon University in 1995. It

is now affiliated with the Department of Political Science at the University of Georgia. The researchers have developed extensive historical databases cataloguing roll call votes of every Member in the House and Senate covering multiple decades. In the spirit of "open-source architecture" mentioned earlier in this report, major datasets and software behind this project have been placed in the public domain and are available to all requestors.

CONGRESSIONAL POLARIZATION—Unfortunately for the promise of compromise, there is concrete evidence, based on extensive analyses of voting patterns over the 20th and 21st centuries, that polarization in the Congress has been on a diverging and steep climb since the mid-1970's. The researchers "find that contemporary polarization is not only real—the ideological distance between the parties has grown dramatically since the 1970's—but also that it is asymmetric—congressional Republicans have moved further away from the center than Democrats during this period." The researchers note, however, that congressional Democrats have moved to the left during this period, and that it is largely attributable to the disappearance of conservative Southern "Blue Dog" Democrats. Finally, they express the opinion that Democrats have also contributed to polarization by embracing identity politics as a strategic tool. Nonetheless, based on straight voting records, they state that "we should be careful not to equate the two parties' roles in contemporary political polarization: the data are clear that this is a Republican-led phenomenon where very conservative Republicans have replaced both moderate Republicans and Southern Democrats." (Source: "Polarization is Real (and Asymmetric)," Revised 16 May 2012, documented and reported on VoteView.com). In a sense, this may reflect what the PEW study cited above described regarding the change in composition within the Republican party indicating self-described conservatives outnumber moderates two-to-one.

LANDMARK LEGISLATION AND BIPARTISAN COALITIONS—Of greater import to us, however, in considering the possible future of the ACA, is a separate research project analyzing the history of Congressional voting patterns on landmark pieces of social safety net/health care legislation. In analyzing votes on landmark legislation, with particular focus on votes crossing party lines, VoteView found that "a spatial inspection of votes on the landmark laws of the last century show that nearly all are bipartisan. The majority party, even though often large enough to pass legislation by itself (e.g., during FDR's and LBJ's tenure) was still able to attract a large number of moderates from the minority party. This makes it much more likely to "stick" during the cycles of American politics." Landmark pieces of legislation cited included the Social Security Act of 1935, the House Civil Rights Act of 1964, the passage of Medicare in 1965, and welfare reform in 1996, among others.

(Source: Landmark Legislation and Bipartisan Coalitions. Posted on June 13, 2012 on VoteView.com).

We caution that the political divergence shown in research data does not automatically lead to a failure of governance. *What is critical to effective leadership is whether, despite differing views, Members of Congress accept the responsibility to reconcile their disagreements and find the common ground necessary to properly discharge their responsibilities on behalf of the nation.*

VOTING ON THE ACA—Relative to this historic perspective on landmark legislation, we examine the parties' votes for the passage of the ACA. The ACA passed the Senate on December 24, 2009 with 60 yea's and 39 nays. It passed the House on March 21, 2010 with 219 yea's and 212 nays. These votes represent a highly partisan divide, raising serious questions right from the beginning about the ability of this law to "stick", to use VoteView's terminology. Indeed, since passage, there have been over 30 attempts to fully repeal, partially repeal or de-fund portions of the ACA by the Republican Majority in the House of Representatives. This suggests an exceptional degree of uncertainty about the future of this particular piece of landmark legislation.

In closing, we caution that the political divergence shown in research data does not automatically lead to a failure of governance. *What is critical to effective leadership is whether, despite differing views, Members of Congress accept the responsibility to reconcile their disagreements and find the common ground necessary to properly discharge their responsibilities on behalf of the nation.* This is never more important than when the country is in a deep, and prolonged, economic recovery struggle as it has been since the Great Recession. Under such circumstances, it is especially important that Members find ways to collaborate to address our most pressing economic and social needs.

CONCLUSION—As of this writing, both parties are in an intense and competitive drive for winning control of the Congress and/or the Presidency. In the upcoming election, swing voters will play a critical role. In this context, it appears certain that serious, collaborative steps will not be taken to address major budget or public program issues until after the election outcomes are known. We note that the so-called "fiscal cliff" looming in early 2013, allows little time for the post-election political order to proceed effectively unless a temporary political solution is struck that buys more time. We draw this report to a close on a note of considerable suspense over what the elections will bring. Our next scheduled report, due for release in early 2013, will focus on the latest actions on health care reform of major import to physicians in medical practice. That report will also consider the characteristics of the new political leadership in Washington, D.C. and what those changes might mean for the future of the ACA, and the major health entitlement programs. In closing, thank you for your time and attention. ■

Appendix

CMS Proposals for 2013 on Value-Based Payments for Physicians

The principal focus of this report has been to provide physicians with information shaping the impact of recent and prospects for future developments in the ACA. In other words, what will shape "the reform of health care reform"?

