



## **Summary of Health Provisions in the Democrats’ Extenders” Bill (H.R. 4213)**

### **MEDICARE PROVISIONS**

#### **Physician Payments**

This provision would increase Medicare physician payment rates for the remainder of 2010 by 2.2% (note: given the rate freeze for the first five months of 2010, this translates to a 1.28% overall increase for the year), preventing physicians from receiving a 21 percent rate cut on June 1<sup>st</sup>. For 2011, payment rates would increase by an additional 1%. In 2012, staff estimates physician payment rates would be cut by 33%. This policy would cause seniors’ Part B premiums to increase by \$6.3 billion. *CBO estimates this provision would directly cost \$25.2 billion and, because of various premium interactions, result in a net deficit increase of \$22.9 billion over 11 years.* Staff notes that House Republicans offered a fully paid-for “doc fix” on the House Floor in November 2009 that would have provided doctors with a 2% payment rate increase in 2010, 2011, 2012, and 2013. Unfortunately, Democrats blocked consideration of our alternative.

#### **Clarifying the “3-Day Payment Window” Rule for Hospitals**

Under current law, all outpatient diagnostic services related to an inpatient admission are included in the bundled diagnosis-related group (DRG) payment for that admission. This provision changes the “3-day Payment Window” rule to require all therapeutic services delivered in the outpatient department, except for ambulance and dialysis services, to be billed (“bundled”) as part of the inpatient hospital’s DRG payment. Hospitals would be prohibited from resubmitting any past claims where therapeutic services could have been unbundled. *CBO estimates this provision would reduce the deficit by \$4.2 billion over 11 years.*

#### **Extension of Hospital Wage Rate Reclassifications**

This provision would extend the “Section 508” reclassifications, which will increase Medicare payment rates for these hospitals, through September 30, 2011. *CBO estimates this provision will increase the deficit by \$300 million over 11 years.*

#### **California Physician Payments**

This provision was included in the House-passed health overall, but was not part of the bill that became law. Under current law, the boundaries of payment localities are determined using data that is almost 20 years old. Physicians practicing in formerly rural areas that are now categorized as being “suburban” complain about being paid less relative to long-standing suburban areas. This provision would provide a special fix for the state of California only, creating new geographic areas for payment purposes, thereby increasing Medicare payments in certain areas through 2016. Other states have similar formerly-rural-now-suburban areas that

are not included in this change. *CBO estimates this provision would increase the deficit by \$400 million over 11 years.*

#### Funding for Claims Reprocessing

The new health law, enacted on March 23, 2010, retroactively extended certain Medicare payment policies for calendar year 2010, requiring the Centers for Medicare and Medicaid Services (CMS) to reprocess Medicare claims back to January 1, 2010. The Democrats repeatedly missed payment policy extension deadlines for services performed in physician offices and outpatient therapy services (among others). The bill would provide \$200 million in taxpayer money for CMS to reprocess these claims, which had already been paid but at a different rate, because of the repeated missed deadlines. *CBO estimates this provision would increase the deficit by \$200 million over 11 years.*

#### Anti-Fraud Efforts: IRS-HHS Data Sharing

This provision would allow the IRS to share taxpayer data with HHS employees to help screen and identify fraudulent providers or providers with tax debts. It would also help recover such debts and block providers who are delinquent in paying their federal taxes from enrolling in Medicare. *CBO estimates this provision would raise \$400 million over 11 years.*

#### Part B Enrollment for TRICARE Beneficiaries

TRICARE beneficiaries who are eligible for Medicare are required to enroll in Medicare to retain their TRICARE eligibility. The Democrats' health law created a new 12-month special Medicare Part B enrollment period (SEP) for those who had previously declined Part B coverage during their initial enrollment period (IEP). Such coverage begins at either the first day of the month in which the beneficiary enrolls in Part B or the first month after the IEP. This provision addresses uncertainty in the Democrats' new health law by clarifying the SEP policy became effective on the day the health law was enacted. *CBO estimates this provision would have a negligible impact on the deficit over 11 years.*

#### Repeal of Cost-Based Rural Clinical Lab Payments

The new health law reinstated cost-based payments for lab services at certain small hospitals for one-year beginning July 1, 2010. This provision repeals this policy. *CBO estimates this provision would have a negligible impact on the deficit over 11 years.*

#### Repealing Skilled Nursing Facility (SNF) Payment Delay

This provision would repeal a one-year delay of the implementation of an updated SNF payment system ("RUG-IV"). This delay was included in the Democrat's health overhaul at the request of the SNF industry, who has now determined that such a delay would not be helpful. *CBO estimates this provision would not impact the deficit over 11 years.*

## No Copayment for Preventive Services Received at Federally Qualified Health Centers (FQHCs)

Under current law, there is no Part B deductible for services that a Medicare beneficiary receives at a FQHC. However, a Medicare beneficiary must pay 20% of most billed charges, including preventive services, delivered in these facilities. The Democrats' health overhaul waived Medicare Part B cost sharing and deductibles for preventive services but did not apply this waiver to preventive services received at FQHCs. This provision would waive Part B coinsurance for preventive services Medicare beneficiaries receive at FQHCs. *CBO estimates this provision would not impact the deficit over 11 years.*

### **KEY HEALTH PROVISIONS OUTSIDE OF THE COMMITTEE'S JURISDICTION**

#### 340B Drug Pricing Program

The 340B program requires drug manufacturers to provide some hospitals (including certain public hospitals, critical access hospitals, children's hospitals, and cancer hospitals) and other entities (such as qualifying federal health centers and federal grantees) that treat low-income and uninsured patients with government-mandated discounts (a.k.a. "price controls"). These price controls ensure that the 340B entities' cost to purchase outpatient drugs does not exceed the Medicaid reimbursement for the same drug. The bill would extend these price controls to inpatient drugs used by uninsured patients and to insured patients who do not have prescription drug coverage. The bill would also reverse a provision in the Democrats' health overhaul which explicitly excluded children's hospitals from receiving 340B pricing for orphan drugs. *CBO predicts these provisions would have a negligible impact on the deficit over 11 years, as any federal savings would be offset by higher Medicaid spending, which CBO says will occur because, facing the expansion of 340B pricing, pharmaceutical manufacturers will provide less generous discounts to Medicaid for its drug purchases.*