CBO's Analysis of the Health Insurance Initiatives in the *Mid-Session Review*

July 18, 2000

The President's *Mid-Session Review* of the budget incorporates modifications to the health insurance initiatives that were included in the budget submitted in February.[1] The Congressional Budget Office (CBO) estimates that those initiatives, as modified, would increase direct spending by $4.7 billion in 2001, $129 billion over the 2001-2005 period, and $429 billion over the 2001-2010 period (see Table 1).[2] The modified proposals would also reduce revenues by $9 billion through 2010. Because the proposals would affect direct spending and revenues, pay-as-you-go procedures would apply to them.

The President's budget does not include a request for appropriations to cover the administrative cost of establishing and operating the prescription drug benefit proposed for Medicare. Assuming that the necessary amounts are appropriated, CBO estimates that administrative spending for the prescription drug benefit would total $0.9 billion in 2001, $3 billion through 2005, and $6 billion through 2010.

POLICY CHANGES IN THE *MID-SESSION REVIEW*

The *Mid-Session Review* modifies the Administration's previous proposals for Medicare by:

- Expanding the proposed Medicare prescription drug benefit to include catastrophic coverage and starting the benefit in 2002 rather than 2003;

- Eliminating provisions in the February budget that would have reduced Medicare's payment rates for certain services (compared with baseline projections);

1. For details of the original initiatives and their cost, see Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001* (April 2000), and *A CBO Analysis of the Administration's Prescription Drug Proposal*, statement of Dan L. Crippen, Director, before the Subcommittee on Health, Committee on Ways and Means, May 11, 2000 (available at www.cbo.gov).

2. These estimates reflect the specifications of the President's proposals that underlie the estimates in the *Mid-Session Review*. On July 11, the Office of Management and Budget informed CBO that some of the drug spending for certain low-income beneficiaries that was assumed to be subsidized in the Administration's estimate would not, in fact, be subsidized. That difference would reduce the cost of the proposals by $17 billion over 10 years. CBO estimates that without those subsidies, direct spending would total $123 billion over the 2001-2005 period and $412 billion over the 2001-2010 period.

TABLE 1. TEN-YEAR ESTIMATES OF CHANGES IN SPENDING AND REVENUES IN THE PRESIDENT'S HEALTH INSURANCE PROPOSALS (In billions of dollars)

	Administration's Estimate	CBO's Estimate
Direct Spending		
Medicaid and SCHIP (Federal payments)		
FamilyCare	76.0	56.2
Other Medicaid/SCHIP proposals	14.4	18.1
Effect of Medicare prescription drug benefit	20.3	40.7
Effect of higher drug prices on Medicaid	0	1.4
Subtotal	110.7	116.4
Medicare		
Prescription drug benefit	232.4	297.0
Changes to traditional Medicare	17.9	26.8
Expanded eligibility for Medicare	2.9	0.2
Medicare competitive defined benefit	-11.9	-13.7
Subtotal	241.4	310.4
Other Federal Programs		
Diabetes research	0.3	0.3
Ricky Ray Hemophilia Relief Trust Fund	0.5	0.5
Effect of higher drug prices on FEHB program (For annuitants)	0	0.1
Subtotal	0.8	0.9
Social Security outlays for expanded eligibility for Medicare (Off-budget)	1.1	1.4
Total (Including off-budget)	354.0	429.1
Revenues		
Tax Credits for Expanded Eligibility for Medicare	-1.6	-8.4
Income Taxes and Medicare Payroll Taxes (On-budget)	0	-0.6
Social Security Payroll Taxes (Off-budget)	0	-0.3
Total (Including off-budget)	-1.6	-9.2
Spending Subject to Appropriations		
Medicare Administrative Costs for Prescription Drug Benefit	0	5.6
Total Budgetary Effect		
Decrease in the Total Budget Surplus Over 10 Years	355.6	443.9

SOURCE: Congressional Budget Office.

NOTE: SCHIP = State Children's Health Insurance Program; FEHB = Federal Employees Health Benefits program.

- Increasing payment rates for services furnished by hospitals, skilled nursing facilities, home health agencies, dialysis facilities, and Medicare+Choice plans (including paying for certain drug benefits offered by Medicare+Choice plans in 2001); and

- Earmarking about $20 billion over 10 years for unspecified policies to increase payments to providers.

