Medicare: Changes Made by the Reconciliation Act of 2010 to Senate-Passed H.R. 3590

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Summary

On December 24, 2009, the Senate passed health reform legislation that would, among other changes, make statutory changes to the Medicare program. H.R. 3590, the Patient Protection and Affordable Care Act, is under consideration by the U.S. House of Representatives.

On March 18, 2010, the House Rules Committee issued an amendment in the nature of a substitute to H.R. 4872, the Health Care Education Affordability Reconciliation Act of 2010 (referred to hereafter as the Reconciliation bill). If passed, the Reconciliation bill would amend H.R. 3590.

The Reconciliation bill includes two titles. The first title contains provisions related to health care and revenues, including modifications to H.R. 3590's Medicare provisions. The second title includes amendments to the Higher Education Act of 1965, which authorizes most of the federal programs involving postsecondary education.

Medicare changes that would be made by the Reconciliation bill, as issued March 18, 2010, to Senate-passed H.R. 3590 are summarized in this report. Among other changes, the Reconciliation bill would:

- phase out the coverage gap under the Medicare prescription drug benefit and close it by 2020;
- change the methodology used to determine Medicare Advantage payment, and create an incentive system to reward high quality plans with higher payments;
- move up reductions in payments to disproportionate share hospitals to 2014, and reduce the cuts;
- revise hospital market basket adjustments;
- change the qualifying date whereby an existing physician-owned hospital would be exempt from the self-referral prohibition;
- change the assumptions used to calculate Medicare reimbursement for advanced imaging services; and
- increase funding for the Health Care Fraud Abuse Control program and provide for enhanced oversight of DME suppliers.

This report will be updated as legislative activity warrants.

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Introduction

On December 24, 2009, the Senate passed a comprehensive health reform bill, the Patient Protection and Affordable Care Act, H.R. 3590, as amended by the Senate.[1] The bill contains numerous provisions affecting Medicare payments, payment rules, covered benefits, and the delivery of care. On March 18, 2010 the amendment in the nature of a substitute to H.R. 4872, the Health Care and Education Affordability Reconciliation Act of 2010, was made public. This Act would amend H.R. 3590 and would make changes to a number of Medicare-related provisions in that bill. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) both issued preliminary cost estimates of the reconciliation proposal on March 18, 2010.[2]

The reconciliation proposal includes two titles. The first title contains provisions related to health care and revenues. Subtitle B of Title I contains provisions that would modify provisions in H.R. 3590 related to Medicare fee-for-service, Medicare Advantage, and Medicare outpatient prescription drug programs. Subtitle D contains provisions related to reducing waste, fraud and abuse in Medicare. Subtitle E contains revenue related provisions including a provision that would make changes to the Medicare tax provision in H.R. 3590. The second title includes amendments to the Higher Education Act of 1965 which authorizes most of the federal programs involving postsecondary education.

CBO estimates that, under current law, total mandatory annual expenditures for Medicare will grow from $501 billion in 2009 to $943 billion in 2019.[3] Cumulative spending for the years 2010 to 2019 is expected to exceed $7 trillion. CBO estimates on the provisions in H.R. 3590 as amended by H.R. 4872 affecting Medicare indicate that, absent interaction effects, net reductions in Medicare direct spending would be approximately $390 billion over the FY2010-2019 period.[4] This is about $10 billion less than the estimated Medicare savings of $400 billion for H.R. 3590. The differences in projected Medicare savings are primarily due to changes that led to reductions in cost savings estimates for provisions related to disproportionate share hospitals and the Independent Payment Advisory Board together with cost increases associated with closing the coverage gap in the outpatient prescription drug benefit. A portion of the projected cost increases are offset by increases in savings estimates of provisions related to the Medicare Advantage program, productivity adjustments for certain inpatient services, and advanced imaging services. Changes by the Reconciliation bill to the Medicare tax provision in H.R. 3590 are estimated to raise an additional $123 billion above the $87 billion raised in the Senate bill, for a total of $210 billion in added revenue over 10 years.

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[1] The measure was introduced and considered as an amendment (S.Amdt. 2786) in the nature of a substitute to H.R. 3590, a homeowner tax credit bill that passed the House unanimously on October 8, 2009. The CBO score of H.R. 3590 can be found at http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf. The JCT score may be found at http://www.jct.gov/publications.html?func=startdown&id=3663.

[2] The CBO score on the Reconciliation bill, H.R. 4872, may be found at http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf. The JCT score may be found at http://www.jct.gov/publications.html?func=startdown&id=3671.

