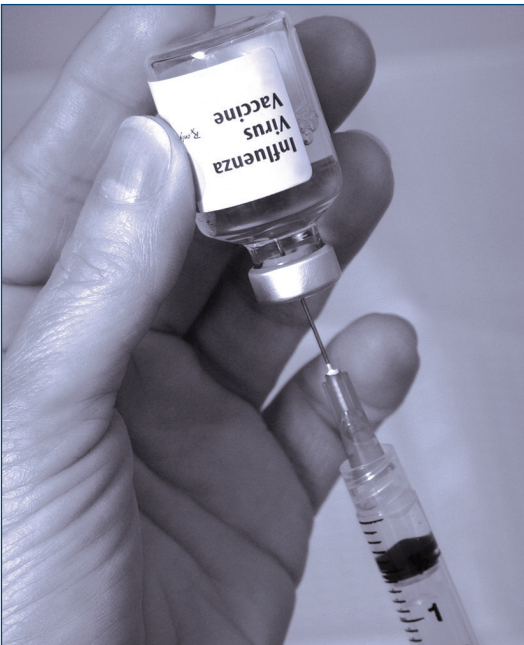


# CBO

## Budget Options Volume I Health Care

A photograph of a "HEALTH INSURANCE CLAIM FORM". The form contains various fields for patient information, including name, address, date of birth, sex, and insurance details. It also includes a section for the patient's signature and date.

DECEMBER 2008





**Budget Options  
Volume 1**

**Health Care**

December 2008

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## Notes

Unless otherwise indicated, all years referred to in this report are federal fiscal years, which run from October 1 to September 30.

The numbers in the text and tables are in nominal dollars (and thus do not reflect adjustments for inflation). Those numbers may not add up to totals because of rounding.

Some tables show an option's net effect on the federal budget deficit. In those cases, positive numbers mean an increase in the deficit, and negative numbers mean a decrease.

The estimates for budget options shown in this report may differ from any subsequent cost estimates for legislative proposals that resemble the options presented here.

On the cover: Influenza vaccine, photo by Jim Gathany, courtesy of the Centers for Disease Control and Prevention, Public Image Library; pills and claim form, images by Maureen Costantino; hospital, copyright JupiterImages; and U.S. Army surgeons, image courtesy of the Tripler Army Medical Center, Public Affairs Office. Cover design by Maureen Costantino.

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## Preface

**T**his volume—which expands on one of the Congressional Budget Office’s (CBO’s) regular reports to the House and Senate Committees on the Budget—presents 115 options for reducing (or, in some cases, increasing) federal spending on health care, altering federal health care programs, and making substantive changes to the nation’s health insurance system.

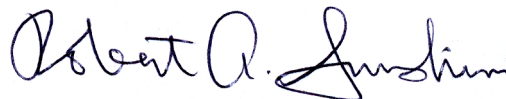
The options compiled for this volume stem from a variety of sources, including extensive discussions with Congressional staff; reviews of legislative proposals, the President’s budget, and academic literature; and analyses conducted by CBO staff, other government agencies, and private groups. Although the number of health-related policy options shown here is significantly greater than in previous *Budget Options* volumes, it is not an exhaustive list: Some options could not be included because of time constraints or analytical complexity. The inclusion or exclusion of a particular policy change does not represent an endorsement or rejection by CBO; to ensure impartiality, the discussion of each option summarizes arguments for and against it. In keeping with CBO’s mandate to provide objective analysis, the report makes no recommendations.

An introductory chapter provides an overview of the volume and offers some important context for understanding the options. Chapters 2 through 12 present those options, organized by broad themes (for example, payment for Medicare services, cost sharing in federal programs, and long-term care). Each chapter is introduced with a page of background information about the theme. The volume is available in multiple formats on CBO’s Web site ([www.cbo.gov](http://www.cbo.gov)).

This report is the product of an enormous effort involving more than three dozen members of the CBO staff over a period of many months. That effort was skillfully coordinated by Lara Robillard (of the Budget Analysis Division) and Lyle Nelson (of the Health and Human Resources Division). The volume was edited by Loretta Lettner and Leah Mazade. Appendix A lists the many CBO staff members who contributed to the report.

