Medicare: FY2010 Budget Issues

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Summary

Federal law requires the President to submit an annual budget to Congress no later than the first Monday in February. 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. President Obama submitted a summary of his FY2010 economic and budget plan to Congress on February 26. The President's detailed budget proposal was released to Congress on May 7.

The President's FY2010 budget estimates current law Medicare outlays of $447 billion in FY2010. The budget includes a number of legislative proposals with estimated savings for Medicare. With these proposals, the President expects to save $520 million in 2010, $92.3 billion over the five-year budget period (FY2010–FY2014), and $287.5 billion (FY2010-FY2019) over the 10-year budget period. The majority of the savings are expected to come from a proposal to establish competitive bidding in the Medicare Advantage (MA) program. The President estimates savings of $47.6 billion from competitive bidding over the five-year budget period and $177 billion over the 10-year budget period. Other savings proposals include adjusting home health payments and bundling payments for inpatient hospital and post-acute care. President Obama proposes to direct savings from these proposals, and other non-Medicare proposals, into a reserve fund to finance future health care reform efforts. The total dollar amount made available for the reserve fund, which is to be available for the next 10 years, is $635 billion.

The President's budget also includes three administrative proposals with expected savings. The President estimates savings of $3.5 billion in FY2010, $12.6 billion over the five-year budget period, and $27 billion over the 10-year budget period from these policies. The President's budget does not specify that savings from these policies will be directed to the reserve fund.

The total estimated savings from the President's legislative and administrative proposals related to Medicare are expected to amount to $4 billion in FY2010, $105 billion over the five-year budget period, and $314.5 billion over the 10-year budget period.

Finally, the President's budget provides for a discretionary funding request of $311 million in FY2010 and $1.7 billion over the five-year budget period to enhance Medicare's health care fraud and abuse control efforts. The President estimates mandatory savings of $485 million in FY2010 and $2.7 billion over the five-year budget period from this investment in discretionary funding.

Both the House and Senate have adopted a FY2010 budget resolution. By establishing aggregate revenue and spending levels for the next five years, the resolution provides a framework for Congress to assess legislation introduced in the coming months. The conference agreement on the budget resolution (S.Con.Res. 13, H.Rept. 111-89) was passed in the House (by a 233-193 vote) and in the Senate (by a 53-43 vote) on April 29. The $3.5 trillion budget resolution allows for $450 billion in Medicare spending in FY2010 and $2.6 trillion in Medicare spending over the five-year budget period. This amount is $38 billion above the budget baseline level projected by the Congressional Budget Office (CBO) for the five- and 10-year budget periods.

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Introduction

Federal law requires the President to submit an annual budget to Congress no later than the first Monday in February.[1] 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. President Obama submitted a summary of his FY2010 economic and budget plan to Congress on February 26. The President's detailed budget proposal was released to Congress on May 7.

The President's FY2010 budget estimates current law Medicare outlays of $447 billion in FY2010,[2] accounting for over 3% of GDP. The budget includes a number of legislative proposals with estimated savings for Medicare. From these proposals, the President expects to save $520 million in FY2010, $92.3 billion over the five-year budget period (FY2010–FY2014), and $287.5 billion (FY2010-FY2019) over the 10-year budget period. The majority of the savings are expected to come from a proposal establishing competitive bidding in the Medicare Advantage (MA) program. The President estimates savings of $47.6 billion from competitive bidding over the five-year budget period and $177 billion over the 10-year budget period. Other legislative proposals with estimated savings for Medicare include adjusting home health payments, reallocating the Medicare improvement fund, and bundling payments for inpatient hospital and post-acute care. President Obama proposes to direct savings from these proposals, and other non-Medicare proposals, into a 10-year reserve fund to finance future health care reform efforts. The total dollar amount made available for the reserve fund is $635 billion.

The President's budget also includes three administrative proposals with expected savings. The President estimates savings of $3.5 billion in FY2010, $12.6 billion over the five-year budget period, and $27 billion over the 10-year budget period from these policies. The President's budget does not specify that savings from these policies will be directed to the reserve fund.

The total estimated savings from the President's legislative and administrative proposals related to Medicare is expected to amount to $4 billion in FY2010, $105 billion over the five-year budget period, and $314.5 billion over the 10-year budget period.

Annual discretionary funding levels for the Centers for Medicare and Medicaid Services (CMS), the administrator of Medicare, are also provided in the President's budget request. The agency's Program Management Budget account funds the majority of Medicare's administrative and oversight functions. The Program Management Budget request for FY2010 is $3.5 billion, an increase of approximately $235 million over FY2009. Of that $3.5 billion, 68% or $2.4 billion would be directed toward Medicare administrative operations activities such as processing and paying claims, responding to beneficiary questions, and conducting appeals. The remaining 32% would be directed toward compensating individuals employed at CMS, performing surveys and inspections of Medicare provider facilities, and conducting research. As part of the agency's survey and certification budget, the President proposes to collect two user fees from health care

[1] 31 U.S.C. 1105(a).

[2] Department of Health and Human Services, *2009 Budget In Brief*, available at http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbrief.pdf.

facilities found to be deficient during an initial Medicare inspection or re-certification.[3] The user fee proposal is expected to provide $9.4 million to CMS in FY2010. The President is also requesting an additional $27 million in FY2010 to support Medicare's Research and Demonstration Program, bringing CMS's total research, demonstration, and evaluation budget to $57 million.