[3] CBO's Baseline Projections of Medicare Spending, March 2009, http://www.cbo.gov/budget/factsheets/2009b/medicare.pdf.

[4] CBO expenditure projections for the Senate bill do not include all of the discretionary costs that would be associated with the legislation. CBO expects Department of Health and Human Services costs to increase at least $5 billion to $10 billion over 10 years.

Key Changes Made to Senate-Passed H.R. 3590 by the Reconciliation Bill

The Medicare provisions in Subtitles B, D and E of Title I in the Reconciliation bill would make modifications to certain Medicare provisions in the Senate H.R. 3590, as well as add several new provisions. Below are summaries of how the Reconciliation bill, as issued March 18, 2010, would change, or add to, Medicare-related provisions in H.R. 3590 together with descriptions of applicable current law.[5]

Changes Affecting Medicare Fee-For-Service Providers

Medicare Disproportionate Share Hospital (DSH) Payments

Provisions in Senate-passed H.R. 3590 (Sec. 3133 as modified by Sec. 10316) reduce the amount of disproportionate share hospital (DSH) payments that are provided to hospitals by 75% (which represents an empirically justified amount) starting in FY2015. Hospitals would receive additional payments based on a formula that incorporates certain factors including the reduction in their DSH funds, the percentage change in the uninsured under-65 population, and the relative share of uncompensated care provided by the hospital.

The Reconciliation bill (Sec. 1104) would implement the DSH changes in FY2014 and modify one of the factors in the formula (regarding the change in the uninsured under-65 population) used to distribute the additional DSH payments. Specifically, under the Senate provision, from FY2015 through FY2018, hospital payments would reflect the difference in the percentage change in the uninsured under-65 population from 2013 to the most recent period minus 1.5 percentage points; in subsequent years, the payments would be based on the percentage difference in the uninsured (without the subtraction). Under reconciliation language, the percentage subtraction would be 0.1 percentage points in FY2014, and 0.2 percentage points in FY2015 through FY2019.

Revisions to Certain Market Basket Reductions

Provisions in the Senate bill (Sec. 3401 as modified by Sec. 10319) would implement a full productivity adjustment for inpatient and outpatient hospital services (IPPS and OPPS respectively), inpatient psychiatric facilities (IPFs), inpatient rehabilitation (IRFs), and long term care hospital (LTCHs) services (and other providers) beginning in FY2012. The update factors for Medicare providers and suppliers would be subject to additional adjustments too. The Reconciliation bill (Sec. 1105) would revise the additional adjustments to the market basket (MB) updates for the IPPS, OPPS, IPF, IRF and LTCH payment systems. Instead of reducing the MB updates by 0.2 percentage points each year from 2014 through 2019 depending upon the level of the insured nonelderly population in relationship to the estimated level of insured, the MB would

[5] See CRS Report R40970, *Medicare Program Changes in Senate-Passed H.R. 3590*, coordinated by Patricia A. Davis for additional detail on how H.R. 3590 would change the Medicare program, on specific Medicare provisions in H.R. 3590, and on the projected budgetary impact of these provisions.

be reduced by 0.3 percentage points in FY2014, by 0.2 percentage points in FY2015 and FY2016, and by 0.75 percentage points in FY2017 through FY2019.

Physician Ownership-Referral

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have an ownership or investment interest. However, among other exceptions, this prohibition does not apply to physicians with ownership or investment interests in a whole hospital. Provisions in H.R. 3590 (Sec. 6001 as modified by Sec. 10601) would exempt only those physician-owned hospitals meeting certain requirements from the self-referral prohibition beginning no later than 18 months after the date of enactment. Specifically, hospitals that have physician ownership and a provider agreement in operation on August 1, 2010, and that met other specified requirements would be exempt from this self-referral ban. The Reconciliation bill (Sec. 1106) would change the target date to December 31, 2010 along with certain conforming changes. The H.R. 3590 provisions also establish a process to allow certain physician-owned hospitals to expand in a limited fashion. The reconciliation provision would allow grandfathered physician owned hospitals that are not the only hospital in their county that treat the highest percentage of Medicaid patients in their county to expand.