The Congressional Budget Office would like to thank the staff of the Medicare Payment Advisory Commission, the Centers for Medicare and Medicaid Services, the Engelberg Center for Health Care Reform at the Brookings Institution, and many others who provided invaluable assistance with data and analysis. In addition, CBO is grateful to the staff of the Joint Committee on Taxation—specifically, the health policy group—which prepared the revenue estimates for several options. CBO, however, is solely responsible for the content of this volume.

Finally, special thanks are due to CBO's former Director, Dr. Peter R. Orszag, who conceived the idea for this report and was instrumental in its development.

A handwritten signature in black ink that reads "Robert A. Sunshine". The signature is written in a cursive style with a large, stylized initial "R".

Robert A. Sunshine  
Acting Director

December 2008



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# Introduction

**E**very two years, the Congressional Budget Office (CBO) issues a compendium of budget options to help inform federal lawmakers about the implications of various policy choices. Because of the major fiscal and policy challenges associated with health care, CBO has expanded its work in this area and divided its *Budget Options* volume into two reports: this first volume focuses solely on budget options related to health care—including financing, delivery, and access—within federal programs and the larger health care system. The second volume, which will consist of options not related to health care, will be released in 2009. In addition, CBO has produced a companion report, *Key Issues in Analyzing Major Health Insurance Proposals*. Both this volume of budget options and *Key Issues* are designed to help policymakers better understand the trade-offs and choices inherent in making changes, large or small, to the American health care system and to federal health care programs.

*Key Issues* focuses on large-scale proposals and explains CBO's approach to analyzing numerous issues that could arise should the Congress seek to enact major changes to the health care system. This volume of health-related budget options does not analyze large-scale proposals but instead presents 115 specific options, encompassing a broad array of issues related to the financing and delivery of health care—more than double the number of health-related options included in the 2007 edition of *Budget Options*. Included are potential changes that would decrease spending and others that would increase it, as well as changes that would reduce or raise revenues. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Addressing health care issues will be crucial to closing the nation's looming fiscal gap—which is caused to a great extent by rising health care costs. Spending on health care has consumed an ever-increasing share of gross domestic

product (GDP) over the past 45 years, and its share will continue to rise unless changes occur to slow the trajectory (see Figure 1-1). If tax revenues as a share of GDP remain at current levels, additional spending for Medicare, Medicaid, and Social Security will eventually cause future budget deficits to become unsustainable.

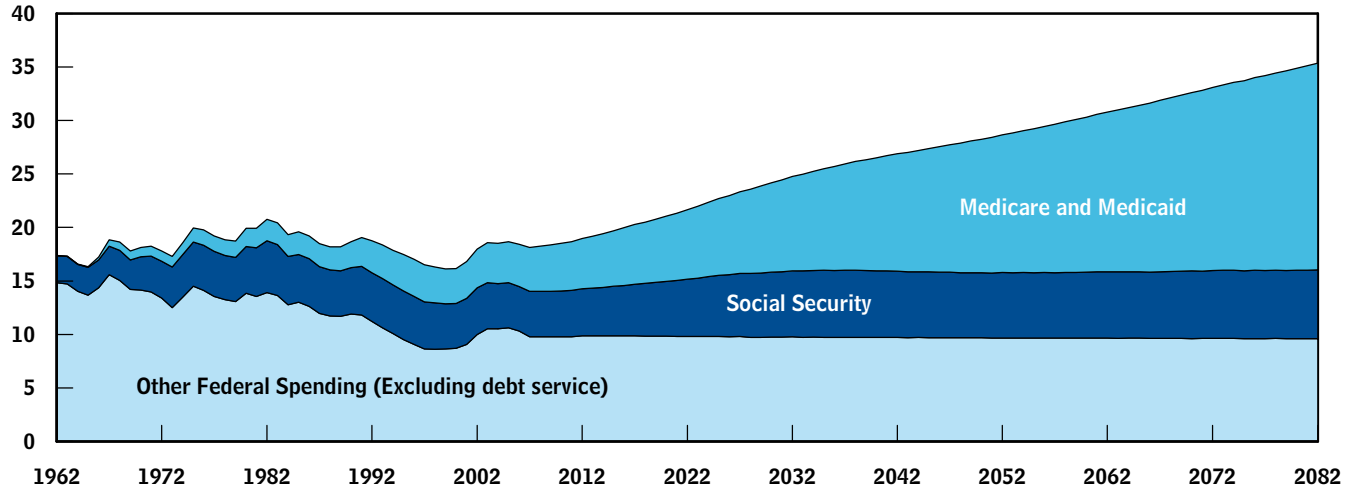
CBO projects that, without any changes in federal law, total spending on health care will rise from 16 percent of GDP in 2007 to 25 percent in 2025 and close to 50 percent in 2082; net federal spending on Medicare and Medicaid will rise from 4 percent of GDP to almost 20 percent over the same period. Many of the other factors that will play a role in determining future fiscal conditions over the long term pale by comparison with the challenges of containing growth in the cost of federal health insurance programs.