Finally, the President's budget provides for a discretionary funding request of $311 million in FY2010 and $1.7 billion over the five-year budget period to enhance Medicare's health care fraud and abuse control efforts. This would bring the total mandatory and discretionary funding for anti-fraud activities in FY2010 to approximately $1.5 billion. The President expects this additional investment in discretionary funding to result in $485 million in mandatory savings in FY2010 and $2.7 billion in savings over the five-year budget period.

Both the House and Senate have adopted a fiscal year FY2010 budget resolution. The conference agreement on the budget resolution (S.Con.Res. 13, H.Rept. 111-89) was passed in the House (by a 233-193 vote) and in the Senate (by a 53-43 vote) on April 29. The conference agreement provides for $450 billion in total outlays (expenditures) for Medicare in FY2010, an increase of $30 billion over 2009, and $2.6 trillion in outlays over five years.

The purpose of this report is to provide a synopsis of the Medicare savings and budget proposals described in the President's FY2010 budget. For each proposal, a summary of current law and a brief description of each proposal are presented. The report concludes with a table detailing the Administration's savings estimates and a summary of the FY2010 budget resolution passed by Congress.

In this report, references are made to the following public laws:

- Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA).
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA).
- Deficit Reduction Act of 2005 (P.L. 109-171, DRA).
- Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA).
- Medicare Improvements for Patients and Providers Protection Act (P.L. 110-275, MIPPA).
- American Recovery and Reinvestment Act (P.L. 111-5, ARRA).

[3] More specifically, the President is proposing to charge a revisit user fee and a recertification user fee. The President expects to collect $9.4 million in FY2010 from the revisit user fee only. No fees are to be collected from the recertification user fee in FY2010.

Medicare Part A

Hospital Readmission Rates

Current Law

In June 2008, the Medicare Payment Advisory Commission (MedPAC) reported that 18% of Medicare acute care hospital admissions result in readmissions within 30 days of a prior hospital discharge. These readmissions accounted for $15 billion in spending in 2005. Further, $12 billion of this spending may represent potentially preventable readmissions. In light of these findings, MedPAC has recommended that payments to hospitals with high readmission rates for select conditions be reduced.

President's Proposal

Beginning in 2012, Medicare's payments for targeted conditions and procedures would be reduced by 30% in cases where the patient is readmitted within 30 days of discharge due to complications or related diagnosis for those hospitals with readmission rates exceeding the 75th percentile. Public reporting of readmission rates would start in 2013. The budget includes estimated savings of $0 in FY2010, $2.5 billion over the five-year budget period, and $8.4 billion over the 10-year budget period for this proposal.

Hospital Quality Payments

Current Law

As required by MMA, since FY2005, acute care hospitals that submit required quality data to CMS receive higher payments. This initiative is called Medicare's Reporting Hospital Quality Data for Annual Payment Update or RHQDAPU program, often referred to as the hospital pay-for-reporting program. Beginning in FY2007, the DRA required hospitals to submit data on an expanded set of quality measures in order to receive a full payment update. Hospitals that do not participate in RHQDAPU or hospitals that do not report their measures successfully to CMS receive an inflation update equal to the hospital market basket less two percentage points.[4]

Currently, hospitals are required to submit data for 43 quality measures. Although participation in the program is voluntary, nearly all acute care hospitals are successfully participating and receiving a full payment update. The Secretary has the authority to expand the set of measures that are included in the RHQDAPU program. On May 1, 2009, the CMS issued a proposed rule

[4] After accounting for certain budget neutrality adjustments, hospital payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. The hospital MB index 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. The update for operating IPPS is established by statute. For additional information on how Medicare pays hospitals and other providers see CRS Report RL30526, *Medicare Payment Policies*, coordinated by Paulette C. Morgan.

that would increase the number of quality measures that hospitals must report from 43 to 46.[5] The reporting requirements for the new measures would take effect in FY2011.

In March 2005, MedPAC recommended that Congress build upon CMS's existing pay for reporting program and establish a quality incentive payment policy for hospitals in Medicare. Under Medicare's pay for performance program, hospitals that achieve high-quality scores relative to established benchmarks or those that improve their quality over time would receive additional payments. As recommended by MedPAC, these quality incentive funds would come from a redistribution of existing Medicare hospital payments.

President's Proposal

Medicare would establish a quality incentive program where a portion of the hospitals' operating payments would be linked to performance on specified quality measures. Initially, in 2011, 5% of hospital payments would be linked to performance; this percentage would increase to 15% by 2015. Any remaining quality payments—payments that would have been distributed to hospitals had they met certain performance benchmarks—would be split equally between additional incentive payments to qualifying hospitals and the Part A Trust Fund.[6] The budget includes estimated savings of $0 in FY2010, $3 billion over the five-year budget period, and $12.1 billion over the 10-year budget period for this proposal.

Bundled Payments for Hospitals and Post-Acute Settings

Current Law

In traditional or fee-for-service Medicare, providers are typically paid an amount for each service delivered based on the expected costs of providing that service. For instance, Medicare pays for most acute care hospital stays and post-acute care services, including inpatient rehabilitation facility stays, long-term acute care hospitals stays, skilled nursing facility stays, and home health care visits, under different prospective payment systems established for each type of provider. Under Medicare's different payment systems, a predetermined amount is paid for each unit of service, such as a hospital discharge, according to a patient's disease or payment classification group. When Medicare beneficiaries are discharged from acute care hospitals and are provided different post-acute care services, each provider receives separate payments for covered services provided across the entire episode of care. MedPAC, among others, has expressed concern that providers do not have financial incentives to coordinate the care provided during the episode of care nor to evaluate the full spectrum of care a patient may receive. Providers are also perceived to lack accountability for the care provided during the episode of illness.

