Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction

Health Care

The President's Plan for Economic Growth and Deficit Reduction lives up to a simple idea: as a Nation, we can live within our means while still making the investments we need to prosper – from a jobs bill that is needed right now to long-term investments in education, innovation, and infrastructure. It follows a balanced approach: asking everyone to do their part, so no one has to bear a disproportionate share of the burden. And it says that everyone – including millionaires and billionaires – must pay their fair share. Pursuing a balanced approach to deficit reduction is critical to being able to keep our promises made to all Americans.

In pursuit of that goal, the President signed into law the Affordable Care Act which not only eliminated insurance company abuses and expanded access to health insurance to tens of millions of Americans, but also took important steps to reduce health care cost growth for future years. Ensuring that Medicare and Medicaid remain strong for the future requires that we take additional steps. The Affordable Care Act was an historic step toward getting health care costs under control, but more needs to be done to protect its solvency as demographics change and costs continue to rise. We can do this without undermining the fundamental compact these programs represent**. The President will veto any bill that takes one dime from the Medicare benefits seniors rely on without asking the wealthiest Americans and biggest corporations to pay their fair share.**

To reduce the deficit and ensure the long-term sustainability of Medicare and Medicaid, the plan includes $320 billion in health savings over the next decade. Due to the structural nature of the reforms, health savings are projected to grow to over $1 trillion in the second decade. The $248 billion in Medicare savings extend the life of the Medicare Trust Fund by roughly three years. The $73 billion in Medicaid and other health program savings include phased-in reforms and targeted savings and flexibility for States. The President's proposals:

- Create payment incentives for skilled nursing facilities to improve their care to prevent avoidable hospital readmissions.
- Include incentives for people with Medicare to choose high-value health services.
- Reform Medicare payments to better align with patient care costs.
- Accelerate the availability of lower-cost generic drugs.
- Take steps to make Medicaid more efficient, accountable, and flexible.

These proposals are presented in the context of a baseline that assumes legislative action to permanently prevent current-law reductions in Medicare physician payment rates, consistent with the Administration's commitment to fix the sustainable growth rate policy in a fiscally responsible way. Specifically, the Administration proposes to:

Improve access to affordable generics and lower Federal Employees Health Benefits (FEHB) drug costs: The package includes proposals designed to improve access to affordable

medications by prohibiting "pay for delay" agreements to increase the availability of generic drugs and biologics; reducing the exclusivity period for brand name biologics; streamlining FEHB pharmacy contracting.

Strengthen Medicare by cutting waste, fraud, and improper payments. Waste, fraud, and abuse in any government program is unacceptable in this fiscal environment and a needless drain on Medicare. To ensure that Medicare dollars are being spent prudently, the Administration proposes several policies, including recovering erroneous payments made to insurers participating in Medicare Advantage; dedicating penalties for failure to use electronic health records toward deficit reduction; updating Medicare payments to more appropriately account for utilization of advanced imaging; and requiring prior authorization for advanced imaging. These proposals would save approximates $5 billion over the next 10 years.

Create Incentives for Use of High-Value Services. The plan includes targeted financial incentives to encourage new Medicare beneficiaries (not seniors currently on Medicare), starting in 2017, to use high-value services. Similar policies have been recommended by experts as a way to improve program performance in the long run and lower overall costs to the system. They would:

- **Modify Medicare Part B deductible for new beneficiaries.** To encourage beneficiaries to seek high-value health care services, the Administration proposes to apply a $25 increase to the Part B deductible in 2017, 2019, and 2021 for new beneficiaries. This proposal will save approximately $1 billion over 10 years.

- **Introduce home health cost-sharing for new Medicare beneficiaries.** This proposal would create a home health copayment of $100 per home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay. This policy would only apply to new beneficiaries beginning in 2017 and is estimated to save approximately $0.4 billion over 10 years.

- **Encourage efficient supplemental coverage choices for new beneficiaries through a Medicare Part B premium surcharge.** To encourage more-efficient health care choices, the Administration proposes a Part B premium surcharge equivalent to about 15 percent of the average Medigap premium for new beneficiaries that purchase Medigap policies with particularly low cost-sharing requirements, starting in 2017. This proposal will save approximately $2.5 billion over 10 years.

