



SENATE REPUBLICAN

POLICY COMMITTEE

Legislative Notice

No. 61

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S. 3101 - The Medicare Improvements for Patients and Providers Act of 2008

Calendar No. 772

S. 3101 was read twice and placed on the calendar via Rule 14 on June 9, 2008.

Noteworthy

- S. 3101 will prevent the mandated cuts to Medicare payments to physicians, and instead increase payments by 0.5 percent through the remainder of 2008 and provide a 1.1 percent update through 2009, as recommended by the Medicare Payment Advisory Commission (MedPAC).
- The increased payments are mainly offset through reductions in Indirect Medical Education (IME) payments to Medicare Advantage plans, imposing additional restrictions on Private Fee for Service (PFFS) Medicare Advantage plans, reductions in the Physicians Assistance and Quality Improvement (PAQI) fund and the Medicare Advantage Stabilization Fund, and cuts to providers like oxygen and power wheelchair suppliers.
- The legislation also expands the Part D Low Income Subsidy program and the Medicare Savings Program, both of which provide assistance to low-income Medicare beneficiaries. Both of these programs have a significant number of seniors who are currently eligible for the programs but not enrolled even at current eligibility levels.
- S. 3101 also includes a number of extensions of expiring programs, revises and expands existing programs, and creates new programs.
- A CBO score of the legislation was not available at press time. However, media reports estimate the cost of the bill to be about \$20 billion.
- The President has indicated that he will veto the legislation because of the reduction in payments and changes in policy regarding Medicare Advantage plans.

Background

Beginning on July 1, 2008, the Sustainable Growth Rate (SGR) formula mandates that Medicare payments to physicians be cut by 10.6 percent.¹ S. 3101 will prevent the mandated cuts to physician payments, and instead increase payments by 0.5 percent through the remainder of 2008 and provide a 1.1 percent update through 2009, as recommended by the Medicare Payment Advisory Commission (MedPAC).

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S. 3101 includes a number of extensions of expiring programs, revises and expands existing programs, and creates new programs. Notably, the legislation expands the Part D Low Income Subsidy program and the Medicare Savings Program, both of which provide assistance to low-income Medicare beneficiaries. Both of these programs have a significant number of seniors who are currently eligible for the programs but not enrolled even at current eligibility levels.

Key Provisions

Medicare Advantage Provisions

Reductions in IME Payments to MA Plans:

Medicare makes both direct graduate medical education (GME) and indirect medical education (IME) payments to hospitals that train residents in approved medical residency training programs.² Additionally, benchmarks for MA plans include a separate IME adjustment to hospitals treating MA enrollees. MedPAC contended that these payments to MA plans were duplicative of the payments already being made to teaching hospitals and that plans were not

¹ Congress has had to act every year since 2002 to prevent cuts mandated by the SGR. Spending for physician payments is based on an annual spending target for Medicare which is intended to restrain the overall rate of growth of Medicare. The SGR formula sets a target for the growth of Medicare spending over time. The SGR is intended to restrain overall Medicare spending by attempting to limit the number of services provided to each beneficiary (volume) and the average costliness and complexity of the health care services (intensity). Spending growth caused by increases in volume and intensity are limited to the country's average economic growth (as measured by GDP). Any excess spending above this amount must be offset by cutting payments to physicians.

² GME payments are made to teaching hospitals to help pay for the direct costs of training physicians (i.e., salaries of medical residents and faculty, and hospital overhead expenses). IME payments are meant to reflect the indirect costs that teaching hospitals incur in caring for patients, such as the costs associated with offering a broader range of services, using more intensive treatments, and conducting more tests.

required to pass these additional payments to the hospitals. MedPAC therefore recommended that Congress remove the IME payments from the MA plan benchmarks.³ MA plans argue that IME payments reflect their increased underlying costs for contracting with more expensive teaching hospitals.

S. 3101 phases out the IME payments to the MA plans, while retaining the IME payments to hospitals.

Restrictions on Private Fee for Service Plans:

S. 3101 also places additional requirements on Medicare Private Fee for Service (PFFS) plans. Medicare Private Fee for Service plans are among the types of plans that private insurers can offer Medicare beneficiaries in return for a capitated (per enrollee) payment. Unlike Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), PFFS plans do not restrict beneficiaries to a network of providers, but allow enrollees to go to any Medicare-eligible doctor or hospital that will agree to serve them. Enrollment is concentrated largely in rural and some suburban areas.⁴ Enrollment in these plans has increased rapidly, and a majority of the growth in Medicare Advantage is projected to be as a result of increased PFFS enrollment.⁵

Because PFFS plans are to a large degree intended to benefit seniors in rural areas without a large number of doctors, they have different requirements than other MA plans. Importantly, PFFS plans are not required to establish networks of physicians, hospitals, and other providers. Currently, a physician is “deemed” a provider and must follow a PFFS plan’s terms and conditions of participation if a physician provides services to a patient who is enrolled in a PFFS plan. Most plans operate without a network to make it easier for them to enter the market, but as a result they may not have the same degree of coordinated care as other MA plans.⁶ PFFS plans also are exempt from many of the reporting requirements imposed on other MA plans—including quality reporting.