[5] Federal Register Doc. 2009-10458 Filed 05/01/2009: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates and to the Long-Term Care Hospital Prospective Payment System and Rate Year 2010 Rates, available at http://www.federalregister.gov/OFRUpload/OFRData/2009-10458_PI.pdf.

[6] Medicare's financial operations are accounted for through two Trust Funds, the Hospital Insurance (HI) or Part A Trust Fund and the Supplementary Medical Insurance (SMI) or Part B Trust Fund, which are maintained by the Department of the Treasury. Medicare Part A is funded through HI which is primarily financed by payroll taxes, while Parts B and D are funded through accounts within the SMI Trust Fund which is primarily financed through general revenue transfers and beneficiary premiums. For beneficiaries enrolled in Part C (Medicare Advantage), payment is made on their behalf in appropriate parts from the Part A and B Trust Funds.

President's Proposal

Medicare would make one payment for inpatient hospital services and post-acute care provided within 30 days of the inpatient discharge starting in 2013. The single payment would be made to hospitals for the costs of both acute and post-acute care. The budget includes estimated savings of $0 in FY2010, $820 million over the five-year budget period, and $16.1 billion over the 10-year budget period for this proposal.

Conflict of Interest in Physician-Owned Hospitals

Current Law

Physicians are generally prohibited from referring Medicare patients for designated health services to facilities in which the physician (or an immediate family member) has a financial interest. Specifically, the physician self-referral statute or "Stark law" prohibits physicians from making a referral to an entity if a physician (or an immediate family member of a physician) has a financial relationship with an entity. The financial relationship consists of either (1) an ownership or investment interest (equity, debt, or other means) in the entity or (2) a compensation arrangement between the physician (or immediate family member) and the entity. However, among other exceptions, physicians are not prohibited from referring patients to hospitals if they have ownership or investment interests in the whole hospital.[7]

President's Proposal

The whole hospital exception would be eliminated, which would prohibit newly established physician owned hospitals from being reimbursed for services furnished to beneficiaries referred to a hospital by a physician with an investment or financial interest in the hospital. Existing physician-owned hospitals would not be affected by this change if they meet certain standards and do not expand. Estimates of the potential savings associated with this proposal are not yet available.

Medicare Part B

Encourage Primary Care Physicians to Administer the Flu Vaccine

Current Law

Medicare uses a fee schedule to reimburse physicians for the services they provide. Under certain circumstances, physician payments are modified (through an incentive payment or a penalty) in order to encourage certain activities (e.g., for reporting on quality measures or for practicing in underserved areas). For example, the ARRA instituted incentive payments for physicians who quickly adopt and become "meaningful users" of health information technology (HIT) starting in

[7] For additional information on the physician self-referral statute or Stark Law, see CRS Report RS22743, *Health Care Fraud and Abuse Laws Covering Medicare and Medicaid: An Overview*, by Jennifer Staman.

2013, with laggards at risk for payment reductions or penalties in future years if they do not become "meaningful" HIT users by the deadline.

President's Proposal

This proposal would reduce payments by 1.5% to primary care physicians who do not meet a benchmark rate of influenza vaccination among their Medicare beneficiaries. This proposal is not expected to have any budget impact over the five- or 10-year budget period.

Physician Bonus-Eligible Organizations (BEOs)

Current Law

Medicare pays physicians on the basis of a fee schedule. Reimbursements are adjusted and vary by physician payment locality to account for geographic variation in input costs, but do not reward for differences in quality or the efficient delivery of services. Medicare has implemented various initiatives to encourage improved quality of care by linking provider payments to achievements on pre-determined performance measures. Currently, physicians are eligible for incentive payments under the Medicare program if they satisfactorily report certain quality measures under the Physician Quality Reporting Initiative.

President's Proposal

This proposal would allow groups of providers meeting certain qualifications to participate, on a voluntary basis, in Medicare as BEOs. In general, a BEO is a group of providers that works together to manage and coordinate care for patients. Under this proposal, BEOs would receive incentive payments if they improve the quality of care for the patients and produce savings. Estimates of the potential savings associated with this proposal are not yet available.

Payments for Imaging Services

Current Law

MedPAC, the Government Accountability Office (GAO), and others have found that the growth in the number of imaging services in the Medicare program has increased more than for other Medicare physician services in recent years. The DRA modified the payment rules for certain imaging services to cap the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services. GAO found that the rate of growth in imaging services declined following this cap.

MedPAC has noted that providers vary in their ability to perform quality imaging services and recommended that Congress direct the Secretary to set standards for all providers who bill Medicare for performing and interpreting diagnostic imaging services.

President's Proposal

Radiology benefit managers would have to authorize the use of advanced imaging services in order to receive payment. The budget includes estimated savings of $0 in FY2010, $70 million over the five-year budget period, and $250 million over the 10-year budget period for this proposal.

