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Bush's '08 Budget: Nothing For Labs, Pathologists To Cheer About

The Bush administration says the Medicare provider cuts in the budget request are needed to help slow the program's rate of spending growth. Congressional Democratic health leaders counter that the cuts unfairly single out providers to achieve the President's goal of balancing the federal budget by 2012.

To the dismay of clinical laboratory interests, the President's budget request for fiscal 2008 repeats his call for nationwide competitive bidding for Medicare lab services, even though a congressionally required lab bidding demo has yet to be launched.

And to the dismay of pathologists and other physicians, the budget plan assumes that their Medicare fees will be cut by an estimated 8% in calendar 2008, as scheduled under current law. Moreover, the plan is silent on how to reform the physician fee update system to avoid even steeper cuts over the next decade.

The budget blueprint, sent to Congress on February 5, seeks massive cuts in Medicare spending of nearly $76 billion over the next five years, with the ax falling on hospitals and other healthcare providers. Higher-income beneficiaries will also pay more in Part B fee-for-service and Part D drug premiums. Medicare managed care plans are left virtually untouched.

Cuts of such magnitude are "dead on arrival" in the Democratic-controlled Congress, say Capitol Hill watchers, but the budget plan does set the stage for debate on the long-term stability of entitlement spending. For more on the Medicare budget controversy, see the *Focus*, pp. 4-6.

Senate Bill Would Make TC 'Grandfather' Protection Permanent

Bipartisan legislation that would make permanent the currently temporary "grandfather" protection for certain pathology technical component (TC) billings by independent labs was introduced in the Senate on January 31.

Similar legislation surfaced in Congress last year, but failed to get enacted. The Centers for Medicare & Medicaid Services had planned to eliminate the protection as of January 1, 2007, but Congress stepped in last December and, as part of the Tax Relief & Health Care Act of 2006, extended it for an additional year, through December 31, 2007.

The new Senate bill—the Physician Pathology Services Continuity Act of 2007, S. 458—would permanently allow certain independent clinical laboratories to bill Medicare directly for the TC of pathology services to hospital inpatients and outpatients. *Continued on p. 2*

INSIDE *NIR*

Senate Bill, *from p. 1*
Co-sponsors are two members of the Finance Committee, Sens. Blanche Lincoln (D-AR) and Craig Thomas (R-WY), and Mark Pryor (D-AR), a member of the Homeland Security & Governmental Affairs Committee.

The "grandfather" protection applies to hospital-lab arrangements in effect as of July 22, 1999, the date when CMS first proposed to end it. The agency contended that Medicare already pays for the TC as part of the hospital's DRG payment, and labs should seek payment from the hospital, not from Part B. Congress has intervened a number of times, however, to block CMS action.

Under CMS policy, the hospital is the "protected" entity, not the lab. Hospitals may switch labs without losing the protection; however, independent labs cannot switch hospitals and still be protected. CMS also has defined the TC of pathology services to include not only anatomic services, but also cytopathology and surgical pathology (Transmittal AB-01-47).

Cementing the "grandfather" protection permanently in law is a key legislative priority for the College of American Pathologists, the American Clinical Laboratory Association, and other healthcare provider groups. CAP notes that ending the protection would severely impact small and rural hospitals that must outsource pathology work since they cannot afford to bring it in-house.

Bush's Healthcare Tax Break Gets Chilly Reception On Capitol Hill

President Bush's proposal to give a standard tax deduction to all Americans who purchase healthcare coverage got a decidedly cold shoulder from a key House Democratic health leader, but a key Senate Democratic health leader was not as dismissive.

Mr. Bush's proposal—announced in his January 23 State of the Union address and proposed in his fiscal 2008 budget request sent to Congress on February 5—would allow families an exemption from payroll and income tax up to $15,000 yearly in premium costs ($7,500 for individuals). Those with employer-sponsored coverage whose value exceeds the limits would be subject to payroll and income tax on the difference.

In response, House Ways & Means health subcommittee chairman Pete Stark (D-CA) said he does not intend for the panel to even consider the President's proposal, but would be open to alternative ideas, starting with expansion of Medicare, a move Stark has long favored as a vehicle toward universal coverage. In the Senate, Finance Committee chairman Max Baucus (D-MT) said he welcomes any proposal for new coverage of the uninsured and better coverage for those who don't have enough, and praised Mr. Bush for putting healthcare at the fore of his State of the Union address.

