CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 22, 2003

H.R. 1
Medicare Prescription Drug and Modernization Act of 2003
As passed by the House of Representatives on June 27, 2003

and

S. 1
Prescription Drug and Medicare Improvement Act of 2003
As passed by the Senate on June 27, 2003, with a modification requested by Senate conferees

SUMMARY

H.R. 1 and S. 1 both would create a voluntary, federally subsidized outpatient prescription drug benefit under a new Part D of the Medicare program, with additional federal subsidies for drug coverage offered to certain low-income Medicare beneficiaries. In addition, the two acts would make changes to the current Medicare+Choice (M+C) program; expand and alter the payment structures for Medicare fee-for-service (FFS) benefits; modify Medicare's regulatory process; and establish a new agency within the Department of Health and Human Services (HHS) that would administer the programs created under the acts. Both H.R. 1 and S. 1 also would make changes to Medicaid, other federal health programs, and the Drug Price Competition and Patent Term Restoration Act of 1984, commonly known as the Hatch-Waxman Act. H.R. 1 also would authorize the creation of health savings accounts (HSAs) and health savings security accounts (HSSAs), which would provide preferential tax treatment for health care expenditures.

Impact on the Federal Budget

CBO estimates that implementing H.R. 1 would increase direct spending by $119 billion over the 2004-2008 period and by $405 billion over the 2004-2013 period. Assuming appropriation of the necessary amounts, CBO estimates that spending subject to appropriation would increase by $5 billion over the 2004-2008 period and by $14 billion over the 2004-2013 period.

Senate conferees requested that the costs of S. 1 be estimated without section 133, relating to requirements that pharmacy benefit managers disclose certain information. CBO estimates that implementing S. 1, with that modification, would increase direct spending by $114 billion over the 2004-2008 period and by $421 billion over the 2004-2013 period. S. 1 without that modification would increase direct spending by $461 billion over that period. Assuming appropriation of the necessary amounts, CBO estimates that spending subject to appropriation would increase by $2 billion over the 2004-2008 period and by $4 billion over the 2004-2013 period.

The drug benefit and Hatch-Waxman revisions in H.R. 1 and S. 1 would reduce spending on health benefits for firms that provide health insurance. As a result, more of employees' and retirees' compensation would be in the form of taxable income. CBO estimates that the drug-benefit and Hatch-Waxman provisions in both S. 1 and H.R. 1 would increase federal revenues by $25 billion over the 2004-2013 period (the Hatch-Waxman provisions account for $0.2 billion of that total). The Joint Committee on Taxation estimates that the establishment of HSAs and HSSAs would decrease revenues by $174 billion over the 2004-2013 period.

Mandates

Both acts would impose intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA), and those mandates, in aggregate, would have costs that exceed the annual threshold established in UMRA ($59 million in 2003, adjusted for inflation in subsequent years). Both acts would preempt state taxes on premiums for prescription drug coverage, resulting in revenue losses to states that would grow from $60 million in 2006 to $90 million in 2010.

In addition, S. 1 would lengthen the period of time that Medicare is a secondary payer for expenses associated with individuals with end stage renal disease. That extension would impose an intergovernmental mandate on state, local, and tribal health plans, which would cost about $7 million annually. S. 1 also would require states to facilitate criminal background checks for new employees at nursing facilities. The cost of that mandate would total about $310 million over the next five years, but states could charge fees to recover those costs. Other mandates in the act would impose minimal or no costs on state, local, or tribal governments.

Both acts contain various provisions that would provide state and local governments with significant assistance, including pharmaceutical assistance programs, greater federal cost sharing in portions of the Medicaid program, and funding or other financial assistance for

other health-related programs. State Medicaid programs would benefit as the costs of prescription drugs for certain individuals who are eligible for both Medicaid and Medicare shift from Medicaid to Medicare.

Both acts contain a number of mandates on private-sector entities, including group health plans, private health insurers that offer Medicare supplemental coverage, and manufacturers of generic and brand-name drugs. CBO estimates that the direct cost of the requirements in S. 1 would exceed the annual threshold specified in UMRA ($117 million in 2003, adjusted for inflation in subsequent years) from 2006 through 2013. CBO is uncertain whether the direct cost of the requirements in H.R. 1 would exceed that threshold.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impacts of H.R. 1 and S. 1 are shown in Table 1. Tables 13 and 14 at the end of this estimate provide detailed back-up for the direct spending estimates. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 750 (administration of justice).

Medicare Prescription Drug Benefit

Under H.R. 1, CBO estimates that direct spending for the prescription drug program would total $415 billion over the 2004-2013 period. Administrative costs, which would be subject to appropriation, would increase that total by $10 billion to $425 billion. CBO estimates that the Medicare prescription drug program under S. 1 would cost about $432 billion over the 2004-2013 period. That amount includes direct spending of $10 billion for a new agency that would administer the prescription drug program and the MedicareAdvantage program. A more detailed breakdown of the budgetary effects of the prescription drug provisions is shown in Table 2. Other information about the impact of the prescription drug provisions is shown in Tables 6 through 9.

TABLE 1. COMPARISON OF THE BUDGETARY EFFECTS OF H.R. 1 AND S. 1 (WITHOUT SECTION 133)

	By Fiscal Year, in Billions of Dollars											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
CHANGES IN DIRECT SPENDING												
H.R. 1												
Medicare Prescription Drug Benefit	*	2	27	39	43	48	54	60	67	75	111	415
Establishment of New Agency [a]	0	0	0	0	0	0	0	0	0	0	0	0
Health Plan Reforms	1	1	1	1	1	1	1	1	1	1	4	8
Medicare Fee-For-Service Provisions	2	2	*	-1	-2	-3	-4	-5	-5	-5	2	-21
Medicare Regulatory Reform	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid and Other Provisions	1	1	1	1	*	*	*	*	*	*	3	3
Total Outlays—Direct Spending	4	6	29	39	42	46	50	56	63	70	119	405
S. 1 (without section 133)												
Medicare Prescription Drug Benefit	*	1	25	39	45	51	56	61	68	76	110	422
Establishment of New Agency [a]	*	*	1	1	1	1	1	1	1	1	4	10
Health Plan Reforms	0	*	*	1	1	2	3	3	4	4	2	18
Medicare Fee-For-Service Provisions	*	2	1	*	-2	-3	-3	-4	-4	-5	3	-16
Medicare Regulatory Reform	0	*	*	*	*	*	*	*	*	*	*	1
Medicaid and Other Provisions	*	*	-1	-1	-1	-2	-2	-2	-2	-2	-4	-14
Total Outlays—Direct Spending	*	3	26	40	44	50	55	61	67	74	114	421
CHANGES IN SPENDING SUBJECT TO APPROPRIATION												
H.R. 1												
Establishment of New Agency [a]	*	*	1	1	1	1	1	1	1	1	4	10
Regulatory Reform and Other Activities	*	*	*	*	*	*	*	*	*	*	2	4
Total Outlays—Discretionary	*	1	1	1	1	2	2	2	2	2	5	14
S. 1. (without section 133)												
Regulatory Reform and Other Activities	*	1	*	*	*	*	*	*	*	*	2	4

Continued

TABLE 1. Continued

	By Fiscal Year, in Billions of Dollars											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
CHANGES IN REVENUES												
H.R. 1												
Prescription Drug Benefit [b]	*	*	1	2	3	3	3	4	4	5	6	25
Health Savings Accounts	-1	-6	-9	-12	-16	-19	-22	-26	-30	-33	-44	-174
Total Revenues	-1	-6	-8	-10	-13	-16	-19	-22	-26	-29	-38	-149
S. 1. (without section 133)												
Prescription Drug Benefit [b]	*	*	1	2	3	3	3	4	4	5	6	25
MEMORANDUM:												
S. 1 (with section 133)												
Outlays for Medicare Prescription Drug Benefit	*	1	26	42	49	55	61	68	75	84	119	461
Total Direct Spending Outlays	*	3	28	43	48	55	61	67	74	82	123	461
Baseline Medicare Direct Spending Outlays	256	272	282	303	323	346	371	400	423	459	1,435	3,434

SOURCES: Congressional Budget Office and the Joint Committee on Taxation (revenue provisions).

NOTES: Components may not sum to totals because of rounding.

* = costs or savings of less than $500 million.

a. The cost of establishing the new agency ($10 billion over the 2004-2013 period) would be direct spending under S. 1, but would be subject to appropriation under H.R. 1.

b. Includes the estimated effect on revenues of provisions that would modify the Hatch-Waxman Act (increase in revenue of $0.2 billion over the 2004-2013 period).

The 10-year total for the prescription drug benefit in H.R. 1 ($415 billion) consists of $579 billion in payments to plans offering qualified prescription drug coverage, $69 billion for low-income subsidies and transitional drug assistance, and $5 billion for additional

Medicaid and Medicare spending. Those costs would be partially offset by $139 billion in premium income and $99 billion in savings to federal drug programs, reflecting the fact that Part D would replace some Medicaid coverage for certain individuals.[1]

Of the 10-year total for S. 1 ($432 billion), $430 billion represents payments to plans offering qualified prescription drug coverage, $96 billion is for low-income subsidies and transitional drug assistance, $45 billion is for certain additional Medicare and Medicaid costs, and $10 billion is for the government's additional administrative costs. Savings of $17 billion from savings to federal drug programs and premiums of $132 billion would offset some of those costs.

The estimated aggregate costs of the prescription drug benefits under the acts differ by only $7 billion over 10 years, though this small difference reflects several large differences between the acts that have offsetting effects on costs. Three factors in particular have the largest effect on estimated costs over the 2004-2013 period:

- *Coverage of Medicaid enrollees in the drug benefit under H.R. 1.* H.R. 1 would cover individuals who currently receive drug coverage under Medicaid (the dual eligibles and others in Medicaid drug-only waiver programs). The cost of covering that population would total about one-quarter of the cost of the drug benefit under H.R. 1 over the 2004-2013 period, CBO estimates. About 57 percent of those costs would be offset by reduced federal spending for Medicaid, as the new Part D benefit would replace some of the drug coverage those beneficiaries would receive through Medicaid under current law. In addition, H.R. 1 would allow the federal government to recover some of the Medicaid savings that states would realize from this change. The Senate act would provide Medicare prescription drug coverage for a much smaller group of Medicaid beneficiaries—those who otherwise would have received only drug coverage from Medicaid under current law. In sum, covering Medicaid enrollees under the Medicare drug benefit makes the estimated federal costs of H.R. 1 about $47 billion higher than those of S. 1 over the 2004-2013 period.

1. H.R. 1 would permit beneficiaries to pay the premium for the drug benefit either by having the premium withheld from their Social Security benefit (as is generally the case for the Part B premium) or by arranging to pay the drug plan directly. This estimate is presented as if all participants in the drug benefit choose to have premiums withheld from their Social Security benefits. To the extent that beneficiaries choose to pay plans directly, federal spending for benefits and premium collections would be reduced equally, and there would be no change in the estimate of the total cost of the Medicare benefit.

TABLE 2. COMPARISON OF THE COSTS OF THE MEDICARE PRESCRIPTION DRUG PROVISIONS OF H.R. 1 AND S. 1 (WITHOUT SECTION 133)

	Outlays By Fiscal Year, in Billions of Dollars											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
H.R. 1												
Medicare Benefit												
Benefits	0	0	32	49	54	60	67	74	82	92	136	511
Subsidy to Employer and Union Plans	0	0	4	6	7	8	9	10	11	12	18	68
Premiums	0	0	-9	-13	-15	-16	-18	-20	-22	-25	-37	-139
Subtotal	0	0	28	42	47	52	57	64	71	79	116	439
Low-Income Subsidy and Transitional Drug Assistance	0	1	4	6	7	8	9	10	11	12	18	69
Medicaid and Other Federal Drug Spending	0	0	-5	-10	-11	-12	-13	-15	-16	-18	-25	-99
Other Direct Spending	*	*	*	*	*	*	1	1	1	1	1	5
Subtotal, Direct Spending	*	2	27	39	43	48	54	60	67	75	111	415
Administration (Discretionary)	*	*	1	1	1	1	1	1	1	2	4	10
Total Outlays	*	2	28	40	44	49	55	61	68	77	115	425
S. 1. (without section 133)												
Medicare Benefit												
Benefits	0	0	28	42	47	52	56	62	68	75	117	430
Premiums	0	0	-9	-13	-14	-16	-17	-19	-21	-23	-36	-132
Administration	*	*	1	1	1	1	1	1	1	1	4	10
Subtotal	*	*	20	30	34	37	40	44	49	54	84	309
Low-Income Subsidy and Transitional Drug Assistance	*	1	3	7	10	12	13	15	16	19	21	96
Medicaid and Other Federal Drug Spending	*	*	-1	-2	-2	-2	-2	-2	-3	-3	-4	-17
Other Direct Spending	0	1	3	4	5	5	6	6	7	8	13	45
Total Outlays	1	1	25	40	46	52	57	63	69	77	114	432

NOTE: Components may not sum to totals because of rounding.

* = costs or savings of less than $500 million.

- *Low-income subsidy provisions in S. 1.* In contrast, the low-income subsidy provisions of S. 1 are more costly than those of H.R. 1. Under S. 1, the government would provide $18 billion to individuals who otherwise would have Medicaid coverage through a drug-only waiver and $78 billion to other low-income beneficiaries. S. 1 would cover a much higher share of those beneficiaries' cost sharing, in part because low-income subsidy payments would not count toward the catastrophic threshold. Thus, the low-income subsidy (and not the Part D benefit) would cover most spending above the catastrophic limit set in the act. By comparison, CBO estimates that H.R. 1 would provide about $49 billion in subsidies to Medicaid enrollees and about $20 billion to other low-income beneficiaries. Under both acts, some of the subsidy costs for those with Medicaid coverage would be offset by savings to the Medicaid program. CBO estimates that the net costs of the low-income subsidy provisions of S. 1 would be about $31 billion higher than the corresponding costs of H.R. 1 over the 2004-2013 period.

- *Additional federal payments to states under S. 1.* The Senate act also would provide additional payments to states to cover the state share of certain cost-sharing amounts paid by Medicaid on behalf of Medicare beneficiaries. CBO estimates those amounts would add about $28 billion over the 2004-2013 period to the costs of S. 1.

Other factors contribute to differences in the estimated costs of the acts, though they are largely offsetting. For example, the benefit structures contained in the two acts differ. H.R. 1 would provide more coverage of beneficiaries' initial drug costs, but would have a larger range of drug spending for which coverage would not be provided. The differences in design would have only a small net effect on the government's cost. Similarly, H.R. 1 specifies a special subsidy mechanism for enrollees who get their drug coverage through employer and union plans (which CBO estimates would cost $68 billion over 10 years); under S. 1 those costs are included in the overall costs of the basic Medicare benefit because employer plans would be subsidized in the same manner as other prescription drug plans.

To estimate the costs of proposed Medicare drug benefits, CBO uses a model that simulates how a given proposal would affect the spending of a representative sample of Medicare beneficiaries. The model contains detailed information about beneficiaries' spending for prescription drugs and Medicare-covered services, their supplemental insurance coverage (both public and private), their health status, and their income.[2] CBO's estimates of Medicare costs result from the operation of that model.[3]

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2. The estimates are based on data from Medicare claims for 1999 and from the 2000 Medicare Current Beneficiary Survey, projected forward using CBO's March 2003 economic assumptions and baseline projections of Medicare spending.

3. For more general information about CBO's prescription drug estimates, see *Issues in Designing a Prescription Drug Benefit for Medicare* (CBO Study: October 2002).

The primary factor that determines the federal costs of a given drug benefit is how much of enrollees' current drug spending the new Medicare benefit would cover. That amount, in turn, depends on the structure of the coverage and the number of people who would enroll. But CBO's estimates also assume that besides simply redistributing who pays for drug spending, the new benefit would cause enrollees to change their behavior. Some might fill more prescriptions or use more brand-name drugs once they gained better insurance coverage, thus increasing overall drug spending. The new Medicare benefit might also give manufacturers greater room to raise prices on certain drugs (if enrollees became less sensitive to the price of their prescriptions). Conversely, spending could fall if the entities that administered the drug benefit made aggressive use of cost-management tools, which can result in substantial price discounts and changes in the mix of drugs prescribed or purchased.

Prescription Drug Coverage Under Part D of Medicare. While H.R. 1 and S. 1 are similar in a number of respects, substantive differences in their provisions affect the benefit structure, service delivery and cost-control mechanisms, eligibility, treatment of employment-based retiree drug coverage, and other private and public programs currently providing drug benefits.

*Benefits and Coverage Limits***.** Both acts define a "standard" drug benefit using similar concepts, but differ on key details.

- Under H.R. 1, the standard benefit for 2006 would: have a $250 annual deductible; cover 80 percent of drug costs between the deductible and a $2,000 initial benefit cap; then provide no coverage until an individual has incurred $3,500 in out-of-pocket costs for the year, at which point total drug spending for an individual without supplemental coverage would be $4,900; and cover 100 percent of all drug costs beyond that point.

- Under S. 1, the standard benefit for 2006 would: have a $275 annual deductible; cover 50 percent of drug costs between the deductible and a $4,500 initial benefit cap; then provide no coverage until an individual has incurred $3,700 in out-of-pocket costs for the year, at which point total drug spending for an individual without supplemental coverage would be $5,813; and cover 90 percent of all drug costs beyond that point.

In both acts, the deductible, initial benefit cap, and catastrophic threshold would be increased each year at the projected rate of growth in per-capita drug expenditures for the Medicare population. (CBO estimates that, on average, per-capita drug spending will increase by about 10 percent annually over the next decade.) Both acts also specify that out-of-pocket costs would count toward the catastrophic threshold *only* if they are incurred by the individual and are *not* reimbursed by third-party insurance coverage (such as supplemental drug coverage provided by a former employer or through a medigap policy)—a feature referred to as the "true out-of-pocket" provision. However, the acts

would exclude certain third-party payments made on behalf of low-income individuals from this true out-of-pocket provision. Under both S. 1 and H.R. 1, costs covered by Medicaid or state pharmaceutical assistance programs would still be counted as true out-of-pocket expenses. Costs covered by the low-income subsidy would be counted toward the catastrophic threshold under H.R. 1, but would not count toward the catastrophic threshold under S. 1.

In addition, H.R. 1 would increase the catastrophic threshold for beneficiaries whose income exceeds $60,000 (with the joint income of couples divided evenly between them). In 2006, the catastrophic spending threshold would increase from $3,500 in out-of-pocket costs for beneficiaries with incomes of $60,000 to $11,600 in out-of-pocket costs for beneficiaries with incomes of $200,000 or more. Income would be verified using tax records, but affected beneficiaries wishing to avoid income verification could accept the highest catastrophic limit. CBO estimates that less than 10 percent of Medicare beneficiaries would be subject to a higher income-related catastrophic threshold, and that a small percentage of those beneficiaries would actually incur out-of-pocket costs in excess of the standard threshold.