S. 3101 requires that, starting in 2011, PFFS plans in areas where two or more network-based MA plans operate must have written contracts with a network of physicians.⁷ It bars employer-sponsored retiree plans from using “deeming” in PFFS plans they supply to retirees. S. 3101 also requires that by January 1, 2010, PFFS plans, including those without provider networks, must have the same quality improvement programs as preferred provider plans. Some are suggesting that this could be a back-door way of eliminating PFFS, as MA quality reporting may require forms of data that plans without provider contracts are not in a position to collect.

³ MedPAC, “The Medicare Advantage Program and MedPAC Recommendations,” June 28, 2007.

⁴ MedPAC, “The Medicare Advantage Program and MedPAC Recommendations,” June 28, 2007.

⁵ Congressional Budget Office, “The Medicare Advantage Program: Enrollment Trends and Budgetary Effects,” April 11, 2007.

⁶ Testimony of Patricia Neuman, Vice President and Director, Medicare Policy Project of the Henry J. Kaiser Family Foundation, “Private Fee-For-Service Plans in Medicare: Rapid Growth and Future Implications,” before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, May 22, 2007.

⁷ All employer-based MA PFFS plans must meet the network requirement.

Changes to Medicare Advantage Marketing Practices:

A number of recent press reports have exposed aggressive marketing tactics designed to enroll seniors into Medicare Advantage plans, including but not limited to PFFS plans. S. 3101 codifies a number of guidelines that America's Health Insurance Plans (AHIP) and their member plans negotiated in order to address these marketing practices, most of which were included in the CMS proposed rule last month. These include a prohibition on door-to-door sales, cold calling, offering free meals, and cross selling of non health-related products. The legislation also requires annual sales training relevant to the specific plans that agents sell, and requires that brokers are licensed and appointed as required under state law.

Increase in the Low-Income Subsidy and Expansion of the Medicare Savings Program

The Medicare Part D benefit provides seniors with assistance for premiums and cost-sharing through the low-income subsidy (LIS) program. The LIS is designed to reduce or eliminate premiums, deductibles, copayments, and additional costs in the coverage gap, or doughnut hole.⁸ Seniors who qualify for Medicaid automatically are enrolled to receive benefits as dual-eligibles, as do those in the Medicare Savings Program (MSP) and those receiving Social Security Income (SSI). Other seniors must qualify and apply if they meet certain income and asset standards. Seniors are eligible for Part D premium and cost-sharing subsidies if they have an income below 150 percent of the federal poverty level (FPL) (\$15,600 for an individual or \$21,000 for a couple), and limited resources⁹ (below \$11,990 for an individual or \$23,970 for a couple).¹⁰ The resource limit to qualify is more generous than under SSI and Medicaid.¹¹ Seniors are eligible for Medicare savings programs if their incomes are below 135 percent of FPL and their assets are no higher than \$4000 individual, \$6000 couple.

Nearly 4 out of 10 seniors who have Part D coverage currently receive some low-income subsidy.¹² According to the Kaiser Family Foundation, as of January 2008, 9.4 million of the 12.5 million beneficiaries eligible for the low-income subsidy based on their estimated income and assets or Medicaid status are enrolled in the program. This includes 6.2 million full-benefit dual eligibles, 1.7 million who were deemed eligible through MSP or SSI, and 1.5 million who actively applied for the LIS subsidy. In total, 2.6 million, or 21 percent, of those currently eligible for the subsidy are not enrolled.¹³ The Kaiser report notes that this number represents

⁸ Kaiser Family Foundation, "Medicare Part D 2008 Data Spotlight: Low-Income Subsidy Plan Availability," April 2008.

⁹ Resources are assets that can be converted into cash within 20 days. An individual's house and car do not count towards the limit.

¹⁰ Kaiser Family Foundation, "Low-Income Assistance Under the Medicare Drug Benefit," February 2008.

¹¹ Kaiser Family Foundation, "Low-Income Assistance Under the Medicare Drug Benefit," February 2008.

¹² Kaiser Family Foundation, "Low-Income Assistance under the Medicare Drug Benefit," February 2008.

¹³ Kaiser Family Foundation, "Medicare Part D 2008 Data Spotlight: Low-Income Subsidy Plan Availability," April 2008.

more than half of those estimated to be eligible but not deemed into the program. Therefore, a large population of seniors remains eligible for the LIS program but is not enrolled.

