FOCUS on Health Reform

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SETTING MEDICARE PAYMENT POLICY: Is There a Role for an Independent Entity?

One of the issues that has emerged in health reform discussions is how to bring about change in the Medicare program to improve efficiency and control health care cost growth. The Obama Administration and some Congressional leaders have proposed establishing a new independent entity that would be given authority to recommend changes in Medicare policy to be implemented by the Administration, subject to Congressional review. The Senate Finance Committee included a provision to establish such an entity in the health care reform legislation reported out of committee on October 2, 2009 (S. 1769, the America's Healthy Future Act of 2009).[1]

This concept represents a significant departure from current practices. Under current law, a Congressional advisory panel known as the Medicare Payment Advisory Commission (MedPAC) is tasked with making recommendations on Medicare payment policies as part of its statutory mandate, but neither Congress nor the Administration is obliged to accept or act on these recommendations. The Administration can also make recommendations to Congress on Medicare payment policies, but ultimately Congress decides how much to pay the medical providers, suppliers and plans that care for Medicare's 46 million beneficiaries, and the Administration implements policy changes through regulations that directly affect provider and plan payments.

The idea of a new entity that focuses on Medicare payments has gained salience in recent health reform discussions involving ways to rein in U.S. health care spending, address inequities in Medicare payment policy, and improve efficiency within the health care delivery system. Proponents say that such an entity would: (1) eliminate the political influence of stakeholders and interest groups in setting Medicare payments; (2) allow these often highly-technical decisions to be made by experts in the field; and (3) "bend the curve" in health care spending generally and in Medicare specifically. Opponents are concerned that such an entity could: (1) impose a hard cap on Medicare spending without addressing the growth in total health care costs; (2) exacerbate the differential between Medicare and private payments to hospitals, physicians and other providers; and (3) potentially raise out-of-pocket costs for beneficiaries or limit their access to care.

This issue brief considers questions associated with the establishment of a new entity to set Medicare payment policy and the implications for beneficiaries, other stakeholders, and program spending.

How are Medicare payments determined today?

Under current law, Congress establishes and adjusts Medicare payment policies for health care providers and facilities, and for health plans that provide benefits to people on Medicare, including Medicare Advantage plans and Medicare Part D prescription drug plans. The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) manages and runs the day-to-day operations of the program, including payment systems, and implements policy changes through regulations that directly affect provider and plan payments. The Medicare Payment Advisory Commission, established under the Balanced Budget Act of 1997, formulates recommendations to Congress on a broad range of Medicare issues, including Medicare payments to physicians, hospitals, private health plans and other providers, and examines the "interaction of Medicare payment policies with health care delivery generally."[2] Before 1997, evaluating and making recommendations on Medicare payments was within the purview of the Physician Payment Review Commission (for physician payments) and the Prospective Payment Assessment Commission (for hospital payments). With the creation of MedPAC in 1997, these entities were merged into a new commission with a broader mandate.

MedPAC serves an important advisory role to Congress but does not have independent decision-making authority and Congress is not obliged to follow its recommendations. MedPAC submits recommendations to Congress annually, but is not required to achieve budgetary or savings targets. Over the past several years, MedPAC

has issued recommendations on a wide range of topics, some of which would achieve savings for Medicare (e.g., reducing payments to Medicare Advantage plans), while others would increase Medicare spending (e.g., increasing payments to primary care physicians) or might have little or no effect on Medicare spending but could improve program quality and efficiency. MedPAC also reports periodically on aspects of the Medicare program of interest to policymakers or mandated by legislation, such as recent assessments of benefit design in traditional Medicare, Medicare Advantage payments, and chronic care management. While Congress retains final authority to make decisions about Medicare payment rates and methodologies regardless of what MedPAC recommends, the Administration has the authority to adopt various Medicare policies recommended by MedPAC that fall outside the scope of Congressional authority.

What are the various options under discussion to create an independent Medicare payment entity?

Options for the design and operation of an independent entity that would be charged with determining Medicare payment policy are under discussion as part of health reform legislation and include a provision in S. 1796, the America's Healthy Future Act of 2009; a proposal by the Obama Administration; and legislation introduced by Senator Jay Rockefeller (D-WV).

- **S. 1796, the America's Healthy Future Act of 2009, would establish an independent Medicare Commission designed to make recommendations to Congress on ways to extend the solvency of Medicare, slow Medicare cost growth, and improve the quality of care for beneficiaries.** As part of the Commission's mandate to reduce the per capita rate of growth in Medicare spending. the CMS Office of the Actuary would be required to calculate a new measure of Medicare excess cost growth in each annual report; if the projected five-year average percentage increase in per capita Medicare spending exceeded the projected five-year average percentage increase in the consumer price index (CPI) and the CPI for medical care (CPI-M), then the Medicare Commission would be required to submit a proposal to Congress that would reduce excess cost growth by a certain amount, with the first set of recommendations due to Congress by January 1, 2014. Beginning in 2018, the growth target for Medicare spending would be set at the five-year average percentage increase in GDP per capita plus one percent. If the Commission fails to act, the Secretary of HHS would be required to submit the proposal instead. The provision keeps the existing MedPAC in place and maintains its role as an advisory body to Congress.