Generic Biologics

Current Law

A biologic is a preparation, such as a drug or a vaccine, that is made from living organisms. The Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98-417), often referred to as the Hatch-Waxman Act, allows the generic company to establish that its drug product is chemically the same as the already approved innovator drug, and thereby relies on the FDA's previous finding of safety and effectiveness for the approved drug.[8]

President's Proposal

Medicare would establish a legal pathway for accelerated FDA approval of generic biologics. A period of exclusivity for the original developer of the product would be guaranteed. Brand biologic manufacturers would be prohibited from reformulating existing products into new products to restart the exclusivity process. The budget estimates an initial cost of $20 million over the five-year budget period and an estimated savings of $6 billion over the 10-year budget period for this proposal.

Medicare Parts A and B

Home Health Update

Current Law

Home health agencies (HHAs) are paid under a prospective payment (PPS) system in which payments are based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The base payment amount is increased annually by an update factor that is determined, in part, by the projected increase in the home health (HH) market basket (MB) index.[9] HHAs that submit required quality data receive a full MB increase. HHAs that do not submit such data receive an update equivalent to the MB update minus 2 percentage points.

[8] Legislation introduced in the 111th Congress (H.R. 1427/S. 726) would expand the regulatory activities of the Federal Food and Drug Administration (FDA) by opening a pathway for the approval of generic biologics, also referred to as follow-on biologics or biosimilars. The new regulatory pathway would be analogous to the FDA's existing authority under the Hatch-Waxman Act.

[9] This index measures changes in the costs of goods and services purchased by HHAs.

In CY2008, refinements to the Medicare HH PPS included a reduction in the national standardized 60-day episode payment rate for four years to account for changes in case mix that are not related to HH patients' actual clinical conditions as well as to account differently for comorbidities and the differing health characteristics of longer-stay patients, among other changes.

In its 2009 Report to Congress, MedPAC reported that indicators on the adequacy of Medicare's payments to HHAs appeared positive and that most HHAs continued to be paid above costs. As a result, MedPAC recommended that home health payments should be significantly reduced in 2010 and payments rebased and revised in 2011.

President's Proposal

The proposal would modify payments to better reflect the average cost of providing care by advancing a planned case-mix adjustment, providing a zero percent MB update in FY2010, and rebasing payments in 2011. The budget includes estimated savings of $460 million in FY2010, $12.2 billion over the five-year budget period, and $34.1 billion over the 10-year budget period for this proposal.

Reallocate Medicare Improvement Fund

Current Law

MIPPA established the Medicare Improvement Fund (Section 1898 of the SSA) and the Medicaid Improvement Fund (Section 1941). The monies in the Medicare Improvement Fund are for the Secretary to make improvements in Medicare Parts A and B. Under current law, $2.29 billion from the Part A and B Trust Funds are to be available for services furnished during FY2014 and an additional $19.9 billion are to be available for fiscal years 2014 through 2017. These amounts are to be taken from the Part A and B Trust Funds in a proportion as the Secretary determines to be appropriate.

Similarly, the monies in the Medicaid Improvement Fund are for the Secretary to improve the management of the Medicaid program by CMS, including oversight of contracts and contractors and evaluation of demonstration projects. Under current law, $100 million is available for FY2014 and $150 million for fiscal years 2015 through 2018.

President's Proposal

The President's budget proposal would reallocate $23.13 billion from the Medicare and Medicaid Improvement Funds toward health care reform over the years 2010-2014.[10]

[10] Under current law, the total amount in the two funds is $22.44 billion, yet the budget brief allocates $23.13 billion.

Improving Medicare Payment Accuracy

Current Law

To protect Medicare from improper payments, CMS contracts with private contractors that review claims to determine whether the services provided are medically reasonable and necessary. Medical review activities are designed to identify and prevent payment errors and mistakes in billing. More specifically, medical review activities ensure that a payment is appropriate for the service that is provided and meets professionally recognized standards of care. As part of this process, Medicare contractors review claims, largely through the use of automated computer edits. When an edit reveals a billing error or problem with a claim, contractors may conduct a manual pre-payment or post-payment claims review, request additional medical documentation from the provider, or contact beneficiaries to verify that the services were actually provided.

Medicare statute provides the Secretary with general authority to prescribe regulations for the efficient administration of the Medicare program. Under this authority, the CMS has implemented regulations requiring providers and suppliers to submit information to enroll in the Medicare program and receive billing privileges. As part of the enrollment process, providers and suppliers are required to submit information necessary to verify identity and state licensure. If enrollment requirements are not met, CMS may revoke Medicare billing privileges. Providers and suppliers must resubmit and recertify the accuracy of their enrollment information every five years. All applications for enrollment are reviewed and processed by Medicare contractors.

President's Proposal

The President proposes to improve screening for improper payments by providing additional resources to contractors to update their claims processing systems. The President also proposes to expand CMS's authority to require providers and suppliers to re-enroll in the Medicare program more frequently. The budget includes estimated savings of $60 million in FY2010, $750 million over the five-year budget period, and $2.1 billion over the 10-year budget period for these two proposals.

Medicare Part C (Medicare Advantage)

Establish Competitive Bidding

Current Law

Under the Medicare Advantage program, Medicare pays private health plans a monthly per capita amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plans. The amount of the payment is based on a comparison of a plan's estimated cost of providing covered benefits (the bid) relative to the maximum amount Medicare will pay the plan to provide those benefits (the benchmark). If the plan's bid is below the benchmark, it is paid the bid plus 75% of the difference between the bid and the benchmark, adjusted for risk. If the plan's bid is above the benchmark, it is paid the benchmark, adjusted for risk, and must charge enrollees a premium equal to the difference between the bid and the benchmark. The benchmark amounts are statutorily determined and in many cases, exceed the average expected expenditures of

Medicare beneficiaries in original Medicare. Recent analyses by MedPAC found that Medicare is projected to pay private plans an average of 14% more per beneficiary in 2009 than it does for beneficiaries in the original Medicare program.

