



Legislative Bulletin.....June 24, 2008

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H.R. 6331 — Medicare Improvements for Patients and Providers Act

**H.R. 6331 — Medicare Improvements for Patients and Providers Act
(Rangel, D-NY)**

Please note the Conservative Concerns beginning on page 10, and those highlighted throughout the bulletin.

Order of Business: The bill is scheduled to be considered under suspension of the rules on Tuesday, June 24, 2008.

Summary: H.R. 6331 eliminates for six months a reduction in Medicare physician payments scheduled to take effect on June 30, 2008, freezing payment levels for the balance of 2008 and providing a 1.1% increase in fee schedule levels for 2009. H.R. 6331 also reduces payments to and modifies the structure of privately-run Medicare Advantage fee-for-service (FFS) plans that have shown significant growth in recent years.

Medicare: H.R. 6331 contains many provisions that would alter Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act as follows. (Note that a Congressional Budget Office score for H.R. 6331 was not available at press time; the scores cited below are for a similar bill, S. 3101, introduced and considered in the Senate, and may vary slightly from the provisions the House will be considering.)

Coverage of Preventive Services. The bill would create a process for the Secretary of Health and Human Services to extend Medicare coverage to additional preventive services under Parts A and B, and would waive the deductible with respect to the initial physical exam provided upon a beneficiary's enrollment in the Medicare program. *CBO scores this provision as costing \$5.9 billion over eleven years.*

Mental Health Parity. The bill would reduce over five years the co-payment for outpatient psychiatric services to 20%, consistent with the co-payment rate for physician visits under Medicare Part B. *CBO scores this provision as costing \$3 billion over eleven years.*

Marketing Restrictions on Private Plans. The bill would impose restrictions with respect to the marketing tactics used by private Medicare Advantage and prescription drug plans. The bill would eliminate unsolicited direct contact to beneficiaries, restrict the provision of gifts to nominal values, require annual training of agents and brokers licensed under state law, and impose related marketing restrictions. *No net cost.*

Low-Income Programs. H.R. 6331 would extend the Qualifying Individual program under Medicare and Medicaid for eighteen months, through December 2009, at a cost of \$500 million. The bill would also expand eligibility for enrollment in the low-income subsidy program by altering the asset test for the Medicare Savings Program, and engaging in further outreach to beneficiaries eligible for participation but not currently enrolled. Other provisions in this section would codify current guidance eliminating the Part D late enrollment penalty for individuals eligible for low-income subsidies, and require the translation of the enrollment form into at least 10 languages other than English. *Total cost of these provisions is \$7.7 billion over eleven years.*

Hospital Provisions. The bill includes several hospital-related provisions, including the extension of rural hospital flexibility program, new grants for the provision of mental health services to Iraq war veterans in rural areas, new grants to certain critical access hospitals, a re-adjustment of target payment amounts for sole community hospitals, a new demonstration program for integrating care in certain rural communities, and the reclassification of certain hospitals. *Total cost of these provisions according to CBO is \$500 million over eleven years.*

Physician Services. The bill makes several adjustments to physician payment rates, including the following:

Conversion Factor: The bill would extend the 0.5% update to the conversion factor for physician reimbursements, currently due to expire on June 30, 2008, through the end of calendar year 2008, effectively freezing payment levels for the balance of the year. For 2009, the conversion factor will be 1.1%. The bill also provides that the adjustments made for 2008 and 2009 will be disregarded for the purposes of computing the sustainable growth rate (SGR) conversion factor in 2010 and future years, which would necessitate a 21% reduction in reimbursement levels in 2010.

Quality Reporting: H.R. 6331 would revise and extend existing quality reporting language to provide a 1.5% bonus payment in 2008, and 2.0% bonus payments in 2009 and 2010, to those physicians reporting selected quality data measurements. *Cost of both the quality reporting and conversion factor provisions is \$6.8 billion over six years, and \$5 billion over eleven.*

Electronic Prescribing: The bill provides bonus payments for physicians who participate in electronic prescribing and report relevant quality measures—2.0% in 2009 and 2010, 1.0% in 2011 and 2012, and 0.5% in 2013. Physicians not participating in the electronic prescribing program will receive reimbursement reductions of 1% in 2012, 1.5% in 2013, and 2% in 2014 and thereafter. *Saves \$1.7 billion over eleven years.*