  The 15-member Commission, appointed by the President and confirmed by the Senate, would be prohibited from submitting proposals that would ration care, increase revenues or change Medicare benefits, eligibility or beneficiary cost-sharing amounts (including Parts A and B premiums), but would *not* be prohibited from making recommendations to reduce premium subsidies for Part D plans (either Medicare Advantage or stand-alone prescription drug plans). Hospitals and hospices would not be subject to cost reductions proposed by the Commission through 2019. The Commission's recommendations would not be subject to administrative or judicial review.

  S. 1796 establishes an expedited process for Congressional consideration of the Commission's proposals, whereby the appropriate committees report legislation implementing the recommendations contained in the Commission's proposal or legislation that satisfies the requirements for reducing Medicare spending by the target amount. If Congress does not enact a legislative package that achieves the required level of Medicare savings, the Commission's (or Secretary's) original proposal would take effect immediately. The Commission would not be required to submit any savings proposals to Congress in a year when the Actuary does not project there to be excess cost growth in Medicare. The legislation includes a provision whereby Congress could discontinue automatic implementation of the Commission's proposals by passing a joint resolution in 2017, which would effectively discontinue the operations of the Commission.

  CBO has scored this provision as generating savings of $22.2 billion between 2010 and 2019, with all of the savings realized between 2015 and 2019 when the Commission would be operational. This score suggests that CBO assumes a level of excess cost growth in Medicare spending within the 10-year budget window that would require the Medicare Commission to generate savings proposals.

- **The Obama Administration has proposed establishing an entity called the Independent Medicare Advisory Council, or IMAC, which would be authorized to recommend changes in Medicare payment policy and other reforms.** The proposal stipulates that recommendations made by the Council could not be expected to increase net Medicare expenditures over a ten-year period, and must either improve the quality of care received by Medicare beneficiaries or improve the efficiency of the program. The Council's recommendations would be submitted in a report to the President, who could either approve or disapprove of the entire set of recommendations. If the President approves, the package of recommendations would be subject to a fast-track 30-day review by Congress, which must enact a joint resolution in order to disapprove the recommendations and block their implementation by the Administration. The resolution would be subject to a presidential veto, which would require a two-thirds majority in both the House and Senate to override.

  If Congress does not pass a resolution of disapproval to block the recommendations from taking effect, the Congressional Budget Office (CBO) will assume the recommendations to achieve Medicare savings will be implemented. If Congress passes a resolution of disapproval, and if the IMAC recommendations would have reduced the growth in Medicare spending, then the CBO will treat the resolution as it would other legislation that proposes to increase Medicare spending.[3] It is not clear whether Congress would be required to offset the CBO-estimated cost increases with other spending reductions or revenue increases in order to meet the requirement of budget neutrality.

- **Senator Rockefeller has introduced legislation (S. 1110 and S. 1380) to rename MedPAC the "Medicare Payment and Access Commission" and make the Commission an executive branch agency with authority to implement Medicare payment and coverage policy.** The Commission would determine Medicare payment policies, methodologies, and rates; determine coverage policies and methodologies; and improve the overall financial stability of the program through payment and coverage policies estimated to reduce Medicare spending growth by no less than 1.5% annually. This proposal delineates no role for the President in reviewing the Commission's determinations, but gives Congress authority to overrule a payment determination by the Commission with a three-fifths majority vote.

Other existing models for the structure and operation of such an entity include the Federal Reserve Board[4] and the Defense Base Closure and Realignment Commission (BRAC).[5] In its ongoing discussions about health reform legislation, Congress could incorporate elements of these proposals, or reject the concept altogether.

Questions for Consideration

As policymakers debate the idea of establishing an independent entity empowered to make decisions on Medicare payment policy, a number of questions could be considered to assess the potential implications for beneficiaries, providers, and the future stability of the program.

- **Would the new entity place firm limits on the growth in Medicare spending, and if so, how?** Current proposals authorize the new entity to recommend changes in payment policy for Medicare-covered services, but they differ with respect to the stringency of their fiscal objectives. S. 1796 requires the Medicare Commission to submit proposals to reduce or eliminate Medicare's excess cost growth, based on a new measure of Medicare's per-capita growth rate compared to growth in the CPI (through 2017) and compared to growth in the gross domestic product (GDP) plus one percentage point (in 2018 and beyond). This requirement effectively places a cap on future increases in Medicare spending. The Commission is prohibited from recommending proposals that would increase total Medicare program spending, and the proposals would take effect unless Congress enacts alternative changes that would achieve the same level of savings. The Administration's proposal says that the Council's recommendations should not exceed aggregate net Medicare expenditures relative to current law (i.e., they should be deficit-neutral), while the Rockefeller proposal requires the Commission to establish policies estimated to reduce Medicare spending by no less than 1.5% annually, with a failsafe to be implemented by the Administration, unless the Medicare Trust Fund is projected to be solvent within a ten-year timeframe.