The *Mid-Session Review* also includes new proposals to:

- Freeze each state's limit on Medicaid disproportionate share hospital (DSH) funds in 2001 at the 2000 level;

- Reduce the amounts that some veterans enrolled in Medicaid must pay for nursing home care; and

- Increase funds for diabetes research and the Ricky Ray Hemophilia Relief Trust Fund, which gives relief payments to certain people infected with the human immunodeficiency virus (HIV).

Finally, the *Mid-Session Review* proposals do not include two provisions from the President's February budget that have become law:

- A demonstration project to pay for services furnished to Medicare patients participating in clinical trials (the President issued an executive memorandum on June 7 requiring Medicare to pay for those services) and

- A school lunch initiative that will result in higher enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) and that was enacted as part of Public Law 106-224, the Agricultural Risk Protection Act of 2000.

Other health insurance provisions proposed in February (including FamilyCare, expanded eligibility for Medicare, and the Medicare competitive defined benefit) have not changed, and CBO has not reestimated their costs.

OVERALL ESTIMATES OF THE PRESIDENT'S INITIAL AND MID-SESSION PROPOSALS FOR HEALTH INSURANCE INITIATIVES

CBO previously estimated that the health insurance initiatives in the February budget would increase direct spending for Medicare, Medicaid, and SCHIP by about $166

billion through 2010 (see Table 2). The policies in the *Mid-Session Review* would cost an estimated $261 billion more, for a total of $427 billion.[3] Changes in the *Mid-Session Review* would also increase direct spending by other agencies by $2 billion over 10 years. Outlays for Social Security, which are off-budget, account for $1 billion of that 10-year total. (The President proposes to move Medicare's Hospital Insurance Trust Fund off-budget as well.)

Expanding the Medicare prescription drug benefit to include coverage of catastrophic drug spending and beginning the benefit a year earlier account for $182 billion of that increase. Those changes more than double the $160 billion estimated cost of the original prescription drug proposal.

Most of the remaining cost increase from the proposals in the *Mid-Session Review* results from dropping provisions that would have reduced payments to Medicare providers and adding provisions that would increase Medicare payments. The dropped policies would have saved an estimated $35 billion over 10 years, and the added policies would increase program spending by $40 billion over the same period. Thus, compared with the President's February proposals, those changes would increase Medicare spending over the coming decade by an estimated $75 billion—with payments to providers rising by almost $84 billion and beneficiaries' premiums growing by more than $8 billion.

COMPARISON OF CBO'S AND THE ADMINISTRATION'S ESTIMATES

Taken together, and including effects on revenues and discretionary spending, the President's health insurance initiatives would reduce the total surplus by $444 billion over the 2001-2010 period, CBO estimates (see Table 1). Of that amount, $116 billion would be spending for Medicaid and SCHIP, $310 billion for Medicare benefits, $2 billion for other federal programs, and $9 billion in forgone tax revenues. In addition, CBO estimates that the Congress would have to appropriate enough money for the Department of Health and Human Services to establish and administer the prescription drug benefit; such costs would total $6 billion through 2010.

The Administration, by contrast, estimates that the health insurance initiatives would reduce the total budget surplus by $356 billion over the 2001-2010 period. That estimate is $88 billion lower than CBO's figure, mainly because of differences in the estimated cost of the prescription drug benefit (including CBO's assumption that sufficient funds would be appropriated to administer the benefit). Although CBO estimates a higher cost for the prescription drug benefit than the Administration does,

3. CBO has made minor technical changes to its estimating methods since preparing estimates of the February budget proposals. Those changes account for a very small portion of the $261 billion difference.

TABLE 2. ESTIMATED EFFECT ON DIRECT SPENDING OF CHANGES IN THE PRESIDENT'S HEALTH INSURANCE PROPOSALS

	Ten-Year Cost (Billions of Dollars)
Medicare	
CBO's Estimate of February Proposals[a]	67.3
Changes in *Mid-Session Review*	
Expand prescription drug benefit[b]	167.6
Drop policies to reduce payment rates	34.9
Add policies to increase payment rates	40.5
CBO's Estimate of *Mid-Session Review* Proposals	310.4
Medicaid and SCHIP	
CBO's Estimate of February Proposals[a]	98.2
Changes in *Mid-Session Review*	
Expand prescription drug benefit[b]	14.6
Other changes and interactions[c]	3.6
CBO's Estimate of *Mid-Session Review* Proposals	116.4
Total (Medicare, Medicaid, and SCHIP)	
CBO's Estimate of February Proposals[a]	165.6
Changes in *Mid-Session Review*	
Expand prescription drug benefit[b]	182.2
All other changes	79.0
CBO's Estimate of *Mid-Session Review* Proposals	426.8

SOURCE: Congressional Budget Office.