In arguing for the tax deduction, the Bush administration says it would end the discrimination in the tax code that gives tax-favored treatment to job-based health coverage. The standard deduction would make private coverage more affordable for those who now buy it with after-tax dollars, the administration says. An estimated 20% of workers now covered through their employers would pay more in taxes or could opt for less generous coverage at lower premiums, notes a White House statement.

Critics say the tax deduction would not help many of the uninsured, since about half of them do not earn enough to have to file an income tax return. Even the Bush

administration acknowledges that the proposed tax code changes would add only about three million to five million to the ranks of those with coverage. Currently, an estimated 47 million Americans are uninsured.

President Sends Mixed Message To States On The Uninsured

While President Bush has pledged to support state initiatives to cover their uninsured residents, his fiscal 2008 budget request could undercut these efforts by proposed changes to Medicaid and SCHIP (the State Children's Health Insurance Program).

The state-support plan, called Affordable Choices, was one of two new healthcare priorities that Mr. Bush announced in his January 23 State of the Union address. It would provide federal grants to help states experiment with ways to make affordable private healthcare coverage available to the uninsured. This initiative, in tandem with the proposed new federal tax deduction for those who purchase private health insurance, reflects the President's view that for most Americans, buying private coverage is "the best way to go."

The Affordable Choices program, led by Health & Human Services Secretary Michael Leavitt, will not entail any new spending. Instead, the Secretary will be able to redirect existing federal dollars from institutions to needy individuals, according to a White House statement. The hospital industry was quick to oppose any diversion of Medicare and Medicaid dollars now set aside for providers that by federal law must provide emergency room and other care in areas with a large uninsured population. These providers are already struggling with low payment rates from federal programs to cover these costs, said the American Hospital Association.

To take advantage of funding under Affordable Choices, notes a White House statement, states could, for example, offer direct premium aid to low-income individuals and establish or expand high-risk pools for very sick individuals deemed uninsurable in the non-group market.

Meantime, state efforts to cover more of the uninsured would be crimped by the President's budget proposals for Medicaid and SCHIP, both of which are key components of plans by states to finance expanded healthcare benefits for low-income children and their families.

The Bush administration seeks net savings in federal Medicaid spending of nearly $26 billion over the next five years, $13 billion of it from legislative changes and $12.7 billion from administrative changes. The biggest savings ($5.3 billion) would result from lowering the administrative match rate to 50%, regardless of the type of activity. Another $5 billion would be saved by revising government provider payments.

The budget proposes to reauthorize SCHIP for five more years, with an additional $5 billion over that period. It also would lower the federal matching rate for uninsured, low-income children in families to 200% of the federal poverty level. Currently, many states offer SCHIP support up to four times that. At a February 7 hearing of the Senate Finance Committee, chairman Max Baucus (D-MT), who has made SCHIP expansion a priority, criticized the request for $5 billion over five years, saying this is only about a third of the funding needed to maintain current enrollment. The request of $5.4 billion for SCHIP in FY 2008 is actually a reduction of $223 million, or 4% from the current level, notes an analysis by Alston & Bird (Washington, DC).

focuson: The FY 2008 Medicare Budget

Bush's Proposals On Collision Course With Democratic Health Leaders

As part of his plan to balance the federal budget by 2012, President George W. Bush is calling for whopping spending cuts in Medicare totaling nearly $76 billion over the next five years, with most of the savings achieved by reducing provider payment updates and raising premiums for higher-income beneficiaries. The plan also seeks savings by introducing nationwide competitive bidding for Medicare lab services, an idea anathema to the clinical laboratory industry.

The Bush administration's budget request for fiscal 2008, submitted to Congress on February 5, underscores major policy differences with the Democratic-controlled Congress. Massive Medicare spending cuts aren't likely to be entertained in either the House or the Senate. However, Democratic healthcare initiatives could be constrained by the party's pledge in the November elections to balance the budget and by congressional pay-as-you-go rules requiring that new spending be offset by cuts elsewhere.