Subject to the approval of the Department of Health and Human Services, both acts would allow the entities delivering Part D benefits to deviate from the standard benefit design as long as: (1) the "actuarial value" of the alternative coverage (based on the drug use of a representative sample of seniors) is at least as great as the standard benefit's; (2) payments by the plan for benefits at the initial benefit cap must be at least as much as the plan would have paid under the standard benefit; and (3) the catastrophic threshold is the same as in the standard benefit. (S. 1 also would prohibit varying the deductible.) Drug plans could offer additional drug coverage, but the costs of any extra benefits would not be federally subsidized.

Table 3 shows how out-of-pocket liabilities—excluding premium payments—would differ under the standard benefit specified in each act, depending on a beneficiary's total drug spending in 2006 under the program (which in general would be less than drug spending under current law for reasons discussed in the section on incentives to control costs). As noted above, beneficiaries with private supplemental drug coverage would have to have greater total drug use before they reach the catastrophic limit on their out-of-pocket costs, while beneficiaries with low income could have much lower out-of-pocket liability.

TABLE 3. ILLUSTRATIVE OUT-OF-POCKET LIABILITY IN 2006 WITH STANDARD DRUG BENEFIT

	Out-of-Pocket Liability in Dollars (for beneficiaries with no supplemental drug coverage)	
Total Drug Spending	H.R. 1	S. 1
500	300	388
1,000	400	638
2,000	600	1,138
3,000	1,600	1,638
4,000	2,600	2,138
5,000	3,500 *	2,888
6,000	3,500 *	3,719
7,000	3,500 *	3,819
10,000	3,500 *	4,119

* Beneficiaries with incomes above $60,000 would have higher out-of-pocket liability at the levels of drug use indicated.

Beneficiaries with the standard coverage would have lower out-of-pocket costs under H.R. 1 if their total drug use in 2006 is relatively low (less than about $3,000) or very high (more than about $5,500), and would have lower out-of-pocket costs under S. 1 in between. CBO estimates that approximately 65 percent of Part B enrollees would have total drug use of $3,000 or less in 2006 and about 15 percent would have total drug use of $5,500 or more. Under the standard benefit of S. 1, with its smaller gap between the initial coverage limit and the catastrophic threshold, beneficiaries would likely face less variability in their out-of-pocket liabilities from year to year. Any comparative analysis is complicated because plans could provide an actuarially equivalent benefit instead of the standard benefit; as a result of that flexibility, under S. 1 drug plans could (subject to HHS approval) offer a benefit that more closely resembles the standard benefit under H.R. 1, as long as it had the same overall value as the standard benefit under S. 1.

Delivery Mechanisms and Plan Costs. Both acts would rely on private entities to deliver Part D benefits, and those entities would be paid based on their expected and actual costs for doing so. As a result, estimated federal costs depend on what types of entities would participate and what sorts of costs they would incur. Under both acts, beneficiaries who receive their Part A and Part B benefits through a private health insurance plan such as a health maintenance organization (HMO) or preferred provider organization (PPO) generally would obtain their drug coverage through that plan (which would be required to provide drug coverage at least equivalent to the standard benefit). Beneficiaries enrolled in the

fee-for-service Medicare program would generally obtain drug coverage through a "prescription drug plan" (PDP) that provides only their Part D benefits. CBO assumes such plans generally would combine the attributes of an insurance company and a pharmacy benefit manager (PBM); but a wide array of organizational arrangements would be allowed.[4] Once enrolled in Part D, beneficiaries could switch among plans on an annual basis, and those plans would be responsible for providing all covered benefits and tracking each enrollee's total drug costs for the year.

Access to Coverage and "Fallback" Provisions. Under H.R. 1, all Medicare beneficiaries are supposed to have a choice of at least two drug plans, but one of those could be an integrated health plan under the Medicare Advantage (MA) or Enhanced Fee-for-Service (EFFS) programs, which would be established under title II to replace the existing Medicare+Choice programs. Under S. 1, all beneficiaries in the fee-for-service Medicare program are supposed to have at least two prescription drug plans from which to choose.

Under both acts, drug plans would be expected to assume financial risk in delivering the Part D benefits—potentially profiting if their costs turn out to be lower than expected or losing money if their costs exceed expectations. However, the two acts also contain so-called "fallback" provisions. Under those provisions, if the number of PDPs that are willing to accept the statutorily specified level of financial risk in a given area is not sufficient, HHS would be authorized to reduce (but not eliminate) the risk faced by plans in that area in order to secure sufficient plan participation. In addition, S. 1 specifies that if the offer of reduced risk does not result in having two prescription drug plans available to enrollees in the original Medicare fee-for-service program in an area, HHS would be required to contract with another organization to offer the prescription drug benefit in that area on a "performance-risk" basis. (With performance risk, the organization would be reimbursed for all benefit costs but a portion of its administrative fee would be tied to certain performance requirements.)

Under both acts, CBO estimates that all Medicare beneficiaries would have access to prescription drug coverage—but in some areas HHS would use its authority to contract with plans on a reduced-risk or (under S. 1) a performance-risk basis. In general, CBO estimates that the share of beneficiaries in fallback plans would start at a higher level and persist for a longer period if it is easier and more attractive to become a fallback plan. Provisions that make it more difficult for drug plans that are willing to bear the statutory level of risk to displace fallback plans also would tend to increase enrollment in such fallback plans. Based on the fallback provisions of H.R. 1, CBO estimates that about 5 percent of Part D

4. Employers and unions that offer prescription drug coverage to their Medicare-eligible retirees could choose to continue to be the primary insurer for those beneficiaries. S. 1 would treat such employment-based plans the same as other participating drug plans. H.R. 1 would provide an alternative subsidy mechanism for those employer and union plans.

participants would be enrolled in reduced-risk plans in 2006, with that share declining gradually in succeeding years. Under S. 1, CBO estimates that about one-third of Part D participants would be in reduced-risk or performance-risk plans in 2006; that share is projected to hold constant through 2013.

CBO estimates a substantially higher share of enrollees in fallback plans under S. 1 than under H.R. 1 for several reasons. First, S. 1 would require more risk-bearing plans to participate in order to avoid triggering the fallback provisions; that could lead some potential entrants to refrain from participating as risk-bearing plans in the expectation that those provisions would indeed be triggered. Second, S. 1 would allow a performance-risk plan to participate under certain circumstances, thus providing another potential avenue for delivering Part D benefits without bearing financial risk. Moreover, under S. 1 a performance-risk plan could participate at the same time as a risk-bearing or reduced-risk drug plan, but the performance-risk plan would have a competitive advantage in building up membership since the premium its enrollees pay would not reflect its own costs of providing coverage. Finally, the prospect that a pharmacy benefit manager serving as a performance- risk plan could retain its enrollees if it later became a risk-bearing plan would tend to discourage other risk-bearing plans from entering that market—since those new entrants would have much more difficulty attracting enrollees—and thus would make such conversions less likely.

Incentives to Control Costs. The incentives drug plans would have to control costs depend primarily on the degree of financial risk they would face in providing the drug benefit and on the extent to which beneficiaries would be exposed to the cost differences among those plans (as expressed through premium levels and cost-sharing requirements). In both acts, "reinsurance" provisions would have the federal government reimburse plans for a share of the actual costs of providing covered benefits to enrollees with relatively high drug expenditures. Those provisions would reduce the impact on plans of having higher-than-expected drug costs or experiencing adverse selection and would lead to smaller federal payments to plans that experience favorable selection; consequently, they would reduce the plans' incentives to attract healthier enrollees but also reduce the incentives for cost control. (Reinsurance payments are discussed further below.) Under S. 1, the financial risks that plans face would be further attenuated by the "risk corridors" it specifies. Under that mechanism, plans that experience benefit costs in 2006 or 2007 that are more than 2.5 percent higher than expected would see an increasing share of those costs covered by additional federal payments, while plans with benefit costs that are more than 2.5 percent below expected costs would essentially have to reimburse Medicare for a corresponding share of the savings. Those thresholds would be increased to 5 percent beginning in 2008.

If no constraints were placed on them, the tools a prescription drug plan could use to manage drug costs would include: enforceable limits on the number and types of drugs included in

its "formulary" or list of preferred drugs; variable or tiered cost sharing to encourage beneficiaries to use less expensive generic drugs or to switch to similar but preferred drugs for which price discounts have been negotiated; and limits on the number and types of pharmacies through which coverage for prescriptions could be obtained. However, both acts would place some limits on the use of such tools. While they contain some provisions that are similar and some that differ along this dimension, the effect of any specific provision on costs often depends on how it would interact with other provisions. For example, both H.R. 1 and S. 1 would (in different ways) limit the ability of drug plans to prohibit their enrollees from using certain pharmacies, but also would give those plans broad latitude in varying reimbursement rates and beneficiaries' out-of-pocket payments between network and other pharmacies.

In general, CBO's analysis indicates that H.R. 1 would give prescription drug plans stronger incentives to control drug costs (because they would bear financial risk), but would go further in restricting some of the tools they could use to do so. S. 1, by contrast, would do more to limit the financial risk drug plans would face (particularly in the first two years of the benefit) but would place fewer constraints on the tools at their disposal. Under H.R. 1, CBO estimates that risk-bearing plans would achieve gross savings throughout the budget window of 25 percent for otherwise uninsured individuals.[5] Since the risk-sharing arrangements under S. 1 would change over time, CBO estimates that the gross savings for plans that bear the statutory level of risk would rise gradually from an average of 22.5 percent in 2006 to an average of 27.5 percent in 2013. Those gross savings reflect an amalgam of three types of savings from management of the drug benefit: savings due to price discounts or rebates from manufacturers and pharmacies; savings from controlling overall drug use; and savings due to changing the mix of drugs used. The gross savings represent savings from managing the drug benefit, but do not reflect the costs of the mechanisms used to achieve those savings. They also do not reflect the effect that the legislation would have on trends in drug prices, changes in drug use by beneficiaries as a result of changes in their own out-of-pocket costs under the proposal, or the impact of any exemption from Medicaid's "best price" provisions for prescription drugs.

Under both acts, CBO estimates that reduced-risk and performance-risk plans would achieve gross savings for otherwise uninsured individuals averaging 15 percent (similar to the effect of cost controls seen in current employer-sponsored drug coverage).

Section 133 of S. 1. Section 133 would bar a pharmacy benefit manager from participating in the delivery of the Part D benefit if it is owned by a pharmaceutical manufacturing company. It also would require each PBM that is involved in delivering the

5. CBO often refers to this percentage as the "cost-management factor (CMF)."

Part D benefit to provide a detailed report annually to the HHS Inspector General and the Justice Department specifying the rebates and other payments it has received from each pharmaceutical manufacturer—both in the aggregate and for each of the top 50 drugs—and payment arrangements with pharmacies for each of those drugs. While the Justice Department could make such information public only in connection with an administrative or judicial action or proceeding, the provision specifies that it is not intended to prevent disclosure of the information that is collected to either House of the Congress or to any duly authorized committee or subcommittee of the Congress.

CBO expects that private firms would perceive a significant risk of public disclosure of the detailed information on drug pricing that this provision would require them to compile and provide to the federal government. That risk arises partly because the information would be in a more accessible form than other data on drug prices that is currently collected by HHS for the Medicaid program or that would be collected under other provisions of S. 1, and partly because more stringent limits on disclosure apply to those other data. Consequently, PBMs operating as part of the Medicare prescription drug plan would find it more difficult to obtain significant price concessions and rebates from drug manufacturers, who would be concerned that the terms of those favorable deals could be determined by competitors or other purchasers. Consequently, CBO estimates that, with this amendment, the degree of drug-cost management under S. 1 would decline and would no longer exceed the levels of cost management seen in the current employer market. The greater difficulty of using price discounts as a way to control drug spending would also reduce the likelihood of having risk-bearing drug plans deliver the Part D benefit, and thus would increase the share of beneficiaries in less tightly managed fallback plans.

As a result, CBO estimates that section 133 would increase the estimated costs of S. 1 over the 2004-2013 period by $40 billion. (At the request of Senate conferees, that impact is not reflected in the estimated cost of S. 1.) In addition to raising federal costs of providing the Part D benefit, the smaller reductions in drug prices under section 133 would translate into higher monthly premiums for Part D ($36 per month in 2006, instead of $34). Beneficiaries' cost-sharing obligations generally also would be higher because they would be paying the same percentage of a higher cost for prescriptions.

Costs of Drug Plans Related to Competition and Risk. In addition to the costs of the covered benefits themselves, along with the costs of processing claims and contracting with pharmacies, prescription drug plans would incur marketing, member acquisition, and member retention expenses (because plans would compete with one another for enrollees). In addition, CBO estimates that plans would incur some costs as a result of having to bear financial risk—whether to offset the costs of purchasing private reinsurance policies or to build up their own reserves in case costs exceed expectations. Specifically, CBO estimates that plans bearing the statutory level of risk would require a "risk premium" in proportion

to the degree of risk they face; that premium would be higher in the initial years of the benefit (when there is greater uncertainty about its costs) than in later years. CBO also assumes some costs associated with compliance with regulatory requirements and with allocating drug costs between Medicare and private lines of business. In sum, CBO estimates that the costs of private drug plans for risk premiums and member acquisition and retention would account for about 8 percent of spending on benefits costs under H.R. 1 and about 7 percent of spending on benefits costs under S. 1.

Federal Subsidies and Beneficiaries' Premiums. The main sources of federal costs for the Part D benefit are the subsidy payments that the federal government would make to the entities providing that benefit (subsidies that CBO estimates would reduce beneficiaries' premiums commensurately). While the specific provisions of the two acts differ, both have the effect of combining a fixed up-front subsidy per enrollee with "reinsurance" subsidies to cover specified percentages of the costs incurred by beneficiaries with high drug use. Under H.R. 1, the federal subsidy payments would cover an estimated 73 percent of benefit and administrative costs for an average drug plan—of which 30 percentage points would come through reinsurance and 43 percentage points would be paid on a prospective per-capita basis. Under S. 1, the overall subsidy rate would average 70 percent—with about 20 percentage points coming through retrospective reinsurance payments and the remainder as a prospective payment. (Among other differences, S. 1 also would permit the up-front subsidies to be adjusted for geographic differences in drug expenditures.)

Reinsurance. Under both acts, federal reinsurance payments generally would begin to cover 80 percent of total drug costs actually incurred for each beneficiary who reaches the catastrophic threshold on out-of-pocket costs. From that point on, H.R. 1 would have drug plans bear the remaining 20 percent of costs, while S. 1 would split the remaining obligation equally between the plan (10 percent) and the beneficiary (10 percent). H.R. 1 also would reimburse plans for 20 percent of their actual costs for providing covered benefits when a beneficiary's total drug use is less than the initial benefit cap but more than half that level (i.e., less than $2,000 but more than $1,000 in 2006). For a drug plan providing the standard benefit, beneficiaries would be liable for 20 percent of their drug costs in that range, while federal reinsurance payments would cover one-fifth of the remaining 80 percent of drug costs. (H.R. 1 also would require HHS to calibrate the reinsurance subsidy schedule each year so that, in the aggregate, reinsurance payments would be expected to cover 30 percent of total covered drug costs under Part D.)

Direct Subsidies and Beneficiaries' Premiums. Costs that drug plans expect to bear but which would not be offset by reinsurance payments would have to be covered by the beneficiaries' premiums and the up-front or "direct" federal premium subsidy payments. Under both acts, the direct subsidy payments would be based on the average expected cost of all drug plans; as a result, beneficiaries who join relatively high-cost plans would pay

correspondingly higher premiums while beneficiaries joining relatively low-cost plans would keep most of the savings through lower premiums. Under H.R. 1, CBO estimates that the average monthly Part D premium would be $35.50 in 2006, and would grow to $62 in 2013. Under S. 1, those premiums are estimated to average $34 in 2006 and $56 in 2013. (CBO has not estimated the degree to which premiums in different plans and in different parts of the country would vary around those averages because, under the payment systems that would be implemented, such variation would not affect federal costs.)

Illustrative Example of Premium and Subsidy Determination. The two acts would establish similar processes for determining the premium that beneficiaries would pay when they join a specific drug plan. Except for those who incur late-enrollment penalties, H.R. 1 and S. 1 both would require that all beneficiaries joining a given plan pay the same monthly premium. Thus, the calculations of beneficiaries' premiums and federal subsidies would be based on the average expected costs of providing covered benefits under the two acts. Table 4 shows a representative calculation for 2006 under each act for an average-cost drug plan (that is, a plan with costs that reflect CBO's estimate of the average of costs for all plans) as well as for a higher- and lower-cost plan. (The cost differences across plans shown here are illustrative and do not represent a CBO estimate of likely premium variations.)

Both acts would require each drug plan (including those integrated with HMOs and PPOs) to submit and justify both their total expected costs of providing covered benefits and administrative services and their expected reinsurance payments, as calculated for a representative Medicare beneficiary. The difference between those two figures would become the plan's bid[6] (which is known as the "monthly plan premium" under S. 1 but is distinct from the beneficiary's monthly premium). From that point forward, the calculations required by the two acts differ but the net result would be similar.

6. Both H.R. 1 and S. 1 also require the direct subsidy payments to be "risk adjusted" to reflect the demographic characteristics and health status of each plan's enrollees. Those payment adjustments are to be budget-neutral and thus would not affect the overall cost of the legislation.

TABLE 4. ILLUSTRATIVE COMPUTATION OF FEDERAL SUBSIDIES AND BENEFICIARIES' PREMIUMS IN 2006 (COSTS AND PAYMENTS ARE SHOWN PER ENROLLEE PER MONTH)

	H.R. 1			S. 1		
	Lower Cost Plan	Average Cost Plan	Higher Cost Plan	Lower Cost Plan	Average Cost Plan	Higher Cost Plan
Expected Cost for Covered Benefits	121	131	141	103	113	123
Less: Expected Reinsurance Payments	-36	-39	-42	-21	-23	-25
Plan Bid	85	92	99	83	91	99
Less: "Direct" Subsidy	-57	-57	-57	-57	-57	-57
Beneficiary's Premium	29	36	43	26	34	42
Share of Expected Cost Covered by Beneficiary's Premium	23%	27%	30%	25%	30%	34%

NOTE: Figures may not add to totals due to rounding

- Under H.R. 1, HHS would use the plans' submissions to calculate a direct subsidy that would cover 43 percent of the expected average costs per enrollee—about $57 per enrollee per month in this example for 2006—and then would pay every plan that monthly amount per enrollee. For each plan, the beneficiaries' premium would equal the difference between the drug plan's bid and the common direct subsidy payment; in an average cost plan, that premium would amount to about $36 and cover 27 percent of the plan's expected average costs. H.R. 1 would allow beneficiaries to choose to pay their Part D premium directly to their plan or to have their Part D premium deducted from their Social Security benefits in the same manner as the current Part B premium, in which case HHS would transfer that amount to the drug plan.

