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Medicare: FY2007 Budget Issues

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Medicare: FY2007 Budget Issues

Summary

Each February, the President submits a detailed budget request to Congress for the following federal fiscal year, along with projections for the five-year budget window. The budget informs Congress of the President's overall federal fiscal policy, based on proposed spending levels, revenues, and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget may also include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law, such as Medicare benefits, these changes are generally included in the budget.

The President's 2007 budget includes Medicare legislative proposals for Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) spending with estimated savings of $2.5 billion in 2007 and $35.9 billion over the five-year budget window. Proposals include savings in many of the Medicare payment updates. There are no projected legislative changes to either Medicare Part C (Medicare Advantage) or to Medicare Part D (Prescription Drugs). The President's budget also includes an automatic reduction to all Medicare payments if general revenue financing is projected to exceed 45% of total Medicare financing, under specific conditions. There are no savings from this proposal in the five-year budget window. Finally, the budget includes legislative proposals for the Program Management Budget account. The President's budget reflects the passage of the Deficit Reduction Act of 2005 (P.L. 109-171, DRA). Therefore, the savings proposals included in the budget are based on changes to law after passage of the DRA. The current law descriptions provided in this report also reflect changes made by DRA.

Each year, the Congressional Budget Office (CBO) conducts an independent analysis of the President's budget. This report includes their estimates of savings for the President's proposed Medicare legislation.

The Senate Budget Committee passed its FY2007 Budget Resolution (S.Con.Res. 83) on March 9. The Chairman's Mark assumes the repeal of the Stabilization Fund included in the Medicare Modernization Act, saving $7 billion over five years. The Mark assumes the enactment of legislation to extend the moratorium on therapy caps (costing $710 million over five years). The Mark includes a point of order if general revenue financing is projected to exceed 45% of total Medicare financing, and if a Medicare funding warning has been submitted to the Senate for two consecutive calendar years. The resolution was passed by the Senate, with amendments, on March 19, 2006.

The House Budget Committee reported its budget resolution on March 29. Action by the full House is expected during the week of April 3. Based on currently available documents, it is unclear whether the resolution includes any of the President's Medicare proposals or other adjustments to funding for these programs. It includes reconciliation instructions for the House Ways and Means Committee, which has jurisdiction over Medicare as well as many other programs.

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Medicare: FY2007 Budget Issues

Each February, the President submits a detailed budget request to Congress for the following federal fiscal year, along with projections for the five-year budget window. The budget informs Congress of the President's overall federal fiscal policy, based on proposed spending levels, revenues and deficit (or surplus) levels. The budget request lays out the President's relative priorities for federal programs, such as how much should be spent on defense, education, health, and other federal programs. The President's budget may also include legislative proposals for spending and tax policy changes. While the President is not required to propose legislative changes for those parts of the budget that are governed by permanent law, such as Medicare benefits, these changes are generally included in the budget.

The President's 2007 budget includes Medicare legislative proposals for Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) spending with estimated savings of $2.5 billion in 2007 and $35.9 billion over the five-year budget window. Proposals include savings in many of the Medicare payment updates. There are no proposed legislative changes to either Medicare Part C (Medicare Advantage) or to Medicare Part D (Prescription Drugs).

The Program Management Budget account request for 2007 is $3.1 billion, which is a decrease of $40 million below the FY2006 level, even with the additional $74 million in funding required by the Deficit Reduction Act of 2005 (P.L. 109-171, DRA). Program management funds are used primarily for operating the Medicare (and Medicaid) program, including (1) paying contractors to pay claims, answer beneficiary questions and conduct appeals; (2) compensation for individuals employed at the Center for Medicare and Medicaid Services (CMS); (3) the cost of surveys of facilities; and (4) conducting research. There is a legislative proposal in the Program Management Budget to collect $35 million in user fees for any return visits to a facility that are required when a deficiency is found based on an initial survey, a recertification, or a beneficiary complaint. Additionally, there is another $133 million in savings, which does not require legislative action, from eliminating paper claims for Medicare contractor transactions.