President's Proposal

The proposal would replace the statutorily determined benchmarks with ones based on plan bids. Benchmarks would be set at the average of plan bids in each county, weighted by plan enrollment in the previous year. The budget includes estimated savings of $0 in FY2010, $47.59 billion over the five-year budget period, and $177.2 billion over the 10-year budget period for this proposal.

Medicare Part D (Prescription Drug Program)

Income-Related Part D Premiums

Current Law

In 2006, Medicare began providing coverage for outpatient prescription drugs under a new Medicare Part D. Coverage is provided through private prescription drug plans (PDPs) or Medicare Advantage prescription drug (MA-PD) plans. The program relies on these private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies covering the bulk of the risk are provided to encourage participation. While all plans must meet certain requirements, there are significant differences among them in terms of benefit designs, drugs included on plan formularies (i.e., list of covered drugs), and cost-sharing applicable for particular drugs.

Medicare Part D is financed through a combination of beneficiary premiums and general revenues. In addition, certain transfers are made from the states. Under current law, Medicare is to provide drug plan sponsors a subsidy that averages 74.5% of the basic coverage for beneficiaries, with beneficiary premiums accounting for the remaining 25.5%. Beneficiaries enrolled in plans with higher than average costs pay higher premiums for such coverage. Persons enrolled in the same plan pay identical monthly premiums, with the exception of those receiving the low-income subsidy or those subject to a late enrollment penalty. Beneficiary premiums under Part D are not subject to income or means testing.

Beginning in 2007, as required by the MMA, higher income Part B enrollees are required to pay higher premiums. For 2009, individuals whose modified adjusted gross income (AGI) in 2007 exceeded $85,000 and each member of a couple filing jointly whose modified AGI exceeded $170,000 are subject to higher premium amounts. In 2009, higher-income premiums range from 35% to 80% of the value of Part B, affecting about 5% of enrollees.[11]

[11] The higher monthly premium amounts for 2009 are based on 2007 income levels and are (1) $134.90—for single beneficiaries with income $85,001-$107,000 or for each member of a couple filing jointly with income $170,001-$214,000; (2) $192.70—for single beneficiaries with income $107,001-$160,000 or for each member of a couple filing jointly with income $214,001-$320,000; (3) $250.50—for single beneficiaries with incomes $160,001-$213,000 and each member of a couple filing jointly with income $320,000-$426,000; and (4) $308.30—for single beneficiaries with incomes greater than $213,000 and each member of a couple filing jointly income above $426,000.

President's Proposal

The proposal would establish income-related premiums for Part D so that beneficiaries with incomes above certain thresholds would pay higher premiums. The premiums would be based on a sliding scale, and the income thresholds would be set at the same levels and adjusted in the same manner as under Part B. The income thresholds would be indexed annually for inflation. The budget includes estimated savings of $0 in FY2010, $2.41 billion over the five-year budget period, and $8.07 billion over the 10-year budget period for this proposal.

Medicare Administrative Proposals

The President's budget estimates savings of $3.5 billion in FY2010, $12.6 billion over the five-year budget period, and $27 billion over the 10-year budget period from three Medicare administrative proposals. These three provisions propose to adjust MA risk score payments, adjust Part D risk scores, and recalibrate case-mix indexes for SNFs. Savings from these administrative proposals are not directed to the health care reform reserve fund.

MA Coding Intensity

Current Law

Medicare Advantage per capita payments to plans are risk adjusted to account for the higher cost of enrolling sicker or older beneficiaries, or the lower cost of enrolling healthier or younger beneficiaries. The DRA required the Secretary to account for differences in diagnosis coding patterns between MA plans and providers under original Medicare when calculating the risk adjustment to plan payments. The coding pattern adjustment was only to be applied to payments in 2008, 2009, and 2010. However, the Secretary delayed the implementation until 2010 in order to conduct additional research. In 2010, risk scores used to adjust payments to MA plans will be reduced by 3.41% to account for differences in coding practices.

President's Proposal

The proposal would adjust MA risk score payments to bring coding intensity growth rates in line with those under original Medicare. The budget includes estimated savings of $2.4 billion in FY2010, $3.3 billion over the five-year budget period, and $3.3 billion over the 10-year budget period for this proposal.

Part D Normalization

Current Law

Medicare makes monthly prospective payments to Part D sponsors based on average plan bids. The payments are adjusted for the expected case mix of enrollees in a particular plan. For example, plans expecting to enroll beneficiaries who use a greater number of and/or more expensive drugs are reimbursed at a higher rate. Following the close of each calendar year, CMS

makes retroactive adjustments to plan payments to reflect updated status information about beneficiary health status and enrollment.

President's Proposal

The proposal would base Part D risk adjustment scores on the health status of individuals enrolled in Part D rather than on all those eligible for the benefit. A "normalization" factor would be used when calculating risk scores for 2010 and is expected to result in a downward adjustment of these scores. The change is intended to help ensure that the average enrollee risk score equals 1.0 and that the beneficiary premium is equal to 25.5% of aggregate plan payments.[12] The budget includes estimated savings of $260 million in FY2010, $2.08 billion for the five-year budget period, and $5.71 billion over the 10-year budget period for this proposal.