- Under S. 1, HHS would pay each drug plan its bid and then determine the average of those bids. The beneficiaries' premium for an average-cost plan would then be set to cover 30 percent of its expected average costs per enrollee (in this example, 30 percent of $113), and for other plans the premium would be increased or decreased to reflect the full difference between that plan's bid and the average bid. Under S. 1, the beneficiaries' premiums would be paid to the government and collected in the same manner as the Part B premium. The difference between the average bid and premium—the direct subsidy—would be paid to employer-based and union-based plans that serve as the drug plan for their retirees.

As shown in Table 4, the estimated average costs and subsidies per enrollee for the basic Medicare drug benefit are higher under H.R. 1 than under S. 1. That difference, however, reflects two important factors besides differences in the extent of the coverage each act provides—thus making it difficult to compare their relative generosity. First, those averages are affected by the composition of enrollees. In particular, because S. 1 would exclude dual eligibles (whose drug spending is subsidized by Medicaid) from Part D, its average cost is likely to be lower than that under H.R. 1 simply because dual eligibles have above-average drug spending. Second, the treatment of low-income subsidy payments under the true out-of-pocket provision would differ between the two acts. As a result, enrollees in the low-income subsidy program under S. 1 would generally not reach the catastrophic threshold on out-of-pocket costs—so payments for their drug spending beyond the initial benefit cap would be counted as low-income subsidy payments rather than as costs of providing the basic Medicare drug benefit. By contrast, H.R. 1 would treat low-income subsidy payments as though they were being made by the individual, and thus those payments would count toward the catastrophic threshold on out-of-pocket costs; once beneficiaries reached that threshold, additional spending would be counted as a cost of providing the basic Medicare benefit, not as a low-income subsidy cost.

Table 4 also illustrates why the extent to which plans would face financial risk—and beneficiaries' premiums would reflect differences in plans' costs—are important considerations in CBO's analysis of a proposal's costs. If plans face such risks and their beneficiaries bear such costs, plans would have strong incentives not to bid lower than their expected costs (because they would have to absorb the difference) or higher than their expected costs (because the beneficiaries' premiums for their plan would be commensurately higher as a result, making such plans unattractive in a competitive market). If, however, drug plans are insulated from the consequences of poorly estimating their expected costs, they would have strong incentives to understate their expected costs; in the absence of financial risk, the resulting lower premium for beneficiaries would encourage enrollment but the costs would ultimately be shifted to the federal government.

Eligibility and Enrollment. Eligibility for benefits under the two acts would differ along two dimensions. First, under S. 1, beneficiaries would have to be enrolled in both Part A and Part B of Medicare to be eligible for Part D; under H.R. 1, beneficiaries could be enrolled in either Part A or Part B. CBO estimates that 6 percent of Medicare beneficiaries would be enrolled in Part A or Part B—but not both. Second, S. 1 would exclude beneficiaries who have comprehensive drug coverage through Medicaid from enrolling in Part D, while H.R. 1 would allow such dual eligibles to enroll in Part D. CBO estimates that 16 percent of Medicare beneficiaries would have Medicaid drug coverage, and that they would account for one quarter of all drug spending by Medicare beneficiaries.

Under both acts, benefits would be provided starting on January 1, 2006, and enrollment would be voluntary—but beneficiaries who do not sign up when they are first eligible, and

those who disenroll and subsequently re-enroll, would be subject to late-enrollment penalties (unless they maintain drug coverage from certain other sources while not enrolled in Part D that is at least equivalent to the Medicare benefit). As a result, beneficiaries would have a strong financial incentive to enroll in Part D even if their current drug use is relatively low. Even those beneficiaries who end up paying more in premiums than they save on their drug costs would benefit from having had insurance protection against the risk of incurring catastrophic out-of-pocket costs.

In view of the federal subsidies provided under the program, the likely savings for beneficiaries who currently have no drug coverage, and the late-enrollment penalties, CBO estimates that nearly all Medicare beneficiaries who are eligible for Part D and enroll in Part B also would enroll in Part D under both H.R. 1 and S. 1. (CBO also estimates that beneficiaries who do not enroll in Part B—such as many federal annuitants—or are not eligible for Part D—such as those with Medicaid coverage under S. 1—would continue to obtain prescription drug coverage from another source.) In particular, eligible beneficiaries who currently have drug coverage would have a strong incentive to enroll in Part D to obtain the new federal subsidies it provides (and the sponsors of their coverage would have strong incentives to foster such enrollment). Also, by encouraging broad and continuous enrollment (and by discouraging disenrollment from Part D), the late-enrollment penalties would make beneficiaries' premiums lower than they would otherwise be and make it easier for drug plans to project their costs.

Interactions with Medigap and Employer Drug Coverage. CBO estimates that about 30 percent of the Medicare population currently has prescription drug coverage though employer-sponsored plans and 11 percent has coverage through individually-purchased medigap plans. For those enrolled in Part D, the Medicare program would become the initial payer for drug benefits, thereby displacing some current spending by employers and certain medigap policies. In addition, both acts contain provisions that would explicitly or implicitly affect whether and how beneficiaries could obtain coverage to supplement the Part D benefit once it became available.

Medigap Drug Coverage. S. 1 would prohibit the sale, issuance, or renewal to anyone enrolled in Part D of any individual medigap policy that includes coverage for prescription drugs; current holders of such policies could switch to another of the medigap policies currently available. H.R. 1, by contrast, would allow beneficiaries who had enrolled in a medigap policy that provides drug coverage before 2006 to retain that policy—but also would establish two new medigap policies that would offer some drug coverage and would require enrollees to pay a portion of the cost sharing for Part A and B services (up to an annual limit on out-of-pocket costs for those services).

Employer Drug Coverage. Currently, retiree health coverage generally supplements Medicare's benefits for Parts A and B. Since Medicare currently covers a large share of

acute medical costs but provides no outpatient drug benefit, a sizable share of the cost of retiree health plans is made up of prescription drug spending—as much as 40 percent to 60 percent by some estimates. Recent trends in the growth of drug spending have led employers to take measures to control their health costs, such as raising cost-sharing obligations, requiring retirees to shoulder a larger share of supplemental premiums, or dropping coverage for future retirees.

CBO estimates that both acts would have a substantial impact on the costs and availability of drug coverage provided by former employers to their retirees. First, CBO estimates that nearly all Medicare beneficiaries who (under current law) would receive drug coverage through their (or their spouse's) former employer would receive some form of subsidy from the Medicare program under H.R. 1 and S. 1—either as a payment to the prescription drug plan in which they enroll or as a payment made directly to the employer. That development alone would result in a substantial reduction in costs for those employers, but some employers likely would see enactment of a Medicare drug benefit as an opportunity to reduce the costs and risks of providing drug coverage and would choose not to supplement Part D's benefit. One recent survey indicated that nearly a quarter of large employers would take that approach if Medicare offered drug coverage that included catastrophic protection above $4,000 in out-of-pocket spending.

In addition, both acts would target greater federal assistance toward those beneficiaries who lack supplemental private drug coverage—most noticeably, through the requirement that third-party reimbursements not count toward the catastrophic threshold. Because federal reinsurance payments are linked to the catastrophic threshold, that true out-of-pocket provision would reduce federal subsidies for beneficiaries with supplemental insurance compared to subsidies for beneficiaries without such insurance. As a result, it would provide a clear financial disincentive for employers to supplement the Part D benefit. The specific provisions of each act are as follows:

- Under S. 1, if a former employer (whether operating the drug plan for its retirees or in coordination with a generally available drug plan) supplemented the Part D benefit so as to maintain the relatively generous drug coverage generally provided today, most beneficiaries with that coverage would not reach the catastrophic threshold on out-of-pocket costs under Part D. In such cases, no federal reinsurance subsidies would be paid. (Under S. 1 those reinsurance payments constitute about one-third of the overall average federal subsidy and might disproportionally affect those with employer coverage since they have higher drug spending on average.)

- H.R. 1 would provide an alternative subsidy mechanism for employer and union plans, which in 2006 would cover 28 percent of each beneficiary's total drug costs between $250 and $5,000 (as long as the overall drug benefit provided was at least equivalent to Part D). Employers seeking to provide supplemental drug coverage

would essentially be required to use that alternative mechanism. CBO estimates that the resulting average subsidies would be lower than the direct and reinsurance subsidies that would be paid on average if those retirees had joined a prescription drug plan and had no additional drug coverage (see Table 8).

Under both acts, employers would have incentives to restructure their drug coverage and other forms of compensation so as to maximize federal subsidy payments. Not all employers would respond to those incentives, but CBO estimates that 32 percent of the Medicare beneficiaries who would have employer drug coverage under current law would not have their employer provide coverage to supplement the Part D benefit under H.R. 1; under S. 1, that share is estimated to be 37 percent.

Transitional Drug Assistance. Both H.R. 1 and S. 1 would establish a prescription drug discount card program prior to the implementation of the Medicare prescription drug program in 2006. That program would enable participants to obtain prescriptions at discounted prices and would provide limited government subsidies to low-income beneficiaries. CBO estimates that spending on benefits for those programs would be about $0.8 billion under S. 1 and $1.2 billion under H.R. 1 over the fiscal years 2004-2006. Most of that spending would occur in 2005.

S. 1 would cover up to $600 in annual drug spending for individuals with incomes below 135 percent of the poverty level and who meet asset limit requirements. Beneficiaries would be required to pay at least 10 percent in coinsurance. As with the Medicare drug benefit, individuals who are fully eligible for both Medicare and Medicaid could not enroll.

H.R. 1 would limit eligibility for transitional benefits to individuals without any other form of drug coverage. There would be no asset limit. The act would cover annual drug spending up to specific limits, which would vary by the beneficiary's income. The benefit would be $800 for individuals with incomes below 135 percent of the poverty level, $500 for individuals with incomes between 135 percent and 150 percent of the poverty level, and $100 for individuals with incomes above 150 percent of the poverty level.

Costs of the transitional card would be slightly higher under H.R. 1 because of greater participation and slightly higher benefits. CBO estimates that participation of Medicare beneficiaries would be higher under H.R. 1 (about 20 percent of Medicare beneficiaries) than under S. 1 (about 10 percent), in part because H.R. 1 would not limit participation for people with substantial assets.

Low-Income Subsidies. In conjunction with the Medicare prescription drug benefit, both acts would provide assistance to beneficiaries with low incomes for some or all of their share of the prescription drug premium and a portion of the cost-sharing amounts required under each act. As discussed in the previous section, beneficiaries' cost-sharing obligations would

vary under the two acts' standard benefits. In addition, the acts differ substantially in their eligibility criteria for low-income subsides and the extent to which cost sharing would be covered above the initial coverage limit. As a result, more individuals would receive low-income subsidies under H.R. 1, but the average amount of spending covered by the low-income subsidy would be substantially higher under S. 1. Over the 2006-2013 period, costs of the low-income provisions would be $68 billion under H.R. 1 and $95 billion under S. 1, CBO estimates. The differences between the two acts are discussed in detail below:

Eligibility criteria for low-income subsidies. Starting in 2006, S. 1 would provide subsidies to individuals who are enrolled in the Medicare drug benefit and have incomes below 160 percent of the federal poverty level. The amount of the subsidy to individuals within this group would vary depending on their income and asset levels, as described below. Under the act, the limit on assets would be $4,000 for an individual and $6,000 for a couple from 2006 through 2008. Starting in 2009, those limits would be increased to $10,000 for an individual and $20,000 for a couple, with adjustments for inflation in later years.

H.R. 1 would provide subsidies to individuals who are enrolled in the Medicare drug benefit, have incomes below 150 percent of the federal poverty level, and have assets below a specific limit. The limit on assets would be $6,000 for an individual and $9,000 for a couple in 2006; those amounts would be adjusted for inflation in later years.

Low-income subsidy benefits. H.R. 1 and S. 1 have very different approaches to providing low-income benefits. S. 1 would provide four different types of subsidies, depending on an individual's income and asset levels.

- *Individuals with incomes below 100 percent of the poverty level and limited assets.* S. 1 would eliminate the deductible and reduce beneficiaries' cost sharing to 2.5 percent for spending below the initial benefit cap, 5 percent for spending between the initial benefit cap and the catastrophic limit, and 2.5 percent for spending above the catastrophic limit. These individuals also would receive a full premium subsidy.

- *Individuals with incomes between 100 percent and 135 percent of the poverty level and limited assets.* S. 1 would eliminate the deductible and reduce beneficiaries' cost sharing to 5 percent for spending below the initial benefit cap, 10 percent for spending between the initial benefit cap and the catastrophic limit, and 2.5 percent for spending above the catastrophic limit. These individuals also would receive a full premium subsidy.

- *Individuals with incomes below 135 percent of the poverty level who do not meet the asset limit.* S. 1 would apply a lower deductible ($50 in 2006) and reduce beneficiaries' cost sharing to 10 percent for spending below the initial benefit cap and 20 percent for spending between the initial benefit cap and the catastrophic limit.

There would be no benefit for spending above the catastrophic limit. These individuals also would receive a full premium subsidy.

- *Individuals with incomes between 135 percent and 160 percent of the poverty level (regardless of asset levels).* These individuals would receive the same benefits as the previous group, except that the amount of the premium subsidy would decline from 100 percent at 135 percent of poverty to zero at 160 percent of poverty.

The subsidies under H.R. 1 would be more straightforward. Under that act, the government would pay all cost sharing—except for nominal copayments—below the initial benefit cap for individuals with incomes below 135 percent of the poverty level. Those individuals also would receive a full premium subsidy. The act would not provide coverage for beneficiaries' spending between the initial benefit cap and the catastrophic limit. The government would pay for premiums on a sliding scale for individuals with incomes between 135 percent and 150 percent of the poverty level.

Average low-income subsidy payments under S. 1 would be about five times higher than under H.R. 1. Under the provisions of S. 1, average payments for cost sharing in 2013 would be $3,400 for those individuals under 135 percent of poverty who meet asset limits and $2,800 for all others. In contrast, average cost-sharing amounts covered under H.R. 1 would be $600 in 2013.

There are two reasons for this difference. First, as noted above, S. 1 would cover a substantial portion of spending above the initial coverage limit and below the catastrophic threshold. Secondly, because payments under the low-income subsidy in S. 1 would not count toward the calculation of total spending at the catastrophic limit, beneficiaries of the Senate's low-income subsidy would be unlikely to reach the catastrophic limit. Thus, the low-income subsidy under S. 1 would cover most of the drug spending for those beneficiaries that is above the catastrophic threshold, whereas, under H.R. 1, the Medicare Part D benefit would cover most of that spending.

Participation in the low-income subsidy program. Based on an analysis of Medicaid administrative data, the Medicare Current Beneficiary Survey, and the Survey of Income and Program Participation, CBO estimates that 26 percent of all Medicare beneficiaries (about 12 million people by 2013) would be eligible for low-income subsidy benefits under S. 1. For H.R. 1, CBO estimates that 32 percent of all Medicare beneficiaries (about 15 million people by 2013) would be eligible for a low-income subsidy. The latter figure includes about 7 million dual eligibles (who would be eligible for Medicaid benefits and excluded from participating in the Medicare prescription drug program under S. 1). Not counting the dual eligibles, about 17 percent of Medicare beneficiaries would be eligible for a low-income subsidy under H.R. 1.

A significant proportion of the eligible population would probably not apply for the low-income subsidies. CBO estimates the number of people who would sign up for low-income subsidies based on participation in the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. The QMB and SLMB programs pay some or all of the premiums and cost sharing under Parts A and B of Medicare for beneficiaries with incomes below 120 percent of the poverty level and limited assets. In those programs, many beneficiaries who are eligible for a low-income subsidy do not enroll. However, because under both acts individuals would be able to enroll either through offices of the Social Security Administration or at local welfare offices, CBO estimates that participation in the low-income subsidy program would be greater than that for other welfare-related programs.

CBO estimates that the number of people receiving low-income subsidies would rise gradually after the implementation of a Medicare drug benefit. (Unlike the drug benefit, both acts would allow individuals to sign up for a low-income subsidy at any time.) By 2013, CBO estimates that about 5 million people (about 40 percent of those eligible) would receive low-income subsidies under S. 1, compared to 9.5 million (about 60 percent of eligibles) under H.R. 1. The projected participation rate for the House act is higher because dual eligibles would be permitted to participate in the low-income subsidy. CBO assumes that all dual eligibles (including those only receiving Medicaid coverage of drugs) would participate because states would have an incentive to fully transfer the costs of covering those individuals to the federal government. Under H.R. 1, about 2.5 million people who are not dual eligibles would receive low-income subsidies by 2013, CBO estimates.

Changes in Drug Spending by Medicaid and Other Federal Programs. Under current law, CBO estimates that about 7.5 million Medicare beneficiaries will have some type of drug coverage through Medicaid in 2006. Both acts would make Medicare the primary payer for prescription drugs for individuals who enroll in the Medicare drug benefit, and as a result would lead to savings for the Medicaid program. Those savings would be split between the federal government and the states at the regular federal match rate (57 percent, on average). Savings also would occur in other federal programs (including those providing health care for federal employees and military retirees).

CBO estimates that direct spending on prescription drugs by Medicaid and other federal programs would decline by $17 billion under S. 1 and by $99 billion under H.R. 1 over the 2004-2013 period. Almost all of those savings would be in the Medicaid program. Since S. 1 would prohibit individuals with full Medicaid coverage from participating in the Medicare drug benefit, the act would reduce Medicaid spending only for individuals who have limited coverage through special waiver programs. H.R. 1 would reduce Medicaid spending by a much larger amount because dual eligibles would be able to both enroll in the Medicare drug benefit and receive a low-income subsidy.

Other Direct Spending. The prescription drug benefit and low-income subsidy programs would have other effects on both Medicaid and Medicare spending. CBO estimates that, on net, those other effects would cost $5 billion under H.R. 1 and $45 billion under S. 1 over the 2004-2013 period.

Both H.R. 1 and S. 1 would increase Medicaid and Medicare spending for individuals newly enrolling in Medicaid programs that provide assistance with Medicare cost sharing and premiums. Additional costs would occur under both acts as federal programs (mainly Medicaid) face increased costs of prescription drugs for their non-Medicare populations. (Such costs would rise because the advent of Medicare prescription drug coverage would increase demand for prescription drugs.) There also would be additional costs under both acts for the administrative costs to state Medicaid programs for the low-income subsidy programs. (Medicaid administrative costs are direct spending.) The cost of those provisions would be similar in both bills—about $17 billion for fiscal years 2004 through 2013, CBO estimates.

Two other effects, however, cause costs under S. 1 to be $40 billion higher than under H.R. 1. First, under H.R. 1 the federal government would recover some of the Medicaid savings that states realize from having dual eligibles covered under the low-income subsidy. H.R. 1 would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2020. The amount of the reduction would be based on the amount of low-income subsidies that Medicare pays for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 93.3 percent in 2006 to 6.7 percent in 2020. CBO estimates that those reductions would lower federal Medicaid outlays by $12 billion over the 2004-2013 period.