However, in the context of discussing in Chapter III the legislative forces affecting prospects for reform of the sustainable growth formula in the Medicare physician fee schedule (MFPS), we alerted physicians to selected highlights of CMS's notice of proposed rulemaking for calendar year 2013 payments under the MPFS. In that context, we are providing additional detail on value-based payments (VBPs) because the structure and effects of those proposed rules have a multi-year impact based on a foundation beginning in 2013.

Separately, we also note that CMS's latest final rule (CMS 1588-F) for hospitals for 2013 payments has proposals for VBPs in the hospital setting that it is important for physicians to be aware of. Finally, we would note that the legislative history and major requirements governing VBPs and associated quality reporting and provider profiling elements, some of which predate the ACA, were covered in the previously released "Roadmap Report" available on our website (refer to pages 53-55). Following are select highlights on CMS's proposals for physicians drawing directly upon the notices of proposed rulemaking and related fact sheets. Additional materials are available on the government's website at http://www.cms.gov.

Physician VBPs

OVERVIEW—According to CMS, the Physician Feedback/ Value-Based Modifier Program is intended to provide comparative performance information to physicians as one part of Medicare's efforts to improve the quality and efficiency of medical care. Their stated goal is to provide meaningful and actionable information to physicians and link it to payment in a way that rewards *value* rather than volume.

The Program contains two primary components:

- The Physician Quality and Resource Use Reports (QRURs, also referred to as "the Reports"). These are also referred to as Physician Feedback Reports.
- The Development and implementation of a Value-based Payment Modifier (VBPM)

The ACA (Section 3003) directs CMS to provide information to physicians and medical practice groups about the resource use and quality of care they provide to their Medicare patients, including quantification and comparisons of patterns of resource use/cost among physicians and medical practice groups. Most resource use and quality information in the QRURs is displayed as relative comparisons of performance among similar physicians (i.e., a peer group). Section 3007 of the ACA mandates that, by 2015, CMS begin applying a VBPM under the Medicare Physician Fee Schedule (MPFS). Both cost and quality data are to be included in calculating payments for physicians.

Value-based Payment Modifier – Starting in 2015, some physicians' payments by Medicare will be affected by application of the VBPM.

Value-based Payment Modifier – By 2017, most physicians paid under the MPFS will see the VBPM applied to claims they submit to Medicare.

Per CMS, in developing its proposals for the Value Modifier, CMS has focused on providing physicians choices as to how their quality of care will be measured and how their payments will be adjusted. Physician groups can avoid all negative adjustments simply by participating in the PQRS. Physicians seeking to be paid according to their measured cost and quality may elect to do so for 2015. CMS's proposals are also designed to align with other CMS quality initiatives to reduce the burden of submitting information, and promote shared physician accountability for beneficiaries.

PROPOSED PERFORMANCE PERIOD—CMS previously established CY 2013 as the performance period for the determination of the Value Modifier to be applied in CY 2015 and proposes to use CY 2014 as the performance period for the Value Modifier to be applied in CY 2016. CMS is proposing to apply the Value Modifier at the Tax Identification Number (TIN) level to items and services paid under the MPFS to physicians under that TIN. This means that if a physician moves from one group to another between the performance period (2013) and the payment adjustment period (2015), the physician's payment will be adjusted based on the Value Modifier earned

by the TIN where the physician is practicing in 2015.

PROPOSED ELECTION ON HOW THE VALUE MODIFIER IS CALCULATED FOR 2015—In this first phase of implementation, CMS is proposing that groups of physicians with 25 or more eligible professionals would be included in the Value Modifier framework. These groups, however, would have options, depending upon whether they satisfactorily report under the PQRS, regarding how their Value Modifier would be calculated for CY 2015 payment.

PROPOSALS FOR MEASURING QUALITY OF CARE AND COST IN THE VALUE MODIFIER—The law requires CMS to measure quality of care furnished as compared to cost using composites of appropriate quality and cost measures. In the MPFS final rule for CY 2012, CMS adopted both a total per capita cost measure for all beneficiaries, as well as four total per capita cost measures for beneficiaries with certain chronic conditions (chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes) to be used under the Value Modifier.

To obtain the quality data, CMS is proposing that groups of physicians with 25 or more eligible professionals satisfactorily submit data using one of the proposed PQRS quality reporting mechanisms for groups of physicians: (1) a common set of quality measures based on clinical data and that focus on preventive care and care for prevalent and costly chronic conditions in the Medicare population; (2) quality measures of their own selection that they report through claims, registries, or EHRs, or (3) a common set of quality measures that focus on preventive care and care for chronic conditions that CMS would calculate from administrative claims data that require no action for the physician group beyond notifying CMS that the group elects this option.

Additionally, CMS is proposing to assess each such group of physicians with 25 or more eligible professionals on quality measures relating to reducing potentially preventable hospital admissions for specific chronic and acute conditions, reducing hospital readmission rates, and increasing the frequency of hospital post-discharge visits.