Other provisions: With respect to physician services, the bill also revises a medical home demonstration project, extends the floor for Medicare work geographic adjustments under the physician fee schedule through December 2009, imposes accreditation requirements on the payment of diagnostic imaging services, and increases payment levels for teaching anesthesiologists. H.R. 6331 also includes a requirement for the Secretary to report to Congress on the creation of a new system of value-based purchasing for physician services. *Total cost of \$1.9 billion over eleven years.*

Other Part B Adjustments. The bill would make several other adjustments to the Part B program, among which are an extension through December 2009 of the exceptions process for Medicare therapy caps (*costs \$1.2 billion over eleven years*), the inclusion of speech-language pathology services as a service for which providers can bill Medicare directly (*\$100 million cost*), the establishment of cardiac and pulmonary rehabilitation programs, a repeal of the transfer of ownership with respect to oxygen equipment, repeal of a competitive bidding demonstration project for clinical laboratory services (*\$100 million cost*), increased payments for ambulance services (*\$100 million cost*), payment clarification for clinical laboratory tests made at critical access hospitals (*\$300 million cost*), and increased payment limits for federally qualified health centers treating Medicare patients (*\$100 million cost*).

Kidney Disease and Dialysis Provisions. H.R. 6331 makes several adjustments to the end-stage renal disease program, including new coverage for kidney disease education services, a 1% increase in dialysis reimbursement rates for 2009 and 2010, and a requirement that the Secretary develop a bundled rate payment system for renal dialysis by January 2011, to be phased in over four years, that includes payment for drugs and tests related to dialysis treatment for which Medicare currently reimburses providers separately. *Costs \$1.5 billion over eleven years.*

Delay of Durable Medical Equipment Competitive Bidding. The legislation would terminate all Round 1 contracts for Medicare durable medical equipment made pursuant to the initial round of competitive bidding completed this spring, and would direct CMS to re-bid Round 1 at some point during 2009. Future rounds of competitive bidding would also be delayed, with Round 2 taking place during 2011, and competitive bidding in rural areas and smaller metropolitan areas being delayed until 2015. The approximately \$3 billion cost of the delay would be paid for by an across-the-board reduction of 9.5% for all supplies scheduled to be subjected to competitive bidding. In addition, the bill would require the CMS contractor to notify suppliers missing financial documentation related to their bids, extend disclosure and accreditation requirements to sub-contractors, and establish an ombudsman within CMS to respond to complaints from suppliers and individuals about the competitive bidding process.

Medicare Advantage Provisions. H.R. 6331 would cut Medicare Advantage payments, primarily through two adjustments. The first would phase out duplicate payments related to indirect medical education (IME) costs at teaching hospitals. Currently, IME costs are incorporated into the benchmark which Medicare Advantage plans bid against, even though Medicare also makes IME payments to teaching hospitals in association with hospital stays for Medicare Advantage beneficiaries. The Administration incorporated this proposal into its Fiscal Year 2009 budget submission to Congress.

The bill also would repeal “deeming” authority language for private fee-for-service plans within Medicare Advantage, which currently can reimburse providers at the traditional Medicare rate and “deem” these providers part of their network. Instead, H.R. 6331 would require private fee-for-service plans to adopt physician networks in areas where at least two other types of coordinated care plans (e.g. Health Maintenance Organizations Preferred Provider Organizations, etc.) operate.

Preliminary data from CMS indicate that the provisions in H.R. 6331 would result in private fee-for-service plans losing their “deeming” authority in 96% of counties in which they currently operate, potentially resulting in loss of beneficiary access to a type of Medicare Advantage plan which has experienced significant growth in recent years. The Congressional Budget Office confirms that the provision would reduce both Medicare outlays and enrollment in the Medicare Advantage program. In a [Statement of Administration Policy](#) on the Senate bill (S. 3101) incorporating these provisions, the Office of Management and Budget opposed the changes as a “fundamental restructuring” of this segment of the Medicare Advantage program that would result in beneficiaries losing access to the enhanced benefits which Medicare Advantage plans provide. The IME provision and the deeming language collectively cut Medicare Advantage by *\$12.5 billion over six years, and \$47.5 billion over eleven years.*

H.R. 6331 includes several other provisions relating to Medicare Advantage plans, including an extension of and revisions to plans for special needs individuals (*costs \$500 million over eleven years*), garnishment of the remaining funds left in the Medicare Advantage stabilization fund (*saves \$1.8 billion over eleven years*), and two studies by the Medicare Payment Advisory Commission (MedPAC) regarding Medicare Advantage quality data and payment formulae.

