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Medicare and the Federal Budget:
Comparison of Medicare Provisions in Recent Federal Budget Proposals and Laws

Medicare savings provisions are often included among broader proposals to reduce the federal deficit and debt. Over the long-term, Medicare faces financial challenges due to the aging of the population and rising healthcare costs (that affect all payers);[1] however, over the next decade, Medicare spending, is projected to grow slower than private insurance on a per capita basis, and at about the same rate as the economy. Total Medicare spending increased by 3 percent in 2012 and is projected to increase by 4 percent in 2013, the lowest rates of growth since 2000.[2] Nonetheless, ongoing efforts to constrain the growth in Medicare spending are often viewed as important components of deficit and debt reduction proposals.

Since 2010, policymakers have enacted legislation that includes reductions in Medicare spending and have also made several attempts to constrain the federal debt. Medicare savings provisions were included in the Affordable Care Act (ACA) of 2010, the Budget Control Act of 2011, the American Taxpayer Relief Act of 2012, as well as other major efforts to reduce the federal deficit and debt. This brief provides a side-by-side comparison of Medicare provisions included in broad-based deficit- and debt-reduction packages put forward by the President and the Chairmen of the House and Senate Budget Committees:

- **President Obama's Budget for Fiscal Year 2014,** released by the Office of Management and Budget on April 10, 2013;
- **The Senate Concurrent Budget Resolution for Fiscal Year 2014,** S.Con.Res. 8, passed by the Senate on March 23, 2013; and
- **The House Concurrent Budget Resolution for Fiscal Year 2014,** H.Con.Res. 25, passed by the House of Representatives on March 21, 2013.

The brief also summarizes the **Continuing Appropriations Resolution, 2014** (H.J. Res. 59), which was passed by both houses and signed into law by President Obama on December 26, 2013. The law is a combination of the "Bipartisan Budget Act of 2013" and the "Pathway for SGR Reform Act of 2013" and is projected to lower the federal debt by approximately $23 billion between 2014 and 2023.[3] The law postpones until April 1, 2014 a reduction in Medicare payments to physicians that was scheduled to occur on January 1, 2014, and replaces it with a 0.5 percent payment increase between January 1 and April 1, resulting in projected increases in Medicare spending of about $7.3 billion between 2014 and 2023. It also extends sequestration for two years (with modifications to the sequestration of Medicare spending in FY2023), reduces Medicare payments for some stays in long-term care hospitals, and extends several Medicare programs and payments to providers. In total, the law is projected to increase Medicare spending by approximately $3.5 billion between 2014 and 2023.[4]

In addition, this brief summarizes Medicare provisions included in other deficit- and debt- reduction proposals released since January 2012 (**Appendix A**) and describes recent activities that pertain to Medicare and the federal budget, including Medicare's role in the ACA, the fiscal cliff and sequestration (**Appendix B**).

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[1] Congressional Budget Office, "The 2013 Long-Term Budget Outlook," September 2013.
[2] Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," February 2013.
[3] Congressional Budget Office, "Bipartisan Budget Act of 2013," December 11, 2013.
[4] Congressional Budget Office, "Estimate of Amendment to H.J. Res. 59, Pathway to SGR Reform Act of 2013," December 11, 2013

SIDE-BY-SIDE COMPARISON OF MEDICARE PROVISIONS IN RECENT FEDERAL BUDGET PROPOSALS AND LAWS

	CONTINUING APPROPRIATIONS RESOLUTION, 2014 (H.J. RES. 59)	PRESIDENT'S FY2014 BUDGET	SENATE CONCURRENT BUDGET RESOLUTION (S.CON.RES. 8)	HOUSE CONCURRENT BUDGET RESOLUTION (H.CON.RES. 25)
Date	**Enacted December 26, 2013**	**Proposed April 10, 2013**	**Proposed March 23, 2013**	**Proposed March 21, 2013**
Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB)	Retains the IPAB.	Would lower the IPAB target rate for Medicare spending from GDP+1 percent to GDP+0.5 percent for 2020 and future years.	Would retain the IPAB.	Would repeal the IPAB. Would limit the growth in Medicare payments per beneficiary to nominal GDP + 0.5 percent.[1]
Sequestration of Medicare spending	Retains the sequestration and extends the sequestration until 2023, requiring the President to sequester the same percentage of Medicare spending in 2022 and 2023 as will be sequestered in 2021. Realigns sequestration of Medicare spending in FY 2023, such that 2.9 percent of payments to providers and plans will be sequestered for the first six months and 1.11 percent will be sequestered for the second six months.	Would replace the sequestration with other savings and revenue provisions.	Would create a deficit-neutral reserve fund that could be used to repeal or replace the sequestration. Would create a deficit-neutral reserve fund to allow Members of Congress to donate 20 percent of their salaries to charity or the Treasury Department during sequestration.	Would retain the sequestration.
Medicare provisions in the ACA	Retains the changes made by the ACA.	Would retain the changes made by the ACA.	Would retain the changes made by the ACA.	Would retain Medicare savings in the ACA. Would create a deficit-neutral reserve fund that could be used to repeal or replace the other health care provisions in the ACA, including other Medicare provisions (see IPAB and prescription drugs below for details).
Age of Medicare eligibility	No provision.	No provision.	No provision.	Beginning in 2024, would gradually raise the age of Medicare eligibility to correspond with Social Security's retirement age.

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DATE	**ENACTED DECEMBER 26, 2013**	**PROPOSED APRIL 10, 2013**	**PROPOSED MARCH 23, 2013**	**PROPOSED MARCH 21, 2013**
Private plan payment reforms, including premium support, competitive bidding, and other such reforms	Creates a deficit-neutral reserve fund for legislation that provides protections from voucher payments for Medicare beneficiaries. Extends the authorization of Special Needs Plans (SNPs) and allows cost contracts in areas with two or more Medicare Advantage coordinated care plans to be extended until January 1, 2015.	Would increase the minimum coding intensity adjustment for payments to Medicare Advantage plans, beginning in 2015. Would align payments for Medicare Advantage employer group waiver plans with the average individual Medicare Advantage bid in each Medicare Advantage payment area, beginning in 2015.	Would create a deficit-neutral reserve fund for legislation that provides protections from voucher payments for Medicare beneficiaries.	Beginning in 2024, would create a Medicare Exchange from which beneficiaries would select a private plan or traditional Medicare. A premium support payment would be provided for people born in 1959 or later; entitlement for people born prior to 1959 would not change but people born prior to 1959 could opt into the premium support system. Premium support payments would be tied to either the second-least expensive private plan or traditional Medicare, whichever costs less.[1] Sick beneficiaries would receive higher payments if their conditions worsened. Beneficiaries would pay the difference between the cost of their plan and the federal contribution. Beneficiaries would receive a rebate if they enrolled in the lowest cost plan.[1] Private plans would be guaranteed issue. Private plans would be required to use community rating and be required to cover at least the actuarial equivalent of the traditional Medicare benefit package.[1]
Part B and Part D premiums	No provision.	Would increase income-related premiums under Medicare Parts B and D by increasing the lowest income-related premium from 35 percent to 40 percent of projected per capita expenditures, and increasing the other income brackets, with a cap at 90 percent of projected per capita expenditures, beginning in 2017, and would maintain a freeze on income-related thresholds until 25 percent of beneficiaries pay income-related premiums.	No provision.	Prior to 2024, would further income-relate Part B and Part D premiums, "similar to the President's proposal in his FY2013 budget," which would have increased the income-related premiums under Medicare Parts B and D by 15 percent, beginning in 2017, with a cap at 90 percent of projected per capita expenditures, and would have maintained a freeze on income-related thresholds until 25 percent of beneficiaries pay income-related premiums. Beginning in 2024, higher income beneficiaries would receive lower federal contributions.

