In this issue:

Congress Returns to Washington; Budget Deal Needed Before January 16 Deadline

Although Congress successfully passed a budget-deal on December 18, including a three-month patch to the 20 percent cut in physician Medicare payments that otherwise would have taken effect January 1, this action does not ensure that Americans will not face another government shutdown in the weeks ahead. Read below

Senate Finance and Ways and Means Committees Mark Up Permanent SGR Replacement Bill

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Obamacare Enrollment Swells in December

The Obama Administration reports that nearly 1 million Americans signed up for health insurance under the Affordable Care Act in time to receive benefits beginning January 1, 2014. Read below

New Obama Administration Report Claims Slow Healthcare Spending Growth

On Monday, January 6, the Centers for Medicare and Medicaid Services' actuaries released a new report showing slowed growth in national healthcare spending in the last four years. Read below

Final USPSTF Screening Recommendations for Lung Cancer Released

On December 30, 2013, the U.S. Preventive Services Task Force (USPSTF) - an independent, volunteer panel of national experts in prevention and evidence-based

medicine - released its final recommendation for the use of annual imaging to screen high-risk individuals for lung cancer. Read below

Congress Returns to Washington; Budget Deal Needed Before January 16 deadline

President Obama signed the Continuing Appropriations Resolution on December 26, 2013, which revises the limits on discretionary appropriations for FYs 2014 and 2015, establishes a FY 2014 Congressional Budget Resolution, and provides a three-month "doc fix" to steep physician Medicare payment reductions that otherwise would have taken effect on New Year's Day. In order to offset higher discretionary appropriations in 2014 and 2015, the legislation extends direct spending sequestration cuts for an additional two years (2022 and 2023).

Although Congress was successful in passing a budget-deal prior to the holidays, this action does not ensure that Americans will not face another government shutdown in the weeks ahead. Each chamber in Congress must still pass an appropriations bill that uses spending levels agreed upon in the December budget deal to determine how the government money is spent. Congress must pass the appropriations package by January 16 to avoid another shutdown, although it could also pass a continuing resolution to give lawmakers a few more days to work out an agreement.

Congress is set to unveil a $1 trillion spending bill this week in a 12-month omnibus bill, which lawmakers hope to pass through both chambers by the January 16 deadline.

The Continuing Appropriations Resolution prevents the 20.1 percent cut in reimbursements for physicians treating Medicare patients scheduled for January 1, 2014 and replaces it with a 0.5 percent increase until April 1, 2014. Lawmakers now have three months to negotiate the replacement to the Sustainable Growth Rate (SGR) formula as well as identify offsets to pay for the repeal (see article below).

The resolution does not provide relief to sequestration reductions impacting Medicare programs, therefore, the two percent reduction to provider and plan payments will continue in 2014 unless Congress takes further action. The bill, in fact, extends sequestration for mandatory programs, such as Medicare, for two more years through 2023.

Senate Finance and House Ways and Means Committees Mark Up Permanent SGR Replacement Legislation

Legislation to replace the Sustainable Growth Rate (SGR) formula used to pay Medicare physicians was passed by the Senate Finance Committee, and House Ways and Means Committee late last year, signaling great promise for a permanent SGR repeal in 2014 – something Congress has been unable to do year after year. These bills have bipartisan and bicameral support.

While the bills, known as the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810) in the House and SGR Repeal and Medicare Beneficiary Access Improvement Act (S. 1871) in the Senate, still need to be reconciled in the first three months of the New Year before the temporary "doc fix" ends on April 1, 2014.

The Senate bill includes a full 10-year payment freeze, while the House bill provides a 0.5 percent positive update for 2014-2016. Many of the other details, however, remain the same, including:

- Permanent repeal of the SGR;
- Funding to shift emphasis toward new payment models that focus on quality of care rather than fee-for-service;
- $125 million to help small physician practices transform to payment models based on the quality of care;
- Consolidation of existing quality improvement programs, such as meaningful use, the physician quality reporting system and the value-based modifier, into a single Value-Based Performance Payment program that would reward high performing practices and that also would decrease penalties assessed on physicians who do not participate in quality programs; and
- Creation of a process to identify misvalued services and redistribute savings on those services within the physician fee schedule.