- **Would the new entity have the authority to recommend policies to increase beneficiary premiums and cost-sharing requirements?** A key concern raised by some policymakers is whether the new entity would have the authority to make changes in Medicare policy that could result in higher premiums, cost sharing, or other out-of-pocket expenses incurred by beneficiaries. For example, could the new entity recommend a new coinsurance on home health visits as part of its package of recommended changes? Could the new entity increase payments to certain providers, as MedPAC has recommended in the past, resulting in higher

beneficiary out-of-pocket spending for Part B coinsurance or higher Part B premiums? The Medicare Commission proposed in S. 1796 would be prohibited from submitting proposals to the Congress that would increase revenues or change Medicare benefits, Part A and B premiums, or cost sharing, but does not explicitly prohibit the Commission from recommending reductions in federal premium subsidies to Part D plans that might result in beneficiary premium increases.

- **Would the creation of this new entity result in scoreable savings?** In a letter to Congressional leaders, the CBO estimates that the Administration's IMAC proposal would yield savings of $2 billion over a ten-year period if enacted in conjunction with H.R. 3200, the America's Affordable Health Choices Act of 2009.[6] CBO scored the provision for a Medicare Commission in the America's Healthy Future Act of 2009 with even greater savings of $22.2 billion over a ten-year period, likely as a result of the explicit spending reductions called for in this proposal if Medicare spending exceeds certain thresholds over time.[7] Moreover, according to CBO, if the President were to accept recommendations for Medicare savings by the Commission, the CBO would modify the baseline accordingly assuming those savings recommendations would take effect. Thus, if Congress acted to disapprove of the recommendations and did not approve another set of proposals generating equal (or greater) savings, this action would be scored as a cost.[8]

Other Questions

- What rules would be established to ensure the independence of the new entity and how would these rules be enforced? Would lobbyists/stakeholders be permitted to serve as members? Would consumers or consumer representatives play a role?
- Would the new entity have authority to make coverage determinations for Medicare, and would these recommendations take into account expected costs of the new device or treatment to the program?
- Would the new entity be able to make recommendations beyond the scope of Medicare to address overall health care spending, including changes affecting Medicaid and other payers?
- Could the new entity recommend a fundamental restructuring of the Medicare program, such as moving from a defined benefit to a defined contribution approach?
- Would the recommendations of the entity be subject to or exempt from judicial review?

Conclusion

In current health reform discussions, the desire of some policymakers to remove political influence from decision-making about Medicare payment policies has been linked with the idea of creating a process that would result in more aggressive action to reduce health care cost growth, improve the delivery and efficiency of health care, and shore up the country's fiscal outlook. The concept of a new entity to make recommendations on Medicare payment policies, which has gained traction in recent months and is incorporated in legislation passed by the Senate Finance Committee, raises many questions and is not without controversy. Consumer advocates have voiced concern about the prospect of diminishing or eliminating the role of Congress on matters that could ultimately affect out-of-pocket costs and access to care for Medicare beneficiaries. Health care providers are similarly concerned about the potential to address perceived problems and inequities in Medicare payment policy without the involvement of elected officials who are directly accountable to their constituents. Thus, the extent of authority granted to an independent Medicare payment entity, how it would operate and be governed, and the potential impact on providers and Medicare beneficiaries and on overall health care costs are likely to be important issues in ongoing discussions as health reform legislation moves forward in Congress.

[1] As of this writing, no similar provision is included in health reform legislation being considered in the House.

[2] P.L 105-33, §1805(b).

[3] See the discussion on "Budgetary Treatment" in Congressional Budget Office, "Approaches for Giving the President Broad Authority to Change Medicare" (July 25, 2009).

[4] The Federal Reserve, the central bank of the United States, is a strong, independent institution that operates apart from other executive agencies and other branches of government. Members of the Board of Governors are appointed by the President, confirmed by the Senate, and serve 14-year, staggered terms. While Congress has oversight over the Federal Reserve, it has no power over day-to-day decision-making. To make changes, Congress must amend the underlying Federal Reserve Act.

[5] BRAC operates only when Congress is periodically handling military base closure/realignment. On five occasions (most recently in 2005) BRAC Commissions have been established to analyze a list of bases recommended for closure/realignment by the Administration. BRAC commissioners are appointed by the President and confirmed by the Senate. BRAC is required to assess whether each base closure recommendation follows statutory requirements, to make any changes necessary, and to report its findings to the President. The President may ask BRAC to make further changes, or may approve the BRAC report and send it to Congress, which then has 45 days to enact a resolution rejecting the report in full. If no resolution is adopted, the report becomes law.

[6] Congressional Budget Office, "Approaches for Giving the President Broad Authority to Change Medicare" (July 25, 2009). This savings estimate is in addition to the Medicare savings attributed to other provisions of H.R. 3200, as estimated by CBO. See Congressional Budget Office, "H.R. 3200, America's Affordable Health Choices Act of 2009, Cost estimate for the bill as introduced on July 14, 2009" (July 17, 2009).

[7] Congressional Budget Office, "Preliminary Analysis of Specifications for the Chairman's Mark of the America's Healthy Future Act, as of October 7, 2009" (October 7, 2009).

[8] Congressional Budget Office, "Approaches for Giving the President Broad Authority to Change Medicare" (July 25, 2009).

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