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DATE	**ENACTED DECEMBER 26, 2013**	**PROPOSED APRIL 10, 2013**	**PROPOSED MARCH 23, 2013**	**PROPOSED MARCH 21, 2013**
Medicare cost sharing	No provision.	Would increase the Part B deductible for new beneficiaries by $25 in 2017, 2019, and 2021. Would introduce a copayment for home health services of $100 per home health episode, for episodes with 5 or more visits not preceded by a hospital or post-acute care stay; this would be applicable to new beneficiaries in 2017 and thereafter.	No provision.	No provision.
Medigap, employer-sponsored, and other supplemental coverage	No provision.	Would introduce a surcharge on Part B premiums that would be equivalent to about 15 percent of the average Medigap premium for new beneficiaries that purchase Medigap policies with "particularly low cost-sharing requirements," beginning in 2017.	No provision.	No provision.
Prescription drugs	Creates a deficit-neutral reserve fund for health care improvement that can be used to introduce legislation to permit the safe importation of prescription drugs approved by the FDA from a specified list of countries.	Would require drug manufacturers to provide rebates to Part D plans that are no lower than the Medicaid minimum rebate level for drugs prescribed to dual-eligible beneficiaries and other Part D low-income subsidy (LIS) beneficiaries, beginning in 2014. Would increase the manufacturer discounts for brand name drugs in the Part D coverage gap from 50 percent to 75 percent in 2015, closing the coverage gap for brand name drugs five years sooner than under current law. Would increase copayments (up to twice the level required under current law) for specified brand name drugs with appropriate generic substitutes, and lower copayments for specified generic drugs by more than 15 percent for Part D LIS beneficiaries, beginning in 2014; beneficiaries could receive drugs at current copayment levels with successful appeal of a coverage determination, and low-income beneficiaries qualifying for institutional care would be excluded from the policy.	Would create a deficit-neutral reserve fund for health care improvement that could be used to introduce legislation to permit the safe importation of prescription drugs approved by the FDA from a specified list of countries.	As part of the repeal of the ACA, would reinstate the Part D prescription drug coverage gap that is being gradually closed by 2020 under current law.

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DATE	**ENACTED DECEMBER 26, 2013**	**PROPOSED APRIL 10, 2013**	**PROPOSED MARCH 23, 2013**	**PROPOSED MARCH 21, 2013**
Prescription drugs (continued)		Would permanently authorize a demonstration (the NET program) that provides retroactive drug coverage for newly-eligible Part D LIS beneficiaries. Would prohibit "pay for delay" arrangements between brand and generic manufacturers. Would reduce payments for Part B drugs from 106 percent to 103 percent of the average sales price. Would shorten the length of exclusivity for biologics from 12 years to 7 years, and prohibit additional periods of exclusivity for brand biologics due to minor changes in product formulations, beginning in 2014.		
Dual-eligible beneficiaries	Extends the program to pay Part B premiums for qualified individuals (QIs) through March 31, 2014.	Would implement a single beneficiary appeals process for managed care plans that integrate Medicare and Medicaid payment and services and serve dual-eligible beneficiaries. Would extend the program to pay Part B premiums for qualified individuals (QIs).	No provision.	Medicaid would provide premium and cost-sharing assistance for dual-eligible beneficiaries, subject to a limit on federal dollars spent on each Medicaid beneficiary (block grant); limit on Medicaid spending would be FY2012 spending levels indexed to the Consumer Price Index (CPI). Beginning in 2024, lower-income beneficiaries would receive additional assistance to cover out-of-pocket costs under a premium support system; amount of assistance not specified. Unspecified as to whether dual-eligible beneficiaries would be required to pay the incremental cost if they chose to enroll in a plan that was more expensive than the federal contribution. Eligibility levels not specified.

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DATE	**ENACTED DECEMBER 26, 2013**	**PROPOSED APRIL 10, 2013**	**PROPOSED MARCH 23, 2013**	**PROPOSED MARCH 21, 2013**
Physician payments/ sustainable growth rate (SGR) formula	Creates a deficit-neutral reserve fund for health care improvement that can be used to introduce legislation that would reform or replace the SGR, among other possible uses. Encourages CMS to identify and implement mechanisms to simplify and reduce the administrative burden of quality measures for physicians. Requires CMS to provide physicians with timely feedback. Provides a statement of support for testing alternative models for Medicare payments to physicians. Prevents a reduction in payments to physicians scheduled to occur on January 1, 2014 as a result of the SGR formula, and provides a 0.5 percent increase in payments between January 1 and April 1, 2014; reductions in payments as a result of the SGR formula are scheduled to go into effect thereafter. Extends the Geographic Practice Cost Index (GPCI) to determine payments to physicians for medical procedures until April 1, 2014.	Following a period of payment stability, physicians would be encouraged to join accountable payment models and over time payment updates for physician services would be linked to participation in the organizations. Physicians who provide lower quality, inefficient care would receive lower payments. Includes statement that the President is "committed to working with Congress to fix the SGR;" adjusted baseline budget assumes no reduction in Medicare physician payments for 2014 to 2023.	Would reform the SGR formula. Baseline assumes Medicare's payment rates for physicians are maintained at the current rate; details not specified. Would create a deficit-neutral reserve fund for health care improvement that could be used to introduce legislation that would reform or replace the SGR, among other possible uses.	Would create a ten-year deficit-neutral reserve fund to revise or replace the SGR formula.
Other Medicare provisions	Creates a deficit-neutral reserve fund for health care improvement that can be used to introduce legislation for the following purposes, among other possible uses: extend Medicare, Medicaid, or other health provisions; promote improvements in health care delivery systems that improve the fiscal sustainability of federal health spending over the long term; or protect access to outpatient therapy services by repealing or increasing the current outpatient therapy caps. Creates a deficit-neutral reserve fund for legislation that would repeal the 2.3 percent excise tax on medical device manufacturers and promote innovation, preserve jobs, and promote economic growth in the medical device industry.	Would reduce bad debt payments from 65 percent generally to 25 percent for all eligible providers over 3 years, beginning in 2014. Would reduce payments for indirect medical education (IME), beginning in 2014. Would reduce critical access hospital payments to 100 percent of reasonable costs, beginning in 2014, and eliminate the designation for those critical access hospitals within 10 miles of the nearest hospital, beginning in 2014. Would reduce fraud, waste, and abuse in Medicare by several measures, including creating new initiatives to reduce improper payments in Medicare and requiring prior authorization for advanced imaging.	Would create a deficit-neutral reserve fund for health care improvement that could be used to introduce legislation for the following purposes, among other possible uses: extend Medicare, Medicaid, or other health provisions; promote improvements in health care delivery systems that improve the fiscal sustainability of federal health spending over the long term; or protect access to outpatient therapy services by repealing or increasing the current outpatient therapy caps. Would achieve savings of $265 billion by realigning incentives throughout the system, cutting waste and fraud, and seeking greater engagement across the health care system.	Would support changes to laws governing medical liability, including limits on noneconomic and punitive damages.

