THE CRD ASSOCIATES'

HEALTH POLICY REPORT

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The Headlines:

- **Is There a Way Out?**
- **ACA and the Demand for Primary Care**
- **Cost of SGR Repeal Increases**
- **Long-Awaited Common Rule Changes May Be Coming**

Is There a Way Out?

As we reported in last month's newsletter, the fiscal year 2016 budget plan the President sent to Congress proposes raising the defense and non-defense spending caps by a combined $75 billion, offsetting the increase with a mix of mandatory spending cuts and revenue from closing tax breaks.

The President and congressional Democrats also would like to get rid of the threat of across-the-board sequestration cuts. With many Republicans, particularly defense hawks, believing the military side of the equation requires more resources, it would seem to set the stage for a "grand bargain" where, once and for all, the President and Congress pull themselves out of the fiscal quagmire.

But some significant hurdles stand in the way of any budget accord, partly because the budget and political environments are very different from those that triggered the 2013 budget deal struck by Rep. Paul Ryan (R-WI) and Senator Patty Murray (D-WA).

For one thing, in fiscal year 2016, defense spending will grow by $1.8 billion to $523 billion, while the nondefense spending would go up by $1.1 billion to $493.5 billion, according to the Office of Management and Budget. Even though those increases are less than the rate of inflation, they are still increases.

Also, the political climate has shifted. With control of both chambers, Republicans have newfound clout in negotiating with the President, and many Republicans, particularly on the far right, support the threat of sequestration as an imperfect, but nevertheless effective way to control discretionary spending. Besides, they say, if defense spending is to increase, offsetting cuts should come out of nondefense discretionary programs.

If there is a deal to be struck, it will happen later this year—and it's more likely to be a small deal rather than a "grand bargain."

House Budget Committee chairman Tom Price (R-GA) and his Senate counterpart Michael B. Enzi (R-WY) are in the process of developing their respective budget resolutions, setting overall spending and revenue targets that will have to be implemented, most likely this fall. It's around that time that Congress will be faced with other critical deadlines, namely raising the debt ceiling, pass the 12 spending bills necessary to avoid another government shutdown and perhaps another vote on SGR repeal. Those action-forcing events may be all the incentive the President and Congress need to come to the bargaining table.

It may not be a banquet table, but at this point a kitchen table could be the best we can hope for.

ACA and the Demand for Primary Care

While Congress continues to debate the merits of the Affordable Care Act (ACA), a new state-by-state analysis by the Commonwealth Fund found that the law may result in roughly 20.3 million additional primary care visits nationally, or about a 3.8 percent increase.

Primary care visits are expected to grow more than hospital inpatient visits, which are likely to increase by 3.1 percent, or hospital outpatient visits, which may rise roughly 2.6 percent, the study said.

Much of the increase in demand for medical services will be driven by patients who are gaining coverage from Medicaid. The ACA allows states to expand eligibility to people with income of up to 138 percent of the federal poverty level. Most states, including those that chose not to broaden eligibility, have seen at least some increase in their Medicaid and children's health coverage populations.

The national increase in primary care visits works out to about an additional 1.34 visits per physician, if doctors use other medical professionals to share the workload and use electronic medical records systems. About 64 percent of those extra visits would come from Medicaid patients, while 36 percent would come from people who get private health insurance through the new marketplaces created ACA.Seven states are projected to see increases of more than 5 percent.

Other studies have found that the coverage expansions may lead to a rise of between 15 million and 26 million primary care visits per year. Those studies predicted that between 4,300 and 7,200 additional primary care physicians would be needed to meet the demands.

Cost of SGR Repeal Increases

The last Congress was the first ever to reach a bipartisan agreement on policy to replace the flawed sustainable growth rate (SGR) formula; however, they passed a 17thpatch when they could not agree on $144 billion in offsets for the bill.

This patch expires at the end of March, and the SGR will dictate a 20.9 percent cut in Medicare reimbursement if Congress does not intervene. While Republican still agrees with the policies advanced in the bipartisan repeal bill, the question of how to pay for it has gotten more difficult. According to the Congressional Budget Office (CBO), the cost of repeal has increased by $30.5 billion since November and is now estimated to cost $174.5 billion.

As more time passes, it seems more likely that Congress will pass the 18th patch to the SGR before the end of March. A 9-month patch that would run through the end of the year and freeze current payment rates will cost $12 billion, and patch that runs through the end of 2016 would cost $30.4 billion.

Long-Awaited Common Rule Changes May be Coming

A long-awaited proposed rule to modernize the federal human subject protection regulations (45 C.F.R. 46) has been received by the White House Office of Management and Budget from the Department of Health and Human Services (HHS), the OMB announced February 24. The OMB review is the last step before any proposed rule is published in the *Federal Register*. While there is no indication of when it might actually be available for public comment or what it may say, receipt of the OMB review is an indication that the HHS has moved forward in clearing the first effort to modernize the Common Rule since those regulations were first published in 1991.

The HHS issued an advanced notice of proposed rulemaking (ANPRM) nearly four years ago. There has been considerable speculation that a proposal might not go forward, but then there were indications at the end of 2014 that the HHS agencies were moving actively considering the issuance of a proposed rule. In December, the National Institutes of Health (NIH) issued a draft policy to require a single institutional review board (IRB) for multisite studies, and that draft policy was similar to one of the provisions in the July 2011 ANPRM.

The ANPRM also included proposals to establish mandatory data security and information protection standards for all studies involving identifiable or potentially identifiable data; update the forms and processes used for informed consent; and revise the risk-based framework to more accurately calibrate the level of review to the level of risk.

While the HHS Office for Human Research Protections administers the Common Rule, there are nearly twenty federal agencies and departments that have signed on to follow the federal human subjects protection regulations including HHS as well as the Education, State and Justice departments.

The OMB announcement is available at
http://www.reginfo.gov/public/do/eoDetails?rrid=124965

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