S. 3101 expands access to the low-income subsidy by exempting from the LIS eligibility determination the value of in-kind support and maintenance as well as the value of any life insurance policy. The bill requires increased distribution of information regarding subsidies to seniors who are potentially eligible and provides increased funding for outreach.¹⁴ It waives the late-enrollment penalty for subsidy-eligible individuals who would otherwise be subject to a penalty. It also requires that the enrollment forms for the LIS be translated into at least 10 languages besides English.

The bill also increases the amount of assets an individual can have to enroll in the Medicare Savings Program (MSP) so that it is the same as the asset requirement for the LIS. The MSP program provides assistance to low-income beneficiaries by helping to pay Medicare premiums and, in some instances, cost-sharing for other Medicare services. That program, too, has had significant problems enrolling those who are currently eligible.¹⁵ The National Academy of Social Insurance (NASI) reported that in 2006 there were roughly 1 million persons (excluding full benefit dual eligibles) enrolled in MSP programs (an estimated 430,000 Qualified Medicare Beneficiary (QMB) program enrollees, 370,000 Specified Low-Income Medicare Beneficiary (SLMB) program enrollees, and 200,000 Qualified Individual program (QI) enrollees). The report also noted that the enrollment rate in MSP programs had traditionally been lower than for other means-tested programs; in 2004 approximately 33 percent of the eligible population was enrolled as QMBs and 13 percent of the eligible population was enrolled as SLMBs.

Electronic-Prescribing

S. 3101 provides financial incentives in 2009-2013 for physicians to use a qualified e-prescribing system. The bonus is 2.0 percent in 2009-2010, 1.0 percent for 2011-2012, and 0.5 percent for 2013. Physicians who fail to e-prescribe by 2012 will begin to have payments reduced by up to 2 percent. The provision exempts physicians who infrequently use prescriptions.

Other Notable Provisions

Extensions of Existing Programs:

- The legislation extends the physician quality reporting initiative (PQRI) for another two years (through December 31, 2010) and increases the PQRI bonus to 2.0 percent for 2009 and 2010.
- Extends other programs, including the qualifying individual (QI) program, the Medicare rural hospital “FLEX” program, the work geographic practice cost index (GPCI) floor,

¹⁴ This month, CMS launched a \$12 million outreach campaign last month to encourage low-income Medicare beneficiaries to enroll in the LIS program.

¹⁵ See Kaiser Family Foundation, “Medicare: Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules,” May 2006.

therapy caps, Transitional Medical Assistance (TMA) and the abstinence education program.

- Extends authority for special needs Medicare Advantage plans to target enrollment to certain populations through 2010, and revises certain regulations related to these plans.

Payment Reforms and Offsets:

- Requires a bundled payment system for the treatment of end-stage renal disease (ESRD).
- Reforms the payment system for oxygen suppliers.
- Reforms the payment system for power wheelchairs to permit the use of a rent-to-own model rather than first-month sale.

Other Initiatives:

- Requires “prompt pay” of pharmacies by prescription drug plans. Part D plans will be required to pay within 14 days for electronic claims and 30 days for other claims.
- Imposes new requirements on diagnostic imaging services.
- Reduces the copayment for mental health services to match that of other outpatient medical care.
- Revokes the unique deeming authority of the Joint Commission.
- Increases funding for the Medical Home demonstration project.
- Repeals the competitive bidding demonstration project for clinical laboratory services and reduces the payment for these services.
- Allows the use of Part-D data for research and oversight purposes.
- Increases coverage of preventive services.
- Increases payments to ambulance services.
- Permits speech language pathologists in private practice to bill Medicare directly for their services.

Significant Gaps Remaining in the Bill

S. 3101 contains a number of gaps that make it difficult to ascertain the bill’s true costs. Generally speaking, these blanks and brackets are percentages or dollar amounts that could be adjusted depending on the preliminary CBO score. However, the bill filed by the Democrats retains these blanks, which makes it difficult to determine the true cost of the bill.

The items that are left bracketed include:

- p. 70; line 22 [\$], regarding Part B subsidy;
- p. 130, line 6 [5 percent], regarding the fee schedule for mental health services;
- p 171, line 13 [1.0], regarding renal dialysis payment in 2010;
- p. 192, lines 8 and 12 [0.65], regarding the phase-out of IME payments in 2010 and in following years;
- p. 246, line 22 [2014], regarding the Medicare Improvement Fund; and
- p. 246, line 23 \$[], regarding the Medicare Improvement Fund.

Cost

No Congressional Budget Office (CBO) estimate of S. 3101 was available at press time. However, media reports estimate the cost of the bill to be about \$20 billion.

Administration Position

The President has indicated that he will veto the legislation because of the reduction in payments and changes in policy regarding Medicare Advantage plans.¹⁶ However, no Statement of Administration Policy had been issued at press time.

¹⁶ Letter from Mike Leavitt, Secretary of Health and Human Services, to Senator Chuck Grassley, May 22, 2008.