The Congressional Budget Office (CBO) estimates that permanent repeal of the SGR formula would cost $116.5 billion over 10 years under a zero percent update scenario. Under a 0.5 percent update scenario, permanent repeal of the SGR formula would cost $136.1 billion over 10 years. With respect to one-year "fixes," CBO estimates a zero percent update for 2014 would cost $19.6 billion over 10 years, while a 0.5 percent update for 2015 would cost $18.7 billion over 10 years.

The Medicare Payment Advisory Commission (MedPAC) has also made recommendations to Congress to repeal the SGR, which it cites as "fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries."

Neither the House nor the Senate is yet to offer a plan as to how they would pay for a permanent SGR repeal.

Obamacare Enrollment Swells in December

The Obama Administration reports that nearly 1 million Americans signed up for health insurance under the Affordable Care Act in December. This dramatic influx in enrollment brings the total number of enrollees to 1.1 million in 36 states.

While this surge represents a significant uptick in enrollment, the total falls far short from the 3.3 million individuals the Administration projected would sign up on the new federal and state exchanges by January. Some reports suggest that, when combined with numbers for state-run markets, total enrollment in the new private insurance plans under the ACA is at approximately 2 million people to date.

Due to initial enrollment delays caused by website malfunctions on HealthCare.gov following it's October 1 rollout, the Administration pushed the enrollment deadline to December 24. Americans who failed to sign up for health insurance before the deadline can still enroll under the Affordable Care Act, however their coverage will not begin until February 2014. The Administration's overall goal remains to enroll 7 million individuals by March 31.

Those who made the deadline began receiving medical coverage on January 1, as guaranteed in the healthcare law. Health insurance companies can no longer deny coverage due to pre-existing health conditions; insurers can no longer charge more for individuals with more chronic conditions; women cannot be charged higher premiums; older individuals cannot be charged more than three times what younger consumers pay; and basic benefits like hospitalization and mental health care must be covered. Nearly all Americans must obtain health coverage or face a tax penalty under the law's individual mandate.

New Obama Administration Report Claims Slow Healthcare Spending Growth

On Monday, January 6, the Centers for Medicare and Medicaid Services (CMS) actuaries released a new report in *Health Affairs* showing slowed growth in national healthcare spending. In a briefing at the National Press Club, CMS actuaries released new data demonstrating that healthcare spending rose just 3.7 percent in 2012, which represents a trend in lower post-recession healthcare spending growth in Medicare and Medicaid as well as spending by private payers over the last four years.

The report comes at a time when the Obama Administration is looking for positive news to report related to the healthcare reform law as newly ensured Americans under the law could begin using their insurance policies on January 1.

The report, however, found that the Affordable Care Act only had a 0.1 percent impact on total healthcare spending between 2010 and 2012.

The report also projects increased healthcare spending in 2014 as a result of more newly insured people enter the marketplace and expanded Medicare programs under the Affordable Care Act.

Final USPSTF Screening Recommendations for Lung Cancer Released

On December 30, 2013, the U.S. Preventive Services Task Force (USPSTF) - an independent, volunteer panel of national experts in prevention and evidence-based medicine - released its final recommendation for the use of annual imaging screenings for high-risk individuals for lung cancer. The USPSTF recommendations state, "the USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery."

The Task Force stated that it found adequate evidence that annual screening for lung cancer with LDCT in a defined population of high-risk persons can prevent a substantial number of lung cancer–related deaths.

The recommendations follow the National Lung Screening Trial (NLST), sponsored by the National Cancer Institute, which confirmed that an annual low-dose CT scan of the chest of high-risk patients has the potential to save lives. The NLST confirmed that 1-in-100 individuals taking part in the trial were found to have lung cancer upon their first screening. The study's outcomes were found to have a lung cancer-specific benefit, or increased survival rate.

In formulating their final recommendations, USPSTF stated that comments to the proposed recommendation released in July 2013, "generally agreed with the recommendation statement, although some suggested restricting screening to a higher-risk group and others suggested expanding eligibility criteria beyond those" adults ages 55 to 74. The Task Force added, "In the current recommendation, the USPSTF recommends annual screening for lung cancer with LDCT in persons who are at high risk based on age and cumulative tobacco smoke exposure."