THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

September 7, 2012

To: Energy and Commerce Committee Members

From: Majority Staff

Re: Health Subcommittee Markup, September 11, 2012

On Tuesday, September 11, 2012, at 2:00 p.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Health will meet in open markup session. A summary of the bills to be considered is below.

I. BACKGROUND

H.R. 4124 – Veteran Emergency Medical Technician Support Act of 2012

The Veteran Emergency Medical Technician Support Act of 2012 would provide demonstration grants to States with emergency medical technician (EMT) shortages to help streamline State requirements and make allowances for returning veterans to enter the EMT workforce without unnecessary duplication of their training by:

- Determining the extent to which the State requirements for education and training of EMTs are equivalent to that of the military; and,
- Identifying methods, such as waivers, for qualified military EMTs to forego duplicative requirements.

The bill would authorize the appropriation of $1 million in total funding for the period of Fiscal Years 2013 through 2017 to carry out this program. To comply with the House cut go protocol, the funding for this program is authorized within amounts for an existing workforce program (the Area Health Education Centers Program). The Secretary of Health and Human Services (HHS) would be required to submit an annual report to Congress on the program.

H.R. 6163 – National Pediatric Research Network Act of 2012

The National Pediatric Research Network Act of 2012 allows the National Institutes of Health (NIH) to establish a national pediatric research network comprised of pediatric research consortia. The Director of NIH may award grants to a pediatric research consortia which are formed from a collaboration of cooperating institutions in order to more effectively conduct research into pediatric disease and conditions. No more than 20 pediatric research consortia can receive awards. Awards to pediatric research consortia can be for:

- Planning, establishing, or strengthening pediatric research consortia;
- Providing support for basic, clinical, behavioral, or translational research to meet unmet needs; and,
- Training researchers in pediatric research techniques.

If the grants are awarded, the Director of NIH shall ensure that an appropriate number of awards go to consortia that focus primarily on pediatric rare diseases, such as spinal muscular atrophy and Duchenne muscular dystrophy, or are related to birth defects, such as down syndrome or Fragile X. In addition, the Director of NIH will establish a data coordinating center to support research and distribute scientific findings and provide reports to the Director of NIH and the Commissioner of the Food and Drug Administration.

H.R. 733 – Pancreatic Cancer Research and Education Act of 2012

An amendment in the nature of a substitute (AINS) will be offered that expands the focus of the introduced bill to recalcitrant cancers, which are cancers that have high mortality rates but have not seen substantial progress in the diagnoses or treatment of the disease. The bill will be retitled the Recalcitrant Cancer Research Act of 2012. The AINS amends the Public Health Service Act to direct the National Cancer Institute to establish a scientific framework that will guide research efforts on recalcitrant cancers by identifying unanswered medical and scientific questions. The scientific framework will include a review of the current literature, identification of relevant scientific advances and qualified researchers, a list of initiatives and partnerships that can advance coordination of research, and research resources such as patient registries and tissue banks. Information on the implementation of the scientific framework for recalcitrant cancers will be included in the NIH Biennial Report. The scientific framework for each initial cancer identified would be updated five years after the initial framework is completed. The NIH would then be required to issue a report to Congress with recommendations on the effectiveness of the scientific framework model.

H.R. 1063 - Strengthening Medicare and Repaying Taxpayers Act of 2011

Medicare in most instances acts as a "primary payer" of health claims - meaning that it pays first, and other sources of coverage available to a senior may act as a secondary source of coverage in instances where Medicare does not cover the item or service. However, this was not always the case. When the program was first authorized in 1965, Medicare was deemed to be the primary payer for Medicare beneficiaries regardless of whether another source of funding was potentially available to cover the costs.

In an effort to return money to the Medicare program, Congress authorized the Medicare Secondary Payer (MSP) program in 1980 (§1862(b) of the Social Security Act) which identified specific conditions under which Medicare is the secondary payer. Those are (1) a group health plan based on their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program.

In certain circumstances, the Centers for Medicare and Medicaid Services (CMS) may make a conditional payment for Medicare covered services where another payer is responsible for payment; however, CMS still has the right to recover the amount of claims paid. In addition to reimbursing CMS for claims paid, settling parties in a lawsuit must account for reasonably-expected future costs of Medicare-covered expenses that may arise later.

Congress amended the MSP statute as part of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 to require new reporting duties for plans in order to help Medicare better identify instances in which it should operate as a secondary payer. Beginning January 1, 2010, section 111 of MMSEA requires insurance carriers and self-insured entities to report potentially eligible beneficiaries to CMS or be fined $1,000 per day for failure to comply. Further, they can seek double damages in instances when an award is made to a Medicare beneficiary for which repayment to CMS is required but not received in a timely fashion.