Skilled Nursing Facility (SNF) Case Mix Recalibration

Current Law

SNFs are paid through a prospective payment system (PPS), which is composed of a daily per-diem urban or rural base payment amount adjusted for case mix and area wages. The case-mix adjustment to the base per diem rate adjusts payments for the treatment and care needs of Medicare beneficiaries and categorizes individuals into groups called resource utilization groups (RUGs). The RUGs system uses patient assessments to assign a beneficiary to one of 53 categories and to determine the payment for the beneficiary's care. The federal payment is also adjusted to account for variations in area wages, using the hospital wage index. Starting January 1, 2006, the SNF case-mix classification was expanded by adding nine new rehabilitation RUGs to the original 44 to better account for the higher costs of beneficiaries requiring rehabilitation and certain high intensity medical services. CMS constructed new case-mix indexes using the Staff Time Measurement (STM) study data that was collected during the 1990s and originally used in creating the SNF PPS case-mix classification system and case-mix indexes.

President's Proposal

The proposal would recalibrate case-mix indexes introduced in 2006 using actual data in the calculation rather than the projected data used initially with the introduction of nine new case-mix groups. The budget includes estimated savings of $840 million in FY2010, $7.3 billion over the five-year budget period, and $18 billion over the 10-year budget period for this proposal.

[12] CMS published this policy in its April 6, 2009 release of the CY2010 "Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies."

Medicare Program Integrity Proposals

Health Care Fraud and Abuse Control Program

Current Law

The HIPAA established the Health Care Fraud and Abuse Control Program (HCFAC) and Medicare Integrity Program (MIP) to conduct health care fraud and abuse activities. HCFAC supports the anti-fraud activities undertaken by the Department of Health and Human Services (DHHS), the HHS Office of the Inspector General (OIG), the Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI). MIP funds are allocated to CMS for Medicare program integrity activities such as medical reviews of claims, provider audits, investigations, and physician education.

To fund these activities, HIPAA established within the Part A Trust Fund an expenditure account called the HCFAC account. Funds are appropriated from the Trust Fund to the HCFAC account in amounts that the DHHS and the DOJ jointly certify as necessary to finance anti-fraud activities. All monies collected from health care investigations and enforcement efforts are to be deposited into the Trust Fund.

HIPAA capped annual mandatory funding for the HCFAC and MIP programs at the FY2003 level of $355 million for HCFAC and $720 million for MIP. The DRA increased funding for MIP by $112 million for FY2006 to implement program integrity and oversight activities for the prescription drug benefit. The DRA also appropriated additional funds for the establishment of a Medicare-Medicaid data matching program ($36 million in FY2008, $48 million in FY2009, and $60 million for FY2010). In 2006, Congress passed the TRHCA, which increased the mandatory annual appropriation for HCFAC by the percentage increase in the consumer price index through 2010. TRHCA, however, did not increase funding for MIP so the annual appropriation for MIP remains at $720 million. In FY2009, total mandatory HCFAC and MIP funding for health care fraud activities totaled $1.2 billion.

In the FY2009 Omnibus Appropriations Act (P.L. 111-8), Congress enacted a discretionary adjustment of $198 million to further support health care fraud activities. Of the $198 million, $147 is allocated to MIP. The remaining $51 million provides additional support to the DOJ, OIG, and CMS. Total mandatory and discretionary funding for health care fraud activities in FY2009 amounts to approximately $1.4 billion.

Every year, HHS and the DOJ are required to release a joint annual report to Congress on HCFAC results and accomplishments. Congress did not require that HHS and DOJ include expenditures or results for the MIP program in these reports.

President's Proposal

The President's FY2010 budget includes a discretionary request of an additional $311 million for FY2010 to support anti-fraud activities. Of this $311 million, the President proposes to allocate the majority of the appropriation ($220 million) to MIP for activities such as establishing additional program integrity offices and regional call centers, program integrity demonstrations, recovering Medicare overpayments, and strengthening program integrity activities in MA and

Part D. The remaining $91 million is to be divided up among CMS ($31 million), the DOJ ($30 million), and the OIG ($30 million). The President has proposed that the $31 million provided to CMS be used for expanding financial oversight of Medicaid. Over the five-year budget period, the President's proposal provides for an aggregate increase of $1.7 billion in discretionary funding for the HCFAC account. The President estimates that this additional investment in discretionary funds will yield approximately $485 million in FY2010 and $2.7 billion in Medicare and Medicaid savings over the five-year budget period.

The President's budget also includes a proposal to change the structure of the HCFAC account by separating the unified funding stream provided to the DHHS and DOJ into separate funding streams. The annual negotiations process between the two agencies would be eliminated. The President proposes to change the due date for the annual HCFAC report from January 1 to June 1.