Pharmacy Provisions. The bill makes changes to the Part D prescription drug program, most notably requiring “prompt payment” by drug plans to pharmacies for prescriptions within 14 days for electronic claims and 30 days for all other claims, at a cost of *\$700 million over eleven years.*

Release of Part D Data. The bill would permit the Secretary to utilize Part D claims data from private plans in order to improve the public health as the Secretary determines appropriate, and would further allow Congressional support agencies to obtain the data for oversight and monitoring purposes. *No net cost.*

Medicare Improvement Fund. H.R. 6331 would establish a Medicare Improvement Fund to allow the Secretary to make enhancements to Medicare Parts A and B, and appropriates funding of \$19.9 billion from FY2014 through FY2017 to fund such efforts. *Costs \$19.9 billion over eleven years.*

Federal Payment Levy. The bill would expand the federal payment levy—which provides for the recoupment of taxes owed the federal government by private contractors—to Medicare provider and supplier payments. *Saves billion over eleven years.*

TMA and Title V Extension. H.R. 6331 would extend for twelve months (until June 30, 2009), both the authorization for Title V programs (abstinence education programs), and the

authorization for Transitional Medical Assistance (Medicaid benefits for low-income families transitioning from welfare to work). TMA has historically been extended along with the Title V Abstinence Education Program. Regarding the Title V grant program, in order for states to receive Title V block grant funds, states must use the funds exclusively for teaching abstinence. In addition, in order to receive federal funds, a state must match every \$4 in federal funds with \$3 in state funds.

Other Extensions. The bill also adjusts the federal Medicaid matching rate for foster care and related services provided by the District of Columbia, and extends certain other provisions, including Medicaid Disproportionate Share Hospital (DSH) payments, TANF supplemental grants, and special diabetes grant programs. *Total cost of \$1 billion over eleven years.*

Additional Background on Senate Legislation: H.R. 6331 closely resembles legislation (S. 3101) originally introduced by Senate Finance Committee Chairman Max Baucus (D-MT). At least one circulating draft of H.R. 6331 includes “Sense of the Senate” language, despite the fact that the bill is ostensibly an original House measure. On June 12, 2008, the Senate by a 54-39 vote failed to invoke cloture on a motion to proceed to consideration of S. 3101.

Despite sharing similar language, H.R. 6331 and S. 3101 differ in a few respects. The House bill excludes cuts to reimbursement of oxygen supplies and power-driven wheelchairs included in the Senate version, instead incorporating the federal payment tax levy and other provisions to compensate for the lost budgetary savings. In addition, H.R. 6331 includes legislation (H.R. 6252) introduced by Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) and Ranking Member Dave Camp (R-MI) to postpone competitive bidding of durable medical equipment. Chairman Baucus had attempted to add these provisions to his Senate legislation, but was unable to persuade enough Senate Republicans to support cloture in order to allow him to do so, largely because Republicans objected to the Medicare Advantage cuts envisioned by his legislation.

Additional Background on Medicare Advantage: The Medicare Modernization Act of 2003 made several changes to the bidding and payment structure for private Medicare Advantage plans to deliver health care to beneficiaries. As currently constructed, plans receive capitated monthly payments that are subject to risk adjustment—so that plans caring for older, sicker beneficiaries receive higher payments than those with healthier populations. In order to determine the capitated payment amount, plans submit annual bids to the Centers for Medicare and Medicaid Services (CMS). The bids are compared against a benchmark established by a detailed formula—but the comparison against the benchmark does not directly allow plans to compete against each other, or against traditional Medicare, when CMS evaluates plan bids.

In the event a plan’s bid is below the annual benchmark, 75% of the savings is returned to the beneficiary in the form of lower cost-sharing (i.e. premiums, co-payments, etc.) or better benefits, with the remaining 25% returned to the federal government. If a plan’s bid is above the benchmark, beneficiaries pay the full amount of any marginal costs above the benchmark threshold.