NOTE: SCHIP = State Children's Health Insurance Program.

a. CBO's estimate of the February budget proposals reflects the estimate of the Medicare prescription drug benefit as revised in testimony presented before the Subcommittee on Health of the House Committee on Ways and Means on May 11, 2000.

b. Consistent with the estimates in the Administration's *Mid-Session Review*, this estimate assumes that subsidies for low-income beneficiaries will cover all of their costs each year in excess of the initial coverage limit but less than the annual out-of-pocket cap. If the President's proposal does not include coverage of those costs, CBO estimates that the change in direct-spending outlays from expanding the prescription drug benefit would be $163.3 billion over 10 years for Medicare, $1.5 billion for Medicaid, and $164.8 billion in total. CBO has made minor technical changes to its estimating methods since preparing estimates of the February budget proposals. Those changes account for a very small portion of the estimated cost of expanding the prescription drug benefit.

c. Includes the effects of dropping the school lunch initiative (because it was enacted), freezing DSH allotments, and interactions with Medicare provisions and with a proposal to change rules regarding the treatment of income for veterans in nursing homes.

that difference is partially offset by CBO's estimate that net federal outlays under the FamilyCare proposal would be $20 billion lower over the 2001-2010 period than the Administration anticipates.[4]

CBO'S ESTIMATES OF THE COST OF THE MEDICARE PRESCRIPTION DRUG BENEFIT

In February, the President proposed to create a voluntary outpatient prescription drug benefit under a new Part D of Medicare. As proposed in February, that benefit would begin in 2003 and be fully phased in by 2009. It would pay half of the cost of prescription drugs, up to a specified cap. The insured half of the benefit would be financed equally by premium payments from enrollees and by general tax revenues. After cost sharing and premiums are taken into account, enrollees would end up paying 75 percent of the cost of covered drugs and the government would pay 25 percent, up to the cap.

The premiums and cost-sharing payments of certain low-income Medicare beneficiaries would be subsidized through the Medicaid program. Subsidies would be available to beneficiaries who were fully eligible for both Medicare and Medicaid or had income below 150 percent of the poverty level. (People with income between 135 percent and 150 percent of the poverty level would receive only assistance with their premiums, on a sliding-scale basis.) The federal government would pay for subsidies for people who were fully eligible for both programs and for other beneficiaries with income below the poverty level at the normal Medicaid matching rate (57 percent, on average), with states paying the rest. Subsidy costs for other beneficiaries would be paid entirely by the federal government. The U.S. territories would not receive any additional funding for those subsidies.

In the *Mid-Session Review*, the President proposed to begin offering the prescription drug benefit in 2002 (so it would be fully phased in by 2008) and to add catastrophic coverage that would pay all of the cost of prescription drugs above a certain amount ($4,000 in out-of-pocket spending in 2002, increasing with inflation in drug prices thereafter). The cost of the catastrophic coverage would be financed entirely by general tax revenues. Consistent with the assumptions underlying the Administration's *Mid-Session Review* estimate, CBO's analysis assumes that Medicaid would subsidize drug spending between the initial coverage limit and the annual out-of-pocket cap for participating beneficiaries with income below 135 percent of the poverty level.

4. See Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001*.

Medicare and Medicaid Spending for the Prescription Drug Benefit

As proposed in the *Mid-Session Review*, the prescription drug benefit would increase direct spending for Medicare and Medicaid by $0.1 billion in 2001, $98 billion over the 2001-2005 period, and $338 billion over the 2001-2010 period, CBO estimates (see Table 3). By contrast, the Administration estimates that the prescription drug benefit would increase federal spending by $253 billion through 2010.

The bulk of estimated spending for the prescription drug benefit over 10 years ($297 billion) would come from Medicare. Payments for drug benefits would total an estimated $442 billion through 2010, but they would be partially offset by $152 billion in premiums paid by beneficiaries. In addition, Medicare would pay employers 67 percent of the premium-subsidy costs that it would have incurred if the retirees for whom employers are providing drug coverage had enrolled in Part D instead. CBO estimates that those subsidies would total $7 billion over the 2001-2010 period.