Overview of Budget Request

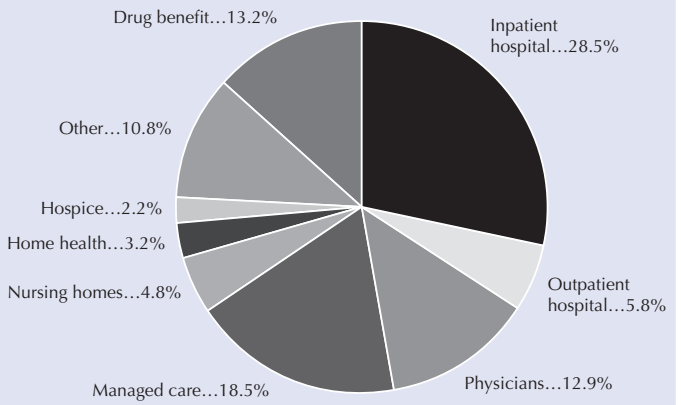
The administration's $2.9 trillion tax and spending blueprint for FY 2008 (which begins October 1 of this year) proposes a big boost for defense spending and the wars in Iraq and Afghanistan, along with big cuts in entitlement and discretionary programs, with Medicare absorbing the biggest reductions. The budget also would make permanent across-the-board tax breaks due to expire at the end of 2010.

Curbing Medicare Spending Growth

The budget seeks net Medicare savings of $65.6 billion over the next five years from legislative changes and $10.2 billion from administrative changes. This would slow the program's annual rate of spending growth from 6.5% to 5.6%, according to HHS budget documents.

Medicare Benefit Outlays by Service, 2008

Total Benefit Outlays: $454 Billion



Source: HHS budget, February 5, 2007

Which providers would get the ax? The budget proposes to:

- Reduce the update for inpatient hospitals, outpatient hospitals, hospices, and ambulance services by -0.65% annually, starting in fiscal 2008. Estimated savings over FY 2008-2012: inpatient hospitals, $13.8 billion; outpatient hospitals, $3.4 billion; hospices, $1.14 billion; and ambulance services, $360 million.
- Freeze the update for skilled nursing facilities and inpatient rehabilitation facilities in 2008 and reduce it by 0.65% annually thereafter. Estimated savings over FY 2008-2012: SNFs, $9.2 billion; rehabilitation hospitals, $1.9 billion.

- Freeze the update for home health agencies in 2008 and reduce it by 0.65% annually thereafter. Estimated savings over FY 2008-2012: $4.7 billion.
- Reduce the annual update for ambulatory surgical centers by 0.65%, starting in 2010 for savings of an estimated $90 million.

Medicare Physician Fee Cut Assumed

For pathologists, the budget is bad news, since it assumes that a projected 8% cut in Medicare physician spending will go forward in 2008, as scheduled under current law. The budget does not address reforms to the statutory Sustainable Growth Rate (SGR) formula used to calculate annual Part B physician fee updates. Under the SGR, when actual Medicare spending for physician services exceeds a target, this triggers a negative update, as has happened for most of this decade and is expected to become even more drastic well into the next unless Congress intervenes. Up to now, lawmakers have blocked physician fee cuts and granted either a modest increase or, as in 2006, a freeze on fees at 2005 levels.

House Ways & Means health subcommittee chairman Pete Stark (D-CA) faulted the Bush administration for failing to address physician payment reform, which he called "a significant problem that … has been allowed to fester and grow." He also criticized the budget for advocating permanent and long-term Medicare spending cuts that, he said, even a GOP-run Congress would not enact.

Senate Finance Committee chairman Max Baucus (D-MT) also criticized the squeeze on Medicare providers, while Medicare managed care plans are slated for payment increases. "If you're going to cut fee-for-service, why not cut Medicare Advantage?" he asked. "That's where the experts say the fat is. I've seen many analysts say that MA plans get more than they need. I've not seen any analysts say they do not."