VALUE MODIFIER PAYMENT ADJUSTMENTS—To balance the goals of beginning the implementation of the Value Modifier in a way that is consistent with the legislative requirements and to give CMS and the physician community experience in its operation, CMS proposes to separate groups of physicians into two categories.

The first category would include those groups of physicians that have met the criteria for satisfactory reporting for an incentive under the options available to groups of physicians under the PQRS Group Practice Reporting Option. In addition, this category includes groups that elect the new PQRS administrative claims-based reporting option. CMS proposes to set the Value Modifier at 0.0 percent for these groups of physicians, meaning that the Value Modifier would not affect their payments under the MPFS, unless such groups of physicians elect the further evaluation of quality and cost of care described below.

CMS proposes to provide groups of physicians that are satisfactory PQRS reporters with the choice of having their value-based payment modifier calculated using a quality-tiering approach. Choosing this option would allow these groups of physicians to earn an upward payment adjustment for high performance (high-quality tier and low-cost tier), and be at risk for a downward payment adjustment for poor performance (low-quality tier and high-cost tier). In 2013, CMS will provide Physician Feedback reports to groups of physicians with 25 or more eligible professionals that preview their Value Modifier (based on 2012 data), prior to the deadline for electing the quality-tiering approach.

The second proposed category would include those groups of physicians with 25 or more eligible professionals that have not met the PQRS satisfactory reporting criteria identified above, including those groups that do not submit any data on quality measures. Because CMS would not have quality measure performance rates on which to assess the quality of care furnished by these groups of physicians, CMS proposes to set their Value Modifier at -1.0 percent. *This downward payment adjustment for the 2015 Value Modifier would be in addition to the -1.5 percent payment adjustment that is required under the PQRS for failing to meet the satisfactory reporting criteria.* Groups of physicians with 25 or more eligible professionals that fail to meet the PQRS satisfactory reporting criteria would, therefore, be subject to downward adjustments during 2015 of 1.5 percent (for not being a satisfactory reporter under the PQRS) and 1.0 percent (for the Value Modifier).

VALUE MODIFIER QUALITY-TIERING METHODOLOGY—For groups of physicians that request to have their Value Modifier calculated using a quality-tiering approach, CMS proposes to examine which groups of physicians have performance that is significantly above or below

the national mean on each quality and cost measure using a standardized score approach. This proposed approach takes into account the varying distributions of scores among physicians across different quality and cost measures. This method would focus the Value Modifier on the outliers in measures of both quality and cost.

CMS is proposing to combine the standardized score for each quality measure into a quality composite using the domains included in the National Quality Strategy (clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency). In addition, CMS is proposing to combine the cost measures into a cost composite. CMS proposes to differentiate the quality composite scores and cost composite scores into three performance tiers – high, average, and low – based on whether the composite score is significantly above or below the national mean.

In order to achieve mandated budget neutrality for the program, positive adjustments to groups of physicians would be offset by negative adjustments to other groups of physicians. Since the total sum of downward adjustments is unknown at this time, CMS is not proposing specific upward payment amount percentage. Rather, as shown in the table below, CMS is proposing to give groups that are high quality and low cost the highest upward adjustment. The value of "x" will depend on the total sum of negative adjustments in a given year. In addition, to ensure that the Value Modifier encourages physicians to care for the severely ill and beneficiaries with complicated cases, CMS is proposing an additional upward payment adjustment for groups of physicians furnishing services to high-risk beneficiaries.

PHYSICIAN FEEDBACK REPORTS—Since 2010, CMS has provided confidential Physician Feedback reports to certain physicians and groups of physicians. The reports quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of their peers. Starting in 2013, CMS anticipates using these reports to inform groups of physicians about their Value Modifier score.

In September 2011, CMS provided Physician Feedback reports (also known as "Quality and Resource Use Reports") to the 35 large medical group practices (each with 200 or more physicians) that participated in the Physician Quality Reporting System Group Practice Reporting Option in 2010. In March 2012, CMS disseminated feedback reports to 23,730 individual Medicare fee-for-service physicians in Iowa, Kansas, Missouri, and Nebraska. The individual physician reports, in summary, showed that approximately 20 percent of beneficiaries received care from multiple physicians without a single physician directing their overall care, based on proportion of visits or costs. These beneficiaries were also the highest risk and highest cost populations.

CMS believes the proposals for the Value Modifier encourage high quality and less fragmented care for these beneficiaries. CMS intends to include episode-based cost measures for several conditions in the Physician Feedback reports. CMS is studying how "episode groupers" that would connect all claims for a beneficiary during a certain timeframe may be used in the reports and will seek input from stakeholders on the development and use of episode groupers before phasing these measures into the Value Modifier.

CMS will accept comments on the proposed rule until Sep. 04, 2012, and will review and respond to all comments in a final rule with comment period to be issued by Nov. 1, 2012.

PROPOSED CALCULATION OF THE VALUE MODIFIER
THE QUALITY-TIERING APPROACH

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

** Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.*

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