Most Medicare Advantage plans use rebates provided when bidding below the benchmark to cover additional services over and above those provided by traditional Medicare, and in so doing reduce beneficiaries' exposure to out-of-pocket costs. A Government Accountability Office (GAO) report released in February 2008 documented that in most cases, beneficiaries receive better benefits under Medicare Advantage than they would under traditional Medicare. The GAO study found that beneficiary cost-sharing would be 42% of the amounts anticipated under traditional Medicare, with beneficiaries saving an average of \$67 per month, or \$804 annually.¹ These savings to MA beneficiaries occurred because plans dedicated 89% of their rebates from low bids to reduced cost-sharing or lower premiums. The remaining 11% of rebates were used to finance additional benefits, such as vision, dental, and hearing coverage, along with various health education, wellness, and preventive benefits.² Due in part to the increased benefits which Medicare Advantage plans have provided, enrollment in MA plans is estimated to rise to 22.3% of all Medicare beneficiaries in 2008, up from 12.1% in 2004.³

Some independent studies have suggested that Medicare Advantage plans incur higher costs than the average annual cost of providing coverage through traditional Medicare, though estimates vary as to the disparity between the two forms of coverage. However, to the extent that MA plans in fact receive payments in excess of the costs of traditional Medicare, this discrepancy remains inextricably linked to two features of the Medicare Advantage program—the increased benefits for beneficiaries, and the complexity of the MA plan bidding mechanism. Because of the problems inherent in the statutory benchmark design, plans have little incentive to submit bids less than the cost of traditional Medicare, as plans that bid above the costs of traditional Medicare but below the benchmark receive the difference between traditional Medicare costs and the plan bid as an extra payment to the plan.⁴

Some conservatives would also argue that a discussion focused solely on Medicare Advantage “overpayments” ignores the significant benefits that MA plans provide to key underserved beneficiary populations. Medicare Advantage plans have expanded access to coverage in rural areas. Moreover, the disproportionate share of low-income and minority populations who have chosen the MA option suggests that the comprehensive benefits provided are well-suited to beneficiaries among vulnerable populations. Data from the Medicare Current Beneficiary Survey demonstrate that almost half (49%) of Medicare Advantage beneficiaries have incomes less than \$20,000, and that 70% of Hispanic and African-American Medicare Advantage enrollees had incomes below the \$20,000 level.⁵

¹ Government Accountability Office, “Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs,” (Washington, Report GAO-08-359, February 2008), available online at <http://www.gao.gov/new.items/d08359.pdf> (accessed May 19, 2008), p. 23.

² Ibid., pp. 17-20.

³ Department of Health and Human Services, “HHS Budget in Brief: Fiscal Year 2009,” available online at <http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf> (accessed May 19, 2008), p. 58.

⁴ The Medicare Payment Advisory Commission (MedPAC) has alleged that the formula-driven benchmarks themselves exceed the cost of traditional Medicare. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, DC, March 2008), available online at http://www.medpac.gov/documents/Mar08_EntireReport.pdf (accessed May 9, 2008), Table 3-3, p. 247.

⁵ America's Health Insurance Plans, “Low Income and Minority Beneficiaries in Medicare Advantage Plans,” (Washington, DC, AHIP Center for Policy and Research, February 2007), available online at <http://www.ahipresearch.org/PDFs/FullReportAHIPMALowIncomeandMinorityFeb2007.pdf> (accessed May 19, 2008), p. 3.

Additional Background on Medicare Physician Reimbursements: Under current Medicare law, doctors providing health care services to Part B enrollees are compensated through a “fee-for-service” system, in which physician payments are distributed on a per-service basis, as determined by a fee schedule and an annual conversion factor (a formula dollar amount). The fee schedule assigns “relative values” to each type of provided service. Relative value reflects physicians’ work time and skill, average medical practice expenses, and geographical adjustments. In order to determine the physician payment for a specific service, the conversion factor (\$37.8975 in 2006) is multiplied by the relative value for that service. For example, if a routine office visit is assigned a relative value of 2.1, then Medicare would provide the physician with a payment of \$79.58 for that service. ($\$37.8975 \times 2.1$)

Medicare law requires that the conversion factor be updated each year. The formula used to determine the annual update takes into consideration the following factors:

- Medicare economic index (MEI)—cost of providing medical care;
- Sustainable Growth Rate (SGR)—target for aggregate growth in Medicare physician payments; and
- Performance Adjustment—an adjustment ranging from -13% to +3%, to bring the MEI change in line with what is allowed under SGR, in order to restrain overall spending.