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DATE	**ENACTED DECEMBER 26, 2013**	**PROPOSED APRIL 10, 2013**	**PROPOSED MARCH 23, 2013**	**PROPOSED MARCH 21, 2013**
	Extends the Medicare therapy cap exception process through March 31, 2014. Extends Medicare rates for ambulance services, the Medicare inpatient hospital payment adjustment for low-volume hospitals, and the Medicare-Dependent Hospital (MDH) program until April 1, 2014. Restricts the increased long-term care hospital (LTCH) rate to patients in LTCH with inpatient stays of at least three days in an Intensive Care Unit or on a ventilator, beginning October 1, 2015. Extends the 25 percent patient threshold payment adjustment for LTCH for an additional three years. Extends funding for the National Quality Forum until currently available funds expire. Extends funding for the State Health Insurance Counseling Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the National Center for Benefits Outreach and Enrollment until April 1, 2014.	Would restructure payments for post-acute care services using a bundled payment approach, beginning in 2018. Would reduce payment updates for certain post-acute care providers, equalize payments for certain conditions commonly treated in inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), and encourage appropriate use of inpatient rehabilitation hospitals, beginning in 2014. Would reduce SNF payments to reduce hospital readmissions, beginning in 2017. Would levy up to 100 percent of payments to Medicare providers with delinquent tax debts, beginning in 2014. Would implement the following changes to encourage additional provider efficiencies: allow only providers who meet certain accountability standards to self-refer radiation therapy, therapy services, and advanced imaging services; reduce payments for clinical laboratory services, and encourage electronic reporting of laboratory results; and expand the availability of Medicare data released to physicians and other providers for performance improvement, and other purposes.	Would create a deficit-neutral reserve fund for legislation that would repeal the 2.3 percent excise tax on medical device manufacturers and promote innovation, preserve jobs, and promote economic growth in the medical device industry. Would create a deficit-neutral reserve fund to ensure that chronic illness is addressed as part of health care improvement. Would create a deficit-neutral reserve fund to require state-wide budget neutrality in the calculation of the Medicare hospital wage index floor.	
Sources and notes	H.J. Res. 59, as signed into law, December 26, 2013.	Office of Management and Budget, "Fiscal Year 2014 Budget of the U.S. Government," April 10, 2013.	S.Con.Res. 8, as passed by the Senate in 113th Congress, March 23, 2013. Committee Print to Accompany S.Con.Res. 8, March 2013.	H.Con.Res. 25, 113th Congress. Report of the Committee on the Budget House of Representatives to Accompany H.Con.Res. 25, March 15, 2013. [1] Provision specified in Chairman Paul Ryan's, "The Path to Prosperity: A Responsible, Balanced Budget," March 12, 2013.

This side-by-side was prepared by Gretchen Jacobson of the Kaiser Family Foundation.

APPENDIX A: Summary Of Other Deficit- And Debt-Reduction Proposals With Major Medicare Provisions (Introduced since January 2012)

This appendix summarizes additional deficit and debt reduction proposals with major Medicare provisions, including the following:

- **Joseph Antos**, as described in "Medicare Makeover: Five Responsible Reforms to Make Medicare Healthy," American Enterprise Institute, December 17, 2012 and "Saving Medicare: A Market Cure for An Ailing Program," American Enterprise Institute, December 2012.
- **Robert Berenson, John Holahan and Stephen Zuckerman**, as described in "Can Medicare Be Preserved While Reducing the Deficit?" March 2013.
- **Bipartisan Policy Center**, as described in "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment," April 18, 2013.
- **Erskine Bowles and Former Senator Alan Simpson**, as described by Moment of Truth Project, "A Bipartisan Path Forward to Securing American's Future," February 19, 2013.
- **Brookings Institution (Engelberg Center for Health Care Reform)**, as described in "Bending the Curve: Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth," April 29, 2013.
- **Brookings Institution (The Hamilton Project)**, as described in "15 Ways to Rethink the Federal Budget," February 26, 2013.
- **Senators Richard Burr and Tom Coburn**, as described in "The Seniors' Choice Act," February 16, 2012.
- **Business Roundtable**, as described in "Social Security Reform and Medicare Modernization Proposals," January 16, 2013.
- **Center for American Progress**, as described in "The Senior Protection Plan," November 13, 2012.
- **Congressional Progressive Caucus**, as described by Economic Policy Institute Policy Center, "The 'Back to Work' Budget: Analysis of the Congressional Progressive Caucus budget for fiscal year 2014," March 13, 2013; and H.Amdt. 3 to H.Con.Res. 25 in the 113th Congress, introduced March 20, 2013.
- **Senator Bob Corker**, as included in S. 3673, "The Dollar for Dollar Act of 2012," 112th Congress.
- **Senator Orrin Hatch**, as described in Letter to Colleagues, January 24, 2013.
- **House Democratic Caucus**, as described in Amdt. 5 to H.Con.Res. 25 in the 113th Congress.
- **National Coalition on Health Care**, as described in "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future," November 8, 2012.
- **Senators Rand Paul, Lindsey Graham, Mike Lee, and Jim DeMint**, as included in S. 2196, "Congressional Health Care for Seniors Act of 2012," 112th Congress; and Senator Rand Paul, "Congressional Health Care for Seniors Act," released March 15, 2012.
- **Republican Study Committee**, as described in "Back to Basics: A Budget for Fiscal Year 2014," March 18, 2013; and Amdt. 4 to H.Con.Res. 25 in the 113th Congress, introduced March 20, 2013.

Joseph Antos (December 17, 2012)

Age of Medicare eligibility: Would increase the eligibility age from 65 to 67, and allow seniors between the ages of 62 and 67 to buy into the program.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would convert Medicare into a defined-contribution/premium support system, with plans competitively bidding in local markets. Would establish a plan option that offers a network of high-quality providers who will accept lower Medicare payments in exchange for recognition of their superior service. Would provide beneficiaries with better tools to compare Medicare Advantage plan options and traditional Medicare, including information on the cost of Medigap insurance and the expected out-of-pocket costs.

Part B and Part D premiums: Would increase the base premium for Part B from 25 percent to 35 percent of program spending and impose a premium for Part A.

Medicare cost sharing: Would unify cost sharing for Part A and B, with 20 percent coinsurance on all services. Would establish health savings accounts for enrollees in traditional Medicare. Would increase the cost-sharing for high-income beneficiaries.

Medigap, employer-sponsored, and other supplemental coverage: Would change Medigap so that policyholders are sensitive to the cost of their medical care. Would modify rules to require insurers to offer Medigap coverage whenever beneficiaries apply for it.

Physician payments/sustainable growth rate (SGR) formula: Would repeal the SGR mechanism for physician payments and replace it with a stable payment system that would spread cuts among physicians, other providers and beneficiaries. Would allow physicians to charge patients a different rate than what Medicare pays, if the physician gives advance notice to the patients. Would institute a new physician payment methodology that rewards quality and prudent medical practice.

Other Medicare provisions: Would allow Medicare authorities greater latitude to adopt innovative payment schedules and management practices that reward improved health care delivery. Would develop other payment models, including competitive bidding for specific services, bundled payment, performance-based payment, and payment methods that encourage management of chronic disease.

Source: Joseph Antos, "Medicare Makeover: Five Responsible Reforms to Make Medicare Healthy," American Enterprise Institute, December 17, 2012; and Joseph Antos, *"Saving Medicare: A Market Cure for An Ailing Program,"* American Enterprise Institute, December 2012.

Robert Berenson, John Holahan, and Stephen Zuckerman (March 7, 2013)

Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB): Would cap growth of per capita spending under traditional Medicare to GDP per capita.

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Age of Medicare eligibility: Would increase the age of eligibility to age 67 by two months per year, beginning in 2014. Would be combined with an income-related buy-in that would allow beneficiaries ages 65 and 66 to purchase Medicare at higher premiums; would provide buy-in subsidies for beneficiaries with incomes below 400 percent of the federal poverty level (FPL).

