

# Summary of Health-Related Provisions in the “Middle Class Tax Relief & Job Creation Act of 2011”

## **MEDICARE EXTENDERS**

Section 2201 - Medicare Physician Payment Rates – This provision would prevent a 27.4 percent cut in Medicare physician payment rates slated to begin on January 1, 2012 and instead increase payment rates by 1 percent in 2012 and again in 2013. The two years of stable Medicare payment rates would be the most certainty physicians have had since 2004. During this period, the Medicare Payment Advisory Commission (MedPAC), Government Accountability Office (GAO), and Department of Health and Human Services (HHS) are required to submit reports to Congress to assist in the development of a long-term replacement to the current Medicare physician payment system. The provision also directs the Committees on Ways and Means, Energy and Commerce, and Finance to study and review this issue during the 112<sup>th</sup> Congress and, as part of that process, to solicit input from key stakeholders. *CBO estimates this provision would increase spending by \$38.9 billion over 10 years.*

Section 2202 - Ambulance Add-On Payments – This provision would extend through December 31, 2012, the following add-on payments: 2 percent for urban ground ambulance services, 3 percent for rural ground ambulance services, and an increase to the base rate for ambulance trips originating in qualified “super rural” areas as calculated by the Secretary (currently 22.6 percent). The bill additionally requires two reports – one from GAO on ambulance provider costs and another from MedPAC on whether or not the ambulance fee schedule should be reformed. These studies will help inform Congress as to whether these add-on payments should be continued in future years. *CBO estimates these provisions would increase spending by \$100 million over 10 years.*

Section 2203 - Outpatient Therapy Caps – This provision would extend the therapy caps exceptions process through December 31, 2013 with modifications that will require that the physician reviewing the therapy plan of care be detailed on the claim, reject all claims above the spending cap that do not include the proper billing modifier, and provide for a manual review of all claims for high cost beneficiaries to ensure that only medically necessary services are being provided. Furthermore, the spending caps (\$1,880 in 2012), which have been in effect since 2006, would be extended to the hospital outpatient department setting to prevent a shift in the site of service to higher cost settings once enforcement of the current exceptions process begins. Exempting these services in the HOPD setting made sense when the hard therapy cap was in place, but it no longer makes sense with the exceptions process. Additionally, HHS would be required to collect data to assist in reforming the payment system for therapy services. MedPAC would be required to recommend improvements to the outpatient therapy benefit to reflect the individual needs of patients. *CBO estimates this provision would reduce spending by \$1.7 billion over 10 years.*

Section 2204 - Physician Work Geographic Adjustment – This provision would extend, through December 31, 2012, the current floor used in calculating the portion of Medicare physician payments that accounts for the geographic area where a physician practices. This provision would increase physician payment rates in roughly 54 of the Medicare program’s 89 geographic areas. Additionally, MedPAC would be required to examine whether and how these geographic work adjustments should be made, as they have been since 2004, to better inform Congress going forward. *CBO estimates this provision would increase spending by \$500 million over 10 years.*

## OTHER HEALTH PROVISIONS

Section 2211 - Qualified Individual (QI) Program – This provision would extend the QI program, which provides federal reimbursement for states to cover Part B premiums for seniors with incomes between 120 and 135 percent of poverty, through December 31, 2012. The provision would reduce the capped allotment states receive to administer the program from \$1 billion in 2011 to \$730 million in 2012, which is anticipated to still fully fund the program. *CBO estimates that this provision would increase spending by \$700 million over 10 years.*

Sec 2212 – Extension of Transitional Medical Assistance (TMA) - This provision would provide for a one-year extension of TMA, through December 31, 2012, for low-income families transitioning into employment. In addition, this provision ensures that only those individuals with incomes below 185 percent of the federal poverty level (FPL) can qualify for TMA benefits. *CBO estimates this provision would increase spending by \$1.2 billion over 10 years.*

Section 2213 – Relaxing Arbitrary Restrictions on Physician-Owned Hospitals – This provision would allow those physician-owned hospitals that were under construction but did not have Medicare provider numbers as of December 31, 2010, to open and operate under the whole hospital exception to the Stark antitrust laws. This will allow these hospitals to bill Medicare for services provided to Medicare beneficiaries in these facilities that were under construction prior to the ban on new physician-owned hospitals. This provision would also relax strenuous new requirements intended to prevent most existing physician-owned hospitals from renovating or expanding. *CBO estimates this provision would increase spending by \$300 million over 10 years.*