Bush Administration's Healthcare Priorities

- Establish a standard tax deduction for those who purchase private health coverage. Families with coverage would not be subject to payroll or income tax on $15,000 for premium costs; for individuals, the limit would be $7,500. Those who have employer-sponsored coverage whose value exceeded the limits would be subject to payroll and income tax on the difference.
- Support state efforts to get more uninsured to purchase private coverage through a new HHS-run Affordable Choices initiative, using federal dollars now targeted to hospitals and other safety net providers to cover care in areas with a large number of uninsured.
- Slow the rate of spending growth in Medicare largely by reducing provider payment updates, or in the case of physician fees, assuming a projected 8% cut scheduled for 2008 under current law.
- Expand health savings accounts (HSAs). These are tax-free accounts used to pay for routine medical expenses and linked to a high-deductible policy for catastrophic costs.
- Create association health plans so small businesses can insure their workers at favorable discounts that big businesses get.
- Reduce medical errors and improve patient safety with better health information technology and e-health personal records.
- Enact medical malpractice reform to cap jury awards and curb "frivolous" lawsuits.
- Promote transparency in healthcare pricing and quality of care to empower patients as "smart shoppers."

The MA program offers beneficiaries a variety of coverage options, including HMOs, PPOs, special needs plans, and private fee-for-service plans. In 2006, about 17% of beneficiaries were enrolled in an MA plan. All beneficiaries also had access to at least one type of MA plan, up from 77% in 2004, according to HHS budget documents.

The Blue Cross and Blue Shield Association urged Congress not to cut payments to MA plans this year, arguing that plan reimbursement has been cut $13 billion in the last two years and further cuts could drive plans to reduce services or leave the Medicare market. About 8.3 million beneficiaries are enrolled in managed care plans, the highest number on record, according to the Blues.

The Medicare Payment Advisory Commission found that MA plans are paid as much as 111% above the rate for fee-for-service, but the Blues dispute this figure, saying it does not account for budget neutrality cuts

In a further curb on Medicare spending growth, the President's budget proposes a hard trigger to cap outlays when projected general revenue funding exceeds 45% of the program's financing. For example, provider payments would be reduced 0.4% annually until funding was back under the target, according to HHS budget documents.

or payment add-ons for indirect costs. The Blues also note that the MA program has sustained cuts of more than $6 billion in the $10 billion managed care reserve fund that Congress has redirected this year to higher primary care payments. More cuts would be "disastrous," said a Blues spokesperson, noting that MA payments are scheduled to rise 1% in 2007, while medical inflation will be up 8%.

Lab Competitive Bidding

The President's budget reiterates his proposal from last year to expand the Medicare competitive acquisition program to go nationwide with competitive bidding for Part B laboratory services, for an estimated savings of $110 million in FY 2008 and $2.38 billion over FY 2008-2012.

But lab industry critics note that the Centers for Medicare & Medicaid Services has yet to launch the lab bidding demonstration required by the Medicare Modernization Act of 2003. At press time, the demo project was awaiting clearance from the Office of Management & Budget, and there was no official word on the proposed demo sites. CMS has announced plans to launch the demo in at least one site by April 1; however, the timeline is expected to be modified, given the delay in getting the go-ahead.

The American Clinical Laboratory Association has registered its opposition to the nationwide bidding plan, saying that the whole notion of competitive bidding is unworkable in the lab arena since it treats testing as a commodity, rather than a complex medical service. ACLA is also lobbying key congressional health committees to get the demo project repealed and has met with "positive reaction," association president Alan Mertz told the *National Intelligence Report*.

Vince Stine, government affairs program director at the American Association for Clinical Chemistry, told *NIR* that AACC also wants no implementation of Medicare lab competitive bidding, adding that the proposal to go nationwide without even testing the idea in the real world "doesn't make much sense."

Lab lobbyists expect a sympathetic ear inside Congress. Both Stark and Rep. Charles Rangel (D-NY), who chairs the full Ways & Means Committee, have said they think Medicare competitive bidding for lab services is a bad idea, and Stark has indicated his subcommittee could revisit the issue through oversight hearings.

Any Threat To Lab Fees?

The President's budget request is silent on Medicare Part B clinical laboratory fees, since these continue to be frozen at 2003 rates through calendar 2008, the final year of the five-year update freeze required by the Medicare Modernization Act of 2003. After 2008, lab fees are entitled by law to an annual Consumer Price Index update unless Congress decrees otherwise.

That possibility is always a concern, Stine said, because it is an option that Congress historically has turned to lab spending as a perennial target for Medicare cuts. And "as we get to the end of the current freeze, there is added concern," he said, "that some might push to extend it."