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would maintain Medicare Advantage plan benchmarks at a maximum of 95 percent of per capita traditional Medicare costs in the highest cost areas and reduce plan benchmarks to 100 percent of per capita traditional Medicare costs in all other areas.

Medicare cost sharing: Would set a maximum on beneficiaries' out-of-pocket expenses that would vary by income. Would reduce premiums and deductibles for beneficiaries with incomes below 300 percent of the FPL.

Prescription drugs: Would require drug manufacturers to provide rebates to Part D plans that are no lower than the Medicaid minimum rebate level for drugs prescribed to dual-eligible beneficiaries. Would eliminate cost-sharing for generic medications and set the co-payment on the substitutable brand-name drugs at $6 for LIS beneficiaries.

Physician payments/sustainable growth rate (SGR) formula: Would repeal the SGR mechanism for physician payment.

Other Medicare provisions: Would increase the Medicare payroll tax by 0.5 percent beginning in 2017. Would reduce indirect medical education (IME) payments to teaching hospitals. Would reduce payments to skilled nursing facilities (SNFs) and home health agencies. Would reduce provider payments for many tests, imaging, and procedures and would eliminate site-of-service differentials for services provided in both outpatient hospitals and physician offices. Would require CMS to conduct surveys of lab fees paid by large payers for clinical lab services to assess the appropriateness of fees in Medicare, and would reduce Medicare lab fees accordingly.

Source: Berenson, Robert, John Holahan, and Stephen Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?" March 2013.

Bipartisan Policy Center (April 18, 2013)

Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB): Would limit growth in federal contributions per Medicare enrollee to more than per capita GDP+05 percent, and apply separately for traditional Medicare, Medicare Networks, and Medicare Advantage, no earlier than 2020.

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would implement a competitive bidding system in regions where plans are currently paid less than the average costs of traditional Medicare. Would update the Medicare Open Enrollment website. Would improve the Medicare Advantage risk adjustment system by incorporating a measure of functional status, and implementing a reinsurance system for Medicare Advantage plans by 2016. Would require all Medicare Advantage plans to provide prescription drug coverage. Would allow Medicare Advantage plans to adopt tiered provider networks. Would end the CMS bonus demonstration program and eliminate bonuses in markets with competitively bid payments.

Part B and Part D premiums: Would establish lower income-related premium thresholds, reducing the lowest income-threshold from $85,000 to $60,000 for individuals, so that approximately 17 percent of beneficiaries pay income-related premiums, beginning in 2016.

Medicare cost sharing: Would unify cost sharing for Part A and B, with a unified deductible of $500 (exempting physician office visits), copayments for most services after the deductible is met, no cost-sharing for preventive care and annual wellness visits, and a limit on out-of-pocket expenses of $5,315. Would federalize cost-sharing assistance to cover 50 percent of cost-sharing for beneficiaries with incomes between 100 percent and 135 percent of the federal poverty level (FPL), and 25 percent of cost-sharing for beneficiaries with incomes between 135 percent and 150 percent of the FPL, with no limit on assets and eligibility based on an individual's modified adjusted gross income (MAGI).

Medigap, employer-sponsored, and other supplemental coverage: Would require Medigap and employer-provided plans (including TRICARE for Life and FEHBP) to include a deductible of at least $250, cover no more than 50 percent of beneficiaries' copayments and coinsurance, and provide an out-of-pocket limit no lower than $2,500, beginning in 2016.

Prescription drugs: Would adjust the cost-sharing for beneficiaries who qualify for the Part D low-income subsidy (LIS) program to encourage the use of lower-cost drugs. Would change the reimbursement of Part B drugs to the average sales price (ASP) plus a flat rate, and would convert drugs paid the average wholesale price (AWP) to the ASP payment method. Would prohibit "pay for delay" agreements that restrict access to generic drugs, and implement reforms to close the "REMS loophole" to encourage generic drug development.

Dual-eligible beneficiaries: Would support the adoption of a broad strategy to deliver Medicare and Medicaid services to dual-eligible beneficiaries through a single program. Would eliminate asset tests for the existing Medicare Savings Programs and Part D low-income subsidy (LIS) program, and further promote the availability of the programs.

Physician payments/sustainable growth rate (SGR) formula: Would repeal the SGR mechanism for physician payments and provide payment updates based on the Medicare Economic Index (MEI) only to physicians that participate in the Medicare provider network option, beginning in 2017; payments would be frozen through 2023 for physicians not accepting financial risk.

Other Medicare provisions: Would offer within traditional Medicare an option for beneficiaries to enroll in a network of providers, similar to ACOs, and the provider networks would have spending targets; beneficiaries who enrolled in the Medicare Network program would receive a premium discount. Would accelerate payment reforms by expanding the voluntary payment bundling demonstration and requiring bundles for inpatient care, physician services, post-acute care, and hospital readmissions by 2018. Would implement lower benchmarks for some equipment types in the durable medical equipment competitive-bidding program. Would equalize payments for evaluation and management services across sites of care and equalize payments for certain procedures provided in both physicians' offices and outpatient departments. Would further limit physician self-referrals. Would reform graduate medical education payments, including reduce indirect medical education (IME) percentage add-on to inpatient hospital admissions from 5.5 percent to 3.5 percent, provide incentive payments to high-performing institutions, increase residency slots with half of the additional slots for primary care and other providers for which there are shortages, reduce the variation in direct graduate medical education payments, and explore the allocation of resources to train non-physician professionals. Would prioritize electronic sharing of information among providers as part of the Medicare and Medicaid electronic health record incentive programs.

Source: Bipartisan Policy Center, "A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment," April 18, 2013.

Erskine Bowles and Former Sen. Alan Simpson (February 19, 2013)

Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB): Would allow IPAB to make recommendations for all providers (no exemptions), and be given the authority to change Medicare's benefit design and cost-sharing. Starting in 2018, would set target for growth of total federal health care spending per beneficiary at GDP per capita. If the growth in spending exceeded GDP per capita, then would consider a variety of reforms ranging from premium support to an all-payer system. Absent reforms, would implement a combination of the following to enforce the cap on spending: reductions in provider payments with a "value based withhold;" across-the-board increases in Medicare premiums; and a reduction in the value of the employer health tax exclusion.

Sequestration of Medicare spending: Would replace the sequestration with other savings and revenue provisions.

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Age of Medicare eligibility: Would gradually increase the eligibility age by one month per year beginning in 2017 until it reaches age 66, and then 2 months per year until it reaches age 67. Would be combined with an income-related buy-in that would allow beneficiaries ages 65 and older to purchase Medicare; would provide buy-in subsidies for lower-income beneficiaries, including 100 percent subsidy for beneficiaries with incomes below 100 percent of the federal poverty level (FPL) in states that do not expand Medicaid eligibility with a sliding scale of subsidies for beneficiaries with incomes between 100 percent and 400 percent of the FPL.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would reform the Medicare Advantage program by making payments based on competitive bidding, if such a system would reduce costs without damaging quality. Would recoup erroneous payments to Medicare Advantage plans. Would eliminate double bonus payments to Medicare Advantage plans.

Part B and Part D premiums: Would increase income-related premiums under Medicare Parts B and D by 15 percent, such that the lowest income-related premium would be increased from 35 percent to 40.25 percent of projected per capita expenditures. Would create a new lower income-related premium threshold at a level that would result in 15 percent of beneficiaries subject to income-related premiums, and freeze the income-related thresholds through 2030.

