SUMMARY OF KEY MEDICARE PROVISIONS IN WHITE HOUSE PROPOSAL AND HOUSE AND SENATE HEALTH REFORM BILLS[1]

	WHITE HOUSE PROPOSAL *Released February 22, 2010; builds on Senate bill (H.R. 3590) as passed on 12/24/2009*	SENATE (H.R. 3590) *Patient Protection and Affordable Care Act, as passed on 12/24/2009*	HOUSE OF REPRESENTATIVES (H.R. 3962) *Affordable Health Care for America Act, as passed on 11/07/2009*
Prevention benefits	*No changes specified.*	Eliminates coinsurance and deductibles for prevention benefits that are rated A or B by the U.S. Preventive Services Task Force (USPSTF), adds annual comprehensive wellness visit and personalized prevention plan, not subject to coinsurance or deductibles, and authorizes the Secretary of HHS to modify coverage of Medicare-covered preventive services to conform with USPSTF recommendations [+$3.7b].	Eliminates coinsurance and deductibles for prevention benefits and covers all recommended vaccines [+$4.2b].
Assistance for low income Medicare beneficiaries	*No changes specified.*	Increases outreach and enrollment assistance to beneficiaries eligible for the Part D low-income subsidy program.	Raises the asset test for the Part D low-income subsidy program beginning in 2012; postpones raising the asset test for the Medicare Savings Program (MSP) from 2010 to 2012 [+$11.8b]. Provides some cost sharing assistance for Medicare beneficiaries under age 65 with income <150% of poverty and limited assets [+$5.3b]. Extends the QI program and lifts the funding cap through 2012 [+$1.5b].
Premiums for higher income beneficiaries	*No changes specified.*	Freezes the threshold for income-related Medicare Part B premiums through 2019 [-$25.0b]. Reduces the Medicare Part D premium subsidy for Medicare beneficiaries with incomes above $85,000/individual and $170,000/couples, effective January 1, 2011, similar to Part B [-$10.7b].	No similar provision.
Medicare Advantage	Creates a set of benchmark payments for Medicare Advantage plans at different percentages of Medicare fee-for-service (FFS) rates, by area, phased in over an unspecified period, taking into account relative payments to fee-for-service costs in an area. Provides bonuses for quality and enrollee satisfaction, and lowers plan rebates for "low-quality" plans. Achieves additional savings by further adjusting payments to plans for coding practices related to the health status of enrollees.	Restructures payments to Medicare Advantage plans, based on the average plan bid in each area, phased in over four years, with bonus payments for quality/improved-quality plans; grandfathers extra benefits in Medicare Advantage plans in areas where plan bids are at or below 75% of traditional Medicare [-$118.1b]. Requires the Secretary of HHS to adjust risk scores for differences in coding patterns, relative to traditional Medicare, 2011-2013, and allows the Secretary to adjust risk scores beyond 2013 [-$0.7b]. Prohibits plans from imposing cost-sharing requirements higher than traditional Medicare for specified services.	Phases down Medicare Advantage payments to 100% of traditional fee-for-service Medicare costs by 2013 and provides bonuses for high-quality plans [-$154.3b]. Requires the Secretary of HHS to adjust risk scores for differences in coding patterns, relative to traditional Medicare, beginning in 2011 [-$15.5b]. Prohibits plans from imposing cost-sharing requirements higher than traditional Medicare [$0b].
Prescription drugs (Part D)	Provides a $250 rebate to Medicare beneficiaries who reach the coverage gap in 2010 (rather than raise the initial coverage limit by $500); eliminates the gap by phasing down the coinsurance rate in the coverage gap from 100% to the standard 25% amount by 2020. Delays implementation of provision to eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.	Reduces coverage gap by $500 in 2010 only but does not eliminate gap by 2019; provides a 50% discount on brand-name drugs in the coverage gap (higher income beneficiaries above $85,000/individuals and $170,000/couples ineligible for discount) [+$17.8b]. Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments, effective 2011 [+$5.4b in new revenue]. Requires Part D plans to offer medication therapy management services to certain beneficiaries [+$0b].	Reduces coverage gap by $500 in 2010 and eliminates the gap by 2019; provides a 50% discount on brand-name drugs in the coverage gap; applies Medicaid rebates for dual eligibles and other Part D low-income subsidy recipients [-$42.3b]. Requires the Secretary of HHS to negotiate Part D drug prices with manufacturers [$0b]. Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments, effective 2013 [+$2.2b in new revenue].

[1]Cost estimates are from Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT): H.R. 3962: www.cbo.gov/doc.cfm?index=10741&zzz=39806 and www.jct.gov/publications.html?func=startdown&id=3633; H.R. 3590: www.cbo.gov/doc.cfm?index=11307 and www.jct.gov/publications.html?func=startdown&id=3663.