If the Democrats are willing to cut Medicare spending, what would that mean to providers, including clinical labs? Would lab services be put back on the table? Lab groups need to be vigilant, Mertz said, to oppose competitive bidding, any extension of the fee update freeze, and any restoration of a 20% lab co-pay.

Medicare Payment & Claims Advisory

Lab Cost Reimbursement Extended For Small Rural Hospitals

Effective January 1 of this year, cost-based reimbursement for outpatient clinical laboratory tests furnished by small rural hospitals is extended for an additional year. Generally, these tests are paid via the Medicare fee schedule, but the Medicare Modernization Act of 2003 added payment on a reasonable cost basis for these tests to hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods beginning July 1, 2004.

In the Tax Relief & Health Care Act of 2006 enacted last December, this provision was extended for another year or cost reporting periods beginning during the three-year period that started July 1, 2004. Also for these services, Medicare beneficiaries are not liable for any cost-sharing. A qualified rural area is one with a population density in the lowest quartile of all rural county populations. Medicare contractors use the Medicare Zip code file to identify these areas (CMS Change Request 5493, February 2, 2007).

Carriers Told To Process All Diagnosis Codes Reported

Effective July 1, local Medicare carriers must capture and process up to eight ICD-9 diagnosis codes reported on a claim, the maximum number allowed by the ANSI 837P 4010A claim format, the Centers for Medicare & Medicaid Services recently announced. Carriers will have 45 days thereafter to update their edits and audits, CMS noted (Change Request 5441, January 19, 2007).

July 1 marks the final phase of the one-year transition to the new policy which, CMS said, carries out its agreement with the clinical laboratory negotiated rule-making committee to automatically consider all diagnosis codes reported. As part of the negotiated rulemaking, Medicare established national coverage policies for 23 frequently ordered lab tests, with each policy listing the ICD-9 codes used to determine the medical necessity of the testing.

Under the old system, carriers used only the first four diagnosis codes reported on a claim to determine Medicare payment. In consequence, many clinical labs used a work-around to ensure they got paid for a proper diagnosis—typically, claims with more than four ICD-9 codes were submitted twice, initially with the first four codes and then again with any additional codes.

CMS On Track With Transition To MACs

The Centers for Medicare & Medicaid Services is on track to fully implement Medicare claims processing reform nearly two years ahead of the 2011 target set by the Medicare Modernization Act of 2003, notes the U.S. Department of Health & Human Services in its fiscal 2008 budget documents. Medicare has already begun the switch from the current system that splits Part A and Part B work between fiscal intermediaries and carriers to a system that consolidates these functions in Medicare Administrative Contractors (MACs). Contracting reform will reduce Medicare claims processing from 40 cost-based contracts to 15 performance-based, competitive contracts, plus eight specialty contractors. In 2006, CMS awarded five of 23 competitive contracts and another seven contractors will be transitioned in fiscal 2007. The President's spending request for FY 2008 provides $254 million in the CMS budget to award all 23 contracts by the end of FY 2009.

Genetic Anti-Discrimination Bill Clears Senate Panel

While similar legislation in the previous GOP-run Congress stalled in the House, legislative analysts say the prospects for passage of a genetic anti-discrimination measure look better with the Democrats in charge.

The Senate Health, Education, Labor & Pensions (HELP) Committee on January 31 approved legislation (S. 358) that would prohibit health insurers and employers from misusing an individual's genetic information.

The bill would bar health insurers from using such information to deny coverage or determine rates or premiums. It also would bar employers from using this information when making decisions on hiring, firing, job placement, or promotion.

S. 358 was introduced by Sen. Olympia Snowe (R-ME) and co-sponsored by Sen. Edward Kennedy (D-MA), who chairs the HELP panel, and the ranking Republican Sen. Mike Enzi (WY). It was approved by a vote of 19-2, with only two Republicans voting no, Richard Burr (NC) and Tom Coburn (OK). The bill is identical to legislation that unanimously passed the full Senate on two occasions, in 2004 and in February 2005.

In the House, a companion measure (H.R. 493) has been introduced by Reps. Louise Slaughter (R-IL) and Judy Biggert (R-IL) and has widespread support. A hearing on the measure was held on January 30 by a subcommittee of the House Education & Labor Committee. Biggert said the bill reflects a compromise on some issues that troubled employers, such as the potential for frivolous lawsuits and excessive damages.

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