The President's budget also includes an automatic reduction to all Medicare payments if general revenue financing is projected to exceed 45% of total Medicare financing, and only when that threshold is met and Congress fails to act on recommendations to reduce that level. In such a case, a four-tenths of 1% reduction would be made across the board to all Medicare payments. This reduction would grow by four-tenths of 1% for every year that the 45% threshold was exceeded. There are no threshold savings included in the five-year budget window.

Following is a brief discussion of current and proposed law for each of the 2007 Medicare mandatory program legislative proposals, along with **Table 1**, detailing

both the Administration's and CBO's estimates of the savings for each proposal. The President's budget reflects the passage of the DRA for the savings proposals. This report's descriptions of current law also reflect passage. **Table 2** provides a list of CRS staff contacts for this report.

Medicare Part A

Hospital Update

Current Law. Inpatient services provided by acute care hospitals are reimbursed based on the inpatient prospective payment system (IPPS). Medicare's payments are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the price of goods and services purchased by hospitals to create one unit of output. Typically, hospitals have received less than the MB index for an update. For FY2005 and beyond, however, hospitals that submit required quality data will receive the full MB update. Those that do not submit the data will receive a reduction, so that the update will be MB-0.4 percentage points (in FY2005 and FY2006) and MB-2 percentage points in FY2007 and beyond. The reduction for not submitting quality data would apply for the applicable year and would not be taken into account in subsequent years.

President's Proposal. Regardless of whether or not a hospital submits quality data, payments for hospital inpatient services would be updated by MB- 0.45 percentage points in 2007 and by MB-0.4 percentage points in 2008 and 2009. Hospitals that do not submit quality data will receive the additional two-percentage-point reduction.

Skilled Nursing Facility Update

Current Law. Skilled Nursing Facility (SNF) care is reimbursed based on a prospective payment system (PPS). The PPS payments are based on a daily ("per-diem") urban or rural base payment amount that is adjusted for case mix and area wages using the hospital wage index. The urban and rural federal per diem payment rates are increased annually by an update factor that is determined by the projected increase in the SNF market basket index. This index measures changes in the costs of goods and services purchased by SNFs. For FY2004 and beyond, the increase in SNF payments are set at the market basket.

President's Proposal. The SNF payments would be frozen in 2007 and would increase by SNF MB-0.4 percentage points in 2008 and 2009.

Inpatient Rehabilitation Facility Update

Current Law. Inpatient Rehabilitation Facilities (IRFs) are paid based upon the IRF-PPS, and paid a fixed amount per discharge. The annual update to the payment is based on MB for rehabilitation, psychiatric, and long-term care. The

update for FY2006 is 3.6%. In FY2006, the IRF-IPPS includes a one-time reduction of 1.9% to account for coding changes.

President's Proposal. IRF payments would be frozen for 2007 and would increase by MB-0.4 percentage points in 2008 and 2009.

Hospice Payment Update

Current Law. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, for each day a beneficiary is under the care of the hospice. The four rate categories are: routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the increase in the hospital market basket. National hospice payment rates for care furnished during FY2006 are as follows: (1) routine home care at $126.49 per day; (2) continuous home care at $738.26 for 24 hours of care, or $30.76 per hour; (3) inpatient respite care at $130.85 per day; and (4) general inpatient care at $562.69 per day.

President's Proposal. The hospice payment update, i.e., the increase in hospital market basket, would be reduced by 0.4 percentage points in 2007 through 2009.

Adjust Payment for Hip and Knee Replacement

Current Law. Patients receiving hip and knee replacements can receive rehabilitative care in a variety of post-acute care settings, including a SNF and an inpatient rehabilitation facility. Generally, care provided in an IRF is paid at a higher rate than care provided in a SNF.

President's Proposal. Eventually, the goal would be to have site-neutral reimbursement rates for hip and knee replacement. The proposal would focus on inpatient rehabilitation facilities. They would be paid the average SNF rate plus one-third of the difference between the average IRF rate and SNF rate.

Medicare Part B

Outpatient Hospital Update

Current Law. Hospital Outpatient Department (HOPD) services are paid based on a prospective payment system. The unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital MB. For CY2006, the Inpatient Hospital MB was 3.7%.

