THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

September 17, 2012

To: Energy and Commerce Committee Members

From: Majority Staff

Re: Committee Markup, September 19-20, 2012

On Wednesday, September 19, 2012, at 4:00 p.m. and Thursday, September 20, 2012, at 11:45 a.m. in room 2123 of the Rayburn House Office Building, the Energy and Commerce Committee will meet in open markup session. A summary of the bills to be considered is below.

I. BACKGROUND

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

Medicare in most instances acts as a "primary payer"" of health claims; it pays first, and other sources of coverage act as a secondary source of coverage when Medicare does not cover the item or service. This was not always the case. When the program first was authorized in 1965, Medicare was always the primary payer for Medicare beneficiaries, even if another source of funding was 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, CMS can seek double damages in instances where 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 created, through informal agency memoranda, 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 2012, seeks to address these issues by making several improvements to the MSP statute including: (1) declaring that the claimant (or applicable plan) may request at any time, but only once beginning 120 days before the reasonably expected date of a settlement or award, a statement from the Secretary of Health and Human Services (HHS) for the conditional reimbursement amount due the Medicare program; (2) requiring the Secretary to set up a process whereby parties to a settlement can secure a final conditional payment amount to be repaid to the Medicare Trust Fund within 95 days of such notice; (3) directing the Secretary to promulgate regulations for a right of appeal for final payment amounts; (4) barring the Secretary from seeking payment of claims below the cost of recouping such payment (threshold to be determined by the Secretary); (5) making discretionary the current civil monetary penalty for an applicable plan's noncompliance; (6) establishing safe harbors from the MSP reporting requirements; and (7) setting a statute of limitations for the MSP program.

The Subcommittee approved H.R. 1063 by a voice vote.

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, 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 also have 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) 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 commissioners that without a waiver, the individual health insurance market could destabilize significantly and consumer choice in health plans could be limited severely.

The Subcommittee approved H.R. 1206 by a voice vote.

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. 1206, please contact Paul Edattel; H.R. 1063, please contact Robert Horne. Both can be reached at (202) 225-2927.