Payment for Imaging Services

The 2010 final rule for payments to providers under the Medicare fee schedule as published in the Federal Register on November 25, 2009, uses an assumption that advanced imaging equipment (such as MRIs) are being used 90% of the time (up from 50% in prior years), following a MedPAC recommendation based on studies that surveyed the actual use of the equipment. Section 3135 of the Senate bill would change the utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 65% for 2010 through 2012. The rate would be further increased to 70% for services provided in 2013 and 75% for services provided in 2014. Sec. 1107 of the Reconciliation bill would set the utilization rate at 75% in 2011 and in subsequent years.

Changes Affecting the Medicare Advantage Program

The Reconciliation bill would change the way payments to MA plans are calculated, tying the maximum possible payment (the MA benchmark) to a percentage of spending in original Medicare—a provision which may reduce benchmarks in many areas. However, the bill would also increase the benchmark for quality plans and vary plan rebates based on quality. The Reconciliation bill would also repeal the Comparative Cost Adjustment (CCA) program, and would require plans to spend a minimum amount of revenue on patient care, or pay a fine.

Under current law, payments to MA plans are determined by comparing a plan’s cost of providing required Medicare benefits (bid) to the maximum amount Medicare will pay for those benefits in each area (benchmark). If a plan bid is below the benchmark, the plan is paid their bid plus a rebate equal to 75% of the difference between the bid and the benchmark. If a plan bids above the benchmark, the plan is paid the benchmark and must charge each enrollee a premium equal to the difference between the bid and the benchmark. Historically, Congress has increased the benchmark amounts through statutorily specified formulas, in part, to encourage plan

participation throughout the country. As a result, the benchmark amounts in some areas are higher than the average cost of original fee-for-service Medicare.

Section 1102 of the Reconciliation bill repeals Section 3201 of H.R. 3590 and replaces it with a different methodology for changing MA payments. Under the Reconciliation bill, the benchmarks in 2011 would be held at the 2010 levels. In 2012, the Reconciliation bill would begin to phase-in blended benchmarks based on a percentage (95%, 100%, 107.5%, or 115%) of a base amount. In 2012, the base amount would be set at per-capita spending in original Medicare; after 2012, the base amount would be either the previous year's base amount increased by the growth in overall Medicare, or per capita spending in original Medicare in that county. The percentage adjustment to the base amount would be lower (95%) in counties where spending in original Medicare is the highest, and higher (115%) in counties where spending in original Medicare is the lowest. The phase-in schedule for the new benchmarks would vary over two, four, or six years depending on the size of the benchmark reduction, with a longer phase-in schedule for areas where the benchmark decreases by larger amounts. The new blended benchmarks would not apply to PACE plans.

Under current law, MA plans are required to have quality improvement programs, however, payments to MA plans are not contingent on the quality of care provided to plan enrollees. Under the Reconciliation bill,[6] starting in 2012, plans that qualify for a quality bonus would receive an increase in their blended benchmark amount, with larger increases for qualifying plans in qualifying areas. A qualifying plan is one that has received a 4-star or higher rating on a 5-star rating scale established by the Secretary. Plans with low-enrollment or new plans could also be eligible to be qualifying plans. A qualifying county would be a county with (1) lower than average per capital spending in original Medicare, (2) 25% or more beneficiaries enrolled in MA in the county, as of December 2009, and (3) a Medicare payment rate to private plans based on the minimum payment for a metropolitan statistical area (urban floor rate) in 2004, based on the payment methodology at the time. Under the bill, a plan's quality rating would also effect the size of the rebate it could receive; plans with higher quality ratings would receive higher rebates, with new rebates ranging from 50% to 70% of the difference between the bid and the benchmark. The change in rebate percentages would be phased-in over three years.

In addition, the Reconciliation bill would require the Secretary to adjust payments to plans for differences in the way diagnosis coding of patients differs between MA plans and original Medicare beyond 2010.[7] In general, MA plan payments are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Deficit Reduction Act of 2005 (P.L. 109-171, DRA) required the Secretary to adjust for patterns of diagnosis coding differences between MA plans and providers under parts A and B of Medicare for plan payments in 2008, 2009, and 2010. The Reconciliation bill would require the Secretary to conduct further analyses on the differences in coding patterns and continue to adjust MA plan payments based on the results after 2010. The

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[6] Section 3201 of the Senate-passed H.R. 3590 included provisions which would provide extra payments for plan quality and care coordination. This section was repealed by the Reconciliation bill.