President's Proposal. Payments for HOPD services would be MB-0.45 percentage points in 2007 and MB -.4 percentage points in 2008 and 2009.

Ambulance Fee Schedule Update

Current Law. Medicare pays for ambulance services on the basis of a national fee schedule which is being phased in over a transition period. Prior to July 2004, a gradually increasing portion of the payment was based on the fee schedule and a decreasing portion on the former payment methodology (costs or charges). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established a new methodology for ground ambulance services beginning July 2004 with payments through 2009 equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. For July through December 2004, the blend was 20% of the national fee schedule rates and 80% of the regional rates. The portion of the blend based on national rates increases each year; in 2006 the blend is 60% national and 40% regional. In CY2010 and subsequently, the payments in all areas will be based on the national fee schedule amount. The fee schedule amounts are updated each year by the CPI-U. The update is 2.5% in 2006. MMA provided an additional 2% payment increase for rural ambulance services and 1% payment increase for urban ambulance services for July 1, 2004, through December 31, 2006.

President's Proposal. The Ambulance Fee Schedule update would be reduced by 0.4 percentage points in 2007, 2008 and 2009.

Expand Competitive Bidding to Laboratory Services

Current Law. The Centers for Medicare and Medicaid Services (CMS) tested a competitive bidding process for durable medical equipment (DME) services. Under the DME demonstration, Medicare's payments for medical equipment and supplies were based on the supplier's bids, as compared with current law DME payments which are based on a fee schedule. CMS plans to expand the process nationwide. This does not apply to laboratory services.

President's Proposal. This proposal would extend competitive bidding to Medicare laboratory services.

Eliminate Indexing of Threshold for Income-Related Part B Premiums

Current Law. Currently beneficiaries enrolled in Part B pay premiums covering about 25% of Part B program costs. Beginning in 2007, individuals whose modified adjusted gross income (AGI) exceeds $80,000 and couples whose modified AGI exceeds $160,000 will be subject to higher premium amounts. The increase will be phased-in over three years. The income levels for determining who pays higher premium amounts would be indexed to the CPI-U.

President's Proposal. The annual income levels of $80,000 for individuals and $160,000 for couples would no longer be indexed each year, so that these levels would remain fixed.

Pay for Short-Term Power Wheelchairs

Current Law. In general, Medicare pays for certain durable medical equipment (DME) items, such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Suppliers are required to transfer the title of DME equipment in the capped rental category to the beneficiary after a 13-month rental period. Beneficiaries have the option to purchase power-driven wheelchairs when they are initially furnished.

President's Proposal. The proposal would reimburse short-term power wheelchair usage based on actual time used versus paying up front at the full purchase price.

Limit Oxygen Rental Period

Current Law. Rental payments for oxygen equipment, including portable oxygen equipment, are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary at that time. Medicare will continue to make payments for oxygen contents (in the case of gaseous and liquid oxygen), for the period of medical need.

President's Proposal. The proposal would move oxygen and oxygen equipment from a 36-month rental period to a 13-month period, the same as the capped rental category. Medicare would continue to pay for refills of gaseous and liquid oxygen, as medically necessary.

Medicare Parts A and B

Home Health Update

Current Law. Home health agencies (HHAs) are paid under a prospective payment system. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits and medical supplies. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket index. This index measures changes in the costs of goods and services purchased by HHAs. The 2006 update for HHAs is frozen. Beginning in 2007, HHAs must submit quality data to the Secretary. Those HHAs that submit the data will receive a full MB update, while those HHAs that do not submit the required data will receive an update of MB-2 percentage points.

President's Proposal. Payments for HHAs would be frozen in 2007 and would increase by HHA MB-0.4 percentage points in 2008 and 2009. HHAs that do not submit quality data will receive the additional two percentage point reduction.