Many claims cannot be settled in a timely or conclusive manner. Under current law, there is no requirement for CMS to provide the parties with amounts due or the amount they should set aside to cover future payments before settlement so the parties can appropriately allocate and resolve these Medicare obligations during settlement. For workers' compensation cases, CMS has—through informal agency memoranda—created a voluntary procedure for parties to seek review and approval of the medical allocations in their proposed settlements. Some have claimed the process for approval is unclear, does not recognize requirements of settlements under State workers' compensation statutes, and causes delay and inefficiency. For liability claims, no such process for prior review and approval exists.

H.R.1063, the Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2011, seeks to address these issues by making several improvements to the MSP statute including: (1) declares that the claimant (or applicable plan) may at any time, but only once beginning 120 days before the reasonably expected date of a settlement or award, request a statement from the Secretary of HHS for the conditional reimbursement amount due the Medicare program; (2) requires the Secretary to respond to such a request with a final payment amount within 65 days of the request and, failing that, within an additional 30 day window or lose the right to recover; (3) directs the Secretary to promulgate regulations for a right of appeal for final payment amounts; (4) bars the Secretary from seeking payment of claims below the cost of recouping such payment (threshold to be determined by the Secretary); (5) makes discretionary the current civil monetary penalty for an applicable plan's noncompliance; (6) establishes safe harbors from the MSP reporting requirements; and (7) sets a statute of limitations for the MSP program.

An amendment in the nature of a substitute is expected to be offered that refines several sections of the bill.

HR 6118 - Taking Essential Steps for Testing Act of 2012

The Clinical Laboratory Improvement Amendments (CLIA) statute requires that laboratories which test or examine human specimens register with the Centers for Medicare and Medicaid Services (CMS) and perform periodic proficiency testing (PT) in order to maintain certification.

CMS is required to revoke the CLIA certificate of any laboratory that refers its proficiency testing samples to another laboratory for testing for a period of one year. In addition, the statute requires that a person who has owned or operated a laboratory which has had its CLIA certification revoked - including those owning multiple labs - may not own or operate a laboratory for a period of two years following such revocation. Current law does not allow CMS to consider the circumstances under which the test was intentionally referred or if the lab acted in good faith to report and address the incident.

H.R. 6118, the Taking Essential Steps for Testing Act of 2012, would address this issue by amending section 353 of the Public Health Service Act to allow the Secretary of HHS discretion to determine whether the one year ban on laboratories that refer PTs should be applied, and the flexibility to levy intermediate sanctions instead of the two-year prohibition against ownership or operation of a lab.

H.R. 1206 - Access to Professional Health Insurance Advisors Act of 2011

Section 1001 of the Patient Protection and Affordable Care Act (PPACA) requires health plans to spend 80 to 85 percent of premium revenue on "reimbursements for clinical services" and "activities that improve health care quality". This requirement, otherwise known as the medical loss ratio (MLR), excludes Federal taxes, State taxes, and licensing and regulatory fees from the premium portion of the calculation. On December 1, 2010, the Department of Health and Human Services (HHS) issued regulations defining approved activities that "improve health care quality" and altering the statutory definition of taxes for purposes of enforcing the MLR requirement.

Some have claimed that by providing HHS the authority to define "activities that improve health care quality", the underlying MLR provision, gives HHS unprecedented control over the design of private health insurance coverage irrespective of consumer health care preferences. Providers have also raised concerns that the MLR requirement severely limits investment in programs and initiatives to reduce fraudulent payments for services, improve health care quality, and advance better care coordination by classifying such investments as administrative costs.

The MLR provision and associated regulation also have major economic consequences for independent insurance agents, brokers, and health benefit specialists. Brokers and agents provide critical support and educational services to individuals and employers seeking affordable health coverage and help ensure plans meet a consumer's specific needs. Yet the MLR requirement includes independent agent and broker fees in an insurer's MLR calculation and classifies fees as an insurer-borne administrative expense. Thus, compensation paid to agents and brokers is penalized by the MLR.

The CEO of the National Association of Health Underwriters (NAHU) has testified that brokers servicing the individual and small-business markets are seeing revenue slashed by 20 to 50 percent. NAHU survey data also indicate that the MLR will force 21 percent of agents to downsize their business as a result.

H.R. 1206 amends the MLR requirement to exclude compensation paid for licensed independent insurance producers from the premium portion of the MLR calculation. H.R. 1206 also requires HHS to defer to a State's findings and determinations as to whether enforcing the MLR requirement will destabilize their respective individual or small group markets for health insurance. To date, HHS has partially or fully denied MLR waivers for 17 of the 18 States that have applied for an MLR adjustment. HHS has denied waivers despite findings from individual state insurance commissioner that without a waiver, the individual health insurance market could significantly destabilize and consumer choice in health plans could be severely limited.

II. CONCLUSION

Should you have any questions regarding the markup, please contact Ryan Long at (202) 225-2927 or the following staff for specific bills: for H.R. 1202, please contact Paul Edattel; H.R. 6118 or H.R. 1063, Robert Horne; and H.R. 6163, H.R. 4124, or H.R. 733, Brenda Destro.