Second, S. 1 would provide states with increased the federal matching funds for Medicaid programs that cover Medicare cost sharing and premiums for certain individuals. States would receive 100 percent funding for Medicaid payments for the Part B premiums for beneficiaries below the poverty level and for Part A cost sharing for certain dual eligibles with income between 75 percent and 100 percent of the poverty level. CBO estimates that those provisions would increase federal spending by $26 billion over the 2004-2013 period. In addition, S. 1 would extend for five years coverage of the Medicare Part B premium for individuals with incomes between 120 percent and 135 percent of the poverty level, which would increase spending by about $2 billion over the 2004-2013 period.

Effect on Revenues. The Medicare prescription drug benefits in both H.R. 1 and S. 1 would result in federal assumption of some spending on prescription drugs that otherwise would be borne by retiree health insurance. That current-law spending on health benefits for retirees is a form of compensation. Under the acts, CBO assumes the savings to employer-sponsored plans would be returned to active workers and retirees as other forms of compensation—that is, as higher wages, pensions, and fringe benefits. On balance, the

composition of the total compensation packages of employees and retirees would shift toward taxable wages and pensions and away from nontaxable health benefits. Under both acts, CBO estimates that the prescription drug provisions would result in an increase in federal revenues of $25 billion over the 2004-2013 period. Social Security receipts, which are off-budget, account for about $8 billion of that total.

TABLE 5. COMPARISON OF THE REVENUE EFFECTS OF H.R. 1 AND S. 1 (WITHOUT SECTION 133)

	By Fiscal Year, in Billions of Dollars											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
H.R. 1												
Income and Payroll Taxes (on-budget)												
Prescription Drug Benefit [a]	*	*	*	2	2	2	2	3	3	3	4	17
Health Savings and Affordability Act	-1	-5	-9	-12	-15	-18	-22	-25	-30	-33	-42	-171
Subtotal, on-budget	-1	-5	-8	-10	-13	-16	-19	-23	-27	-30	-38	-154
Social Security Payroll Taxes (off-budget)												
Prescription Drug Benefit [a]	*	*	*	1	1	1	1	1	1	1	2	8
Health Savings and Affordability Act	*	*	*	*	*	*	*	*	*	*	-1	-3
Subtotal, off-budget	*	*	*	*	1	1	1	1	1	1	1	5
Total Revenues—H.R. 1	-1	-6	-8	-10	-13	-16	-19	-22	-26	-29	-38	-149
S. 1. (without section 133)												
Income and Payroll Taxes (on-budget)	*	*	*	2	2	2	2	3	3	3	4	18
Social Security Payroll Taxes (off-budget)	*	*	*	1	1	1	1	1	1	2	2	8
Total Revenues—S. 1	*	*	1	2	3	3	3	4	4	5	6	25

NOTES: *= less than $500 million. Components may not sum to totals because of rounding

a. The $25 billion increase in federal tax revenues over the 2004-2013 period includes an estimated $0.2 billion increase in revenues as a result of the effect on the cost of employer-sponsored health insurance of provisions in each bill that would modify the Hatch-Waxman Act.

TABLE 6. BASIC INFORMATION ABOUT ESTIMATES FOR S. 1 AND H.R. 1, CALENDAR YEAR 2006

	S. 1	H.R. 1
Average total drug spending per Medicare enrollee (whether in Part D or not)	$3,127	$3,081
Overall participation rate as a share of Part B enrollment[a]	75%	93%
Average total drug spending per participant	$3,009	$3,074[b]
Average value of drug benefit, gross	$1,350	$1,400[b,c]
Average value of drug benefit, net of premiums paid	$941	$1,064[b,c]
Average monthly beneficiary premium	$34.00	$35.50
Average percent subsidy (by Medicare) of standard Part D benefit	70%	73%[d]
Percent of Medicare drug expenditures above catastrophic spending limit	21%	36%[d]
Percent of Part D participants in fallback plans	32%	5%

SOURCE: Congressional Budget Office.

NOTES: Premium and cost-sharing subsidies for low-income beneficiaries are not included in this table. The figures for S. 1 do not include the impact of section 133.

a. Medicaid enrollees who receive prescription drugs through their medical benefit (i.e., "full dual eligibles") could not participate under S. 1 but could participate under H.R. 1. In addition, CBO estimates that about 7 percent of Medicare beneficiaries have other coverage through current employers, Tricare For Life, or the Federal Employees Health Benefit Program and would not choose to participate in Part D.

b. Includes beneficiaries with employer-sponsored coverage whose former employers receive the alternative subsidy.

c. Under H.R. 1, the difference between gross and net benefits is not equal to the average annual premium because most beneficiaries with employer-sponsored coverage would not enroll in Part D and thus would not pay Part D premiums. If beneficiaries whose employers receive the alternative subsidy were excluded, the average gross value of the drug benefit would be $1,569, and the average net value would be $1,143.

d. Does not include spending under the alternative employer subsidy.

TABLE 7. DISTRIBUTION OF TOTAL DRUG SPENDING BY PART D PARTICIPANTS, CALENDAR YEAR 2006

	Percent of participants whose last dollar of drug spending falls…		Percent of total drug spending accounted for by those participants		Percent of drug spending in the interval	
	S. 1	H.R. 1	S. 1	H.R. 1	S. 1	H.R. 1
Below the deductible ($250 under S. 1; $275 under H.R. 1)	20%	21%	*	*	8%	8%
Between the deductible and the initial coverage limit ($4,500 under S. 1; $2,000 under H.R. 1)	61%	34%	43%	13%	65%	40%
Between the initial coverage limit and the catastrophic limit	13%	34%	34%	44%	15%	32%
Above the catastrophic limit ($5,812.50 under S. 1; $4,900 under H.R. 1)[b]	6%	12%	23%	42%	11%	20%

SOURCE: Congressional Budget Office.

NOTES: * = Rounds to less than one percent. Columns may not add up to 100 percent due to rounding. The figures for S. 1 do not include the impact of section 133.

a. Excludes beneficiaries with employer-sponsored coverage whose former employers receive the alternative subsidy.

b. Those limits correspond to $3,700 in out-of-pocket spending under S. 1 and $3,500 under H.R. 1. Stated limits would apply to individuals without supplemental coverage. The effective limits would be higher for beneficiaries with supplemental coverage. Under H.R. 1, the catastrophic limits would also be higher for higher-income enrollees.

TABLE 8. DISTRIBUTION OF PROGRAM PARTICIPATION AND SPENDING BY TYPE OF SUPPLEMENTAL COVERAGE UNDER CURRENT LAW, CALENDAR YEAR 2006

	Number of Participants (in millions of full-year equivalent beneficiaries)		Average Medicare Subsidy (In dollars)		Average Total Drug Spending (In dollars)	
	S. 1	H.R. 1 [a]	S. 1	H.R. 1 [a]	S. 1	H.R. 1 [a]
Beneficiaries with employer-based coverage						
Employer projected to provide coverage	7.3	7.8	952	758	3,743	3,824
Employer projected to discontinue coverage	4.3	3.8	1,471	1,302	3,534	3,118
Beneficiaries with other drug coverage[b]	6.4	13.4	1,002	1,391	3,059	3,322
Beneficiaries with no other drug coverage	12.1	12.4	715	832	2,354	2,316
All	30.0	37.4	941	1,064	3,009	3,074

SOURCE: Congressional Budget Office.

NOTES: Premium and cost-sharing subsidies for low-income beneficiaries are not included in this table. The figures for S. 1 do not include the impact of section 133. Columns may not add up to totals due to rounding.

a. Includes Medicare beneficiaries who enroll in Part D as well as beneficiaries with employer-sponsored coverage whose former employers receive the alternative subsidy.

b. Includes participants with coverage through private medigap policies, the Federal Employees Health Benefits Program, Tricare For Life, state pharmacy assistance, and Medicaid drug coverage (under H. R. 1). Under S. 1, Medicaid enrollees who are eligible for prescription drugs as part of their medical benefit ("full duals") would not be eligible to participate, but recipients of Medicaid drug-only waivers would participate.

TABLE 9. DISTRIBUTION OF MEDICARE ENROLLEES AND CUMULATIVE SPENDING BY INCOME CATEGORY, CALENDAR YEARS 2006-2013

	Enrolled in Medicaid[a]	<150% of FPL	150-250% of FPL	>250% of FPL	Total
UNDER H.R. 1					
Percent of Medicare Part B beneficiaries	20%	22%	21%	37%	100%
Of those, percent participating in Part D	100%	97%	93%	87%	93%
In Billions of Dollars [b]					
Medicare Part D spending					
Part D benefit spending net of premiums	161	83	79	142	465
Cost-sharing assistance for low-income beneficiaries	23	10	0	0	33
Premium assistance for low-income beneficiaries	30	9	0	0	39
Spending on Cost Sharing					
Out-of-pocket spending by beneficiaries[c]	21	93	88	153	356
Third-party spending (e.g., supplemental insurance)	110	31	60	162	363
Spending on premiums	11	28	27	41	107
Total drug spending among Part D participants	357	254	256	499	1,365
UNDER S. 1 (Excluding section 133)					
Percent of Medicare Part B beneficiaries	21%	22%	21%	37%	100%
Of those, percent participating in Part D	13%	97%	93%	88%	75%
In Billions of Dollars [b]					
Medicare Part D spending					
Part D benefit spending net of premiums	19	71	77	154	320
Cost-sharing assistance for low-income beneficiaries	17	69	4	0	90
Premium assistance for low-income beneficiaries	3	13	0	0	16
Spending on Cost Sharing					
Out-of-pocket spending by beneficiaries[c]	9	79	98	170	357
Third-party spending (e.g., supplemental insurance)	0	0	38	109	147
Spending on premiums	2	26	35	59	121
Total drug spending among part D participants	50	258	252	492	1,051

SOURCE: Congressional Budget Office.

NOTE: Figures may not add up to totals shown due to rounding. FPL = Federal poverty level.

a. Includes recipients of Medicaid drug-only waivers.

b. Spending figures in this table are on a calendar-year basis and, for that reason, differ somewhat from the budget estimates shown in other tables.

c. Does not include premiums paid for supplemental coverage.

Establishment of a New Agency

S. 1 and H.R. 1 both would provide for the establishment of a new agency—the Medicare Benefit Administration, under H.R. 1, or the Center for Medicare Choices, under S. 1—to administer both the new Part D prescription drug benefit and the existing Part C Medicare+Choice program (which would be renamed the Medicare Advantage program). The primary roles of the new agency would be to establish and manage a process for beneficiaries to enroll in the Part D benefit; to negotiate contracts with both Medicare Advantage plans under Part C and with Medicare prescription drug plans under Part D; and to establish and implement procedures for making payments to Medicare Advantage plans under Part C and Medicare prescription drug plans under Part D. Under S. 1, the new agency also would determine the national average premium for the Part D benefit.

The new agency also would be responsible for enforcing the true out-of-pocket provisions of both acts, whereby out-of-pocket costs count towards the catastrophic threshold only if they are incurred by the individual and are not reimbursed by third-party insurance coverage. As a part of this process, the new agency would coordinate with the Treasury and Labor departments to determine the amount of beneficiaries' out-of-pocket costs that were being reimbursed by third-party insurance coverage.

The new agency also would have to establish an Office of Beneficiary Assistance, which would disseminate information to beneficiaries by mail, internet, and toll-free numbers about their Medicare benefits and their rights regarding grievances and appeals. The Secretary of HHS would appoint a Medicare Ombudsman within the Office of Beneficiary Assistance, to provide assistance to Medicare beneficiaries regarding complaints or grievances they have with any part of the Medicare program. Funding for the new agency would be mandatory under S. 1 and subject to appropriations under H.R. 1.

In addition to the responsibilities the acts would place on the administrator for the new agency, the acts would require several other federal agencies or departments to undertake various tasks. The Social Security Administration (SSA) would be required to collect enrollees' premiums through deductions from their Social Security checks, an activity similar to what SSA does with Medicare Part B premiums. However, premiums for Part D would differ from enrollee to enrollee depending on the plan in which the enrollee was subscribed. The introduction of the new premium would require SSA to expand the layout of its Master Beneficiary Record to create new data fields, which in turn would require modifications to numerous computer programs. Based on discussions with SSA staff, CBO estimates that initial start-up costs could be about $60 million over the 2004-2005 period. Thereafter, the annual costs would be $20 million to $30 million. These estimates include the cost of cases where changes would have to be completed manually, and the costs of responding to additional calls to the agency’s 800 number.

H.R. 1 would require the Department of the Treasury to provide HHS tax return information to be used in assessing whether an enrollee would have sufficient income (above $60,000 in 2006 and indexed for later years) to be subject to higher limits on out-of-pocket costs.

If the enrollee submitted more recent tax information, Treasury would be required to verify the information for HHS. Based on information from Treasury staff, CBO expects that such data matching would have relatively small costs.

Both acts also call for HHS to coordinate with the Treasury and Labor departments in determining which enrollees have supplemental drug coverage from retiree health benefit plans and other sources. After discussion with the staffs of the various agencies, CBO expects that most of the work would have to be undertaken by HHS, and that the costs to Treasury and Labor would be modest.

CBO estimates that the added administrative costs to the government, for the new agency and existing ones, would amount to $3.6 billion over the 2004-2008 period and $10 billion over the 2004-2013 period, assuming the appropriation of the necessary amounts under H.R. 1.

Health Plan Reforms

Title II of H.R. 1 and S. 1 would modify the formula used to establish payment rates for private health plans that provide Part A and Part B Medicare benefits, and would allow certain types of plans to participate on a regional rather than county basis. Both acts would require health plans to offer the prescription drug benefit defined in Part D—those costs are included in the estimate for Part D.

In 2006, both acts would replace the Medicare+Choice program with new programs (Medicare Advantage and Enhanced Fee-For-Service under H.R. 1, MedicareAdvantage under S. 1), in which private plans would submit bids stating the price at which they will provide all Medicare benefits. The acts would modify the Medicare+Choice payment rates to establish "benchmark" amounts for those new programs. Those benchmarks would be compared to the bids to determine payments to plans and to establish premiums paid by enrollees in those plans. H.R. 1 also would use the modified Medicare+Choice rates in the formula to set the Part B premium for beneficiaries enrolled in both private plans and in the traditional fee-for-service program in certain competitive areas, beginning in 2010. Each act contains other provisions related to health plans and demonstration projects.

CBO estimates that, over the 2004-2013 period, title II of H.R. 1 would increase direct spending by $7.5 billion and title II of S. 1 would cost about $18 billion (see Table 10). Of the latter amount, $12 billion would be spent on preferred provider organization and fee-for-service demonstration projects from 2009 through 2013.

TABLE 10. CHANGES IN DIRECT SPENDING, TITLE II OF H.R. 1 AND S. 1

	By Fiscal Year, in Billions of Dollars											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
CHANGES IN DIRECT SPENDING												
H.R. 1												
Medicare Advantage and Enhanced Fee-For-Service Programs												
Payments to Medicare Advantage plans	0.7	0.9	0.1	-0.1	-0.1	0	0	0	0	0.1	1.6	1.6
Payments to Enhanced Fee-For-Service plans	0	0	0.5	0.7	0.7	0.8	0.8	0.9	1.0	1.0	1.9	6.4
Subtotal	0.7	0.9	0.6	0.6	0.6	0.7	0.8	0.9	1.0	1.1	3.5	8.0
FEHBP-Style Competition												
Payments to plans and providers	0	0	0	0	0	0	*	-0.1	-0.2	-0.3	0	-0.6
Premium rebates for beneficiaries who switch from FFS to plans	0	0	0	0	0	0	*	0.1	0.1	0.2	0	0.4
Premiums from beneficiaries who remain in FFS (nonswitchers)	0	0	0	0	0	0	*	0.1	0.0	-0.1	0	*
Premium rebates for beneficiaries who remain in plans (nonswitchers)	0	0	0	0	0	0	-0.1	-0.1	-0.2	-0.2	0	-0.5
Subtotal	0	0	0	0	0	0	*	-0.1	-0.2	-0.4	0	-0.7
Other Provisions	*	*	*	*	*	*	*	*	*	*	0.2	0.2
Total Outlays—Title II of H.R. 1	0.7	1.0	0.7	0.6	0.7	0.7	0.8	0.9	0.8	0.7	3.6	7.5
S. 1												
MedicareAdvantage Program	0	-0.1	0.3	0.5	0.7	0.8	0.9	0.9	1.0	1.2	1.5	6.2
Alternative Payment Projects												
Preferred provider organizations	0	0	0	0	0	0.9	1.2	1.3	1.3	1.4	0	6.0
Fee-For-Service modernization	0	0	0	0	0	0.9	1.2	1.3	1.3	1.4	0	6.0
Other Provisions	*	*	*	*	*	*	*	*	*	*	0.1	0.1
Total Outlays—Title II of S. 1	0	*	0.3	0.5	0.7	2.5	3.3	3.5	3.7	3.9	1.5	18.3

NOTES: * = cost or savings of less than $50 million.
FEHBP = Federal Employees Health Benefits Program.

Changes to the Medicare+Choice Program for 2004 and 2005. Under current law, Medicare+Choice plans are paid the highest of three amounts (with adjustments for expected differences in costs related to health status):

- A "floor" amount (in 2003, monthly payments of $547.54 in urban areas and $495.39 in rural areas);
- An "applicable blend" of local and national per-capita amounts; and
- A "minimum update" of 2 percent over the payment rate in the previous year.

The blend amount is a 50:50 blend of a local per-capita amount (based on projected spending at the county level in 1997, updated for changes in national per-capita Medicare spending) and the national average of the local amounts, adjusted for local input prices. Therefore, the blend amount is halfway between the local amount and the price-adjusted national amount, and it will be higher than the local amount if the price-adjusted national amount is higher than the local amount. However, a budget-neutrality provision in current law has the effect of preventing the use of the blend amount in establishing payment rates if the blend amount is higher than the local amount. Under current law, therefore, the blend amount is applicable—for establishing payment rates—only if the blend amount is less than or equal to the local per-capita amount.

The floor and blend amounts are updated each year by the percentage change in national per-capita Medicare spending. Ultimately, all payment rates will be the higher of the floor or the applicable blend amount. The minimum update is a transitional mechanism that applies in counties where the payment rate is above that ultimate payment rate. Under current law, CBO projects that the payment rate in all counties will transition to the higher of the floor and the applicable blend by 2009.

H.R. 1 would set the payment rate for M+C plans in 2004 as the highest of four amounts: (1) the floor as determined under current law, (2) a modified blend amount, (3) the 2003 rate updated by the projected change in national per-capita Medicare spending, and (4) projected per-capita spending for county residents in the fee-for-service sector. The new blend amounts would be about 7 percent higher than under current law, and they would be applicable if the national per-capita amount is higher—not lower, as in current law—than the local amount. H.R. 1 also would add spending for Medicare-covered services by veterans' and Department of Defense health programs to the calculations of local rates in the blend and per-capita spending in the fee-for-service sector. In 2005, the M+C payment rate would be the 2004 rate increased by the projected change in national per-capita Medicare spending between 2004 and 2005, with an adjustment to correct errors in the previous forecast of the growth rate.

S. 1 would retain the current-law formula for establishing Medicare+Choice payment rates in 2004, but it would change the minimum update in 2005 to be 3 percent over the 2003 payment rate (instead of 2 percent over the 2004 rate).