Establish Federal Data Sharing Clearinghouse for Medicare Secondary Payer

Current Law. The law authorizes a data match program intended to identify cases where an insurer other than Medicare is the primary payer. This information is used to both facilitate recoveries when incorrect Medicare payments have been made and identify secondary payer situations before Medicare payments are made. Medicare recipients are matched against data contained in Social Security Administration and Internal Revenue Service files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. The Centers for Medicare and Medicaid Services (CMS) sends questionnaires to certain identified employers to determine which of them offers health insurance, and to determine the insurance status of specific beneficiaries. Currently Medicare has a voluntary arrangement with about 40% of employers.

President's Proposal. The proposal would establish a federal data sharing clearinghouse to clarify and expand Medicare secondary payer instances. This proposal would extend the arrangement to all employers who would be required to provide CMS with coverage information. This information would be used to ensure that proper payments were made by the responsible insurer and to recover improperly made payments. The data would be shared with Medicare, Medicaid, Tricare, the Veterans' Administration, the Federal Employees Health Benefits Program, Indian Health Service, and others.

Extend Medicare Secondary Payer Status for End Stage Renal Disease

Current Law. The Medicare Secondary Payer (MSP) program prohibits Medicare payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. Medicare is the secondary payer to insurance plans and programs under certain conditions for beneficiaries covered through a group health plan based on either their own or their spouse's current employment. For individuals with Medicare entitlement based on End Stage Renal Disease (ESRD), Medicare is the secondary payer for the first 30 months of ESRD benefit eligibility. After 30 months, Medicare becomes the primary insurer. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis.

President's Proposal. Medicare secondary payment status for ESRD enrollees would be extended from 30 to 60 months.

Phase-Out Medicare Bad Debt Payments

Current Law. Medicare pays the costs of certain items on a reasonable cost basis (outside the applicable prospective payment system) including the unpaid debt for beneficiaries' coinsurance and deductible amounts. While some providers receive 100% reimbursement for allowable bad debt, since 2001 acute care hospitals receive 70% of the reasonable costs. Beginning in 2006, SNFs also receive 70% for only those beneficiaries who are not dually eligible for Medicare and Medicaid. For the

dual eligibles, the bad debt reimbursement will remain at 100%. Other providers currently receiving reimbursement for bad debt include critical access hospitals, rural health clinics, ESRD facilities, federally qualified health clinics, community mental health clinics, and certain health maintenance organizations, among others.

President's Proposal. This proposal would phase out bad debt reimbursement to providers between 2007 and 2011. There would be no special exemptions for dual eligibles in SNFs or in other providers.

Premium Interactions

Because Medicare Part B premiums are based on a percentage of total Part B costs, any changes to the Medicare Part B program or to the calculation of Medicare Part B premiums will also have a secondary budgetary effect. When the higher income beneficiaries begin paying a larger share of premiums, Medicare Part B revenues will increase. Further some Medicare beneficiaries may decide not to enroll in Part B, while other current enrollees may dis-enroll, because of their larger premiums. The interaction with the indexing proposal is included as a "savings" because the increased revenues are estimated to translate into less spending to provide services for these higher income beneficiaries.

There is a cost associated with Part B benefit savings that occurs because any savings to the program are shared between the Medicare program and beneficiaries, as beneficiaries pay a share (generally 25% of program costs, or beginning in 2007 for certain higher income beneficiaries a larger share) of program costs. For example, for those beneficiaries paying 25% of premiums, for every dollar saved, the Medicare outlays will be reduced by about $0.75 and beneficiaries will save about $0.25. The savings for the individual proposals listed in **Table 1** are the "gross" savings and the offset for savings to beneficiaries is shown in the interaction line of the table.

Forty-Five Percent Rule

Current Law. The hospital insurance (HI) and supplementary medical insurance (SMI) trust funds are overseen by a board of trustees who make annual reports to Congress. The MMA (Section 801) requires the trustees report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenues financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds). The 2005 trustees report projected that the 45% trigger would first be exceeded in 2012 which was beyond the required seven-year test period (i.e., 2005-2011). The 2005 report, therefore, did not include a determination of excess general revenue funding. However, the 2012 estimated date for exceeding the trigger suggests that such a determination could be included in the 2006 report.

MMA (Sections 802-804) further requires that if an excess general revenue funding determination is made for two successive years, the President is required to submit a legislative proposal to respond to the warning. The Congress is required to consider the proposal on an expedited basis. However, passage of legislation within a specific time frame is not required.