Every November, the Centers for Medicare and Medicaid Services (CMS) announces the statutory annual update to the conversion factor for the subsequent year. The new conversion factor is calculated by increasing or decreasing the previous year’s factor by the annual update.

From 2002 to 2007, the statutory formula calculation resulted in a negative update, which would have reduced physician payments, but not overall physician spending. The negative updates occurred because Medicare spending on physician payments increased the previous year beyond what is allowed by SGR. The SGR mechanism is designed to balance the previous year’s increase in physician spending with a decrease in the next year, in order to maintain the aggregate growth targets. Thus, in light of increased Medicare spending in recent years, the statutory formula has resulted in negative annual updates. It is important to note that while imperfect, the SGR was designed as a cost-containment mechanism to help deal with Medicare’s exploding costs, and to some extent it has worked, forcing offsets in some years and causing physician payment levels to be scrutinized annually as if they were discretionary spending.

Since 2003, Congress has chosen to override current law, providing doctors with increases each year, and level funding in 2006. In 2007, Congress provided a 1.5% update bonus payment for physicians who report on quality of care measures; however, Congress also provided that the 2007 “fix” would be disregarded by CMS for the purpose of calculating the SGR for 2008, resulting in a higher projected cut next year. The specific data for each year is outlined in the following table.

Year	Statutory Annual Update (%)	Congressional “Fix” to the Update (%)*
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2002	-5.4	-5.4**
2003	-4.4	+1.6
2004	-4.5	+1.5
2005	-3.3	+1.5
2006	-4.4	0
2007	-5.0	+1.5****
2008	-10.1§	0.5 (proposed)

* The annual update that *actually went into effect* for that year.

** CMS made other adjustments, as provided by law, which resulted in a net update of - 4.8%; however, Congress did not act to override the -5.4% statutory update.

*** The full 1.5% increase was provided to physicians reporting quality of care measures; physicians not reporting quality of care received no net increase.

§ The Tax Relief and Health Care Act signed last year provided that 2007’s Congressional “fix” was to be disregarded for the purpose of calculating the SGR in 2008 and future years.

Because the Tax Relief and Health Care Act (P.L. 109-432), signed into law in December 2006, provided that 2007’s Congressional “fix” was to be disregarded for the purpose of calculating the SGR in 2008 and future years, the 10.1% negative annual update for 2008 will be restored once the December 2007 legislation expires on July 1, 2008, absent further Congressional action. In addition, H.R. 6331 includes a similar provision noting that the “fix” proposed would be disregarded for the purpose of calculating the SGR in 2010 and future years, resulting in a projected 21% reduction in fee schedule levels in January 2010.

Additional Background on Durable Medical Equipment: In addition to providing coverage for outpatient physician services, Medicare Part B also helps pay for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) needed by beneficiaries. Currently, Medicare reimburses beneficiaries for supplies using a series of fee schedules, which are generally based on historical prices subject to annual updates or other adjustments. Medicare finances 80% of the actual costs or the fee schedule amount, whichever less, with the beneficiary paying the difference. The Centers for Medicare and Medicaid Services (CMS) estimates that about 10 million individuals—or about one-quarter of all beneficiaries—receive medical supplies under Part B in a given year, at a cost to Medicare of approximately \$10 billion annually.⁶

In recent years, some conservatives have raised concerns that the prices on the Medicare fee schedule for DMEPOS were in excess of market prices. In 2002, testimony by the Department of Health and Human Services Inspector General revealed that the prices paid by Medicare for 16 selected items of durable medical equipment were higher than prices paid by Medicaid, the Federal Employee Health Benefits (FEHB) plans, and consumers purchasing directly from retailers. The Inspector General projected that using the lower prices by other payers for these 16 common items alone would have saved Medicare more than \$100 million annually.⁷

⁶ Cited in Government Accountability Office, “Medicare: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical,” (Washington, Report GAO-08-767T), available online at <http://www.gao.gov/new.items/d08767t.pdf> (accessed June 9, 2008), p. 3.