The President's prescription drug proposal would also increase net federal spending for Medicaid: by $12 billion through 2005 and $41 billion through 2010, CBO estimates. The premium and cost-sharing subsidies that Medicaid would pay for low-income Medicare beneficiaries would cost the federal government $65 billion over 10 years, but that increase would be partly offset by savings in Medicaid, because Medicare would replace Medicaid as the primary payer for drug spending for people who were fully eligible for both programs. The federal share of those Medicaid savings would total $50 billion through 2010, CBO estimates. In addition, Medicaid spending would rise by $24 billion over 10 years because the new drug benefit would induce more low-income Medicare beneficiaries to enroll in Medicaid and would require Medicaid to continue paying the Part B premium (at a 100 percent federal matching rate) for certain people who under current law would become ineligible after December 31, 2002. Finally, Medicaid's administrative spending would rise by $2 billion through 2010 because of the costs of administering subsidies and handling claims for new Medicaid enrollees.

In addition to direct spending for Medicare and Medicaid, the proposed drug benefit would necessitate additional administrative costs. If the benefit was implemented promptly, Medicare's administrative costs would amount to $0.9 billion in 2001, CBO estimates, to hire additional staff, promulgate regulations, contract with pharmacy benefit managers, buy computer systems, notify beneficiaries, and prepare the Social Security Administration to deal with millions of beneficiaries and the additional premium offsets against their Social Security benefits. Those administrative costs would total about $6 billion through 2010 if sufficient funds to establish and operate the benefit were appropriated.

TABLE 3. CBO'S ESTIMATE OF THE PRESIDENT'S *MID-SESSION REVIEW* PROPOSAL FOR A PRESCRIPTION DRUG BENEFIT IN MEDICARE (Outlays, by fiscal year, in billions of dollars)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001-2005	Total, 2001-2010
Direct Spending												
Medicare												
Benefits	0	20.1	30.8	36.8	41.9	48.3	54.3	61.9	69.8	78.2	129.6	442.2
Part D premium receipts	0	-7.5	-10.4	-13.0	-14.4	-17.0	-18.6	-21.5	-23.9	-26.1	-45.2	-152.3
Subsidy to health plans for retirees	0	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1	1.2	2.1	7.1
Subtotal	0	12.9	20.9	24.5	28.2	32.2	36.6	41.5	47.0	53.2	86.5	297.0
Medicaid (Federal)[a]												
Part D benefits and premiums	0	2.3	4.1	5.8	6.7	7.5	8.3	9.2	10.2	11.3	18.9	65.4
Change to current-law drug spending	0	-2.4	-3.5	-4.1	-4.7	-5.5	-6.2	-7.1	-8.0	-9.0	-14.7	-50.4
Part A/B benefits and premiums	0	0.5	1.3	2.3	2.7	2.9	3.1	3.4	3.6	3.9	6.8	23.7
Administrative costs	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.9	2.0
Subtotal	0.1	0.6	2.2	4.1	4.9	5.1	5.4	5.7	6.1	6.4	11.9	40.7
Total	0.1	13.5	23.1	28.6	33.0	37.3	42.0	47.2	53.1	59.7	98.4	337.7
Spending Subject to Appropriations												
Medicare Administrative Costs	0.9	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	3.0	5.6

SOURCE: Congressional Budget Office based on the March 2000 baseline.

a. Consistent with the estimates in the Administration's *Mid-Session Review*, this estimate assumes that subsides for low-income beneficiaries will cover all of their costs each year in excess of the initial coverage limit but less than the annual out-of-pocket cap. If the President's proposal does not include coverage of those costs, CBO estimates that direct-spending outlays for the prescription drug benefit would be as follows:

Medicare Outlays	0.0	12.8	20.7	24.1	27.7	31.7	36.1	40.8	46.3	52.5	85.3	292.7
Medicaid Outlays	0.1	-0.1	0.9	2.8	3.3	3.7	3.8	4.2	4.4	4.6	7.0	27.7
Total	0.1	12.7	21.6	26.9	31.0	35.4	39.9	45.0	50.8	57.0	92.3	320.4

Effect of the Prescription Drug Benefit on Other Federal Purchasers of Drugs

Medicare enrollees who spent enough on prescription drugs to trigger the catastrophic coverage would no longer have to be conscious of the price of drugs. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly drugs with no close substitutes. CBO estimates that after 10 years, the average price of drugs consumed by Medicare beneficiaries would be 8 percent higher if the President's proposal was enacted.