Over the 2004-2006 period, CBO estimates that those changes in the Medicare+Choice payment formulas would increase payments to Medicare+Choice plans by $1.9 billion under H.R. 1 and would reduce payments to those plans by $0.1 billion under S. 1.

Medicare Advantage and Enhanced Fee-For-Service Programs. Beginning in 2006, both H.R. 1 and S. 1 would replace Medicare+Choice with programs intended to expand the

geographic availability of private health plans beyond the areas served by Medicare+Choice plans under current law. Both acts would permit plans to operate on a county basis, as they do under the Medicare+Choice program. In addition, both acts would encourage participation in the Medicare program on a regional basis by preferred provider organizations—which generally establish contractual relationships with networks of providers that are broader than the networks established by Medicare+Choice plans.

S. 1 would allow PPOs to operate only on a regional level, whereas H.R. 1 would allow both PPOs and private fee-for-service (PFFS) plans, which do not establish limited networks of providers, to serve regional or county areas. Both acts would require the Secretary of HHS to establish at least 10 regions; S. 1 stipulates that a region could be no smaller than a state.

Both acts would require plans to modify Part A and Part B benefits by offering a unified deductible and a cap on out-of-pocket spending. In addition, with the exception of private fee-for-service plans under S. 1, health plans would be required to offer the prescription drug benefit established under Part D of Medicare.

Benchmark amounts, beginning in 2006. Under current law, Medicare+Choice plans are paid amounts established by the Medicare+Choice payment formulas. Beginning in 2006, both acts would require all health plans to submit a bid—the price at which they are willing to provide the Medicare benefit package in their service areas. A comparison between those bids and benchmarks based on the Medicare+Choice payment formulas would be used as a basis for paying plans and determining the amount of the difference (if any) that would be shared between the Medicare program and the plan's enrollees.

Under H.R. 1, the benchmark at the county level would be the modified M+C payment rate in 2005 updated by the percentage change in national per-capita Medicare spending. Under S. 1, the benchmark at the county level would be the higher of the floor amount as set under current law and projected per-capita Medicare spending in the fee-for-service sector for beneficiaries residing in the county. Both acts would set the benchmark for plans that operate on a regional basis as the weighted average of the county-level benchmarks, using total Medicare enrollment in each county as the weight. The benchmark in some counties, and, in general, the regional benchmarks, would be higher under H.R. 1 than under S. 1, because only H.R. 1 would establish the benchmark using the new blend amount in areas where it is higher than either the floor amount or per-capita spending in the fee-for-service sector.

Plans' Bids and Beneficiaries' Premiums. Under current law, Medicare+Choice plans are required to report their expected average cost, on a per-capita basis, of providing Medicare-covered benefits, and to compare that cost to the expected average payment rate under the Medicare+Choice payment formula. Any excess of payments over their reported costs has

to be used to provide additional benefits or to reduce payments from Medicare. To the extent that a plan chooses to provide additional benefits—which can include reduced cost-sharing obligations—all of the difference between payments and costs is passed on to beneficiaries. However, if Medicare's payments are reduced, the Medicare program keeps 20 percent of any reduction, and returns the other 80 percent to the plan's enrollees (by reducing the amount withheld from the beneficiary's Social Security check to pay the Part B premium). Currently, nearly all plans choose to spend the excess in the form of additional benefits.

Under both H.R. 1 and S. 1, regional and county-level plans would submit bids reflecting the price at which they are willing to provide the Medicare benefit package in their service areas. The acts differ in how bids would be used to set beneficiaries' premiums. If a plan's bid is above the benchmark, both acts would require beneficiaries to pay the difference, in addition to the usual Part B premium. However, if a plan's bid falls below the benchmark, H.R. 1 would require it to rebate 75 percent of the difference to beneficiaries (the Medicare program would retain the other 25 percent); S. 1 would preserve the requirement under current law that plans provide extra benefits or reduce the Part B premium.

Both acts also would allow only the three lowest regional bids to be accepted per contract term. However, neither act would limit the number of plans participating on a county-level basis.

Payments to plans. Plans that bid higher than the benchmarks would be paid the benchmark amounts under both acts. (Beneficiaries would have to make up the difference.) The proposals differ, however, in how they would treat plans that bid below the benchmarks. Under H.R. 1, plans would be paid their bid plus the amount, if any, rebated to beneficiaries (75 percent of the difference between the bid and the benchmark); plans would be required to pass along that rebate to enrollees. Under S. 1, the government would collect premiums from beneficiaries and pay plans the benchmark amount minus any Part B premium reduction. (That is the same method prescribed under current law for plans that offer premium rebates, except the benchmark amount would replace the M+C payment rate.) S. 1 also would provide risk corridors for regional plans in 2006 and 2007. That is, if a plan's costs differ substantially from its bid, Medicare would compensate the plan for some of its excess costs or the plan would return some of its savings to Medicare.

Effect on enrollment in plans. Under H.R. 1, CBO estimates that the number of beneficiaries enrolled in county-based plans would be about the same as the 8 percent of Medicare beneficiaries CBO projects will be enrolled in plans in 2013 under current law. An additional 3 percent of Medicare beneficiaries would enroll in either regional PPOs or PFFS plans, increasing total plan enrollment to 11 percent by 2013. That estimate does not

take into account the effect on enrollment of the "FEHBP-style competition"[7] provision, as discussed below. Under H.R. 1, CBO estimates that rebates to beneficiaries would average $70 per month for plan enrollees in 2006. That estimate assumes that plan's bids would reflect their costs (including a normal profit for health plans in a competitive market).

Under S. 1, CBO estimates that total enrollment in private health plans (including PPOs) would be 1 percentage point higher in 2013 than under current law, or 9 percent of Medicare beneficiaries. (That estimate does not reflect the effect of the demonstration program involving alternative payments for preferred provider organizations.) The increase in plan enrollment under S. 1 would be lower than under H.R. 1 mainly because the benchmarks in some counties, and in regions generally, would be lower—due largely to the addition of the new blend amount to the H.R. 1 benchmark calculation.

Budgetary effects. CBO estimates that the Medicare Advantage and Enhanced Fee-For-Service provisions of H.R. 1 would increase direct spending by $6 billion over the 2006-2013 period. All of that increase in spending would result from higher payments for beneficiaries who switch from the traditional fee-for-service program to enroll in regional plans. CBO projects higher spending for those beneficiaries because, in areas where regional plans would participate, benchmark amounts would be higher than the plans' costs (and their bids), which, in turn, would be higher than Medicare spending in the fee-for-service sector. Thus, Medicare would both pay more to regional plans than it would pay in the fee-for-service sector, and Medicare would provide rebates to beneficiaries who enroll in those regional plans.

For county-based plans under H.R. 1, by contrast, CBO estimates that H.R. 1 would have a negligible effect on federal spending. That is because plans' costs (and their bids), on average,[8] would be slightly below per-capita spending in the fee-for-service sector. Benchmarks would average slightly above fee-for-service spending, and all of the savings from paying plans their bids would be returned to beneficiaries through rebates.

CBO estimates the MedicareAdvantage provisions of S. 1 would increase direct spending by $6 billion over the 2004-2013 period. CBO expects that most plans would provide additional benefits rather than premium rebates, because the full value of the difference between a plan's costs and the benchmark could be returned to beneficiaries instead of

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7. FEHBP refers to the Federal Employees Health Benefits program.

8. That average masks wide variation in the relationship between plans' costs and per-capita spending in the fee-for-service sector. In the current Medicare+Choice program, CBO estimates that plans' costs range from 40 percent below per-capita spending in the fee-for-service sector to 40 percent above. CBO expects that comparable variation would persist under the Medicare Advantage program.

returning 20 percent of the difference to the Medicare program. The estimated cost, therefore, reflects the difference between paying plans the benchmark amounts and the M+C payment rates in current law.

FEHBP-Style Competition. Under H.R. 1, beneficiaries who enroll in Medicare Advantage or Enhanced Fee-for-Service plans that bid below the benchmark would get a premium rebate. Initially, however, there would be no change in how the Part B premium is established for beneficiaries who remain in the fee-for-service sector. Beginning in 2010, the so-called FEHBP-style competition provision would modify the Part B premium amount for beneficiaries who live in an area served by at least two Medicare Advantage plans or at least two Enhanced Fee-for-Service plans, regardless of whether the beneficiary is enrolled in the fee-for-service sector or in a private plan. An area with at least two Medicare Advantage plans would be treated as a competitive Medicare Advantage area, regardless of whether it is also served by two Enhanced Fee-for-Service plans.

The act would establish a competitive benchmark for each area that ultimately would be the weighted average of plan bids and per-capita spending in the fee-for-service sector. The weight applied to fee-for-service spending would be the percentage of Medicare beneficiaries in the fee-for-service sector in the competitive area or in the nation—whichever is lower. Premium rebates or surcharges ultimately would be calculated for fee-for-service enrollees in a manner similar to how premium rebates or surcharges would be calculated in the Medicare Advantage and Enhanced Fee-for-Service programs. Fee-for-service enrollees would be charged the full amount by which per-capita FFS spending exceeds the competitive benchmark, or they would receive a rebate of 75 percent of the amount by which the competitive benchmark falls below per-capita spending in the fee-for-service sector. H.R. 1 would phase in the competitive benchmark and the premium rebates or surcharges over a five-year period.

Effect on monthly premiums. CBO estimates that about 40 percent of Medicare beneficiaries (and about 75 percent of Medicare Advantage enrollees) would live in areas that would be designated competitive Medicare Advantage areas. On average, in those areas, Medicare Advantage plans would submit bids that would be below per-capita spending in the fee-for-service sector. Thus, the competitive benchmark would be below both the Medicare Advantage benchmark and fee-for-service per-capita spending. As a result, CBO expects that the introduction of FEHBP-style competition would reduce the amount of premium rebate for enrollees in Medicare Advantage plans and would increase the Part B premium for beneficiaries in the fee-for-service sector. CBO estimates that monthly premiums in 2010 would increase by less than $1 for enrollees in Medicare Advantage plans and in the fee-for-service sector. By 2013, monthly premiums would increase by about $4 for enrollees in Medicare Advantage plans and by $3 for beneficiaries in the fee-for-service sector (see Table 11).

TABLE 11. ESTIMATED EFFECT OF FEHBP-STYLE COMPETITION IN H.R. 1 ON PART B PREMIUMS

	By Fiscal Year, in Dollars Per Month			
	2010	2011	2012	2013
FFS Enrollees in Medicare Advantage Competitive MSAs	1	1	2	3
FFS Enrollees in Competitive Regions	-6	-11	-12	-10
Medicare Advantage Enrollees in Competitive MSAs	1	2	3	4
EFFS Enrollees in Competitive Regions	7	15	24	34

NOTES: FFS = Fee-for-Service; MSA = Metropolitan Statistical Areas; EFFS = Enhanced Fee-for-Service

CBO estimates that about 6 percent of Medicare beneficiaries (and 60 percent of enrollees in Enhanced Fee-for-Service plans) live in areas that would be designated competitive EFFS areas. Enhanced Fee-for-Service plans in those areas would submit bids that would average about 5.5 percent above per-capita spending in the fee-for-service sector, CBO estimates. Thus, the competitive benchmark would be below the EFFS benchmark and above per-capita spending in the fee-for-service sector. As a result, the introduction of FEHBP-style competition would reduce the amount of premium rebates for enrollees in Enhanced Fee-for-Service plans and would generate premium rebates for beneficiaries in the fee-for-service sector. CBO estimates that monthly premium rebates in 2010 would be $7 lower for enrollees in Enhanced Fee-for-Service plans, while monthly premiums would be reduced by $6 for beneficiaries in the fee-for-service sector. By 2013, monthly premium rebates would be cut in half (a $34 reduction) for enrollees in Enhanced Fee-for-Service plans, while monthly premiums would be reduced by $10 (9 percent) for beneficiaries in the fee-for-service sector.

Effect on enrollment in plans. By 2013, CBO estimates that about 400,000 beneficiaries who live in competitive Medicare Advantage areas would switch from the fee-for-service sector to Medicare Advantage plans as a result of the increase in Part B premiums for those remaining in the fee-for-service sector. CBO anticipates no comparable increase in enrollment in Enhanced Fee-for-Service plans, because premiums would be reduced slightly for beneficiaries in the fee-for-service sector (although total premiums after rebates would still be lower in EFFS plans than in fee-for-service).

Budgetary effects. CBO estimates that the FEHBP-style competition program would save $0.7 billion over the 2010-2013 period. About $0.6 billion in savings would result from

lower payments for beneficiaries who switch from the fee-for-service sector to Medicare Advantage plans in competitive areas. However, those savings would be partially offset by about $0.4 billion in premium rebates to those beneficiaries. The aggregate amount of premiums collected from beneficiaries who remain in the fee-for-service sector would not change significantly, because higher premiums paid by fee-for-service enrollees in competitive Medicare Advantage areas would be offset by rebates paid to fee-for-service enrollees in competitive EFFS areas. However, the FEHBP-style competition program would reduce the amount of rebates paid to beneficiaries who remain in plans by about $0.5 billion, compared to the amount of rebates that would be paid under the Medicare Advantage and EFFS programs.

Alternative payment demonstration projects. S. 1 would require the Secretary of HHS to implement demonstration PPO and FFS payment projects in at least one designated region beginning in 2009 (the projects could be implemented in different regions). For PPOs, payments would be based on bids rather than a pre-determined benchmark amount. For FFS, beneficiaries would be provided with preventive, chronic care, and disease management services that are not covered under current law. CBO estimates those provisions would increase direct spending by $12 billion over the 2009-2013 period.

Medicare Fee-For-Service Provisions

Titles III through VII of H.R. 1 and title IV of S. 1 would modify Medicare's payment rates or coverage rules for many services in the fee-for-service sector, including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, and providers of durable medical equipment. In addition, both acts would provide for various demonstration projects and an expansion of covered services under Medicare as well as the inclusion of additional classes of providers. The net effect of the fee-for-service provisions would be to reduce federal spending by $21 billion under H.R. 1 and $15 billion under S. 1 over the 2004-2013 period. (Details on the costs or savings from specific provisions are shown by the bill title and section number in Tables 13 and 14 at the end of this estimate.)

Notably different between the two acts, however, are the mechanisms by which they would offset increased payments in the fee-for-service sector. H.R. 1 would establish copayments for home health services, change hospital inpatient payment rates, and implement competitive bidding for currently covered outpatient drugs and durable medical equipment. S. 1 would offset additional fee-for-service spending by imposing copayments on certain laboratory services, freeze payments for durable medical equipment, prosthetics, and orthotics, increase the length of time that Medicare is secondary payer for end-stage renal disease patients, extend customs user fees, and require the Internal Revenue Service to deposit fees from installment agreements in the Treasury as miscellaneous receipts.

Both acts would increase the deductible for Part B services (the amount beneficiaries must pay each year before the Medicare program will begin paying for Part B services), change the reimbursement of currently covered outpatient drugs, and clarify the legal basis for collecting from third-party insurers when Medicare is the secondary payer.

Hospital Inpatient Services. H.R. 1 and S. 1 would increase the standardized payment amount (SPA)—the base amount a hospital receives for each discharge under the prospective payment system—for rural and small urban hospitals to the same amount large urban hospitals receive. The acts would change the share of the SPA that is based on labor costs, but only in cases where raising the labor share would result in a higher payment to hospitals. H.R. 1 and S. 1 would increase the adjustment to the base payment for rural and small urban hospitals that serve a disproportionate share of low-income patients (H.R. 1 would cap that adjustment at 10 percent). The acts would expand the criteria by which a hospital could qualify as a critical access hospital (CAH), and would enable CAHs to bill Medicare for additional items and services. H.R. 1 also would increase payments to CAHs for inpatient, outpatient, and skilled nursing services by 2 percent. H.R. 1 and S. 1 would increase the number of medical residents whose training Medicare would subsidize, although H.R. 1 would limit the year-to-year increases. Finally, the acts would increase payment rates for inpatient services furnished by hospitals in Puerto Rico.

Under current law, Medicare makes additional payments to hospitals that use certain new technologies. However, the cost of those additional payments is offset by reducing the SPA. H.R. 1 would expand the number of technologies eligible for additional payments and would no longer reduce the SPA to offset the cost of those payments.

Under current law, payment rates under the prospective payment system for the operating costs of hospital inpatient services will be increased each year by the percentage change in input prices. H.R. 1 would adjust those payment rates by 0.4 percentage points less than the change in input prices.

S. 1 would adjust payment rates by up to 25 percent for hospitals with fewer than 2,000 annual discharges. (That adjustment would be 25 percent for hospitals with the fewest discharges and would decline as the number of discharges approached 2000.)

CBO estimates that, over the 2004-2013 period, the hospital inpatient provisions contained in H.R. 1 would cost $8 billion and those in S. 1 would add $21 billion in outlays.

Skilled Nursing Facilities. H.R. 1 would increase skilled nursing facility (SNF) payments for AIDS patients to 128 percent above the current daily payment rate. CBO estimates this provision would cost less than $50 million over the 2004-2013 period.

Both H.R. 1 and S. 1 would eliminate federally qualified health centers and rural health clinics from consolidated billing under Medicare's nursing home benefit. CBO estimates that this provision would cost $0.1 billion over the 2004-2013 period under H.R. 1. Because this provision under S. 1 includes an additional clause allowing facilities jointly-owned by two or more hospitals to bill Medicare separately for SNF services currently paid under the SNF daily rate, CBO estimates S. 1 would cost $0.3 billion over the 2004-2013 period.

Hospice Care. S. 1 and H.R. 1 each contain provisions that would change the Medicare hospice benefit. Both acts would authorize a hospice program to enter into an arrangement with another hospice program for the provision of hospice services in extraordinary circumstances.

S. 1 would permit nurse practitioners, physician assistants, and clinical nurse specialists who are a beneficiary's primary caregiver to continue to be the primary caregiver and review hospice plans for care after election of the hospice benefit.

H.R. 1 would permit nurse practitioners who are a beneficiary's primary caregiver to continue to be the primary caregiver after election of the hospice benefit. In addition, H.R. 1 would authorize a rural hospice demonstration project for beneficiaries who are unable to receive care in the home for lack of appropriate caregiver. H.R. 1 also would provide for coverage of hospice consultation services to terminally ill beneficiaries.

CBO estimates that S. 1 would increase outlays for hospice care by less than $50 million over the 10-year period, while H.R. 1 would cost $1 billion from 2004 through 2013.

Physician Services. H.R. 1 would set the update to payment rates under the physician fee schedule at no less than 1.5 percent in 2004 and 2005 and would mandate studies on payments and access to physicians. The act also would create additional bonus payments for physicians practicing in areas with low physician-to-beneficiary ratios.

S. 1 would set rates for Medicare physician services in Alaska at 90 percent of the rate paid by the Department of Veterans Affairs in 2005 and 2006.

Both H.R. 1 and S. 1 would set a floor on geographic adjustment factors used to set the physician payment rates. H.R. 1 would set a floor on the work adjustment factor, while S. 1 would set a floor on the work, medical malpractice, and practice expense adjustment factors.