President's Proposal. The President's budget includes an automatic reduction to all Medicare payments if general revenue financing is projected to exceed 45% of total Medicare financing, and only when that threshold is met and Congress fails to act on recommendations to reduce that level. In such a case, a four-tenths of 1% reduction would be made across the board to all Medicare payments. This reduction would grow by four-tenths of 1% for every year that the 45% threshold was exceeded. There are no threshold savings included in the five-year budget window. The CBO estimate of the President's budget assumes that the trigger will be reached in FY2011.

CBO Estimate

As shown in **Table 1**, CBO has slightly different estimates of the Medicare savings proposals included in the President's budget. However, the CBO estimates have a separate savings estimate for the Medicare Advantage program as a result of the savings in fee-for-service spending. According to HHS, they have incorporated the MA savings into the individual proposals, making a direct comparison of individual savings, such as hospital update, difficult to compare. Therefore, it is more appropriate to compare total savings. For the five-year budget window, CBO estimates slightly higher savings of $37 billion, compared with the Administration's estimate of $35.9 billion.

Congressional Activity

Senate Activity

The Senate Budget Committee passed its FY2007 Budget Resolution (S.Con.Res. 83) on March 9, which will now be considered by the Senate. The Chairman's Mark assumes that the authorizing committees, which for Medicare is the Senate Finance Committee, will continue to examine and reform programs to achieve savings and demonstrate continued progress toward deficit reduction. However, the Mark does not provide the Senate Finance Committee with reconciliation instructions.

The Chairman's Mark provides $382 billion for Medicare in 2007, an increase of $55 billion over 2006, or 17%. Without legislative changes, Medicare spending is projected to grow to $518 billion in 2011, an average annual growth rate of 9.7% and total growth of 59%. However, the Mark assumes savings in Medicare spending through the repeal of the Stabilization Fund included in the Medicare Modernization Act, saving $7 billion over five years. The Mark assumes an increase in Medicare

spending for extending the moratorium on therapy caps (costing $710 million over five years).

The Mark also includes a new point of order against direct spending legislation if and when it is determined that within seven years the General Fund contributions to Medicare funding will exceed 45% of total Medicare outlays, and if a Medicare funding warning has been submitted to the Senate for two consecutive calendar years. Direct spending proposals will not be subject to points of order if new spending is offset by changes in spending, receipts, or revenues. The Chairman may withdraw the notification when legislation to reduce the general fund contribution to Medicare is enacted.

The Mark also includes several deficit-neutral reserve funds for legislation that could affect Medicare, including a reserve fund that provides incentives or other support for the adoption of health information technology to improve health care quality, and also provides for performance-based payments, based on an accepted clinical performance measure that improves the quality in health care. The Chairman of the Budget Committee may make adjustments in allocations and aggregates so that such legislation would not increase the deficit in 2007 or for the period of 2007-2011. Similarly, the Mark includes $1.75 billion in reserve funds for the Centers for Medicare and Medicaid Services (CMS) to create a demonstration project that assigns a case manager to coordinate the care of chronically ill and other high-cost Medicare beneficiaries in traditional fee-for-service Medicare.

The resolution was passed by the Senate, with amendments, on March 19, 2006. Some of the amendments that passed could affect the Medicare program. S.Amdt. 3004 would ensure that any savings associated with legislation that authorizes the Secretary of Health and Human Services to use the Medicare's collective purchasing power to negotiate prices in fallback plans for Part D prescription drugs, and by private drug plans (if asked) and in other circumstances — but not permitting a uniform formulary or price setting — is reserved for deficit reduction or to improve the Medicare drug benefit.