Reduce certain Medicare special payments: Medicare historically has supplemented its payments for services to maintain the robustness of the provider network. These payments have helped to offset bad debt that providers accrue, support the extra costs of training physicians, and protect the viability of rural providers. These goals are important, but evidence suggests that some rates are too high. The plan includes proposals to:

- **Align Medicare policy with private sector practice in coverage of bad debts.** For most eligible provider types, Medicare currently reimburses generally 70 percent of bad debts resulting from beneficiaries' non-payment of deductibles and copayments after

providers have made reasonable efforts to collect the unpaid amounts. This proposal will align Medicare policy more closely with private sector standards by reducing bad debt payments to 25 percent for all eligible providers over three years starting in 2013. This will save approximately $20 billion over 10 years.

- **Reduce graduate medical education payments to better align with patient care costs.** Medicare compensates teaching hospitals for the indirect costs stemming from inefficiencies created from residents "learning by doing." The Medicare Payment Advisory Commission (MedPAC) has determined that these Indirect Medical Education (IME) add-on payments are significantly greater than the additional patient care costs that teaching hospitals experience. This proposal would reduce the IME adjustment by 10 percent beginning in FY 2013, and save approximately $9 billion over 10 years.

- **Better align Medicare payments to rural providers with the cost of care.** Medicare makes a number of special payments to account for the unique challenges of delivering medical care to beneficiaries in rural areas. But these programs have expanded so that they now include one-third of all hospitals and have exceeded the scope and purpose for which they were created. The Administration proposes to improve the consistency of payments across hospital types, provide incentives for efficient delivery of care, and eliminate higher than necessary reimbursement. Together, these rural proposals will save approximately $6 billion over 10 years.

Encourage efficient post-acute care. Medicare covers services in skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and home health. Over the years, expenditures for these services have increased dramatically, and payments in excess of the costs of providing high quality and efficient care place a drain on Medicare. Moreover, payment for the same service varies by provider type. Recognizing the importance of these services, the Administration proposes the following policies that will save $42 billion over 10 years and improve the quality of care:

- **Adjust payment updates for certain post-acute care providers.** This proposal would gradually realign payments with costs through adjustments to payment rate updates in 2014 through 2021 for these providers.

- **Equalize payments for certain conditions.** This policy would reduce the differences in payment by IRFs and SNFs for treatment of specified conditions to encourage care in the most clinically appropriate setting beginning in FY 2013.

- **Encourage appropriate use of inpatient rehabilitation hospitals.** This proposal would update compliance requirements to better ensure that the higher IRF payments apply to cases requiring this level of care.

- **Adjust SNF payments to reduce hospital readmissions.** Nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. To promote high quality care in SNFs, this

proposal reduces SNF payments by up to 3 percent beginning in FY 2015 for facilities with high rates of care-sensitive, preventable hospital readmissions.

Align Medicare drug payment policies. There are substantial differences in rebate amounts and net prices paid for brand name drugs under Medicare versus Medicaid, with Medicare receiving significantly lower rebates and paying higher prices. Moreover, Medicare per capita spending in Part D is growing significantly faster than spending in Parts A or B. This proposal would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Medicare Low-Income Subsidy beginning in 2013. This option is estimated to save $135 billion over 10 years.

Increase Medicare Parts B and D premiums for higher-income beneficiaries. Under Medicare Parts B and D, certain higher-income beneficiaries must pay higher premiums. Beginning in 2017, the Administration proposes to increase income-related premiums under Medicare Parts B and D. It also extends the freeze in the income thresholds until 25 percent of beneficiaries pay the higher premium. This proposal will save approximately $20 billion over 10 years.

Strengthen the Independent Payment Advisory Board (IPAB): The proposal would strengthen IPAB by reducing its growth rate target (from GDP per capita plus 1 percent to plus 0.5 percent). It would also provide additional tools like the ability to consider value-based benefit design and enforcement mechanisms. IPAB will continue to be prohibited from making recommendations to ration care, increase beneficiary premiums or cost sharing, or restrict benefits.

Reduce fraud, waste, and abuse in Medicaid. Medicaid funds should not be wasted on fraudulent claims, abuses of the rules, or general waste in implementing the program. The following policies will save $1.4 billion over the next 10 year while reducing waste, fraud, and abuse:

- Strengthen third-party liability for Medicaid beneficiary claims.
- Require manufacturers that improperly report items for Medicaid drug coverage to fully repay States.
- Track high prescribers and utilizers of prescription drugs in Medicaid.
- Enforce Medicaid drug rebate agreements.
- Increase penalties on drug manufacturers for fraudulent non-compliance with Medicaid drug rebate agreements.
- Require drugs to be properly listed with the FDA to receive Medicaid coverage.
- Prohibit States from using Federal funds as the State share of Medicaid or CHIP, unless specifically authorized by law.