CBO estimates that payments to physicians spending would rise by $5 billion under S. 1 and by $7 billion under H.R. 1 over the 2004-2013 period.

Hospital Outpatient Services. S. 1 and H.R. 1 both contain provisions that would affect services provided under the Hospital Outpatient Prospective Payment System (OPPS). Both acts would modify the existing hold-harmless program for rural hospitals with fewer than 100 beds, which is scheduled to expire on January 1, 2004. S. 1 would reinstate the program for calendar year 2006 and also expand the definition of a qualifying hospital to include sole community hospitals in rural areas. H.R. 1 would extend the hold-harmless program for two years until January 1, 2006, and would expand the definition of a qualifying hospital to include sole community hospitals in rural areas.

In addition, S. 1 would increase payment rates for clinic and emergency room services furnished by small rural hospitals during calendar years 2005, 2006, and 2007.

S. 1 and H.R. 1 both contain provisions that would modify payment rates for drugs and biologicals provided under the OPPS. Both acts would set fixed payment rates, tied to average wholesale price (AWP), for certain drugs and biologicals paid under the OPPS. S. 1 would adjust payment rates for these drugs for two years, beginning in calendar year 2005, while H.R. 1 would adjust payment rates for three years, beginning in calendar year 2004. Both acts also would limit any future application of a standard known as "functional equivalence" that has been used in the past to remove certain drugs from eligibility for additional pass-through payments.

CBO estimates that, over the 2004-2013 period, the provisions in H.R. 1 would increase Medicare payments for hospital outpatient services by $1 billion, while S. 1 would increase such payments by $2 billion over the same period.

Other Provisions Relating to Part B Services. S. 1 and H.R. 1 both contain provisions that would increase the Part B deductible, which is currently set at $100. Under S. 1, the Part B deductible would increase to $125 beginning in 2006, and rise annually thereafter at the percentage increase in the consumer price index for all urban consumers. Under H.R. 1, the Part B deductible would increase at the annual rate of growth in Part B services, beginning in 2004. CBO estimates that, by 2013, the Part B deductible would reach $164 under H.R. 1 and $149 under S. 1 (see Table 12).

TABLE 12. THE ESTIMATED AMOUNT OF PART B DEDUCTIBLE OVER THE 2004-2013 PERIOD UNDER CURRENT LAW, H.R. 1, AND S. 1

	In Dollars									
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Current Law	100	100	100	100	100	100	100	100	100	100
H.R. 1	103	109	113	119	125	132	140	148	156	164
S. 1	100	100	125	128	131	135	138	141	145	149

Both acts would change how certain mammography services and clinical pathology services are reimbursed. S. 1 would make all clinical laboratory diagnostic tests subject to the of Part B deductible and coinsurance requirements. The act also would make adjustments to payments for clinical laboratory services in sole community hospitals and rural health clinics. H.R. 1 would cover an initial preventive physical for new enrollees within the first six months of Medicare coverage and would exclude screening tests for colorectal cancer from the Medicare Part B deductible.

H.R. 1 and S. 1 both would provide for an update to the rate Medicare pays for dialysis for end-stage renal disease (ESRD) patients. H.R. 1 would provide for an update for one year only, with composite rates reverting to current law in 2005. The updates in S. 1 occur in 2005 and in 2006 and would affect each subsequent year. S. 1 also would provide for the bundling of the composite rate services and other ESRD-covered drugs under one payment with an annual update to reflect the growth in the price of drugs.

S. 1 would freeze payment updates for durable medical equipment and off-the-shelf orthotics from 2004 through 2010. In addition, S. 1 would provide for reimbursement of total body orthotic management devices for individuals with severe musculoskeletal conditions who are in the full-time care of a skilled nursing facility.

S. 1 also would provide for a temporary increase in the payment rate for ground ambulance services. Rural ground ambulance services would receive a 5 percent increase and all other ground ambulance services would receive a 2 percent increase. In addition, air ambulance services that are medically necessary and comply with equipment and crew requirements would be reimbursed at the air ambulance rate. H.R. 1 would also change payments for

ambulance services. The act would require the Secretary to increase the base rate paid for ground ambulance services that originate in qualified rural areas. In addition, H.R. 1 would change the phase-in of the blend of the fee schedule and the regional fee schedule. The phase-in would begin in 2004 and be completed by 2010.

H.R. 1 would establish a competitive bidding program for durable medical equipment, off-the-shelf orthotics, and other equipment and supplies. The Secretary would select multiple contractors for each competitive area established, based on the bid amount and the contractors' ability to meet quality and financial standards. In addition, a demonstration program would be established for clinical laboratory services. H.R. 1 also would reduce the payment update for ambulatory surgical centers by 2 percent from 2004 through 2008. The act also would place under the fee schedule for orthotics and prosthetics payments for custom-molded shoes, extra-depth shoes and inserts.

CBO estimates that these provisions in S. 1 would result in a $31 billion reduction in Part B spending between 2004 and 2013. The provisions of H.R. 1 would reduce Part B spending by $12 billion over the 10-year period.

Currently Covered Outpatient Prescription Drugs. S. 1 and H.R. 1 both would alter the payment methodology for currently covered outpatient prescription drugs. Under current law, Medicare pays 95 percent of the average wholesale price (AWP) for covered drugs—generally, those furnished incident to a physician visit.

H.R. 1 would establish a competitive acquisition structure for currently covered outpatient prescription drugs. Beginning in 2005 for oncology drugs, and in 2006 for all other drugs, contractors would bid for the right to supply the drugs to physicians in an area. The Secretary would award a minimum of two contracts per area based on the bid prices and the ability of each bidder to supply the drugs and meet certain quality, service, and financial performance standards. The Secretary would reject bidders if their prices, on average, would exceed 100 percent of widely-available market prices. Medicare would pay contractors the average of the bid prices in their area for each drug.

Each year, physicians would elect to either receive their prescription drugs through a contractor or be reimbursed directly by Medicare. If the physician chose to be reimbursed directly, the Secretary would pay for multi-source drugs (that is, drugs available from at least two manufacturers) at 112 percent of the manufacturer's average sales price (ASP) in 2005 and 2006, and at 100 percent of the ASP in subsequent years. Single-source drugs would be reimbursed at 112 percent of the lesser of the ASP or the wholesale acquisition cost (WAC) in 2005 and 2006, and then at 100 percent of the lesser of the ASP or WAC in subsequent years.

Under H.R. 1, Medicare also would cover intravenous immune globulin for treatment at home of primary immune deficiency diseases. In addition, H.R. 1 would require the Secretary to conduct demonstration projects to evaluate the effects of covering oral chemotherapeutic agents and other prescription drugs that are replacements for drugs furnished incident to a physician visit.

CBO estimates that those provisions of H.R. 1 would reduce Medicare spending by $13 billion over the 2004-2013 period.

Under S. 1, Medicare payments during 2004 would be 85 percent of the AWP in April 2003 for single-source drugs (that is, drugs available only from a single manufacturer) that had an AWP on that date. Medicare would pay 100 percent of the AWP in 2004 for single-source drugs that did not have an AWP until after April 2003. In subsequent years, new drugs would be paid at 100 percent of the AWP in the first year of coverage, and payment rates for previously-covered drugs would be adjusted each year by the percentage change in the consumer price index for medical care.

Payments under S. 1 for multiple-source drugs would be the lesser of 85 percent of the AWP and the price at which the drug is widely available in the market. The act would limit the decrease in payment rates to 15 percent a year.

S. 1 also would provide coverage in 2004 and 2005 for self-injected biologicals that are prescribed as complete replacements for a drug or biological provided in a physician's office and for self-injected drugs for multiple sclerosis.

CBO estimates that those provisions of S. 1 would reduce Medicare spending by $14 billion over the 2004-2013 period.

Demonstration Projects and other Services. S. 1 and H.R. 1 would provide for demonstration projects, including projects on health care quality, clinical care management, modifying the definition of homebound under the Medicare home health program, providing payment for additional classes of providers, rural hospice services, weight loss programs, direct access to physical therapy, and other additional beneficiary services. S. 1 also would pay for some routine costs associated with clinical trials. CBO estimates that covering these services would increase outlays by $1 billion over he 2004-2013 period under both S. 1 and H.R. 1.

Home Health Services. Both S. 1 and H.R. 1 would make changes to the Medicare home health benefit. H.R. 1 would change payment updates from the current fiscal year basis to

a calendar year basis and would reduce the update to payment rates from 2004 through 2006 by 0.4 percentage points. In addition, H.R. 1 would impose a copayment of 1.5 percent of the estimated payment per episode of care (an episode of care is defined as a 60-day period).

S. 1 would limit the reduction in the area wage index used in adjusting the home health payment rate to no greater than 3 percent below the prior year's rate in both 2005 and 2006.

Both H.R. 1 and S. 1 would provide for an adult day care demonstration project for users of home health and a demonstration project for changing the benefit's homebound criteria. Both bills increase payment rates for rural home health agencies, with S. 1 providing a 10 percent increase and H.R. 1 providing a 5 percent increase above current rates.

CBO estimates that S. 1 would increase outlays for home health services by $1 billion over the 2004-2013 period, while H.R. 1 would reduce home health outlays by $7 billion over the same period because of the lower updates and the imposition of copayments.

Medicare as Secondary Payer (MSP) and Internal Revenue Service Provisions. Both H.R. 1 and S. 1 would clarify the legal basis for collecting from third-party insurers the excess amounts that Medicare paid to providers when the third-party insurer should be the primary payer and Medicare should be secondary.

S. 1 also would extend the time that Medicare is the secondary payer for ESRD patients from 30 months to 36 months. The act also would require the Internal Revenue Service to deposit fees from installment agreements in the Treasury as miscellaneous receipts.

CBO estimates the MSP provisions of H.R. 1 would reduce outlays by $9 billion over the 2004-2013 period. The provisions in S. 1 would reduce outlays by $10 billion over that period.

Medicare Regulatory Reform

H.R. 1 and S. 1 would require CMS to modify how Medicare regulations and policies are developed and enforced, and would change the procedures used to resolve disputes involving payment for services covered by Medicare. The acts would transfer certain administrative law judges from the Social Security Administration to HHS. They also would change the procedures by which Medicare makes contracts with entities to process and pay claims, and would place new requirements on those contractors. H.R. 1 and S. 1 would require the Secretary of HHS to conduct several demonstrations, to initiate new

outreach and education programs, and to complete several studies and reports. CBO estimates that implementing these provisions would add $4 billion in discretionary costs over the 2004-2013 period, assuming appropriation of the necessary amounts.

The procedural changes required by both acts would affect spending for services covered by Medicare, which is direct spending. Many of the acts' requirements would codify existing practices, while the other requirements would cause minor increases or decreases in spending for covered services. CBO estimates that implementing title IX of H.R. 1 would have no significant net effect on direct spending over the 2004-2013 period. Provisions of S. 1 that would change procedures for appealing local coverage determinations and would appropriate additional funds to the Medicare Integrity Program for provider education would increase direct spending by an estimated $1 billion over the 10-year period.

Medicaid and Other Provisions

In addition to the Medicare provisions discussed above, S. 1 and H.R. 1 both contain other provisions that would affect direct spending. In S. 1, there are several provisions that would decrease net spending by $14 billion over the 2004-2013 period, CBO estimates. Most of that amount is due to a provision affecting customs user fees, which is discussed below and has an estimated 10-year savings of $18 billion. That provision is not included in H.R. 1. CBO estimates that other provisions of S. 1, including certain loan guarantees, would increase net spending by about $4 billion, and that the other provisions of H.R. 1 would increase net spending by about $3 billion over the 2004-2013 period.

Medicaid and the State Children's Health Insurance Program. Most of the additional non-Medicare spending in H.R. 1 and S. 1 would be from changes to the Medicaid and State Children's Health Insurance (SCHIP) programs. CBO estimates that S. 1 would increase spending for those programs by $3 billion and H.R. 1 would increase spending by $4 billion for fiscal years 2004 through 2013.

Both acts would increase disproportionate share hospital (DSH) payments in the Medicaid program by increasing allotment amounts for all states. That increase under S. 1 would be temporary and would affect spending only in 2004 and 2005. S. 1 would authorize additional DSH payments to certain states with relatively low DSH spending and to Tennessee, Hawaii, and Indiana. CBO estimates that enacting the DSH provisions of S. 1 would increase Medicaid spending by a total of $2 billion over the 2004-2013 period. H.R. 1 would increase DSH payments by a total of $4 billion over the same period.

S. 1 also contains several other provisions that would affect Medicaid and SCHIP. Those provisions would allow states to cover certain legal immigrants under Medicaid and SCHIP

in fiscal years 2005 through 2007, increase the federal match rate to 100 percent for certain Medicaid services provided to Native Hawaiians, and provide additional safeguards to Medicaid recipients in nursing homes. CBO estimates that those provisions would increase spending by a total of $1 billion over the 2004-2013 period.

Extension of Customs User Fees. Under current law, customs user fees expire at the end of fiscal year 2003. S. 1 would extend the fees through the end of fiscal year 2013. This extension would increase offsetting receipts by almost $18 billion over the 2004-2013 period.

Federal Reimbursement for Certain Emergency Health Services. S. 1 would appropriate $250 million annually in fiscal years 2005 through 2008 for emergency health services provided to undocumented aliens. The act would allocate two-thirds of those funds to states based on the number of undocumented aliens living in each state and would provide the remaining funds to the six states with the highest number of apprehensions of undocumented aliens. All funds would remain available until expended. CBO estimates that this provision would increase spending by a total of $1 billion between 2005 and 2010.

Access to Affordable Pharmaceuticals and Drug Competition Act of 2003. Titles VII and IX of S. 1 and title XI of H. R. 1 contain provisions that would change the Drug Price Competition and Patent Term Restoration Act of 1984, commonly know as the Hatch-Waxman Act. That act established an abbreviated approval process for generic drugs. The changes contained in S. 1 and H.R. 1 would accelerate the availability of generic drugs in cases where a generic applicant challenges the brand-name manufacturer's patent.

By making generic drugs available more quickly, CBO estimates that the changes to the Hatch-Waxman Act contained in S. 1 would lower total drug spending within the U.S. by $7 billion over the 2004-2013 period. Of that 10-year total, savings for existing mandatory federal programs are estimated to be $750 million. These provisions also would affect the cost of the prescription drug benefit established by S. 1. CBO estimates that they would reduce the cost of that program by $650 million, which is reflected in the net cost of the drug benefit. The act's changes to the Hatch-Waxman Act also would affect spending subject to appropriation, for programs such as veterans health care, the Department of Defense health care programs, and the Federal Employees Health Benefits Program for active workers. CBO estimates that savings for these programs would be $200 million over the next 10 years.

The changes to the Hatch-Waxman Act contained in H.R. 1 would have a similar effect, also lowering total drug spending within the U.S. by about $7 billion over the 2004-2013 period, CBO estimates. Savings for drugs covered under current law by mandatory federal programs are estimated to be $800 million, and the cost of the prescription drug benefit

under H.R. 1 would be reduced by $700 million (which is reflected in the net cost of the drug benefit). CBO estimates that savings in federal programs subject to appropriation would total $200 million over the 2004-2013 period.

The changes to the Hatch-Waxman Act under both H.R. 1 and S. 1 would affect spending on prescription drugs by employer-sponsored health insurance plans, and would result in a shift in the composition of total compensation from nontaxable health benefits toward taxable wages and salaries. CBO's estimate of the effect on revenues of the Hatch-Waxman revisions ($0.2 billion over the 2004-2013 period) is combined in Table 1 with the effect on revenues of the prescription drug benefit.

On June 12, 2003, the Food and Drug Administration (FDA) issued a final rule that will change how the Hatch-Waxman Act is implemented. This new rule includes some of the provisions contained in S. 1 and H.R. 1. CBO has incorporated the effect of the FDA rule into projections of spending and revenues under current law. The estimated savings under S. 1 and H.R. 1 are for provisions that reach beyond the effect of FDA's final rule. The two acts each would:

- Eliminate the 30-month stay for all patents listed after the abbreviated new drug application (ANDA) has been filed. (The FDA rule will eliminate the 30-month stay for most, but not all, so-called "late-listed" patents.)

- Permit generic applicants to file a counterclaim that patent information contained in the Orange Book be removed or corrected. (The Orange Book is the FDA publication, *Approved Drug Products with Therapeutic Equivalence Evaluations,* which contains patent information associated with pharmaceuticals.) This counterclaim could be filed only if a lawsuit were brought by the brand-name company to defend a challenged patent.

- Modify the trigger for the 180-day marketing exclusivity period available to the first generic applicant. Under current law, the period of exclusivity is triggered either by a court decision that the patent is invalid or not infringed or by commercial marketing by the first generic applicant. Under the acts, the exclusivity period would start when the applicant began to market its drug commercially.

- Cause the 180-day exclusivity period available to the first applicant to be forfeited under certain conditions. For example, the first applicant would have to market the drug within 75 days after any applicant has obtained a favorable court decision on all challenged patents. The court decisions that could trigger such a forfeiture event include an appellate court ruling, an unappealed district court ruling, or a settlement order that all patents challenged by the first applicant are invalid or not infringed.

The exclusivity period would also be forfeited if an agreement is reached between the first generic applicant and the brand-name manufacturer of the drug that violates antitrust laws.

- Require that certain agreements between generic and brand-name manufacturers be reported to the Federal Trade Commission (as well as the Department of Justice under S. 1).

- Require that a generic applicant notify the brand-name manufacturer within 20 days after the FDA has filed the ANDA containing a patent challenge.

S. 1. also would clarify that a generic company has a right to seek a declaratory judgment that marketing its generic drug would not violate the patent rights of the brand-name drug. Under that act, the failure of the brand-name company to bring a lawsuit within 45 days would establish an "actual controversy"—a requirement for a court to consider a request for a declaratory judgment. In addition, the act would encourage the courts to consider whether an infringed patent was listed in the Orange Book in a timely manner before awarding treble damages.

H.R. 1 also would require that certain types of agreements between generic manufacturers be reported to the Federal Trade Commission. In addition, the act would grant the brand-name company a right of confidential access to an ANDA containing a patent challenge of non-infringement in order to determine if legal action should be brought to defend the patent.

Importation of Prescription Drugs. Title VIII of S. 1 and title IX of H.R. 1 contain provisions regarding the importation of prescription drugs. Under both acts the Secretary of HHS would be required to issue regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States. The regulations would be issued only if the Secretary demonstrates that the importation of prescription drugs would pose no additional risk to the public's health and safety and would result in a significant reduction in the cost of covered products to the American consumer. Secretaries have previously chosen not to implement importation regulations similar to those authorized in these acts, partly because of a belief that such imports could pose some risk to the public's health and safety. Consequently, CBO assumes that the Secretary would not issue the regulations allowing the importation of prescription drugs and, therefore, does not estimate any savings or costs associated with this provision for S. 1 or H.R. 1.