Medicare cost sharing: Would replace current Medicare cost-sharing with a unified deductible, and uniform co-insurance up to an initial out-of-pocket limit, with 5 percent coinsurance required for expenses between the initial limit and a maximum out-of-pocket limit; out-of-pocket limits would be income-adjusted and low-income beneficiaries would have lower deductibles than higher income beneficiaries. Would make the modifications to the benefit package such that the average out-of-pocket costs (including premiums) are held constant. Would provide CMS the authority to adjust coinsurance rates based on the value of the procedure, on a net cost-neutral basis. Would have CMS offer an alternative Medicare benefit package focused on care coordination that would, for example, merge Parts A, B, and D into a single benefit package and offer lower cost sharing for beneficiaries who use high-value providers and services; the package could also offer coverage above the standard package to minimize the need for supplemental insurance, could be targeted to high-cost populations, and could be offered alongside traditional Medicare and Medicare Advantage or as a demonstration project.

Medigap, employer-sponsored, and other supplemental coverage: Would prohibit Medigap and TRICARE for Life plans from covering the Medicare deductible and no more than 50 percent of the base coinsurance, up to the initial limit; in the interim, would apply a surcharge to the Part B premium of Medigap plans. Would apply a surcharge to the Part B premium of beneficiaries with retiree health plans, and give retirees the option of cashing out the value of their health plan in the form of a Part B premium subsidy; beneficiaries with Federal Employees Health Benefit (FEHB) plans would be required to cash out the value of their plan.

Prescription drugs: Would require drug manufacturers to provide rebates to Part D plans that are no lower than the Medicaid minimum rebate level for drugs prescribed to dual-eligible beneficiaries. Would prohibit "pay for delay" arrangements between brand and generic manufacturers.

Physician payments/sustainable growth rate (SGR) formula: Would replace cuts required by the SGR formula with a smaller reduction in payments. Would allow CMS to make budget-neutral adjustments to payments to improve the quality of care. Would direct CMS to establish a new physician-payment system that promotes new models, such as Accountable Care Organizations and patient-centered medical homes, and encourage care coordination, prioritizes primary care, and reduces Medicare costs. Would default to the reinstatement of a re-based SGR mechanism if a new physician-payment mechanism was not implemented by CMS.

Other Medicare provisions: Would increase funding for CMS pilots and demonstrations. Would expand the Hospital Readmissions Reduction Program to include more medical conditions and higher penalties on more types of physicians; would calibrate penalties to adjust for demographics, types of conditions, and timing of readmission, and allow lower penalties for providers who reduced readmissions or complications over time or demonstrated that readmissions lead to lower mortality rates. Would expand the Medicare Acute Care Episode (ACE) demonstration program and moving towards a system with more bundled payments for care. Would expand competitive bidding for medical devices, laboratory tests, radiologic diagnostic services, and other services. Recommends that CMS study new ways to increase transparency of prices and quality, prohibit "gag clauses," require CMS to publicly release Medicare and Medicaid claims data, and mandate public reporting of prices for a basket of routine elective procedures. Would enact Medicare malpractice reforms. Would adopt the President's proposal to reduce the annual growth in payments to SNFs, IRFs, long-term care hospitals, and home health facilities. Would phase out all reimbursements for bad debts, reduce subsidies for graduate medical payments, and reduce payments for rural hospitals. Would provide the Secretary of HHS the authority to better align clinical lab payments with the private sector, and reclassify certain payments to hospital outpatient evaluation and management visits so that they are treated similarly to physician office visits. Would implement multiple steps to reduce fraud and abuse, including validating high-cost, high-fraud physician orders, provide the IRS the authority to penalize providers with delinquent debt, require prior authorization for advanced imaging, further restrict physician self-referrals, and adopt the reforms in the Coburn-Carper FAST Act, as well as other measures.

Source: Moment of Truth Project, "A Bipartisan Path Forward to Securing American's Future," February 19, 2013.

Brookings Institution, Engelberg Center for Health Care Reform (April 29, 2013)

Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB): Would cap growth of per capita spending under traditional Medicare to GDP per capita.

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would require Medicare Advantage plans to report the same quality measures as Medicare Comprehensive Care (MCC) organizations. Would update capitated payments to Medicare Advantage plans by GDP per capita. Would change the payment system to provide 100 percent of the difference between plans' bid and the benchmark (i.e., the maximum amount Medicare will pay) if the plan uses the entire amount to reduce premiums, and provide 50 percent of the difference if the plan uses the amount to provide additional benefits.

Medicare cost sharing: Would set a maximum on beneficiaries' out-of-pocket expenses and require copayments, rather than coinsurance, for most services. Would require MCCs to provide clear information on enrollees' costs for their services. The benefit restructuring changes (including changes to Medigap) would be implemented so that they do not increase beneficiaries' overall cost sharing.

Medigap, employer-sponsored, and other supplemental coverage: Would require Medigap plans to have an actuarially-equivalent co-pay of at least 10 percent.

Dual-eligible beneficiaries: Would make permanent the CMS Capitated Financial Alignment Demonstration.

Physician payments/sustainable growth rate (SGR) formula: Would repeal the SGR and replace it with an alternative system to promote better coordinated care, and provide higher payments to providers participating in MCCs.

Other Medicare provisions: Would create MCCs that would receive capitated, case-based, or bundled payments based on current beneficiary spending and quality of care, with spending limits increased by GDP per capita; MCCs could offer enrollees reduced premiums or cost-sharing. Would expand bundled payments with performance measures, in order to help implement MCC payment reforms.

Source: Engelberg Center for Health Care Reform at Brookings, "Bending the Curve: Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth," April 29, 2013.

Brookings Institution, The Hamilton Project (February 26, 2013)

Medicare cost sharing: Would unify Parts A and B with a combined annual deductible of $525 and set the coinsurance rate above the deductible equal to 20 percent up to an annual out-of-pocket maximum that would vary by income, ranging from $1,983 for beneficiaries with incomes between 100 percent to 200 percent of the FPL to $5,950 for beneficiaries with incomes above 400 percent of the FPL. Deductibles for beneficiaries with incomes below 200 percent of the FPL would be reduced to $250. *(Proposal authored by Jonathan Gruber)*

Medigap, employer-sponsored, and other supplemental coverage: Would apply an excise tax of up to 45 percent on Medigap plan premiums, and employer-sponsored retiree coverage for beneficiaries over age 65 (not for early retirees). *(Proposal authored by Jonathan Gruber)*

Other Medicare provisions: Would implement global payment model (operating independently from traditional Medicare) to pay provider systems to cover all beneficiary spending, and would implement regulatory neutrality between Medicare Advantage plans and Accountable Care Organizations (ACOs) with equivalent payments for both models. *(Proposal authored by Michael Chernew and Dana Goldman)*

Source: The Hamilton Project, "15 Ways to Rethink the Federal Budget," February 26, 2013.

Sens. Richard Burr and Tom Coburn (February 16, 2012)

Constraints on federal health/Medicare spending, including the Independent Payment Advisory Board (IPAB): Would repeal the IPAB.

Age of Medicare eligibility: Would increase the age of eligibility from 65 to 67, by increasing the age of eligibility by two months each year, beginning in 2014.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: In 2016, would transition Medicare to a premium support program in which traditional Medicare and private plans would compete with each other, providing actuarially equivalent benefits with all plans covering basic hospital, surgical, physician and emergency care. The federal contribution would be tied to the weighted average bid and increase each year based on plan bids. Beneficiaries would pay the difference between the defined federal contribution and the bid for the plan in which they choose to enroll.