Those higher prices would also affect spending for prescription drugs by other federal programs, such as Medicaid, the Federal Employees Health Benefits (FEHB) program, and programs of the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the Coast Guard. CBO estimates that higher drug prices would add $1 billion over the 2001-2010 period to direct spending for Medicaid and for annuitants covered by the FEHB program. CBO has not estimated the higher discretionary spending needed by federal agencies (for current workers covered by FEHB) as well as by DoD, VA, PHS, and the Coast Guard. The net impact for active and retired postal employees over that period would be negligible.

Effect on Revenues

Higher drug prices would also lead to a loss of federal revenues from income and payroll taxes by raising the cost of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the decrease in revenues would amount to about $1 billion through 2010. Social Security payroll taxes, which are off-budget, account for $0.3 billion of that total.

CBO'S ESTIMATES OF THE COSTS OF CHANGES IN MEDICARE'S PAYMENT RATES

The Balanced Budget Act of 1997 holds the rate of increase in Medicare's payments for many services below the annual rate of inflation through 2002, with full adjustment for inflation resuming in 2003. In February, the President proposed to continue holding those payment increases below the rate of inflation through 2005. The *Mid-Session Review* proposals, however, dropped those provisions. They also eliminated provisions that would have reduced payments to compensate health care facilities for bad debt, that would have set up preferred provider organizations, and that would have modified the phase-in of improved methods of adjusting payments to Medicare+Choice organizations to reflect differences in financial risk based on the health status of their enrollees. Because those dropped provisions would have

reduced Medicare spending by $35 billion through 2010, spending under the policies of the *Mid-Session Review* would be higher by that amount.

In addition, the new proposals would increase Medicare's payment rates to hospitals, skilled nursing facilities, home health agencies, dialysis providers, and Medicare+Choice organizations in the following ways:

- Payment rates for hospital inpatient services would receive a full adjustment for inflation in 2001;
- A scheduled reduction in rates paid to teaching hospitals in 2001 would be canceled;
- A scheduled reduction in rates paid to hospitals that serve a significant number of low-income patients in 2001 would be canceled;
- Rates paid to hospitals in Puerto Rico would be increased;
- Rates for home health services would receive a full adjustment for inflation in 2001, and a 15 percent reduction in those rates would be postponed from 2002 to 2003;
- Rates for skilled nursing facilities would receive a full adjustment for inflation in 2001;
- Limits on payments to therapists would be postponed until 2002;
- Payment rates for dialysis services would be increased by 2.4 percent in 2001; and
- Medicare would pay for qualifying drug benefits offered by Medicare+Choice plans in 2001.

The proposal also earmarks about $20 billion over 10 years for unspecified policies to increase payments to providers. The estimate assumes that the those policies would, in fact, increase payments to providers by the earmarked amounts. CBO estimates that those provisions would increase Medicare spending by $40 billion over the 2001-2010 period.

ESTIMATES OF CHANGES AND INTERACTIONS IN MEDICAID AND SCHIP

Other effects of the *Mid-Session Review* proposals would increase Medicaid and SCHIP spending by nearly $4 billion over the 2001-2010 period, compared with CBO's estimate of the President's initial budget proposals. That increase reflects the deletion of the school lunch initiative (because it was enacted in P.L. 106-224), the addition of a proposal to change Medicaid's DSH allotments, and interactions with other policies. (The net effect of the school lunch initiative on Medicaid and SCHIP was negligible.)

Medicaid DSH

The Balanced Budget Act limits total Medicaid spending on DSH payments to fixed annual amounts that decline through 2002. The *Mid-Session Review* includes a proposal that would freeze each state's DSH allotment for 2001 at the 2000 level. That proposal would increase federal Medicaid spending by $0.3 billion in 2001, CBO estimates.

Veterans in Nursing Homes

The new proposals would also permanently extend a provision that allows people who receive both a veteran's pension and nursing home care from Medicaid to keep $90 of their pension each month instead of using it to defray nursing home costs. Under current law, that provision will expire at the end of 2002. CBO estimates that making the provision permanent would increase federal Medicaid spending by $0.9 billion over the 2001-2005 period and $2.5 billion through 2010.