Increase State flexibility and streamline oversight in Medicaid: This proposal would give State the flexibility to use a "benchmark" benefits plan for optional populations with income above 133 percent of the Federal poverty line. It also would consolidate and streamline redundant error rate programs.

Accelerate State innovation waivers: This proposal empowers States to develop their own strategies to ensure their residents have the same access to high quality, affordable health care as would be achieved under the Affordable Care Act. It does so by making the health reform law's State Innovation Waivers available starting in 2014, three years earlier than under the current law. These State strategies would provide affordable insurance coverage to at least as many residents as without the waiver, and must not increase the Federal deficit.

Limit Medicaid provider taxes. Many States impose taxes on health care providers to help finance the State share of Medicaid program costs. While often a source of real financing, some States increase payments to those same providers in the amount of the revenue they receive in taxes, drawing Federal Medicaid matching payments with little benefit to the low-income populations the program serves. The Administration proposes to limit these types of State financing practices by phasing down, but not eliminating, Medicaid provider taxes. By delaying the effective date until 2015, the proposal gives States time to prepare for the change. This proposal is projected to save $26.3 billion over 10 years.

Simplify Federal Medicaid payment formulas for States. Under current law, States face a patchwork of different Federal payment contributions for individuals eligible for Medicaid and the Children's Health Insurance Program (CHIP). Beginning in 2017, this proposal would replace the currently complicated formulas with a single matching rate specific to each State based on enrollment starting in 2014 that automatically increases if a recession forces enrollment and State costs to rise. The full Federal funding for people gaining Medicaid coverage in 2014 through 2016 would be preserved. The proposal may improve coverage since it gives States a financial incentive to enroll newly eligible individuals for Medicaid early. The more newly eligible people they enroll in the first year or so of the program, the higher the blended matching rate will be in 2017. This proposal is projected to save $14.9 billion over 10 years.

Reduce unnecessary taxpayer Medicaid spending on overpayments for medical equipment. This proposal limits Federal reimbursement for a State's Medicaid spending on certain durable medical equipment services to what Medicare would have paid in the same State for the same services. This proposal is projected to save the Federal government $4.2 billion and State governments more than $3 billion over 10 years.

Re-base Medicaid formula for supporting hospitals that serve low-income Americans in 2021. Supplemental disproportionate share hospital payments are intended to help support hospitals that provide care to disproportionate numbers of low-income and uninsured individuals. The Administration proposes to better align these future Medicaid supplemental payments to hospitals with reduced levels of uncompensated care. This proposal is projected to save $4.1 billion over 10 years.

Better target Medicaid resources by updating income definition. Starting in 2014, eligibility for Exchange premium tax credits and cost sharing reductions, Medicaid, and CHIP will be determined based on an individual's or family's modified adjusted gross income (MAGI). The Administration proposes to amend this definition for purposes of health insurance assistance programs to include total Social Security benefits, consistent with current Medicaid practice,

which will enable States to better target those in need. This proposal is projected to save $14.6 billion over 10 years.

Prioritize prevention and public health fund investment: The Administration proposals to improve its targeting of the Prevention and Public Health Fund, maintaining $13.8 billion for effective, evidence-based activities, while reducing the Fund by $3.5 billion over 10 years.

Pursue balanced deficit reduction to prevent drastic cuts. We have little doubt that some of these proposals will not be popular with all those that they affect. These are tough choices that we had to make -- and some of these changes are those that we would not make if it were not for our fiscal situation. But we are all in this together, and all of us must contribute to getting our economy moving again and on a firm fiscal footing. If we all don't pitch in, we know what happens if we try to do this much deficit reduction without a balanced approach – because the congressional Republicans have proposed to do that. Millionaires and big corporations keep all their special tax breaks and tax cuts while there are severe cuts in programs we need to grow and prosper on which many Americans rely. For instance, under their budget, Medicare would end as we know it. It would be turned into a voucher program, and since that voucher would not keep pace with health care costs, a typical 65-year-old in the first year of this new arrangement would see her out-of-pocket costs increase by $6,400. And their proposed restructuring of Medicaid would cut funding by a third and could leave an estimated 50 million Americans in need without health insurance.

We believe the President's plan is the most fair and effective way to keep the promises made to all Americans while achieving the deficit reduction needed to win the future.