Part B and Part D premiums: Would raise Medicare Part B premiums by 3 percent of overall program costs, beginning in 2013, so that a 9 percent increase is achieved by 2016; lower income beneficiaries would be held harmless from increased Part B premiums. In 2016 and thereafter, higher income beneficiaries would receive lower federal contributions and pay higher premiums, and lower income beneficiaries would receive higher federal contributions and pay lower premiums.

Medicare cost sharing: Would unify Parts A and B with combined annual deductible of $550; set coinsurance rate equal to 20 percent up to an annual out-of-pocket total of $5,500 and coinsurance rate equal to 5 percent for out-of-pocket expenses between $5,500 and $7,500 per year; set annual out-of-pocket maximum at $7,500, with higher out-of-pocket limits for beneficiaries with incomes greater than $85,000/individual, $170,000/couple. Would require beneficiaries with incomes exceeding $1 million to pay the full cost of their Part B and Part D premiums, and have higher unified deductibles than other beneficiaries.

Medigap, employer-sponsored, and other supplemental coverage: Would prohibit Medigap plans from covering the first $500 of beneficiaries' cost-sharing and limit coverage above $500 to 50 percent of the next $5,000 of Medicare cost-sharing.

Physician payments/sustainable growth rate (SGR) formula: Would freeze current physician payment rates until a premium support model is implemented in 2016.

Other Medicare provisions: Would offer a new, voluntary care coordination benefit.

Source: Senator Richard Burr and Senator Tom Coburn, "The Seniors' Choice Act," February 16, 2012.

Business Roundtable (January 16, 2013)

Age of Medicare eligibility: Would gradually raise Medicare eligibility age from age 65 to 70, for people younger than age 55 in 2013.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would offer beneficiaries the choice between private plans and traditional Medicare by 2015. Private plans would be allowed to sell across state lines and modify the existing set of Medicare benefits. The traditional Medicare program would compete with private plans and would have the flexibility to modify the Medicare benefit package. Premiums would be community rated, plans would be required to accept all applicants, and payments to plans would be risk adjusted.

Medicare cost sharing: Would consider additional means testing for Medicare services by 2015.

Dual-eligible beneficiaries: Would retain existing financial support low-income beneficiaries with improvements in care coordination and a focus on wellness and chronic care management.

Source: Business Roundtable, "Social Security Reform and Medicare Modernization Proposals," January 16, 2013.

Center for American Progress (November 13, 2012)

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would set Medicare Advantage benchmarks based on the average plan bid, beginning in 2014, and would improve the accuracy of adjustments for coding intensity differences.

Part B and Part D premiums: Would freeze the share of beneficiaries who will pay income-related premiums at 10 percent for 2019 and thereafter, and would increase the premiums for beneficiaries paying income-related premiums by 15 percent, beginning in 2014.

Medicare cost sharing: Would set annual out-of-pocket limits, ranging from $5,000 per year to $10,000 per year, based on beneficiaries' incomes. Would direct the Institute of Medicine to recommend additional improvements to align incentives with high-quality care. Would implement the changes such that average cost-sharing would not increase and the value of the benefit package would not decrease.

Medigap, employer-sponsored, and other supplemental coverage: Would prohibit Medigap plans from covering the first $500 of beneficiaries' cost-sharing for beneficiaries with incomes above 400 percent of the federal poverty level, with exemptions for primary care and care for chronic disease.

Dual-eligible beneficiaries: Would coordinate care for dual-eligible beneficiaries, by allowing dual-eligible beneficiaries to choose a primary care medical home and allowing states and medical homes to retain a share of any savings if quality standards are met.

Prescription drugs: Would extend Medicaid rebates to low-income beneficiaries; maximize use of generic drugs; prohibit "pay for delay" agreements that restrict access to generic drugs; and shorten the exclusivity period for brand-name biologic drugs.

Physician payments/sustainable growth rate (SGR) formula: Would repeal the SGR mechanism (holding beneficiaries who do not pay income-related premiums harmless from premium increases resulting from the repeal); incentivize alternatives to fee-for-service payment by reducing payments to specialists by 3 percent and reducing payments to primary care physicians who are not participating in a

certified primary care medical home by 3 percent, beginning in 2017; permanently increase payments for primary care services by 10 percent; identify and correct overpriced physician services; and expand the ban on physician self-referrals.

Other Medicare provisions: Would use competitive bidding for all health care products, including durable medical equipment, imaging services, laboratory tests, and other health care products; publicly release claims data, including Medicare claims data; accelerate use of alternatives to fee-for-service payment, including bundled payments; promote shared decision making; strengthen value-based purchasing for hospital readmissions; reduce payments to skilled nursing facilities with high rates of rehospitalization; implement value-based purchasing for ambulatory surgical centers; reduce payments for graduate medical education (GME); make GME payments performance-based and other additional GME requirements; reduce payments to home health providers, skilled nursing facilities, hospital inpatient and outpatient services, rural hospitals, and end-stage renal disease facilities; reduce Medicare bad debt; and reduce fraud and improper payments.

Source: Center for American Progress, "The Senior Protection Plan," November 13, 2012.

Congressional Progressive Caucus (March 12, 2013)

Sequestration of Medicare spending: Would repeal the sequester.

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Prescription drugs: Would allow the Secretary of Health and Human Services (HHS) to negotiate Medicare Part D prescription drug prices with pharmaceutical manufacturers; and prohibit "pay for delay" agreements that restrict access to generic drugs.

Other Medicare provisions: Would broaden the Medicare hospital insurance tax on wages to include income from S corporations for employee-shareholders of businesses with three or fewer principal shareholders; and accelerate the use of bundled payments.

Source: Economic Policy Institute Policy Center, "The 'Back to Work' Budget: Analysis of the Congressional Progressive Caucus budget for fiscal year 2014," March 13, 2013; and H.Amdt. 3 to H.Con.Res. 25 in the 113th Congress, introduced March 20, 2013.

Sen. Bob Corker, S. 3673 (December 12, 2012)

Age of Medicare eligibility: Would increase the age of eligibility by 2 months per year for individuals who attain age 65 after January 1, 2014 but before 2025, such that the age of eligibility will be 67 in 2025 and thereafter.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would sunset Medicare Advantage plans, beginning in 2017, and would allow beneficiaries the option of enrolling in a Total Health plan or traditional Medicare, beginning in 2017. All Total Health plan sponsors would be required to provide a plan that provides the standard basic benefit package (same benefits as traditional Medicare), and may also provide plans with supplemental coverage. All beneficiaries would be guaranteed a choice of at least 2 plans in an area. The federal contribution for beneficiaries not subject to income-related premiums would be equal to 85 percent of the 40th percentile of the monthly plan bid amounts (excluding supplemental coverage benefits), weighted by enrollment, and including traditional Medicare as a bid.

Part B and Part D premiums: Premiums for beneficiaries not subject to income-related premiums would be equal to the difference between the plan bid and the federal contribution, but would not be allowed to be less than $0. Beneficiaries with annual incomes greater than $50,000 (for individuals) would be subject to income-related premiums in 2013 or thereafter; beneficiaries with annual incomes greater than $250,000 (for individuals) would receive no federal contribution. The income thresholds to determine applicability of income-related premiums would continue to be frozen until December 31, 2021, with no adjustment for inflation.