Even if the Secretary were to implement these provisions, they would probably not produce substantial savings to the federal government. Manufacturers of brand-name drugs are

unlikely to increase their sales in Canada enough to permit a significant share of their United States market to be imported from Canada. Further, Canada's market for prescription drugs is much smaller than that in the United States. If manufacturers were unable to limit the supply of drugs entering the U.S. market from Canada, the likely result would be that brand-name drug prices in Canada would rise much more than the price in the U.S. would decline.

Health Savings Accounts and Health Savings Security Accounts

Title XII of H.R. 1 would authorize the creation of health savings accounts and health savings security accounts, which would provide preferential tax treatment for qualified health care expenditures. In general, both types of accounts would be available to individuals who are not eligible for Medicare and who cannot be claimed as a dependent on another person's tax return.

Eligibility for HSAs would be limited to individuals who are covered by a health insurance policy with an annual deductible between $1,000 and $2,500 for self-only coverage and between $2,000 and $5,050 for family coverage. The policy also would need to include limits on annual out-of-pocket expenses of no more than $3,350 for self-only coverage and $6,150 for family coverage.

Eligibility for HSSAs would be limited to individuals who are uninsured or who are covered by a health insurance policy with an annual deductible of at least $500 for self-only coverage and at least $1,000 for family coverage. HSSAs would have no maximums for either the deductible or out-of-pocket expenditures. All of those amounts for both HSAs and HSSAs would be indexed to the consumer price index for urban consumers.

Contributions made by eligible individuals to these health accounts would be deductible in determining adjusted gross income for federal income tax purposes. Employers' contributions also would be deductible (if they would have been deductible if made by the employee). The maximum annual contribution to an HSA would be 100 percent of the annual deductible under the individual's high deductible plan. The maximum annual contribution to an HSSA would be $2,000 for persons with self-only coverage and uninsured individuals with no dependents who do not file a joint federal income tax return, and $4,000 for those with family coverage and uninsured individuals with dependents or who file a joint return. (Individuals ages 55 and older would be allowed to contribute larger amounts.) The contribution amounts would not be indexed for inflation. The maximum allowable contribution to an HSSA would be phased out for taxpayers with adjusted gross income above certain levels. For individuals with self-only coverage and those who do not

file a joint return, the phase-out range would be $75,000 to $85,000. For individuals with family coverage and individuals filing a joint return, the phase-out range would be $150,000 to $170,000.

In general, distributions from HSAs and HSSAs for qualified medical expenses would be excludable from gross income. Qualified medical expenses would not include premiums for health insurance other than for long-term care insurance, premiums for health coverage during any period of continuation coverage required by federal law, and premiums for health care coverage while an individual is receiving unemployment compensation under federal or state law. In the case of HSSAs, qualified medical expenses would also include health insurance premiums if no portion of the premium is paid by the employer or former employer of the individual or individual's spouse, and health insurance for individuals ages 65 and older (including Medicare expenses).

Several factors suggest that many people would eventually establish HSSAs. The relatively low minimum deductible requirement of HSSAs would allow many policyholders, particularly those with nongroup health insurance which often includes high deductibles, to meet the qualifications immediately. In addition, some people who are currently uninsured would find the HSSA an attractive option that could enable them to purchase health insurance policies. Assuming that deductibles tend to increase over time as health care costs increase, the minimum deductible requirement ($500 for single policies and $1,000 for family policies) would become increasingly less restrictive over the ten-year period ending in 2013 because it would grow only at the rate of the consumer price index, which is expected to be substantially lower than the rate of growth in per-capita health care spending. In addition, high-deductible plans are becoming a much more common design for employer-sponsored health care benefit packages as employers respond to rapid growth in health care costs over the past few years. Title XII would accelerate that trend as employers adapted their benefit offerings to take advantage of the accounts' tax advantages.

The Joint Committee on Taxation (JCT) estimates that title XII would reduce federal tax revenues by a total of about $44 billion from 2004 through 2008, and $174 billion from 2004 to 2013. Nearly all of that revenue loss would come from the creation of the HSSAs. The five and ten-year revenue losses from HSSAs would be about $39 billion and $163 billion, respectively. JCT estimates that, by the end of 2013, approximately 42 million HSSAs would be in existence. The remaining revenue loss would come from HSAs, which would be far smaller in number, and two other provisions. One provision would allow a portion of unused balances in health care flexible spending accounts to be carried forward to the next year. The other provision would relax rules requiring employers to report certain health care expenditures to the Internal Revenue Service, resulting in diminished tax compliance.

EFFECT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

Both acts contain several intergovernmental mandates as defined in UMRA. CBO estimates that, in aggregate, the cost of those mandates would exceed the threshold established in UMRA ($59 million in 2003, adjusted annually for inflation).

Preemption of State Premium Taxes. Both acts would prohibit states from imposing taxes on premiums or similar payments made in association with prescription drug coverage authorized by the acts. This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in prescription drug plans would result in a shift away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues. CBO estimates that about 9 million people would change their insurance coverage for prescription drugs from taxable plans to plans authorized by the acts. As a result, states would be unable to collect premium taxes (ranging from 0.2 percent to 3.0 percent of premiums) on those plans. CBO estimates that state losses of premium tax revenue as a result of this preemption would grow from about $60 million in 2006 to $90 million in 2010.

Background Checks for Employees of Nursing Facilities. S. 1 would require states to conduct background checks for potential employees of nursing facilities, including skilled nursing facilities. States would be required to check appropriate state records, transmit information between nursing facilities and the Attorney General, review all of the information, and submit reports to facilities. CBO estimates that approximately 1.5 million background checks would be necessary each year once the background checks are fully implemented and that the cost of each check would be about $50. Assuming that the number of checks phases in over time, the cost of the requirement would total about $25 million in 2006 and increase to $80 million by 2010. States would be able to charge fees to recover the costs of conducting these checks.

End-Stage Renal Disease. S. 1 would expand an existing mandate on group health plans (including those operated by state, local, and tribal governments for their employees) regarding the coverage of Medicare enrollees with end stage renal disease. Beginning in 2004, the bill would extend from 30 months to 36 months the time period during which Medicare would be second payer (and other plans would be the primary payers) for the expenses of Medicare enrollees with ESRD who also are covered by a group health plan. CBO estimates that the direct cost to state, local, and tribal plans of this extension would total about $7 million annually.

Certification of State Pharmaceutical Programs. In both acts, health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, would be required to disclose whether the coverage they offer provides benefits at least equivalent to the benefits in the acts. That disclosure requirement would be an intergovernmental mandate. CBO estimates that the costs of the mandate would be minimal.

Preemption of State Laws and Waiver of Licensing Requirements. Both acts would allow the Secretary of HHS to waive state licensing requirements for prescription drug plans under certain circumstances: if a state fails to act on a license application on a timely basis, a state denial is based on discriminatory treatment, state solvency requirements differ from those in the acts, or the state has licensing requirements that differ from those in federal law. In cases where the Secretary waives licensing requirements, states would lose fees associated with those licenses. CBO cannot estimate the magnitude of such losses because we have no basis for predicting how often waivers would be possible or granted.

The standards in both acts would supersede state laws and regulations governing prescription drug plans. While these preemptions would limit the application of state laws, they would impose no duties on states that would result in additional spending.

S. 1 also contains other preemptions that would limit the application of state laws. The act would prohibit states from requiring issuers of Medicare supplemental policies to offer prescription drug coverage, and it would preempt all state laws and regulations governing the electronic transmission of medical information. It also would protect skilled nursing facilities from liability resulting from employee background checks, thus preempting state liability and employment laws. In all of these cases, the act would limit the application of state laws, but it would impose no duty that would result in additional spending.

Coding Requirements. Current law requires the Secretary of HHS to rely on the recommendation of the National Committee on Vital and Health Statistics (NCVHS) when establishing coding standards for collecting and reporting health data by public and private health plans and health care providers. H.R. 1 would allow the Secretary to establish a new coding system in the absence of a recommendation by the NCVHS. This expanded authority could increase the cost of an existing mandate on public and private health plans and providers regarding the coding system they must use. It is unclear, however, whether the Secretary would actually require the implementation of a new coding system in the absence of a recommendation from the NCVHS, and it is also unclear whether the NCVHS will recommend a new system in the near future under current law. As a result, CBO does not have a basis for determining whether the affected public and private entities would face additional costs.

Other Impacts

To different degrees, both acts would provide a number of benefits to state and local governments: savings and additional federal funding for Medicaid programs, prescription drug assistance for state pharmaceutical programs, and funding for a variety of state, local and tribal health programs.

Medicaid and SCHIP. Both acts would result in a net savings for state Medicaid programs. On the one hand, state Medicaid programs would benefit as the costs of prescription drugs for certain individuals who are eligible for both Medicaid and Medicare shift from Medicaid to Medicare. However, some of these savings would be offset by new administrative requirements related to eligibility determinations and by additional Medicaid spending for new enrollees. Some of the states' savings would be reduced under H.R. 1 as the federal government would reduce Medicaid payments to states to recover some of those savings. Both acts also would increase federal payments to states for disproportionate share hospitals in the Medicaid program. CBO estimates that the net savings to states from those and other provisions would total about $44 billion over the 2004-2013 period under H.R. 1 and about $20 billion over the 2004 -2013 period under S. 1.

State Pharmaceutical Programs. In both acts, state pharmaceutical assistance programs could qualify for subsidies and cost-sharing payments for individuals in their programs. As a result, CBO estimates that states would save at least $450 million a year, beginning in 2006.

Other Provisions. H.R. 1 would extend municipal health service demonstration projects through 2009, and it would provide an additional five-year period of funding for grants in the Medicare Rural Hospital Flexibility Program. S. 1 would appropriate $250 million annually for fiscal years 2005-2008 for formula grants to states for emergency health services furnished to undocumented aliens. It also would authorize $25 million annually through 2008 for grants to states for rural hospitals, and it would broaden reimbursement categories for tribal hospitals that provide services to Medicare Part B beneficiaries. Finally, S. 1 would provide for loan guarantees and financial assistance for improvements in health care infrastructure, and it would establish a revolving loan program to make and guarantee loans in rural areas.

EFFECT ON THE PRIVATE SECTOR

S. 1 and H.R. 1 each contain several private-sector mandates. CBO estimates that the direct cost of the requirements in S. 1 would exceed the annual threshold specified in UMRA ($117 million in 2003, adjusted annually for inflation) in each of the years from 2006

through 2013. For reasons described below, we are not able to provide a precise estimate of those costs. CBO is uncertain whether the direct cost of the requirements in H.R. 1 would exceed the annual threshold specified in UMRA.

Both acts would impose new requirements on private-sector health insurers that offer supplemental (medigap) policies to Medicare beneficiaries. Under S. 1, insurers would not be allowed to offer policies that include prescription drug coverage to any Medicare beneficiary who enrolls in the new Part D program. Under H.R. 1, insurers would not be allowed to offer existing types of coverage that include prescription drugs to any Medicare beneficiary who is not already enrolled in one of those plans by 2006. However, H.R. 1 would allow insurers to offer two new types of supplemental coverage that would complement the new Part D drug coverage. Both bills also would require insurers who sell medigap policies that do not contain prescription drug coverage to make those policies available, just as they do to seniors newly eligible for Medicare, to any beneficiary who enrolls in the new Part D program and who, at the time of enrollment in Part D, held a medigap policy that included prescription drug coverage.

Under current law, CBO estimates that approximately 3 million Medicare beneficiaries will purchase medigap policies that cover prescription drugs in 2006. Under S. 1, while CBO estimates that nearly all of those beneficiaries would enroll in Medicare Part D, most would also continue to purchase supplemental drug coverage if it remained available. The cost of the mandate that would ban medigap policies that include drug coverage would be the forgone profit of insurers who would otherwise have provided those policies. But most beneficiaries who would otherwise have purchased a medigap plan with drug coverage would, under the act, purchase a medigap plan without such coverage. CBO estimates that the net effect of these two factors would be a reduction in profits of $20 million for medigap insurers in 2006. In addition, CBO estimates that, under S. 1, the reduction in insurers' profits attributable to the requirement that those who offer medigap plans without drug coverage offer those plans on favorable terms to beneficiaries who formerly held a medigap drug plan would be about $130 million in 2006. The sum of these two mandate costs would rise from about $150 million in 2006 to $280 million in 2013.

Under H.R. 1, CBO estimates that most beneficiaries who would be barred from purchasing existing medigap plans that include drug coverage would purchase the newly available medigap plans with drug coverage, so that the net cost to insurers of not allowing them to issue the existing plans would be small. Similarly, CBO estimates that relatively few beneficiaries who would otherwise have purchased medigap plans with drug coverage had they not been barred from doing so would purchase medigap plans without drug coverage under H.R. 1. Thus, the cost to insurers of the requirement to provide non-drug coverage on favorable terms would be small. CBO estimates that the direct cost of the medigap mandates in H.R. 1 would not exceed the $100 million threshold specified in UMRA.

Both acts also would impose new requirements on manufacturers of brand-name and generic drugs. Under the acts, generic and brand-name companies that enter into certain agreements that relate to generic drugs for which a paragraph IV certification under the Food, Drug, and Cosmetic Act have been filed with the FDA would have to submit those agreements to the Federal Trade Commission. H.R. 1 also would impose that requirement on agreements between generic drug companies. Although those requirements would impose administrative and legal costs on the affected entities, CBO estimates that the aggregate amount of the added expense would be small.

In addition, both acts would require group health plans that provide prescription drug coverage, including retiree prescription drug plans, to certify whether that coverage provides benefits at least equivalent to the benefits under Part D. Such a certification would be needed by enrollees who wanted to enter the Medicare drug benefit late because they had previously obtained coverage by the certifying plan. CBO estimates that the direct cost of that provision would be small.

S. 1 contains additional private-sector mandates. It would instruct the Secretary of Health and Human Services to develop standards for the electronic transmission of prescription information by health plans and health care providers. Plans and providers would not be required to transmit or receive prescriptions electronically, but those who did so would be required to comply with the standards. Prescribers and health plans also would be required to provide written prescriptions without additional charge if patients requested them. Because the specific requirements imposed under this provision would depend on future decisions and actions of the Secretary, CBO cannot determine their direct cost to the affected entities.

S. 1 also would expand an existing mandate on group health plans regarding the coverage of Medicare enrollees with end stage renal disease. Beginning in 2004, the act would extend from 30 months to 36 months the time period for which Medicare would be second payer (and the private plans would be the primary payers) for the expenses of Medicare enrollees with ESRD who are also covered by the group health plan. CBO estimates that the direct cost of this added requirement to private-sector plans would be about $30 million in 2004, rising to about $50 million in 2013.

In addition, S. 1 would extend through 2013 customs user fees that are scheduled to expire at the end of fiscal year 2003 under current law. The Unfunded Mandates Reform Act does not clearly specify how to calculate the cost of extending an existing mandate that has not yet expired. Under one interpretation, UMRA requires that the direct cost be measured relative to an assumption that the current mandate will not exist beyond its current expiration date. Under that interpretation, CBO estimates that the direct cost would be $1.3 billion in

2004, rising to $2.3 billion in 2013. Under the other interpretation, UMRA requires the direct cost be measured relative to the mandate currently in effect. Under that interpretation, the direct cost of this provision would be zero.

Finally, S. 1 would instruct the Secretary of HHS to issue regulations permitting pharmacists and wholesalers to import prescription drugs from Canada. If those regulations went into effect, an additional provision would be triggered that would require manufacturers of prescription drugs not to discriminate against a pharmacist or wholesaler. Manufacturers would be considered to discriminate if they entered into a contract for sale of a drug, placed a limit on the supply, or employed any measure that would provide the drug to the pharmacist or wholesaler on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser. This requirement would potentially impose a significant new mandate on drug manufacturers and could have considerable effects on drug pricing, both domestically and internationally. However, as discussed earlier, CBO assumes that if S. 1 were enacted, the Secretary would not implement these regulations and the requirement not to discriminate would not be imposed. Thus, CBO estimates that the direct cost of this potential new requirement on prescription drug manufacturers would be zero.

H.R. 1 contains additional mandates. Under current law, the Secretary of HHS is required to rely on the recommendation of the National Committee on Vital and Health Statistics (NCVHS) when establishing coding standards for collecting and reporting health data by public and private health plans and health care providers. H.R. 1 would allow the Secretary to establish a new coding system in the absence of a recommendation by the NCVHS. This expanded authority could increase the cost of an existing mandate on public and private health plans and providers regarding the coding system they must use. It is unclear, however, whether the Secretary would actually require the implementation of a new coding system in the absence of a recommendation from the NCVHS, and it also is unclear whether the NCVHS will recommend a new system in the near future under current law. As a result, CBO does not have a basis for determining whether the affected private entities would face additional costs under the act.

H.R. 1 also would bar group health plans from requiring dental providers to obtain a claims determination from Medicare for dental benefits specifically excluded from Medicare coverage as a condition for obtaining a claims determination for such benefits under the group health plan. CBO estimates that direct cost of this requirement would be small.

