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CRS Report for Congress

Summary of Major Provisions in House-Passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008

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Summary

On June 24, 2008, the House passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008, under suspension of the rules by a vote of 355 to 59. The bill is designed to avert the Medicare reduction in payments for physicians, which would otherwise occur by law beginning on July 1, 2008, and make other changes. The bill would freeze physician fees at the current level until January 2009. In January 2009, fees would increase by 1.1%. In 2010, fees would revert back to current law levels, resulting in a 21% reduction to Medicare physician payments, according to the Congressional Budget Office (CBO). CBO estimates that the physician payments provision would cost $9.7 billion. Other provisions in the bill would offset these and other costs, so that in total, the provisions in H.R. 6331 would reduce deficits (or increase surpluses) by $0.3 billion over the 2008-2013 period and by less than $50 million over the 2008-2018 period.[1] The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program and (2) the physician assistance and quality initiative (PAQI) fund. The bill also makes changes to the Medicare, Medicaid, and other programs of the Social Security Act. This report focuses on the major provisions of H.R. 6331, with the most significant budgetary impacts, and is not meant to reflect all of the provisions.

Physician Payments and Other Physician Issues

H.R. 6331 is designed to avert the Medicare reduction in payments for physicians, which would otherwise occur by law beginning on July 1, 2008. Under current law, annual payment updates for physicians are linked to a formula (typically referred to as the Sustainable Growth Rate, or SGR formula). Under the formula, if cumulative spending

[1] The CBO cost estimate is available at [http://cbo.gov/ftpdocs/94xx/doc9494/RangelLtr HR6331.pdf].

on Medicare physician services since April 1996 exceeds cumulative target expenditures over the same period, a reduction in the update for physician payments is required (i.e., a reduction in the conversion factor). This has been the case since 2002; however, Congress has overridden the reduction since 2003.

The latest override, included in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA), increased the update to the conversion factor for Medicare physician payment by 0.5% (compared with 2007 rates) for the first six months of 2008. Absent any additional changes, the current update formula requires a reduction in the fee schedule of 10.6% for physician reimbursement for services provided between July 1 and December 31, 2008, and by additional amounts annually for at least several years thereafter. H.R. 6331 would temporarily avert this reduction and would extend the 0.5% increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008. For 2009, the update to the conversion factor would be 1.1%. The conversion factor for 2010 and subsequent years would be computed as if these modifications had never applied.[2] CBO estimates that these changes would cost $9.7 billion over the 2008-2010 period.

H.R. 6331 would modify the funding to the physician assistance and quality initiative (PAQI) Fund, created by the Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA). The PAQI fund is available to the Secretary of Health and Human Services (HHS) for physician payment and quality improvement initiatives. The MMSEA, as well as provisions in the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 2008 (division G of the Consolidated Appropriations Act of 2008), modified the amounts that will be available in the PAQI Fund and the years in which the monies can be spent. This provision would modify the statute so that funds for expenditures during 2013, an amount equal to $4.96 billion, would be eliminated. H.R. 6331 also contains a contingency that would apply if a Supplemental Appropriations Act, 2008, is passed that includes a provision modifying the PAQI Fund. The contingency effectively removes the monies from the fund, returns them to the Medicare Part A and Part B Trust Funds, and makes them available for other purposes.

The physician quality reporting system, which currently runs through 2009, would be extended through 2010 and beyond. Under current law, eligible professionals who provide covered professional services are eligible for the incentive payment if (1) there are quality measures that have been established under the physician reporting system that are applicable to any services furnished by such professional for the reporting period, and (2) the eligible professional satisfactorily submits data to the Secretary on the quality measures.

H.R. 6331 would also make other changes for physicians by establishing a physician feedback program, with the intent to improve efficiency and to control costs, and would require the Secretary of Health and Human Services to develop a plan to transition to a

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[2] For a further explanation of how physicians are paid under Medicare and why this reduction would occur, see CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan.

value-based purchasing program for payment under the Medicare program for covered professional services.

CBO estimates that changes in Section 131 of H.R. 6331 (including the changes to physician payment, the PAQI Fund, and other changes described above) would cost $6.4 billion over the 2008-2013 period and $4.5 billion over the 2008-2018 period.

H.R. 6331 would also establish a Medicare Improvement Fund that would be available to the Secretary to make improvements under the original Medicare fee-for-service program under parts A and B for Medicare beneficiaries. For FY2014 through FY2017, $19.9 billion would be made available from the Part A and B Trust Funds. A contingency provision would also apply to the funding of the Medicare Improvement Fund in the case that a Supplemental Appropriations Act, 2008, is passed. CBO estimates that these changes would cost $0.1 billion over the 2008-2013 period and $24.2 billion over the 2008-2018 period.

Medicare Advantage

H.R. 6331 would phase out Medicare indirect medical education (IME) payments to private health plans. IME payments account for a number of factors that may legitimately increase costs in teaching hospitals. Under the statutory rules for Medicare payments to Medicare Advantage (MA) plans, an MA plan whose payment is based on Medicare fee-for-service rates also may be eligible to receive a payment for IME. In addition, Medicare pays teaching hospitals directly for the cost of IME when an MA enrollee is treated in the hospital.