⁷ Testimony of Janet Rehnquist, Inspector General of the Department of Health and Human Services, before Senate Appropriations Subcommittee on Labor, HHS, and Education, June 12, 2002 hearing, available online at <http://www.oig.hhs.gov/testimony/docs/2002/020611fin.pdf> (accessed June 16, 2008).

In response to the above findings, Congress in the Medicare Modernization Act (MMA) of 2003 (P.L. 108-173) enacted cuts in the fee schedule levels for the 16 specific items studied by the Inspector General’s testimony, while creating a new competitive bidding process for DMEPOS suppliers in Section 302 of the law. This nationwide program followed on the heels of three demonstration projects, authorized under the Balanced Budget Act of 1997, established during the period 1999-2002 in Florida and Texas. The pilot programs demonstrated the ability of competitive bidding to reduce the costs of DMEPOS by an average 19.1%—saving the federal government \$7.5 million, and \$1.9 million in reduced beneficiary co-payments—while maintaining beneficiary access to required items.⁸

In addition to a program of competitive bidding for DMEPOS, the MMA also established a new accreditation process for suppliers designed to review suppliers’ financial records and other related documentation to establish their status as *bona fide* health equipment suppliers. A November 2007 CMS estimate indicated that 10.3% of payments to medical equipment suppliers were improper—a rate of questionable payments more than double those of other Medicare providers.⁹ Coupled with the new competitive bidding program, the accreditation mechanism was intended to eliminate “fly-by-night” DMEPOS suppliers from operating within the Medicare program, and thus was included in the anti-fraud title of MMA.

In recent months, the competitive bidding program has come under criticism due both to procedural concerns as to how the bidding process was conducted—several of which CMS is working to address—and broader concerns as to whether the program will adversely affect beneficiary access to supplies and/or DMEPOS suppliers, particularly small businesses, whose bids were priced unsuccessfully. Some conservatives may question the need to delay the competitive bidding process, particularly on the latter grounds. CMS provided specific opportunities for small businesses to participate in the DMEPOS competitive bidding process, resulting in approximately half of firms who accepted winning bids having revenues of less than \$3.5 million. These small business opportunities occurred in the context of a market-oriented bidding mechanism that, when fully implemented, will save taxpayers approximately \$1 billion annually—and will provide additional savings to Medicare beneficiaries in the form of reduced co-payments. In addition, the accreditation mechanism established by Section 302 of MMA provides a quality check previously lacking for DMEPOS purchases and suppliers.

Cost to Taxpayers: A Congressional Budget Office (CBO) score for H.R. 6331 was unavailable at press time. However, a CBO estimate on a similar bill (S. 3101) introduced and considered in the Senate noted that that legislation would increase spending on physician and related services by \$19.8 billion over six years and \$62.8 billion over the 2008-2018 period. These spending increases would be offset by spending cuts in other health spending, primarily Medicare Advantage plans. Overall, S. 3101 was projected to reduce direct spending by \$5 million over the six- and eleven-year budget windows.

⁸ Testimony of Thomas Hoerger, Senior Fellow, Research Triangle Institute International, before House Ways and Means Subcommittee on Health, May 6, 2008 hearing on Durable Medical Equipment Competitive Bidding, available online at <http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=6906> (accessed June 9, 2008).

⁹ Cited in Government Accountability Office, “Medicare Competitive Bidding,” pp. 10-11.

Committee Action: The bill was introduced on June 20, 2008, and referred to the Energy and Commerce and Ways and Means Committees, neither of which took official action on the legislation.

Possible Conservative Concerns: Numerous aspects of H.R. 6331 may raise concerns for conservatives, including, but not necessarily limited to, the following:

- **Process.** The Centers for Medicare and Medicaid Services notes that in 2006, total expenditures for the Medicare program were \$408.3 billion.¹⁰ According to the World Bank, the \$408.3 billion spent on Medicare in 2006 *exceeded the Gross Domestic Product of 164 of the world's 180 national economies.*¹¹ Some conservatives may therefore be concerned that legislation making significant changes to a program larger than the national economies of Israel, Colombia, and the Czech Republic *combined* is being considered under expedited procedures on the suspension calendar.
- **Government Price Fixing.** By making alterations in physician and other Medicare fee schedules, H.R. 6331 would reinforce a system whereby Congress, by adjusting various reimbursement levels, permits the government, rather than the private marketplace, to set prices for medical goods and services. Senate Finance Committee Chairman Max Baucus admitted some disquiet about this dynamic—and Congress' lack of expertise to micro-manage the health care system—at a health care summit on June 16: “How in the world am I supposed to know what the proper reimbursement should be for a particular procedure?”¹² Yet H.R. 6331, based on legislation Chairman Baucus himself introduced, would retain the current system of price-fixing—while repealing a competitive bidding demonstration project for clinical laboratory services and delaying a competitive bidding program designed to inject market forces into the purchase of durable medical equipment and supplies.
- **Budgetary Gimmick.** Because language in H.R. 6331 stipulates that the conversion factor adjustments in the bill shall not be considered when determining future years' SGR rates, physician reimbursement rates will be reduced 21% in 2010—an action which, given past trends, many observers would consider highly unlikely. Therefore, some conservatives may be concerned that this language is designed to mask the true cost of the physician reimbursement adjustments included in the bill, creating a budgetary gimmick that future Congresses will feel pressured to remedy.
- **Undermines Medicare Advantage.** H.R. 6331 includes several provisions designed to “reform” private fee-for-service plans operating within Medicare Advantage that would

¹⁰ CMS Office of the Actuary, “Brief Summaries of Medicare and Medicaid,” (Baltimore, MD, November 2007), available online at <http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2007.pdf> (accessed June 21, 2008), p. 15.

¹¹ Available online at <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP.pdf> (accessed June 21, 2008).

¹² Quoted in Anna Edney, “Bernanke: Health Care Reform Will Require Higher Spending,” *CongressDailyPM* June 16, 2008, available online at http://www.nationaljournal.com/congressdaily/cdp_20080616_8602.php (accessed June 16, 2008).

reduce their payments by \$47.5 billion over eleven years, effectively ending their “deeming” authority, and requiring virtually all private fee-for-service plans to contract with health care providers. Some conservatives may be concerned that these changes would undermine the effectiveness of the Medicare Advantage program, which has grown in popularity among seniors due to the benefit enhancements that private coverage can provide.

- **Creates New Medicare Fund.** The bill would establish a new Medicare Improvement Fund, which would receive \$19.9 billion for the “enhancement” of traditional Medicare Parts A and B during Fiscal Years 2014-2017. Some conservatives may consider this account a new “slush fund” that will be used to finance further expansions of government-run health programs, rather than to bolster Medicare’s precarious financial future.
- **Release of Part D Data.** H.R. 6331 would authorize the Secretary to utilize Part D claims data from private health plans for any use deemed by the Secretary as relating to the public health, and would further authorize Congressional support agencies to utilize the same data for oversight purposes. Some conservatives may be concerned that these wide-ranging provisions could lead to the public release of private and proprietary information related to the claims and bidding practices of private health plans providing prescription drug coverage under Part D, and could be used to initiate “fishing expedition” investigations at the behest of Democrats philosophically opposed to having private entities provide coverage to Medicare beneficiaries.
- **Delays Competitive Bidding.** H.R. 6331 would delay the first round of competitive bidding for durable medical equipment, and would nullify contracts signed by CMS for the first round of bidding this spring. Re-opening the bidding process could prejudice entities who won their bids earlier this year, while potentially reducing savings to the federal government by allowing suppliers to bid more strategically in a re-bid scenario. Some conservatives may be concerned that the delay contemplated by H.R. 6331 would allow a new Administration to take steps undermining the competitive bidding program through the regulatory process, and/or allow a new Administration and a future Congress to make the “temporary” delay permanent and abolish competitive bidding outright.

Administration Position: Although a formal Statement of Administration Policy (SAP) was unavailable at press time, reports indicate that the Administration opposes the legislation and will likely issue a veto threat on the bill.

Does the Bill Expand the Size and Scope of the Federal Government?: Yes, the bill would expand eligibility for participation in the Medicare Savings Program.

Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?: No.

Does the Bill Comply with House Rules Regarding Earmarks/Limited Tax Benefits/Limited Tariff Benefits? An earmarks/revenue benefits statement required under House Rule XXI, Clause 9(a) was not available at press time.

Constitutional Authority: A committee report citing constitutional authority is unavailable.

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