S.Amdt. 3073 addresses the Medicare Prescription Drug program. If the Committee on Finance of the Senate reports a bill, an amendment, or a conference report, that (1) authorizes the Secretary of Health and Human Services to extend the initial open enrollment period under Part D of Title XVIII of the Social Security Act beyond May 15, 2006; (2) provides funding to the Centers for Medicare and Medicaid Services and the Social Security Administration for the purpose of conducting enrollment activities for the period of any extension of the initial open enrollment period; (3) waives the application of the late enrollment penalty for the period of any extension of the initial open enrollment period; and (4) permits beneficiaries to change their enrollment election in such Part D once during the initial open enrollment period, including throughout any extension of the initial open enrollment period; the Chairman of the Committee on the Budget of the Senate may make the appropriate adjustments in allocations and aggregates to the extent that such legislation would not increase the deficit for FY2007 and for the period of FY2007-FY2011.

S.Amdt. 3110 would establish a reserve fund for a physician payment increase under Medicare, if: (1) the Committee on Finance Reports a bill, an amendment, or a conference report that has the effect of increasing the reimbursement rate for Medicare physician services; and (2) the committee is within its allocation as provided under Section 302(a) of the Congressional Budget Act of 1974; the chairman of the Committee on the Budget of the Senate may make the appropriate adjustments in allocations and aggregates to the extent that such legislation would not increase the deficit for FY2007 and for the period of FY2007-FY2011.

House Activity

The House Budget Committee reported its budget resolution on March 29. Action by the full House is expected during the week of April 3. Based on currently available documents, it is unclear whether the resolution includes any of the President' s Medicare proposals or other adjustments to funding for these programs. It includes reconciliation instructions for the House Ways and Means Committee, which has jurisdiction over Medicare as well as many other programs. Because the Committee has jurisdiction over many programs, the reconciliation instructions may have no impact on Medicare.

Table 1. President's Budget Medicare Legislative Proposals

(dollars in billions)

Medicare legislative proposals	HHS estimates		CBO estimates	
Years	2007	2007-2011	2007	2007-2011
Medicare Part A				
Hospital update	-$0.5	-$6.6	-$0.4	-$5.3
Skilled nursing facility update	-0.7	-5.1	-0.4	-3.1
Inpatient rehabilitation facility update	-0.2	-1.6	-0.1	-0.7
Hospice payment update	**	-0.6	**	-0.6
Adjust payment for hip and knee replacement rehabilitation	-0.4	-2.4	-0.4	-2.4
Medicare Part B				
Outpatient Hospital update	-0.1	-1.5	-0.1	-1.3
Ambulance fee schedule update	**	-0.3	**	-0.2
Clinical Lab: competitive bidding	0	-1.4	0	-1.1
Power wheelchairs: modify payment	-0.1	-0.5	-0.4	-0.7
Limit oxygen rental period	0	-6.6	-0.2	-6.2
Medicare Parts A and B (dollars for combined A and B spending)				
Home health update	-0.4	-3.5	-0.3	-3.2
Medicare secondary payer: establish federal data sharing clearinghouse	**	-0.6	**	-0.6
Extend Medicare secondary payer for status for ESRD	-0.1	-1.0	**	-0.5
Phase-out Medicare bad debt payments	-0.2	-6.2	-0.1	-5.0
Premiums and interactions				
Net effect of eliminating Part B income related premium indexing threshold	**	-1.9	0	-2.0
Interaction with Part B benefit savings	0.1	3.8	0.2	3.0
Interaction with Medicare advantage	****	****	-0.4	-5.3
Forty-five percent rule				
Required Medicare spending reduction	0	0	0	-1.8
Total	-$2.5	-$35.9	-$2.6	-$37.0

Note: Total may not add due to rounding.

** Less than $50 million.
**** HHS estimate of Interaction with Medicare Advantage included in individual proposals.

Table 2. Staff Medicare Contacts for this Report

Staff contact	Issue areas	Phone
Hinda Chaikind	Medicare Advantage ESRD Medicare Secondary Payer	7-7569
Paulette C. Morgan	Medicare Advantage Durable Medical Equipment	7-7317
Jennifer O'Sullivan	Physicians and Other Providers Medicare Part B Premiums Ambulance Services Laboratory Services	7-7359
Julie Stone	Skilled Nursing Facilities Home Health Hospice	7-1386
Sibyl Tilson	Inpatient Hospitals Inpatient Rehabilitation Facilities Outpatient Hospitals Bad Debts	7-7368