Medicare cost sharing: The basic benefit package for traditional Medicare would have a unified deductible of $550, followed by 20 percent coinsurance up to total out-of-pocket expenses of $5,500, which would then be followed by 5 percent coinsurance up to an annual out-of-pocket limit of $7,500, beginning in 2015 with thresholds indexed to increase by the Chained Consumer Price Index for Urban Consumers (CPI-U).

Medigap, employer-sponsored, and other supplemental coverage: National Association of Insurance Commissioners (NAIC) would be required to review and revise the Medigap benefit packages to allow for revised benefit packages to be implemented by January 1, 2015. Revised plans would be prohibited from covering the unified deductible and more than 50 percent of the cost-sharing after the unified deductible. Medigap policies could not be issued after December 31, 2016 to beneficiaries who previously were not covered by a Medigap policy.

Dual-eligible beneficiaries: States could apply for a waiver of any or all requirements to offer a Total Health plan for dual-eligible beneficiaries to coordinate Medicare and Medicaid; all proposals would be required to not increase federal expenditures and state Total Health plans would be required to provide coverage that is at least a comprehensive as other Total Health plans. State waivers would be limited to 5 years, with options to renew the waivers thereafter.

Other Medicare provisions: Would limit payments for graduate medical education (GME) to no more than 120 percent of the national average salary paid to medical residents in 2010, increased by the Chained CPI-U; and reduce payments for indirect graduate medical education (IME), home health, and bad debt.

Source: *S. 3673, "The Dollar for Dollar Act of 2012," as introduced by Senator Bob Corker on December 12, 2012, 112th Congress.*

Sen. Orrin Hatch (January 24, 2013)

Age of Medicare eligibility: Would gradually raise the age of eligibility from 65 to age 67, by increasing the age of eligibility by two months each year.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would provide a federal contribution to beneficiaries "based on" bids submitted by private plans and traditional Medicare. The federal contribution would help cover the plan premium; beneficiaries who chose plans that cost less than the contribution would receive the differences through lower premiums or additional health benefits. Plan coverage requirements would be defined by the federal government.

Medicare cost sharing: Would unify cost sharing for Part A and Part B, by creating a combined annual deductible and setting a coinsurance rate and annual out-of-pocket maximum.

Medigap, employer-sponsored, and other supplemental coverage: Would limit Medigap plans from providing first-dollar coverage for cost-sharing.

Dual-eligible beneficiaries: Would limit the amount of federal dollars spent on each Medicaid beneficiary (block grant), including dual-eligible beneficiaries, with adjustments for eligibility categories and health status. Federal government would also monitor Medicaid programs on quality, access, and coverage metrics.

Source: Letter to Colleagues from Senator Orrin Hatch, Ranking Member of the Committee on Finance, January 24, 2013.

House Democratic Caucus (March 20, 2013)

Sequestration of Medicare spending: Includes a policy statement that the sequester should be repealed and replaced with spending reductions and revenue increases.

Medicare provisions in the ACA: Includes a policy statement that the ACA should not be repealed.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Includes a policy statement that any legislation that would transform the Medicare program into a premium support system should be rejected.

Physician payments/sustainable growth rate (SGR) formula: Would create a deficit-neutral reserve fund for improvements to Medicare that could be used to introduce legislation to reform the Medicare payment system for physicians and other care providers, building on delivery system reforms underway.

Other Medicare provisions: Would create a deficit-neutral reserve fund for extending expiring Medicare, Medicaid, or other health provisions.

Source: Amdt. 5 to H.Con.Res. 25 in the 113th Congress, introduced March 20, 2013.

National Coalition on Health Care (November 8, 2012)

Medicare provisions in the ACA: Would retain the changes made by the ACA.

Medicare cost sharing: Would empower the Secretary of HHS to vary cost-sharing based on evidence, and lift curbs on tiered cost-sharing in Medicare Advantage.

Dual-eligible beneficiaries: Would increase beneficiary protections in the state demonstrations; allow Medicare pilot ACOs to also assume risk for Medicaid long-term services and supports for dual-eligible beneficiaries; expand the PACE program, pay PACE providers based on Medicare Advantage benchmarks, improve the risk adjustment system for PACE plans, and create outlier financial protection for new PACE sites; and streamline state contracts with Special Needs Plans for dual-eligible beneficiaries.

Prescription drugs: Would integrate medication adherence measures into initiatives; shorten the exclusivity period for brand-name biologic drugs from 12 to 7 years; encourage use of generic drugs in the low-income subsidy population; and reform reimbursement for Part B drugs.

Physician payments/sustainable growth rate (SGR) formula: Would eliminate the SGR mechanism for paying physicians, test and implement new value-based models of provider payment, provide financial incentives for providers to move towards a value-based payment model, and encourage and reward primary care; equalize payment rates for services delivered in outpatient and physician office settings; and reduce payments for primary care physicians who fail to meet flu shot benchmarks for their patient population.

Other Medicare provisions: Would expand participation in CMS demonstrations and pilots by allowing rolling application; apply payment incentives for participation in quality and value initiatives; sustain CMS funding; encourage bundled payments; expand penalties for potentially avoidable health care-acquired complications and readmissions; reform post-acute and home health payment; implement a value-based withhold for provider payments if savings do not materialize; implement a Medicare Health Rewards program; require Medicare to cover participation in the Diabetes Prevention Program for eligible pre-diabetics; pilot reference pricing for treatments and diagnostic tests; expand competitive bidding for durable medical equipment; include the provision of palliative care in the quality metrics for the Value-Based Purchasing Program; support education of palliative care professionals; provide behavioral health providers access to incentive payments for the meaningful use of health information technology; re-evaluate payment codes for traditional Medicare; strengthen anti-fraud programs; dedicate penalties imposed on Medicare and Medicaid providers that fail to meet standards for the use of health information; and reduce payments for advanced imaging.

Source: National Coalition on Health Care, "Curbing Costs, Improving Care: The Path to an Affordable Health Care Future," November 8, 2012.

Sens. Rand Paul, Lindsey Graham, Mike Lee, and Jim DeMint (March 15, 2012)

Age of Medicare eligibility: Would increase the age of eligibility from 65 to 70, by increasing the age of eligibility by three months each year, beginning in 2014.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would allow all beneficiaries to use a federal contribution to either enroll in a plan offered as part of the Federal Employees Health Benefit Plan (FEHBP), or, for beneficiaries with employer-sponsored insurance, use towards the purchase of an employer-sponsored health plan, beginning in 2014. Federal contributions would be the same as current FEHBP contributions, which are approximately 75 percent of the cost of the "average plan." Beneficiaries would pay the difference between the defined federal contribution and the bid for the plan in which they chose to enroll. A new "high-risk pool" for the highest-cost beneficiaries would be created for the costliest 5 percent of all people enrolled in FEHBP; health care plans would be reimbursed for 90 percent of the total medical expenses of high-cost people.

Part B and Part D premiums: Beneficiaries who could not afford to pay plan premiums would receive additional premium assistance and cost-sharing through Medicaid. Low-income beneficiaries, for whom monthly plan premiums would exceed monthly Social Security benefits or Railroad Retiree benefits, could pay to OPM the amount the beneficiary desires. Beneficiaries with incomes between $85,000 and $1,000,000 per individual would receive smaller federal contributions, phasing down from 80 percent to 15 percent of the defined federal contribution towards plan premiums; millionaires would receive no federal subsidy and would pay the full cost of premiums.

Medicare cost sharing: Private plans offered as part of the FEHBP would have a limit on out-of-pocket spending, with the limit varying by plan.

Medigap, employer-sponsored, and other supplemental coverage: Medigap policies would be terminated as of January 1, 2014.