Beginning in 2010, this bill would require that the Medicare Advantage benchmarks (the maximum amount Medicare is willing to pay a private plan to provide required Medicare benefits) for every county be adjusted to phase out the cost of indirect medical education (IME). The amount phased-out each year would be based on a ratio of (a) a specified percentage (0.60% in the first year), relative to (b) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio would be to phase out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator phase-out percentage would be increased by 0.60 percentage points each year. This provision would not apply to the benchmarks for MA plans in the PACE program (Programs of All-Inclusive Care for the Elderly).

H.R. 6331 would also change access requirements for Private Fee-for-Service plans (PFFS). Under current law, PFFS, unlike most other MA plans, are not required to form networks of medical providers to meet certain access requirements. PFFS plans (both non-employer- and employer-sponsored) may fulfill access requirements by establishing payment rates for medical providers that are no less than the rates under original Medicare. Any provider who, before delivering a service, knows that a beneficiary is enrolled in the PFFS plan, and has been given, or has reasonable access to, the PFFS plan's terms and conditions for participation, is a "deemed" provider.

Beginning in year 2011, this bill would require non-employer-sponsored MA PFFS plans (operating in areas with *at least* two other plans that have provider networks) to meet Medicare access requirements by establishing written contracts with providers.

Non-employer sponsored MA PFFS plans (operating in areas with *less than* two other plans that have provider networks) could continue to meet Medicare access requirements through deeming.

Beginning in year 2011, employer-sponsored MA PFFS plans would be required to establish written contracts with providers. Employer-sponsored MA PFFS plans would no longer be able to meet access requirements, in whole or in part, by establishing payment rates that are equal to or greater than those under original Medicare.

CBO combined the savings estimates for the changes to IME and PFFS. It estimated that these provisions would save $12.5 billion over the 2008-2013 period and $47.5 billion over the 2008-2018 period.

The bill would also reduce the initial funding to the MA Regional Plan Stabilization Fund to one dollar. When the fund was first established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA), it had an initial funding level of $10 billion. Subsequent legislation reduced this amount to $1.79 billion. The MMA also requires that a portion of the savings accrued in the regional plan bidding process be added to the Fund. This bill would not alter that funding stream, so that money from the regional plan bidding process would continue to flow into the Fund. Expenditures would be delayed one year, until 2014. CBO estimates that these changes would save $1.3 billion over the 2008-2013 period and $1.8 billion over the 2008-2018 period.

Other Provisions

The sections of the bill described below are primarily other provisions with significant costs or savings that would cost or save at least $2 billion over the 10-year period (2008-2018), as estimated by CBO.

H.R. 6331 would add "additional preventive services" to the list of Medicare-covered preventive services. The term "additional preventive services" would mean services not otherwise described in Medicare law that identify medical conditions or risk factors that the Secretary determined met certain specified conditions. The bill would also waive the deductible for the initial preventive physical exam (also known as "Welcome to Medicare") and extend the eligibility period for this service from the first six months to the first year of Part B enrollment. CBO estimates that these changes would cost $1.4 billion over the 2008-2013 period and $5.9 billion over the 2008-2018 period.

The bill would increase the percentage that Medicare generally pays for mental health services from 50% to 80% over the 2010-2014 period; when the provision was fully phased-in in 2014, outpatient psychiatric services would be paid on the same basis as other Part B services. CBO estimates that these changes would cost $0.5 billion over the 2008-2013 period and $3 billion over the 2008-2018 period.

H.R. 6331 would increase, effective January 1, 2010, the assets tests applicable under the Medicare Savings program (MSP) to those applicable under the low-income subsidy program under the Medicare Part D prescription drug program ($6,290 for an individual, $9,440 for a couple in 2008, updated annually). CBO estimates that these

changes would cost $1.6 billion over the 2008-2013 period and $7.0 billion over the 2008-2018 period.

The bill would repeal the current law requirement for competitive bidding for clinical laboratory services. In addition, it would specify that the clinical laboratory fee schedule update otherwise slated to occur each year would be reduced each year from 2009 through 2013 by 0.5 percentage points. CBO estimates that these changes would save $0.6 billion over the 2008-2013 period and $2.0 billion over the 2008-2018 period.

H.R. 6331 also makes changes to low-income programs for Medicare beneficiaries, as well as Medicaid. It makes changes to Medicare provisions for hospitals, renal dialysis coverage, and Medicare prescription drug coverage, among others. Finally, the bill would terminate all contracts under the first round of the Durable Medical Equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) competitive acquisition program, set to start July 1, 2008. It would require the Secretary to re-bid the first round in 2009 and would delay the second round of bidding until 2011. To pay for the cost of the program delay, the bill would require a 9.5% reduction in the fee schedule payments for all round 1 DMEPOS items and services both inside and outside of competitive acquisition areas. CBO estimates that the changes to the DEMPOS competitive bidding program would have a negligible budgetary impact.