Interactions with Medicare Provisions

Because Medicaid pays Medicare premiums and cost sharing for certain low-income beneficiaries enrolled in both programs, the proposed changes in Medicare's payment rates, which would affect premiums and cost sharing, would also have an impact on Medicaid spending. CBO estimates that those changes, in combination with the effect of higher prices for prescription drugs, would increase federal spending for Medicaid by $1 billion over 10 years (compared with CBO's estimate of the President's initial budget proposals).

ESTIMATES OF OTHER PROVISIONS

In addition, the *Mid-Session Review* proposes to add $475 million in mandatory funding to the Ricky Ray Hemophilia Relief Trust Fund in 2001 and to increase mandatory funding of diabetes research by a total of $300 million from 2003 through 2007. Those provisions would boost direct spending by $774 million over the 2001-2010 period, CBO estimates.

PROPOSED ACCOUNTING CHANGES AND INTRABUDGETARY TRANSACTIONS

The *Mid-Session Review* also contains two proposals regarding the budgetary treatment of Medicare's Hospital Insurance (HI) trust fund. One would transfer additional funds from the general fund of the Treasury to the HI trust fund; the other would place the receipts and outlays of that fund off-budget.

Transfers to the HI Trust Fund

The Administration proposes to assign an extra $115 billion to the HI trust fund over the next 10 years: $31 billion in 2001, $14 billion in 2002, and $70 billion between 2008 and 2010, over and above the income the fund would ordinarily receive. (The President's budget in February proposed larger transfers, totaling $299 billion over the 2001-2010 period.) These transfers are described as "interest savings resulting from devoting the Medicare surplus to debt reduction"—although, under current law, the trust fund is already credited with interest earnings on the surplus it generates.

Since the transferred amounts would not be needed immediately to pay benefits, they would add to trust fund balances and make the HI program appear more "solvent." But the solvency of a trust fund is not a meaningful measure of the government's ability to meet its future obligations because the fund's balances are not assets of the government. Rather, the government's ability to meet its long-term obligations to Medicare beneficiaries will depend on its overall fiscal condition. Under current policies, as the population ages, payroll tax collections will become inadequate to finance Medicare, which will have to be funded through general revenues and, eventually, through proceeds from borrowing. That will be true whether or not trust fund balances exist on paper.

The only way that today's lawmakers can make a set of future obligations more affordable for future generations is to take actions that enhance long-term economic growth. By themselves, legislated changes in trust fund balances would affect neither the size of the economy nor the resources available to the government

in the future. There is some risk, however, that larger trust fund balances could obscure the long-term fiscal threat posed by the aging of the population and deter needed reforms by giving lawmakers and the public a false sense of security.

Taking the HI Trust Fund Off-Budget

The Administration also proposes to change the budget categorization of the HI trust fund so that its receipts and outlays would be considered off-budget, like those of the Social Security trust funds. That change is intended to ensure that HI surpluses over the next 10 years "are not used for other purposes and therefore will be used to reduce the debt," according to the *Mid-Session Review*.

That proposed accounting change would have no effect on the economy. It would reduce on-budget surpluses while correspondingly increasing off-budget surpluses, but it would not, by itself, reduce the debt or change the government's financial position.

However, if the Congress and the President agreed to avoid on-budget deficits in future years, that accounting change might make the surpluses generated by the HI program (and any additional transfers from the general fund) less vulnerable to proposals to increase spending or reduce taxes. If taking the HI trust fund off-budget thereby increased the likelihood of maintaining projected budget surpluses and paying down debt held by the public, it would enhance long-term economic growth.