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Physician payments	*No changes specified.*	Provides a 10% bonus for some primary care physicians and a 10% bonus for general surgeons practicing in underserved areas [+$3.5b].	Provides a 5% bonus for primary care practitioners and an additional 5% bonus for those practicing in underserved areas [+$4.7b].
Provider payment reforms	*No changes specified.*	Revises annual updates for inpatient hospital, long-term care hospitals, home health, skilled nursing facility, home health providers, and other providers, and incorporates adjustments to reflect productivity gains [-$186.4b]. Increases payments for rural health care providers and facilities, including extra protections for frontier states [+$2.0b]. Reduces Medicare DSH payments by 75% and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided, beginning in 2015 [-$25.1b]. Tests pay-for-performance programs for certain providers [+$0b].	Freezes market basket for parts of fiscal year 2010 for certain providers; reduces annual payment updates for inpatient hospital, home health, skilled nursing facility and other providers; incorporates adjustments to reflect expected productivity gains [-$228.0b]. Increases payments for rural health care providers and facilities [+$2.1b]. Reduces Medicare Disproportionate Share Hospital (DSH) payments based on reduction in uninsured and amount of uncompensated care provided, beginning in 2017 [-$10.3b].
Independent Payment Advisory Board	*No changes specified.*	Establishes new Independent Payment Advisory Board and requires the Board to submit a proposal with recommendations for reducing Medicare spending, while maintaining quality and access, if Medicare per capita growth rates exceed targets, beginning in January 2014. Requires the Board to submit an advisory report for years it does not submit a proposal. Requires proposals to be automatically implemented unless Congress enacts alternative proposals that achieve same level of savings, or the Secretary had implemented recommendations in the prior year. Prohibits the Board from recommending changes that would ration care or modify benefits, eligibility, premiums, or taxes. Exempts certain providers from recommendations prior to 2019. Requires the Board to submit biennial recommendations on slowing the growth in national health expenditures, beginning 2015. Requires the Board to submit an annual report on system-wide health care costs, access, utilization, and quality of care, beginning July 1, 2014 [-$28.0b].	No similar provision.
Institute of Medicine (IOM) studies	*No changes specified.*	No similar provisions.	Funds an IOM study on geographic adjustment factors in Medicare and requires the IOM to make recommendations. Requires the Secretary of HHS to issue regulations to revise the geographic adjustment factors based on IOM recommendations. Also requires IOM to study geographic variation in health care spending and recommend changes to Medicare payments that promote high-value care [-$14.3b].
CMS Center for Medicare and Medicaid Innovation	*No changes specified.*	Establishes new CMS Center for Medicare and Medicaid Innovation to test payment and service delivery pilots, focusing on programs expected to reduce costs while preserving or enhancing quality of care; permits programs that reduce spending and improve patient care to be expanded. Secretary may limit testing of models to certain geographic areas and may expand nationally without Congressional authorization [-$1.3b].	Establishes new CMS Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality/ efficiency and reduce costs, with dedicated funds to permit coverage of additional benefits; permits successful models to be expanded [-$1.7b].

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Other health system reforms	*No changes specified.*	Reduces payments to hospitals with excess preventable readmissions [-$7.1b] and hospital-acquired infections [-$1.4b]. Establishes pilot programs for bundling payments for post-acute care [$0b]. Develops value-based purchasing for hospitals, ambulatory surgical centers, skilled nursing facilities, and home health agencies [$n.s.]*. Allows accountable care organizations to share savings achieved for Medicare [$-4.9b].	Reduces payments to hospitals and post-acute care providers with high rates of preventable readmissions [-$9.3b]. Establishes bundled payments for post-acute care [$n.s.]*. Establishes Medicare accountable care organizations [-$2.6b] and pilot programs for medical homes [+$1.8b].
Part A Hospital Insurance payroll tax	Adopts the Senate bill approach to increase the Medicare Part A (Hospital Insurance) payroll tax rate by 0.9% (from 1.45% to 2.35%) on earnings over $200,000/individual, $250,000/couple. Adds a 2.9% assessment on unearned income on taxpayers with income above $200,000/individual, $250,000/couple. Specifies that funds from the additional tax on earned income shall be credited to the Part A Trust Fund and funds from the new tax on unearned income shall be credited to the Part B (Supplementary Medical Insurance) Trust Fund.	Increases the Medicare Part A (Hospital Insurance) payroll tax in 2013 by 0.9% (from 1.45% to 2.35%) on earnings over $200,000/individual, $250,000/couple; funds deposited into the Medicare Part A Trust Fund [+$86.8b in new revenue].	No similar provision.
Expanded Medicare eligibility	*No changes specified.*	Deems qualifying individuals exposed to asbestos in Montana mines entitled to Medicare Part A benefits, and eligible to enroll in Part B. The Secretary may develop a pilot program to deliver comprehensive, coordinated, and cost-effective care to this population [+$0.3b].	No similar provision.
Program integrity	Includes several provisions to strengthen program integrity, such as: establishes a new Medicare and Medicaid sanctions database to strengthen law enforcement activities; enhances authority for the Secretary of HHS to exclude from Medicare individuals who knowingly submit false or fraudulent claims; creates greater accountability for Medicare administrative contractors; limits fraudulent health care providers or suppliers from discharging through bankruptcies amounts due to the Secretary; and establishes higher penalties for individuals who purchase, sell or distribute Medicare beneficiary identifications.	Includes several provisions to strengthen program integrity, such as: enhances penalties on providers for waste, fraud, and abuse; establishes new standard fraud liability in Federal health care programs; expands the Recovery Audit Contractors program to Medicaid, Medicare Advantage, and Part D; expands authority to suspend payments to physicians pending a fraud investigation; requires overpayments to be reported and returned in a specified time period; and reduces maximum period for submission of Medicare claims to not more than 12 months [-$6.1b].	Includes several provisions to strengthen program integrity, such as: increases funding; enhances penalties on providers for waste, fraud, and abuse; enhances authority of CMS to monitor providers in "high-risk" program areas and authorizes the Secretary of HHS to establish screening procedures for new providers; requires overpayments to be reported and returned in a specified time period; and reduces maximum period for submission of Medicare claims to not more than 12 months [-$1.6b].
Net Medicare savings	*CBO cost estimate not available*	**$390 Billion**	**$475 Billion**

* "n.s." indicates exact cost estimate not specified; CBO indicates the amount is between +/- $50 million.

For additional information, see www.kff.org/healthreform/7948.cfm.