## HEALTH OFFSETS

### Section 2221 – ObamaCare Exchange Subsidy Recapture

The Democrats' health care law fails to adequately protect taxpayers from overpayments of the federal subsidies to purchase health insurance, even in the case of fraud, by limiting the amount of subsidies that can be recaptured if an individual/family receives a greater subsidy than he/she/they are entitled to. This provision would increase the maximum amount of subsidy overpayments that must be repaid. Similar policies were overwhelmingly adopted in last year's "doc fix" and the repeal of the onerous 1099 reporting requirement earlier this year. *The Joint Committee on Taxation (JCT) estimates this provision would reduce the deficit by \$13.4 billion over 10 years and reduce the number of people receiving health insurance in the Exchanges by roughly 170,000 in 2021.*

Subsidy Recipients' Income (as percent of poverty level)	CURRENT LAW Maximum Amount of Overpayments Recaptured from Individuals (amounts double for households)	PROPOSAL Maximum Amount of Overpayments Recaptured from Individuals (amounts double for households)
Under 100%		\$300
At least 100% but less than 150%	\$300	\$400
At least 150% but less than 200%		\$500
At least 200% but less than 250%	\$750	\$750
At least 250% but less than 300%		\$1,100
At least 300% but less than 350%	\$1,250	\$1,250
At least 350% but less than 400%		\$1,600
400% or above	Full repayment	Full repayment

Section 2222 Reduction in the Prevention & Public Health Fund

The Prevention and Public Health Fund, Section 4002 of Obamacare, is a \$17.75 billion account (FY12-FY21) that provides the Secretary of HHS unlimited authority to spend above and beyond appropriated levels for any activity authorized by the Public Health Service Act. This provision would reduce the funding for the Prevention and Public Health Fund. *CBO estimates this provision would reduce spending by \$8 billion over 10 years.*

Section 2223 - Parity in Payments for Hospital Outpatient Department (HOPD) Evaluation and Management (E/M) Office Visit Services

– Under current law, Medicare pays more for E/M office visit services furnished in the HOPD setting than it does for the exact same services performed in the physician office setting. While the amount Medicare pays physicians for these services in an HOPD would remain unchanged under the bill, the hospital facility fee payment would be reduced, equalizing total Medicare payments for identical services, regardless of where it is furnished beginning in 2012. The non-partisan MedPAC offered this policy as a potential offset to address the costs associated with addressing Medicare physician payments. *CBO estimates this provision would reduce spending by \$6.8 billion over 10 years.*

Section 2224 - Reducing Bad Debt Payments – Under current law, Medicare reimburses hospitals and skilled nursing facilities (SNFs) for 70 percent of the beneficiary cost-sharing they are unable, or unwilling, to collect (“bad debt”). Certain other providers, such as federally qualified health centers (FQHCs) and dialysis centers, are reimbursed 100 percent for the bad debt. These high reimbursements are believed to discourage providers from doing enough to collect unpaid cost-sharing that they are required, by CMS, to take reasonable steps to collect. This provision would phase down the bad debt reimbursements to 55 percent over a three-year period beginning in 2013 (NOTE: President Obama recommended that bad debt payments be reduced to 25%). *CBO estimates this provision would reduce spending by \$10.6 billion over 10 years.*

Section 2225 - Medicaid Disproportionate Share Hospital (DSH) Allotments - This provision would rebase the DSH allotments for FY2021 and determine future allotments from the rebased level using current law methodology. *CBO estimates this provision would reduce spending by \$4.1 billion over 10 years.*

Sections 5601 and 5602 – Increasing Medicare Premiums for High Income Beneficiaries - This provision would adopt President Obama’s recommendation to increase Medicare Part B and D premiums for high-income beneficiaries beginning in 2017. Specifically, this provision would: extend the current freeze of the income brackets beyond 2019 until 25 percent of beneficiaries are paying income-related premiums; increase the premiums that high-income beneficiaries pay by 15 percent; and reduce the initial high-income threshold from \$85,000 for singles and \$170,000 for couples to \$80,000 and \$160,000, respectively. *CBO estimates this provision would reduce spending by \$31 billion over 10 years.*