Other

Health Care Reform Reserve Fund

The President's budget establishes a reserve fund of $635 billion over 10 years to finance health care reform efforts. The Medicare legislative proposals described in this report are expected to contribute $520 million in FY2010, $92.3 billion over the five-year budget period, and $287.5 billion over the 10-year budget period to this reserve fund. Another $1.5 billion in FY2010, $8.8 billion over the five-year budget period, and $21.7 billion over the 10-year budget period would come from legislative proposals to reform the Medicaid program. Examples of Medicaid legislative proposals include increasing the Medicaid brand-name drug rebate and extending drug rebates to Medicaid managed care organizations. Together, the total estimated Medicare and Medicaid contributions to the reserve fund are $2 billion in FY2010, $101.1 billion over the five-year budget period, and $309.1 billion over the 10-year budget period. Other funding for the reserve fund would come from a budget proposal to limit the value of itemized deductions to what they would be at a 28% tax rate. The proposal, which would become effective after 2010, would raise $44.9 billion over the five-year budget period and $135.3 billion over the 10-year budget period.

Medicare Trustees Report

The Part A and B Trust Funds are overseen by a board of trustees that reports annually on the operations of the Trust Fund. The 2009 report, issued May 12, 2009, projected that the Part A Trust Fund will become insolvent in 2017, two years earlier than projected in the 2008 report. The short-range (10-year) financial status of the Part A Trust Fund has not been considered satisfactory since 2003; however, the outlook has worsened as a result of the current economic recession. The Trustees Report indicated that in 2008, spending for Part A began to exceed revenue; future HI expenditure growth is estimated to average 6.3% over the next 10 years, while HI income growth is expected to average only 3.8%.

The Part B Trust Fund is considered to be adequately financed over the next 10 years and beyond because premium and general revenue income for Parts B and D are adjusted each year to meet expected costs. However, the report notes that Part B costs have been increasing rapidly, with an average 7.8% annual growth over the last five years. Although the Part B Trust Fund does not

face depletion because of the way that it is financed, there is concern that over time the economy will be unable to support the increasing reliance on the general revenues needed to fund it.

Forty-Five Percent Rule (the Medicare Trigger)

The MMA amended the Social Security Act, adding an additional responsibility that requires the Medicare Board of Trustees to examine and make a determination if general revenue Medicare funding is expected to exceed 45% of Medicare outlays for the current fiscal year or any of the next six fiscal years. An affirmative determination in two consecutive annual reports is considered to be a Medicare funding warning in the year in which the second report is made.[13]

Because the Medicare trustees issued such a warning in 2008, the MMA requires that the President submit legislation to Congress responding to the warning within the 15-day period, beginning on the date of the budget submission to Congress this year. However, the President considers this requirement to be advisory and not binding, in accordance with the Recommendations Clause of the Constitution. That said, the budget includes proposals, that if enacted, would bring the share of Medicare funded by general revenues below 45% (estimated Medicare savings are $92.3 billion over the five-year budget period, $287.5 billion over the 10-year budget period, and about $49.9 billion in 2014). The budget requests that these savings be set aside in the reserve fund for health care reform. Finally, the President's budget asserts that there are more significant ways to measure the health of the Medicare program than the warning, such as the overall financial burden of the program on the U.S. economy, the number of workers for each Medicare beneficiary, and/or Medicare spending as a percent of GDP.

For the fourth consecutive year, the 2009 Trustees Report found that general revenue funding is projected to exceed 45% of total Medicare expenditures within seven years (in 2014), thus triggering another funding warning that will need to be addressed by the President in 2010.

The President's FY2010 Budget Medicare proposals and estimated savings are summarized in **Table 1**.

Table 1. President's FY2010 Budget Medicare Proposals and Estimated Savings

(dollars in millions)

Proposals	HHS Estimates		
Legislative Proposals	**2010**	**2010-2014**	**2010-2019**
Medicare Part A			
Hospital Readmission Rates	0	-2,450	-8,430
Hospital Quality Payments	0	-2,980	-12,110
Bundled Payments for Hospitals and Post-Acute Settings	0	-820	-16,100
Conflict of Interest in Physician-Owned Hospitals	—	—	—
Medicare Part B			

[13] For additional information about the Medicare funding warning, see CRS Report RS22796, *Medicare Trigger*, by Hinda Chaikind and Christopher M. Davis.

Proposals	HHS Estimates		
Legislative Proposals	**2010**	**2010-2014**	**2010-2019**
Flu Vaccine	0	0	0
Physician Bonus Eligible Organizations (BEOs)	—	—	—
Payments for Imaging Services	0	-70	-250
Generic Biologics	0	20	-6,000
Medicare Parts A and B			
Home Health Update	-460	-12,150	-34,070
Reallocate Medicare Improvement Fund	0	-23,130	-23,130
Improving Medicare Payment Accuracy	-60	-750	-2,100
Medicare Part C (Medicare Advantage)			
Establish Competitive Bidding	0	-47,590	-177,200
Medicare Part D (Prescription Drug Program)			
Income-Related Part D Premiums	0	-2,410	-8,070
TOTAL Legislative Proposals	-520	-92,330	-287,460
Medicare Administrative Proposals			
MA Coding Intensity	-2,400	-3,300	-3,300
Part D Normalization	-260	-2,080	-5,710
SNF Case Mix Recalibration	-840	-7,320	-18,000
TOTAL Administrative Proposals	-3,500	-12,610	-27,010
TOTAL Legislative and Administrative Proposals	-4,020	-104,940	-314,470
Medicare Program Integrity Proposals*			
Health Care Fraud and Abuse Control Account (HCFAC)	-485	-2,714	—
TOTAL, Medicare Proposals	-4,505	-107,654	-314,470

Source: Department of Health and Human Services Fiscal Year 2010 Budget in Brief, May 7, 2009. p. 61. Available at http://www.hhs.gov/asrt/ob/docbudget/index.html and CRS analysis of the President's budget.