[7] Section 3203 of the Senate-passed H.R. 3590 provided the Secretary with the authority to expand the use of coding intensity adjustments to MA risk scores for 2014 and subsequent years. That provision was repealed by the Reconciliation bill.

bill would also set a minimum adjustment in 2019 to be applied until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

The requirement for a six-year program that will begin in 2010 to examine comparative cost adjustment (CCA)[8] in designated CCA areas would be repealed by the Reconciliation bill. Specifically this program requires that payments to local MA plans in CCA areas would, in part, be based on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up of down.

A Medical Loss Ratio (MLR) identifies the proportion of a plan's premium revenue that the plan devotes to the provision of health care services. The remaining proportion represents the amount spent on managing the plan, including administrative costs, advertising, and profits. Beginning in 2014, Section 1103 of the Reconciliation bill would require plans that have an MLR of less than .85 to remit to the Secretary a payment equal to their total revenue multiplied by the difference between .85 and their MLR. This amount would be available to be used by the CMS Program Management Account. The Secretary would be required to restrict enrollment in an MA plan if its MLR was below .85 for three consecutive years and terminate the plan's contract if the plan failed to meet the MLR requirements for five consecutive years.

Changes to the Medicare Part D Outpatient Prescription Drug Benefit

Medicare law sets out a defined standard benefit structure under the Part D prescription drug benefit that includes a gap in coverage, commonly referred to as the "doughnut hole". In 2010, the standard benefit includes a $310 deductible and a 25% coinsurance until the enrollee reaches $2,830 in total covered drug spending (Medicare and beneficiary spending combined). After this initial coverage limit is reached, the enrollee is responsible for the full cost of the drugs until total costs hit the catastrophic threshold, $6,440 in 2010. In general, in 2010, Part D enrollees who do not receive assistance in the form of the Part D low-income subsidy, would be responsible for a total of $4,550 in out-of-pocket costs before reaching the catastrophic phase ($310 deductible, $630 in co-insurance in the initial coverage phase, and $3,610 in the coverage gap).[9]

The Senate-passed H.R. 3590 would make a number of changes to the Medicare Part D program including requiring, consistent with a voluntary agreement with the pharmaceutical industry, that beginning July 1, 2010 drug manufacturers provide certain Part D enrollees with discounts of 50% for brand name drugs during the coverage gap (Section 3301). Plan enrollees receiving the low income subsidy, enrolled in an employee–sponsored retiree drug plan, or with annual incomes that exceed the Part B income thresholds as determined under current law ($85,000 for singles and $170,000 for couples in 2009) would not be eligible for the discount. H.R. 3590 also would increase the initial coverage limit by $500 in 2010 (Section 3315).

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[8] The Comparative Cost Adjustment (CCA) program was required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-132) to: (1) examine a new MA payment system under which payments to MA plans would be based on a weighted average of plans bids; and (2) introduce possible adjustments (either increases or decreases) to fee-for-service Part B premiums, based on a comparison of the costs of providing required fee-for-service benefits to the costs of providing the same benefits in the MA program. It is to take place over a six-year period starting in 2010. The Senate-passed H.R. 3509 did not contain a provision to repeal the CCA program.

[9] Part D premiums are not included in the calculation of a beneficiary's out-of-pocket costs.

The Reconciliation bill (Section 1101) would repeal Section 3315 of H.R. 3590; and, instead of increasing the coverage limit by $500, the bill would provide rebates of $250 to Part D enrollees who enter the coverage gap in 2010. Additionally, under the Reconciliation bill the discount would begin January 1, 2011 instead of July 1, 2010, and higher income enrollees would be eligible to receive the discount. The Reconciliation bill would also phase out the Part D coverage gap. Specifically, the bill would gradually reduce the amount of enrollee cost sharing for both generic and brand name drugs through the coverage gap; in 2020 and beyond, beneficiary cost sharing would equal or be actuarially equivalent to 25% (similar to cost sharing during the initial coverage phase). The beneficiary co-payments and the value of the manufacturer discount for brand name drugs would count towards the calculation of Part D enrollees' out-of-pocket costs in determining when the catastrophic threshold would be reached; the Medicare covered portion would not be included in this calculation.

Changes to Medicare Taxes

Both H.R. 3590 and the Reconciliation bill include additional hospital insurance taxes on high-income taxpayers. Under current law, employers and employees each pay a payroll tax of 1.45% to finance Medicare Part A. The Senate-passed H.R. 3590 would impose an additional payroll tax of 0.9 percentage points on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers effective for taxable years after December 31, 2012. The additional tax only applies to wages above these thresholds. For these workers, the payroll tax would increase to 2.35% for wage income over the thresholds noted above. These additional revenues would go to the Medicare Hospital Insurance Trust Fund (often called Part A). (The Reconciliation bill amends this to clarify that married taxpayers filing separately are subject to a $125,000 threshold.) According to the Joint Committee on Taxation, the Senate H.R. 3590 revenue provision would raise $86.8 billion over a 10-year period.