ADDITIONAL TABLES

SUMMARY OF CBO'S ESTIMATE OF THE PRESIDENT'S *MID-SESSION REVIEW* PROPOSALS FOR MEDICARE
(By fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001-2005	Total, 2001-2010
Gross Medicare Outlays (Direct Spending)													
Prescription Drug Benefit	0	0	0	31.3	37.4	42.6	49.1	55.2	62.9	70.9	79.4	131.7	449.3
Changes to Traditional Medicare	0	5.5	8.1	-1.0	2.4	2.7	2.9	2.6	2.2	1.8	1.6	17.8	28.9
Expanded Eligibility for Medicare	0	0	1.8	3.3	4.0	5.0	5.8	6.5	7.1	7.9	9.1	14.1	50.4
Medicare Competitive Defined Benefit	0	0	0	-1.9	-4.2	-7.2	-11.0	-12.5	-14.2	-16.1	-18.1	-13.3	-85.2
Total	0	5.5	30.3	31.8	39.7	43.0	46.9	51.7	58.0	64.7	71.9	150.3	443.5
Offsetting Receipts (Premiums)[a]													
Prescription Drug Benefit	0	0	0	-10.4	-13.0	-14.4	-17.0	-18.6	-21.5	-23.9	-26.1	-45.2	-152.3
Changes to Traditional Medicare	0	-1.4	-0.6	-0.2	-0.1	-0.1	-0.1	*	*	0.1	0.2	-2.4	-2.1
Expanded Eligibility for Medicare	0	0	-2.0	-3.2	-4.0	-5.0	-5.8	-6.4	-7.0	-7.9	-9.0	-14.2	-50.2
Medicare Competitive Defined Benefit	0	0	0	1.6	3.5	6.1	9.3	10.6	11.9	3.5	15.2	11.2	71.5
Total	0	-1.4	-10.1	-12.2	-13.5	-13.3	-13.5	-14.4	-16.5	-18.2	-19.9	-50.6	-133.1
Net Medicare Outlays (Direct Spending)													
Prescription Drug Benefit	0	0	0	20.9	24.5	28.2	32.2	36.6	41.5	47.0	53.2	86.5	297.0
Changes to Traditional Medicare	0	4.1	7.5	-1.1	2.3	2.6	2.8	2.6	2.2	2.0	1.7	15.5	26.8
Expanded Eligibility for Medicare	0	0	-0.2	*	*	*	0.1	0.1	0.1	0.1	*	-0.1	0.2
Medicare Competitive Defined Benefit	0	0	0	-0.3	-0.7	-1.1	-1.8	-2.0	-2.3	-2.6	-2.9	-2.1	-13.7
Total	0	4.1	20.2	19.6	26.2	29.7	33.3	37.3	41.5	46.5	52.1	99.7	310.4
Memorandum:													
Administrative Costs for Prescription Drug Benefit (Subject to appropriations)	0.9	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	3.0	5.6

SOURCE: Congressional Budget Office.

NOTE: * = between -$50 million and $50 million.

a. A reduction in offsetting receipts is equivalent to an increase in outlays.

DETAILS OF CBO'S ESTIMATE OF THE PRESIDENT'S *MID-SESSION REVIEW* PROPOSALS FOR MEDICARE: TRADITIONAL BENEFITS FOR CURRENT-LAW ENROLLEES (By fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001-2005	Total, 2001-2010
Fee-for-Service Updates													
Prospective payment system update	0	0.6	0.6	0.6	0.7	0.9	1.1	1.1	1.1	1.2	1.2	3.3	9.1
Indirect medical education adjustment	0	0.1	*	0	0	0	0	0	0	0	0	0.1	0.1
Disproportionate share hospital adjustment	0	0.1	*	0	0	0	0	0	0	0	0	0.2	0.2
Puerto Rico prospective payment system	0	*	*	*	*	*	*	*	*	*	*	0.1	0.3
Delay in therapy caps from 2001 to 2002	0	1.0	0.2	0.1	0	0	0	0	0	0	0	1.3	1.3
Home health adjustment	0	0	1.0	0.3	0.1	0.2	0.2	0.2	0.2	0.3	0.3	1.6	2.7
Skilled nursing facility adjustment	0	*	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.5	1.4
Dialysis adjustment	0	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	1.4
Fee-for-Service Modernization													
Centers of excellence	0	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.9
Disease management and primary care case management	0	0	*	*	*	*	*	*	*	*	*	*	*
Competitive acquisition	0	0	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.8
Contracting reform	0	0	0	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.8
Cost-Sharing Changes													
20 percent copayment for laboratory services	0	0	0	-0.5	-0.7	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.9	-6.4
Index Part B deductible to consumer price index	0	0	0	*	-0.1	-0.2	-0.3	-0.3	-0.4	-0.5	-0.6	-0.3	-2.4
Eliminate cost sharing for preventive services	0	0	0	0.6	0.8	0.8	0.8	0.9	0.9	0.9	1.0	2.1	6.6
Other Fee-for-Service Provisions													
Reduce EPO payment rate	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-1.2
MSP reporting by insurers	0	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.5	-1.3
Restrictions on partial hospitalization	0	*	*	*	*	*	*	*	*	-0.1	-0.1	-0.1	-0.3
Clarify partial hospitalization benefit	0	*	*	*	*	*	*	*	*	*	-0.1	-0.1	-0.3
Eliminate physicians' markup of outpatient drugs	0	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.0	-2.1
Reduce payments for bad debt	0	0	0	0	0	0	0	0	0	0	0	0	0
Reduce payment rates for four lab tests by 30 percent	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5	-1.2
National payment limit for prosthetics and orthotics	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.5	-1.3
Eliminate certain HPSA bonus payments	0	*	*	*	*	*	*	*	*	*	*	-0.2	-0.4
Cover 48 months of immunosuppressive drugs	0	*	*	*	*	*	*	*	*	*	*	*	0.2
Medicare+Choice													
Eliminate BBRA slowdown of phase-in of risk adjustment	0	0	0	0	0	0	0	0	0	0	0	0	0
Shift timing of payment from October to September 2002	0	0	3.9	-3.9	0	0	0	0	0	0	0	0	0
Interaction with changes in fee-for-service spending	0	0	0.3	0.1	*	*	*	*	*	-0.1	-0.2	0.3	0.1
Unspecified Policies													
Amount earmarked for increases in Part A spending[a]	0	1.2	1.3	1.4	1.4	1.5	1.5	1.4	1.3	1.2	1.1	6.7	13.0
Amount earmarked for increases in Part B spending[a]	0	0.7	0.7	1.0	1.0	1.1	1.1	1.0	0.9	0.8	0.8	4.4	9.0
Total (Gross mandatory Medicare outlays)	0	5.5	8.1	-1.0	2.4	2.7	2.9	2.6	2.2	1.8	1.6	17.8	28.9
Offsetting Receipts (Premiums)[b]	0	-1.4	-0.6	-0.2	-0.1	-0.1	-0.1	*	*	0.1	0.2	-2.4	-2.1
Net Medicare Outlays	0	4.1	7.5	-1.1	2.3	2.6	2.8	2.6	2.2	2.0	1.7	15.5	26.8