Notes: "—" indicates that estimates are not yet available. "*" indicates that the savings from the Medicare Program Integrity Proposals are associated with an increase in discretionary spending for the HCFAC account.

Congressional Activity

The Congressional Budget Act of 1974 (Titles I-IX of P.L. 93-344, as amended; 2 U.S.C. 601-688) provides for the annual adoption of a concurrent resolution on the budget. The budget resolution provides Congress with a framework for subsequent legislative action on budgetary legislation, including legislation affecting Medicare spending, during the year.[14] On April 29, the House (by a 233-193 vote) and Senate (by a 53-43 vote) agreed to the conference report to accompany the budget resolution for FY2010 (S.Con.Res. 13, H.Rept. 111-89).[15]

The FY2010 budget resolution allows for $450 billion in Medicare spending in FY2010 and $2.6 trillion in Medicare spending over the five-year budget period. This amount is $38 billion above the budget baseline level projected by the Congressional Budget Office (CBO) for the five- and 10-year budget periods. The conference agreement also includes House and Senate reserve funds for health care reform legislation that allow for revisions of the budget levels associated with the budget resolution, as long as such legislation is not projected to increase the deficit.

In addition, the conference agreement includes reconciliation directives to multiple committees in the House and Senate, which may involve health care reform legislation.[16] Under reconciliation, Congress instructs designated committees to develop legislation designed to achieve desired budgetary outcomes by a certain date.[17] The FY2010 budget resolution requires the designated committees to report such legislation by October 15.[18] While legislation projected to increase Medicare spending may be included as part of reconciliation, it may be constrained by other House and Senate rules, specifically the pay-as-you-go (PAYGO) rules in each chamber (House Rule XXI, clause 10, and Section 201 of S.Con.Res. 21, the FY2008 budget resolution). Therefore, such rules, as well as other provisions of the budget resolution, effectively require that any Medicare reform legislation not cause an increase in the projected deficit.[19]

[14] For further information on the budget resolution and its enforcement, see CRS Report 98-721, *Introduction to the Federal Budget Process*, by Robert Keith.

[15] Prior to agreeing to the conference report, the House and Senate adopted their respective versions of the FY2010 budget resolution (H.Con.Res. 85 and S.Con.Res. 13) on April 2.

[16] The joint explanatory statement to accompany the conference report on the FY2010 budget resolution suggests that the reconciliation directives are intended for health care reform legislation (see p. 108 of H.Rept. 111-89).

[17] Reconciliation legislation, once reported, is considered under special procedures that limit what matters may be included in reconciliation legislation, prohibit certain amendments, and encourage completion in a timely fashion. For more information on reconciliation legislation, see CRS Report 98-814, *Budget Reconciliation Legislation: Development and Consideration*, by Bill Heniff Jr.

[18] The Senate Committees on Finance and Health, Education, Labor, and Pensions are instructed to report changes in laws within their jurisdictions to reduce the deficit by $1 billion each over the period FY2009-FY2014. In the House, the Committees on Energy and Commerce, Ways and Means, and Education and Labor are instructed to report changes in laws to reduce the deficit by $1 billion over the period FY2009-FY2014.

[19] However, the budget resolution conference agreement does provide (in Section 421) that in the House any projected increase in the deficit resulting from legislation relating to the Medicare payment system for physicians, up to specified amounts, may not count for PAYGO purposes if the House has passed legislation reinstating a statutory PAYGO requirement, or such requirement is in the legislation. The budget resolution conference agreement does not include a similar provision that would apply in the Senate. For more information on PAYGO requirements, see CRS Report RL34300, *Pay-As-You-Go Procedures for Budget Enforcement*, by Robert Keith.

Table 2. CRS Medicare Contacts

Topic	Staff member	Phone number
Part A		
Hospital Readmission Rates	Sibyl Tilson	7-7368
Hospital Quality Payments	Sibyl Tilson Holly Stockdale	7-7368 7-9553
Bundled Payments for Hospitals & Post-Acute Settings	Sibyl Tilson Julie Stone	7-7368 7-1396
Conflict of Interest in Physician-Owned Hospitals	Sibyl Tilson	7-7368
Part B		
Flu Vaccine	Jim Hahn	7-4914
Physician Bonus Eligible Organizations (PBEOs)	Jim Hahn	7-4914
Payments for Imaging Services	Jim Hahn	7-4914
Generic Biologics	Judy Johnson	7-7077
Parts A&B		
Home Health Update	Julie Stone	7-1386
Reallocate Medicare Improvement Fund	Jim Hahn	7-4914
Improving Payment Accuracy	Holly Stockdale	7-9553
Part C (Medicare Advantage)		
Establish Competitive Bidding	Paulette Morgan	7-7317
Part D (Medicare Prescription Drug Program)		
Part D Normalization	Patricia Davis	7-7362
Medicare Administrative Proposals		
MA Coding Intensity	Paulette Morgan	7-7317
Part D Normalization	Patricia Davis	7-7362
SNF Case Mix Recalibration	Julie Stone	7-1386
Medicare Program Integrity Proposals		
Health Care Fraud and Abuse Control Account (HCFAC)	Holly Stockdale	7-9553
Other		
Health Care Reform Reserve Fund	Holly Stockdale	7-9553
Forty-five Percent Rule (Medicare Trigger)	Hinda Chaikind	7-7569

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