The Reconciliation bill would also impose an additional tax on net investment income and the revenues accrued from this tax would go to the Federal Supplementary Medical Insurance Trust Fund (often called Part B). The Reconciliation bill defines net investment income to be interest, dividends, annuities, royalties, rents and taxable net capital gains. It excludes distributions from a qualified annuity from a pension plan.[10] Specifically, effective for taxable years after December 31, 2102, the bill would impose a tax equal to 3.8% of the *lesser* of:

(1) Net investment income for such taxable year, or

(2) The excess of modified adjusted gross income (MAGI)[11] over $250,000 for joint filers, $125,000 for married filing separately and $200,000 for all other returns.

Households with modified adjusted gross income under these thresholds would not be subject to the investment income tax. While those with incomes over the threshold would pay an additional tax whose amount would depend on the size of their net investment income relative to the amount that MAGI exceeds the thresholds. This tax is also applicable to certain estates and trusts.

[10] As defined in Sec. 401(a), 403(a), 403(b), 408, 408A, or 457(b) of the Internal Revenue Code.

[11] Modified adjusted gross income includes adjusted gross income plus foreign earned income.

The active income from trade for self-employed and S-corporations would not be subject to the tax.[12] For these entities, the tax would apply only to passive income and trade income related to commodity trading. There is a special provision for the application of the tax to S-Corporations who sell their businesses. JCT estimates that the investment income provision would raise an additional $123.4 billion over a 10-year period, for a total revenue effect of $210.2 billion for this provision.

Changes to Address Fraud and Abuse

In an effort to further reduce Medicare fraud, waste, and abuse, the Reconciliation bill adds three new provisions related to community mental health centers (Sec. 1301), Medicare's claims review processes (Sec. 1302), and data sharing between the IRS and CMS (Sec. 1303) and modifies two other provisions included in H.R. 3590.

Under current law, community mental health centers (CMHCs) must meet certain requirements in order to receive payment under Medicare. For example, CMHCs must demonstrate that they can provide the core mental health services described in the Public Health Service Act and that they are licensed in the state in which they are operating. Section 1301 of the Reconciliation bill would require that a CMHC also demonstrate that it provides a significant share of its service to individuals not eligible for Medicare. Section 1301 would also restrict Medicare reimbursement for mental health services delivered in an individual's home or in an inpatient or residential setting.

To protect the Medicare program from improper payments and fraudulent billing, Medicare contractors have the authority to review a provider's claims prior to payment. This is referred to as prepayment medical review. Under Medicare statute, contractors can only conduct prepayment review of a provider's claims under certain circumstances: (1) to develop a claims payment error rate and (2) only in instances where there is a likelihood of a sustained or high level of improper billing. Section 1302 of the Reconciliation bill would repeal these statutory limitations on prepayment review.

Section 1303 of the Reconciliation bill would require the Secretary of the Treasury to disclose certain tax return information (i.e., the amount of tax debt) related to Medicare providers and suppliers to HHS. HHS would be authorized to use such information to determine whether or not the provider or supplier should be allowed to enroll or re-enroll in Medicare or to determine whether enhanced oversight measures are necessary.

Activities to fight health care fraud, waste, and abuse are funded by the Health Care Fraud and Abuse Control (HCFAC) account. The total mandatory and discretionary funding level for HCFAC for FY2010 is approximately $1.5 billion. The Senate-passed H.R. 3590 would appropriate an additional $10 million in mandatory funding for HCFAC for fiscal years 2011 through 2020. Section 1304 of the Reconciliation bill would appropriate an additional $250 million to HCFAC over fiscal years 2011 through 2016. The annual amount of the appropriation would begin at $95 million in FY2011 and decrease to $20 million by FY2015 and FY2016.

[12] Corporations may elect S-corporation status if they meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 100 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations, which are subject to the corporate income tax.

Lastly, H.R. 3590 included a provision that would provide the Secretary with the authority to impose enhanced screening and oversight measures on providers enrolling and re-enrolling in Medicare. Sec. 1305 of the Reconciliation bill would require the Secretary to withhold payment to DME suppliers for 90-days in instances when the Secretary determines that there is a significant risk of fraud.

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