SOURCE: Congressional Budget Office.

NOTE: * = between -$50 million and $50 million; EPO = erythropoietin; MSP = Medicare as secondary payer; HPSA = health professional shortage area; BBRA = Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999.

a. After specifying the amounts earmarked for increases in Part A and Part B spending, the Administration added proposals to increase payment rates for hospitals in Puerto Rico and to increase funding for Ricky Ray grants. The Administration stated that the earmarked amounts would be reduced to offset the cost of those proposals. CBO adjusted the amounts earmarked for Part A and Part B to reflect its estimates of the Puerto Rico provision and the Ricky Ray provision, respectively.

b. A reduction in offsetting receipts is equivalent to an increase in outlays.

CBO'S ESTIMATE OF THE PRESIDENT'S *MID-SESSION REVIEW* PROPOSALS FOR MEDICAID AND SCHIP
(Federal outlays by fiscal year, in billions of dollars)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001-2005	Total, 2001-2010
Medicaid												
FamilyCare	0.2	-0.1	*	*	0.2	-7.3	-3.6	0.7	1.0	1.5	0.3	-7.4
Medicare Prescription Drug Benefit	0.1	0.6	2.2	4.1	4.9	5.1	5.4	5.7	6.1	6.5	11.9	40.7
Restore Eligibility to Certain Legal Immigrants	0.0	0.1	0.3	0.5	0.8	1.0	1.3	1.7	2.0	2.4	1.7	10.2
Other Medicaid Proposals and Interactions	0.3	0.3	0.6	0.7	0.8	0.9	1.0	1.2	1.3	1.6	2.7	8.7
Total	0.7	1.0	3.1	5.3	6.6	-0.3	4.2	9.3	10.4	11.9	16.6	52.1
SCHIP												
FamilyCare	-0.3	1.4	2.4	3.1	4.4	17.5	13.0	7.3	7.7	7.2	10.9	63.7
Other SCHIP Proposals	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Total	-0.3	1.4	2.4	3.1	4.5	17.5	13.1	7.4	7.8	7.3	11.2	64.3
Total (Medicaid and SCHIP)												
Total	0.4	2.4	5.5	8.5	11.1	17.2	17.2	16.7	18.2	19.2	27.8	116.4

SOURCE: Congressional Budget Office.

NOTE: * = between -$50 million and $50 million.