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TABLE 13. ESTIMATED IMPACT ON DIRECT SPENDING OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AS PASSED BY THE HOUSE OF REPRESENTATIVES ON JUNE 27, 2003

	By Fiscal Year, Outlays in Billions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Medicare Outlays											
Title I: Medicare Prescription Drug Benefit	0.2	1.6	27.0	39.0	43.1	48.1	53.6	60.0	67.1	75.4	415.0
Title II: Enhanced Fee-For-Service, Medicare Advantage, and Competition	0.7	1.0	0.7	0.6	0.7	0.7	0.8	0.9	0.8	0.7	7.5
Title III: Combatting Waste, Fraud, and Abuse											
301 Medicare secondary payor provisions	-0.4	-0.6	-0.8	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2	-1.3	-8.9
302 Competitive acquisition of certain items and services	0	-0.2	-0.5	-0.8	-1.0	-1.1	-1.2	-1.3	-1.5	-1.6	-9.2
303 Competitive acquisition of covered outpatient drugs and biologicals	0	-0.4	-0.4	-0.8	-1.1	-1.5	-1.8	-2.1	-2.5	-2.9	-13.4
304 Recovery audit contractor demonstration	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Title III	-0.4	-1.1	-1.7	-2.4	-3.0	-3.6	-4.0	-4.5	-5.1	-5.8	-31.4
Title IV: Rural Health Care Improvements											
401 Hospital inpatient: DSH adjustment	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	2.1
402 Hospital inpatient: equalize standardized amount	0.5	0.6	0.7	0.7	0.8	0.8	0.9	0.9	1.0	1.1	7.9
403 Hospital inpatient: essential rural hospital	0	*	*	*	*	*	*	*	*	0.1	0.4
404 Hospital inpatient: more frequent market basket updates	0	0	0	0	0	0	0	0	0	0	0
405 Critical access hospitals	*	0.1	0.1	0.1	0.1	*	*	*	*	*	0.5
406 Redistribution of unused resident positions	0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.5
407 HOPD PPS: small rural and sole community hospitals	0.1	0.2	*	0	0	0	0	0	0	0	0.3
408 Skilled nursing facilities: PPS health center exclusion	*	*	*	*	*	*	*	*	*	*	0.1
409 Hospice: authorize nurse practitioners	*	*	*	*	*	*	*	*	*	*	0.1
410 Ambulance: rural payments (lowest quartile)	*	*	*	*	*	*	*	*	0.1	0.1	0.4
411 Home health: extend rural update	*	0.1	0.1	0	0	0	0	0	0	0	0.2
412 FQHC: safe harbor	0	0	0	0	0	0	0	0	0	0	0
414 Sole community hospitals: missing cost reports	0	*	*	*	*	*	*	*	*	*	0.1
415 Telemedicine demonstration extension	*	*	*	*	0	0	0	0	0	0	*
416 Hospital inpatient: labor share of wage index	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	5.4
417 Physician: incentive payments	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.8	6.0
418 Rural hospice demonstration	*	*	*	*	*	*	*	*	*	*	*
Subtotal, Title IV	1.8	2.2	2.2	2.2	2.4	2.5	2.6	2.8	3.0	3.2	24.9
Title V: Part A											
501 Hospital inpatient: acute care hospital updates	-0.3	-0.7	-1.1	-1.2	-1.2	-1.3	-1.4	-1.5	-1.6	-1.7	-12.0
502 Hospital inpatient: new technologies under PPS	0	0	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.4	2.5
503 Hospital inpatient: Puerto Rico federal rates	*	*	*	*	*	*	*	0.1	0.1	0.1	0.4
504 Hospital inpatient: wage index adjustment	*	*	*	*	*	*	*	*	*	*	0.4
505 MedPAC report on specialty hospitals	0	0	0	0	0	0	0	0	0	0	0
511 Skilled nursing facility payments	*	*	0	0	0	0	0	0	0	0	*
512 Coverage of hospice consultation services	*	*	*	*	*	*	0.1	0.1	0.1	0.1	0.5
513 Correction of Trust Fund holdings	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Title V	-0.2	-0.6	-0.8	-0.8	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2	-8.3

Continued

TABLE 13. Continued

	By Fiscal Year, Outlays in Billions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Title VI: Part B											
601 Physician: update revisions	0.6	1.2	0.8	0.2	-0.4	-0.6	-0.6	-0.7	-0.5	0.3	0.2
604 Inclusion of podiatrists and dentists in private contracting	*	*	*	*	*	*	*	*	*	*	*
605 Physician: work GPCI floor	0.2	0.3	0.1	0	0	0	0	0	0	0	0.6
611 Preventive physicals	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	2.3
612 Cholesterol and blood lipid screening	0	0.1	0.1	*	*	*	*	*	*	*	0.3
613 Waive deductible for colorectal cancer screens	*	*	*	*	*	*	*	*	*	*	*
614 Mammography payments	*	*	*	*	*	*	*	*	*	0	0.2
621 HOPD PPS: payment reforms	0.3	0.4	0.3	0.1	0	0	0	0	0	0	1.1
622 Ambulance: payments	*	*	*	*	*	*	0	0	0	0	0.2
623 Dialysis	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	1.2
624 Therapy: one year moratorium on cap in 2004	0.4	0.1	0	0	0	0	0	0	0	0	0.5
625 Ambulatory surgical centers: payment adjustments	*	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.4	-2.1
626 P&O: payments for shoes and inserts	*	*	*	*	*	*	*	*	*	*	-0.1
627 Waive late enrollment penalty for military retirees	*	*	*	*	*	*	*	*	*	*	0.2
628 Part B deductible	-0.1	-0.2	-0.4	-0.6	-0.8	-1.1	-1.4	-1.8	-2.1	-2.5	-11.2
629 Extend coverage of intravenous immunoglobulin	*	*	*	*	*	*	*	*	*	*	0.1
630 Diabetes laboratory diagnostic tests	*	*	*	*	*	*	*	*	*	*	*
631 Demonstration for certain drugs and biologicals	*	0.1	0	0	0	0	0	0	0	0	0.1
Subtotal, Title VI	1.7	2.3	1.2	-0.1	-1.0	-1.5	-1.9	-2.3	-2.4	-2.1	-6.2
Title VII: Parts A and B											
701 Home health: update	-0.1	-0.3	-0.3	-0.4	-0.5	-0.5	-0.6	-0.7	-0.7	-0.8	-4.9
702 Home health: copay	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-2.1
704 Home health: homebound demonstration	*	0.1	*	0	0	0	0	0	0	0	0.2
711 Direct graduate medical education: extend update limitation	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-1.3
721 Chronic care management: fee-for-service	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5
722 Chronic care management: Medicare Advantage	*	*	*	*	*	*	*	*	*	*	0.1
732 Home health: medical adult day care demonstration	0	0	0	0	0	0	0	0	0	0	0
733 National and local coverage determinations	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
734 Pathology: grandfather	0.1	0.1	0.1	0.1	0.1	*	0	0	0	0	0.5
735 Pancreatic islet cell transplants	*	*	*	*	*	*	*	*	*	*	0.1
736 Demonstration for consumer-directed care	0	*	*	*	*	*	*	*	*	0.1	0.3
Subtotal, Title VII	-0.1	-0.2	-0.3	-0.4	-0.5	-0.7	-0.8	-0.9	-1.0	-1.1	-5.9
Title VIII: Medicare Benefits Administration	0	0	0	0	0	0	0	0	0	0	0
Title IX: Regulatory Reduction and Contracting Reform	*	*	*	*	*	*	*	*	*	*	*
Subtotal, Gross Medicare Outlays	3.7	5.3	28.3	38.2	40.8	44.7	49.4	54.9	61.3	69.1	395.6
Premium Collections	-0.5	-0.5	-0.2	0.3	0.6	0.9	1.1	1.3	1.4	1.5	6.0
Subtotal, Net Medicare Outlays	3.1	4.8	28.1	38.5	41.5	45.6	50.5	56.2	62.7	70.7	401.6
Medicaid Outlays											
Title X: Medicaid											
1001 Increase DSH payments	0.9	0.8	0.7	0.6	0.4	0.3	0.1	0	0	0	3.8
1002 Clarification of best price exemption	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Title X	0.9	0.8	0.7	0.6	0.4	0.3	0.1	0	0	0	3.8

Continued

TABLE 13. Continued

	By Fiscal Year, Outlays in Billions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Other Direct Spending											
Title XI: Access to affordable pharmaceuticals	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.2	-0.8
Total Changes in Direct Spending											
Estimated Outlays	4.1	5.5	28.8	39.0	41.9	45.8	50.5	56.1	62.6	70.5	404.6

SOURCE: Congressional Budget Office.

NOTES: Components may not sum to totals due to rounding.
This table does not include sections that would affect spending subject to appropriation.

* = costs or savings of less than $50 million.

DSH = disproportionate share hospital
FQHC = Federally-qualified health center
GPCI = geographic practice cost index
HOPD = hospital outpatient department
MedPAC = Medicare Payment Advisory Commission
P&O = prosthetics and orthotics
PPS = Prospective Payment System

TABLE 14. ESTIMATED IMPACT ON DIRECT SPENDING OF S.1, THE PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003, AS PASSED BY THE SENATE ON JUNE 27, 2003 (WITHOUT SECTION 133)

	By Fiscal Year, Outlays in Billions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Changes in Direct Spending											
Title I: Medicare Prescription Drug Benefit (without section 133)	0.5	1.0	24.6	38.9	45.3	50.8	55.6	61.5	68.0	75.6	421.8
Title II: MedicareAdvantage	*	*	0.3	0.5	0.7	2.5	3.3	3.4	3.7	3.9	18.3
Title III: Center for Medicare Choices	0.2	0.5	0.9	1.1	1.1	1.2	1.2	1.3	1.4	1.5	10.2
Title IV: Medicare Fee-For-Service Improvements											
401 Hospital inpatient: equalize standardized amount	0.5	0.6	0.7	0.7	0.8	0.8	0.9	0.9	1.0	1.1	7.9
402 Hospital inpatient: labor share of wage index	0	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7	0.7	5.0
403 Hospital inpatient: low-volume adjustment	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	1.9
404 Hospital inpatient: rural DSH adjustment	0	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	3.0
405 Critical access hospitals	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	1.1
406 Hospice: authorizing use arrangements (traveling hospice)	0	0	0	0	0	0	0	0	0	0	0
407 Hospice: non-physician practitioners	0	*	*	*	*	*	*	*	*	*	0.1
408 Medical education: psychologists	*	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.4
409 Hospital inpatient: Puerto Rico federal rates	0	0.1	0.1	0.1	0.1	0.1	*	0	0	0	0.4
410 Geriatric fellowships	*	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.5
411 Dental graduate medical education	*	*	*	*	*	*	*	*	*	*	0.1
412 Hospital services provided to Indians	*	*	*	*	*	*	*	*	*	*	0.3
414 Rural community hospital demonstration	0	0	0	0	0	0	0	0	0	0	0
415 Critical access hospital demonstration	0	0	0	0	0	0	0	0	0	0	0
416 Grandfather long-term care hospitals	*	*	*	*	*	*	*	*	*	*	*
417 Treatment of certain entities (North Carolina counties)	0	0	0	0	0	0	0	0	0	0	0
418 Indirect medical education adjustment	*	*	*	*	*	*	*	*	*	*	0.3
419 Hospital inpatient: wage index revision	0	0	0	0	0	0	0	0	0	0	0
420 FQHC: conforming amendments	0	0	0	0	0	0	0	0	0	0	0
420A Hospitals with disproportionate indigent care revenues	*	*	*	*	*	*	*	*	*	*	0.1
421 Physician: wage index revisions (interacted with AWP)	0.2	1.0	1.5	1.6	0.6	0	0	0	0	0	4.8
422 Medicare incentive payment program	*	*	*	*	*	*	*	*	*	*	0.2
423 HOPD PPS: small rural and sole community hospitals	0	0	0.2	0.1	0	0	0	0	0	0	0.2
424 HOPD PPS: rural hospitals emergency and clinic visits	0	*	*	*	*	0	0	0	0	0	0.1
425 Ambulance: temporary increase	0	0.1	0.1	0.1	0	0	0	0	*	0	0.3
426 Ambulance: air ambulance coverage	0	*	*	*	*	*	*	*	*	*	0.1
427 Laboratory: payment to sole community hospitals	0	0.1	0.1	0	0	0	0	0	0	0	0.2
428 Rural health clinic reimbursement	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	1.5
429 Skilled nursing facilities: consolidated billing exclusions	0	*	*	*	*	*	*	*	*	*	0.3
430 DME and P&O: freeze payments for certain items	-0.1	-0.2	-0.3	-0.5	-0.7	-0.9	-1.1	-1.3	-1.4	-1.5	-7.7
431 Laboratory: coinsurance and deductible	-1.0	-1.4	-1.6	-1.7	-1.8	-1.9	-2.1	-2.2	-2.4	-2.6	-18.6
432 AWP (excluding ESRD provision)	-0.3	-0.6	-0.7	-1.0	-1.4	-1.7	-2.0	-2.3	-2.8	-3.3	-16.0
432 AWP ESRD provision	0	*	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	1.3
433 Increase Part B deductible	0	0	-0.6	-1.0	-1.1	-1.2	-1.4	-1.6	-1.8	-2.0	-10.6
434 Revisions to reassignment provisions	*	*	*	*	*	*	*	*	*	*	*
435 Pathology extension	0	0.2	0.1	0	0	0	0	0	0	0	0.3
436 Treatment of pass-through drugs	0	0.5	0.7	0.2	0	0	0	0	0	0	1.4
437 Limit application of functional equivalence standard	0	0	0	0	0	0	0	0	0	0	0
438 Routine costs associated with clinical trials	0	*	*	*	*	*	*	*	*	*	0.4
439 Waive late enrollment penalty for military retirees	*	*	*	*	*	*	*	*	*	*	0.2
440 Chiropractor demonstration	0	*	*	*	*	*	*	*	*	*	*
441 Health care quality demonstration	0	*	*	*	*	*	0	0	0	0	*
442 Complex clinical care management demonstration	0	*	*	*	0	0	0	0	0	0	*
443 Care coordination demonstration	0	*	0.1	0.1	0.1	0.1	*	0	0	0	0.2
445 Mammography	0	*	*	*	*	*	*	*	*	*	0.1

Continued

TABLE 14. Continued

		By Fiscal Year, Outlays in Billions of Dollars										
		2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
446	Outpatient vision services	*	*	*	*	*	*	*	*	*	*	*
448	Marriage and family therapists; mental health counselors	*	*	*	*	*	*	*	*	*	*	0.3
449	Physical therapy demonstration	0	*	*	*	0	0	0	0	0	0	0.1
450	Homebound demonstration	*	0.1	*	0	0	0	0	0	0	0	0.2
450A	Brachytherapy demonstration	*	*	*	*	0	0	0	0	0	0	*
450B	Total body orthotics	*	*	*	*	*	*	*	*	*	*	0.1
450C	Indian hospital and clinic reimbursement	0	*	*	*	*	*	*	*	*	0.1	0.3
450D	Cardiovascular screening	0	0.1	0.1	*	*	*	*	*	*	*	0.3
450E	Self-injectable biologicals	0.7	1.0	0	0	0	0	0	0	0	0	1.7
450F	ESRD Medicare Secondary Payor extension	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.5
450G	Internal Revenue Service deposits	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.8
450H	Telehealth	*	*	*	*	*	*	*	*	*	*	0.1
450I	Certified registered nurse first assistants demonstration	*	*	*	*	*	0	0	0	0	0	*
450J	Children's hospitals	*	*	*	*	*	*	*	*	*	*	*
450K	Physician services in Alaska	*	*	*	0	0	0	0	0	0	0	0.1
450L	Weight loss management demonstration	*	*	0	0	0	0	0	0	0	0	*
452	Home health: area wage adjustment factors	0	0	0.1	0.1	*	0	0	0	0	0	0.2
453	Physician referrals	0	0	0	0	0	0	0	0	0	0	0
456	Kidney disease education	*	*	*	*	*	*	*	*	*	*	0.3
457	Frontier extended stay clinic demonstration	*	*	*	*	*	*	*	*	*	*	0.2
458	National coverage determinations	0	0	0	0	0	0	0	0	0	0	0
459	Home health: rural add-on	0	0	0.1	0.2	*	0	0	0	0	0	0.4
461	Medicare Secondary Payor provisions	-0.4	-0.6	-0.8	-0.8	-0.9	-0.9	-1.0	-1.1	-1.2	-1.3	-8.9
462	Islet cell transplant demonstration	*	*	*	*	*	0	0	0	0	0	0.1
464	Sense of the Senate regarding physician payment updates	0	0	*	*	*	0	0	0	0	0	*
	Subtotal, Title IV	-0.1	2.5	1.4	-0.1	-2.5	-3.8	-4.7	-5.4	-6.2	-7.1	-26.1
	Premium Collections	0.1	-0.2	0.1	0.4	1.0	1.3	1.5	1.7	1.9	2.1	9.9
Title V:	Appeals, Regulatory, and Contracting Improvements	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
Title VI:	Other Provisions											
601-602	Increase Medicaid DSH payments	0.8	0.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	2.1
603	Medicaid DSH reporting requirements	0	0	0	0	0	0	0	0	0	0	0
604	Clarification of best price exemption	0	0	0	0	0	0	0	0	0	0	0
605	Medicaid/SCHIP coverage of certain legal immigrants	0	0.1	0.2	0.2	*	0	0	0	*	*	0.5
606	Consumer ombudsman	*	*	*	*	*	*	*	*	*	*	0.4
608	Health care infrastructure improvement	0	*	0	0	0	0	0	0	0	0	*
610	Emergency health services for undocumented aliens	0	0.1	0.2	0.3	0.3	0.1	*	0	0	0	1.0
611	Appropriation to HCFAC account	*	*	*	*	0	0	0	0	0	0	0.1
612	Civil penalties under the False Claims Act	0	0	0	0	0	0	0	0	0	0	0
613	Civil monetary penalties under the Social Security Act	0	0	0	0	0	0	0	0	0	0	0
614	Extension of customs user fees	-1.3	-1.5	-1.5	-1.6	-1.7	-1.8	-1.9	-2.0	-2.1	-2.3	-17.8
615	FQHCs and Medicare managed care	*	*	*	*	*	*	*	*	*	*	0.1
616	Advance directives	0	0	0	0	0	0	0	0	0	0	0
618	Extension of municipal health services demonstration	0	*	*	*	*	*	0	0	0	0	0.1
620	Citizens health care working group	0	0	0	0	0	0	0	0	0	0	0
623	Restoration of Hospital Insurance Trust Fund	0	0	0	0	0	0	0	0	0	0	0
626	Committee on drug compounding	0	0	0	0	0	0	0	0	0	0	0
630	Suspension of OASIS collection	0	0	0	0	0	0	0	0	0	0	0
631	Employer flexibility	0	0	0	0	0	0	0	0	0	0	0
632	FMAP increase for Native Hawaiians	*	*	*	*	*	*	*	*	*	*	0.2
633	Extension of Michigan IMD moratorium	*	*	*	*	*	*	*	*	*	*	*
634	GAO study on drug price controls in G-7 countries	0	0	0	0	0	0	0	0	0	0	0
635	Safety Net Organizations and Patient Advisory Commission	0	0	0	0	0	0	0	0	0	0	0
636	Protections for nursing home residents	0	0	*	*	*	*	*	0.1	0.1	0.1	0.3
	Subtotal, Title VI	-0.4	-0.3	-1.0	-1.0	-1.3	-1.5	-1.7	-1.8	-1.9	-2.1	-13.0

Continued

TABLE 14. Continued

	By Fiscal Year, Outlays in Billions of Dollars										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2013
Title VII: Access to affordable pharmaceuticals	*	*	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6
Title VIII: Importation of prescription drugs	0	0	0	0	0	0	0	0	0	0	0
Title IX: Drug Competition Act of 2003	*	*	*	*	*	*	*	*	*	*	-0.2
Total Changes in Direct Spending	0.3	3.4	26.3	39.8	44.3	50.4	55.2	60.6	66.7	73.9	421.1
MEMORANDUM:											
Outlays with Section 133											
Medicare Prescription Drug Benefit (Title I)	0.5	1.0	26.2	41.9	48.9	54.9	61.3	67.6	74.9	84.1	461.5
Total Direct Spending	0.3	3.4	27.9	42.9	48.0	54.5	60.9	66.7	73.7	82.5	460.7

SOURCE: Congressional Budget Office.

NOTES: Components may not sum to totals due to rounding.
This table does not include sections that would affect spending subject to appropriation or are duplicative.

* = costs or savings of less than $50 million.

AWP = average wholesale price
DME = durable medical equipment
DSH = disproportionate share hospital
ESRD = end-stage renal disease
FMAP = Federal medical assistance percentage
FQHC = Federally-qualified health center
GAO = General Accounting Office
HCFAC = Health Care Fraud and Abuse Control
HOPD = hospital outpatient department
IMD = Institution for Mental Diseases
P&O = prosthetics and orthotics
PPS = Prospective Payment System
SCHIP = State Children's Health Insurance Program