Other Medicare provisions: No Medicare bonus or incentive payments, and no payments for graduate medical education would be made after January 1, 2014.

Source: S. 2196, "Congressional Health Care for Seniors Act of 2012," as introduced by Senator Rand Paul on March 15, 2012, 112th Congress; and Senator Rand Paul, "Congressional Health Care for Seniors Act," released March 15, 2012.

Republican Study Committee (March 18, 2013)

Medicare savings in the ACA: Would retain Medicare savings in the ACA. Would repeal the other health care provisions in the ACA, including other Medicare provisions.

Age of Medicare eligibility: Would increase the age of eligibility by two months per year beginning in 2024, until the eligibility age reaches 70.

Private plan payment reforms, including premium support, competitive bidding, and other such reforms: Would transition Medicare to a premium support system, as proposed by the House Republican Budget, beginning in 2019. Entitlement would not change for individuals ages 60 or older in 2013. Would create a Medicare Exchange for beneficiaries to choose among private plans or traditional Medicare. Premium support payments would be adjusted for health status, geography, and income.

Part B and Part D premiums: In 2019 and thereafter, higher income beneficiaries would receive lower federal contributions and pay higher premiums, and lower income beneficiaries would receive higher federal contributions and pay lower premiums.

Medicare cost sharing: Private plans offered in the Medicare exchange would be required to protect beneficiaries from catastrophic health care costs.

Dual-eligible beneficiaries: Medicaid would continue to provide premium and cost-sharing assistance for dual-eligible beneficiaries, subject to a limit on federal dollars spent on each Medicaid beneficiary (block grant).

Physician payments/sustainable growth rate (SGR) formula: Would create a deficit-neutral reserve fund that could be used to introduce legislation to reform or replace the SGR formula.

Other Medicare provisions: Would address Medicare waste, fraud, and abuse; details not specified.

Source: Republican Study Committee, "Back to Basics: A Budget for Fiscal Year 2014," March 18, 2013; and Amdt. 4 to H.Con.Res. 25 in the 113th Congress, introduced March 20, 2013.

APPENDIX B: Timeline of Medicare's Role in Recent Federal Budget and Deficit Reduction Activities, January 2010 – December 2013

February 18, 2010. President Obama established the National Commission on Fiscal Responsibility and Reform by Executive Order, chaired by Erskine Bowles and Alan Simpson.

March 23, 2010. The Affordable Care Act was signed into law, with Medicare savings totaling $716 billion over a ten year period (2013-2022), according to CBO.[1] This law was not primarily focused on reducing the federal deficit and debt, but, in addition to other measures, included provisions to slow the growth in Medicare spending, including reductions in payments to plans and providers, increases in Medicare premiums for higher-income beneficiaries, increases in the Medicare payroll tax for high earners, and a variety of delivery system and payment reforms.

December 1, 2010. The National Commission on Fiscal Responsibility and Reform released a plan with both spending reductions for Medicare and other programs, along with tax increases. No action was taken on these recommendations by the Congress.

Summer 2011. President Obama and Speaker Boehner engaged in negotiations, but were unable to reach a "grand bargain" on a package of savings and/or revenue provisions.

August 2011. President Obama signed the Budget Control Act (BCA) of 2011 into law, raising the debt ceiling by $2.1 trillion and setting forth a process of lowering the federal deficit, with multiple actions required, including: sequential increases in the debt ceiling, the establishment of the Congressional Joint Select Committee on Deficit Reduction, a vote by the House and Senate on a Balanced Budget Amendment to the Constitution,[2] and sequestration of federal spending, including Medicare.[3] The BCA requires reductions in discretionary appropriations and mandatory spending totaling $1.2 trillion to be divided equally across FY2013 through FY2021, with half of the sequestered spending each year drawn from defense functions, and the other half drawn from non-defense functions, including Medicare, cost-sharing subsidies in the health reform exchanges beginning in 2014, and other health programs. Medicaid is exempt from sequestration, as are some other low-income programs and Social Security.

The BCA limits the amount of Medicare (non-administrative) savings that can be achieved by sequestration, capping reductions at 2 percent of Medicare payments to hospitals, physicians and other health care providers and plans, including Medicare Advantage and Part D (prescription drug) plans. It also includes protections for beneficiaries, by prohibiting the sequestration from affecting Medicare beneficiary premiums under Parts B and D, cost sharing for Medicare-covered services, Medicare premium and cost-sharing subsidies under Part D, and revenues to the Medicare Part A trust fund. The Office of Management and Budget estimated that Medicare payments to plans and providers will be reduced by $11.3 billion for FY2013; these payment reductions took effect April 1, 2013.[4]

September through November 2011. The Joint Select Committee on Deficit Reduction, known informally as the "Super Committee," was tasked with decreasing projected deficits by $1.5 trillion between FY2012 and FY2021, and given broad authority to propose changes to meets its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the federal budget.

November 21, 2011. The Super Committee announced that it was not able to reach a bipartisan agreement, and the President and Congress did not subsequently enact legislation by the January 15, 2012 deadline to reduce deficits by $1.5 trillion over ten years. As a result, automatic, across-the-board reductions in federal spending, known as "sequestration," were slated to occur January 2, 2013.

January 2, 2013. The President signed the American Taxpayer Relief Act of 2012, which postponed sequestration until March 1, 2013. The Act also provided a zero percent update for Medicare payments to physicians under the Sustainable Growth Rate (SGR) formula for calendar year 2013 (preventing a scheduled 27 percent reduction in payments), with costs partly offset by various Medicare savings provisions. It also extended current-law tax rates for higher-income individuals, among other provisions.

March 1, 2013. President Obama issued a sequestration order, requiring federal spending to be reduced by $85 billion for Fiscal Year (FY) 2013; the reductions were slated to occur within 30 to 60 days.

March 21, 2013. The House of Representatives passed a budget resolution to reduce federal spending by $4.6 trillion over 10 years; the bill was defeated in the Senate.

March 23, 2013. The Senate passed a budget resolution to reduce federal spending by $1.85 trillion over 10 years.

April 1, 2013. Sequestration of Medicare payments to providers and plans took effect.

April 10, 2013. President Obama released his budget for FY2014, which would reduce health care spending by $401 billion over 10 years.

December 10, 2013. Chairmen of the House and Senate Budget Committees reached an agreement and introduced the Bipartisan Budget Act of 2013.

December 26, 2013. President Obama signed into law the Continuing Appropriations Resolution, 2014 (H.J. Res. 59), which included the Bipartisan Budget Act of 2013 and the Pathway for SGR Reform Act of 2013. The bill was projected to reduce federal spending by approximately $23 billion over ten years, including increases in Medicare spending of approximately $3.5 billion between 2014 and 2023.[5]

ENDNOTES

[1] Congressional Budget Office, "Letter to the Honorable John Boehner Providing an Estimate for H.R. 6079, the Repeal of Obamacare Act," July 24, 2012.

[2] The House of Representatives voted on the balanced budget amendment on November 18, 2011; the measure did not receive the two-thirds majority needed to advance a constitutional amendment. On December 14, 2011, two balanced budget amendments failed in the Senate.

[3] Kaiser Family Foundation, "The Budget Control Act of 2011: Implications for Medicare," November 2012.

[4] Office of Management and Budget, "OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013," March 1, 2013.

[5] Congressional Budget Office, "Bipartisan Budget Act of 2013," December 11, 2013, and the Congressional Budget Office, "Estimate of Amendment to H.J. Res. 59, Pathway to SGR Reform Act of 2013," December 11, 2013.

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