Concerns about the rising cost of health care would be less pressing if there was unambiguous evidence that greater spending meant better health outcomes or a higher quality of care. The evidence, however, suggests that the nation's increasing spending on health care may not be improving the quality of that care or health outcomes. In addition, the fact that clear geographic variations in health care spending lead to no corresponding differences in measured health outcomes suggests that the potential exists to reduce health care spending without affecting the quality of health care (see Figure 1-2).

Another challenge facing policymakers is the fact that roughly 45 million Americans lack health insurance. This volume analyzes several approaches to increasing health insurance coverage. Trying to improve access to, and the quality of, health care while simultaneously constraining spending is a difficult challenge, and the existence of millions of individuals without health insurance adds an extra layer of complexity to such efforts.

**Figure 1-1.****Projected Federal Spending Under One Fiscal Scenario**

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Note: The figure, from the December 2007 *Long-Term Budget Outlook*, portrays CBO's "alternative fiscal scenario," which deviates from the agency's baseline projections to incorporate some changes in policy that are widely expected to occur and that policymakers have regularly made in the past.

**The Options in This Volume**

The options presented in this volume would generate increases or decreases in federal spending or revenues and have different implications for overall spending on health care. Some would result in a reallocation of total costs among different sectors (the federal government, businesses, households, and state and local governments) rather than a change in overall costs; others would involve some combination of shifting among sectors and an increase or decrease in total costs.

In this volume, CBO has tried to be as comprehensive as possible, presenting options that would have a variety of effects. Some options would affect the behavior of individuals; others focus on the actions of health care providers. Still others would change government payment policies or alter the government's role in the health care system. The options are grouped in chapters, each focusing on a particular theme. Appendix B groups the options by major federal program, provider of services, or type of policy change.

For several options, the primary impact would be a potential improvement in the quality of health care,

rather than a reduction in spending, especially over the 10-year budget-projection window. This does not mean that there is no merit in pursuing options that primarily affect quality, rather than cost; it means, however, that some quality improvements, by themselves, might improve health outcomes but would not necessarily result in savings to the federal government, particularly in the short term. In some cases, the lack of estimated savings for an option may reflect the absence of evidence that wide-scale adoption would reduce spending measurably. In a few cases, there is no budget estimate for a particular option because CBO does not have sufficient basis to produce an estimate at this time. In those instances, the option includes a qualitative discussion.

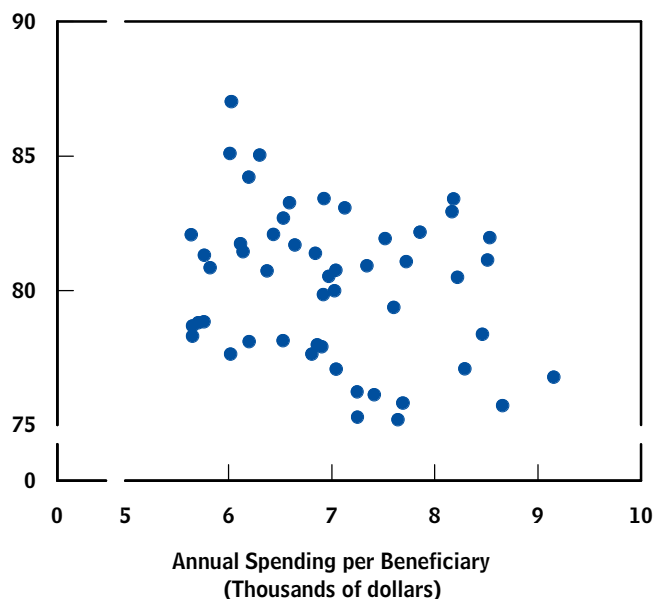
Each option is accompanied by a table showing the option's estimated effect on spending or revenues—some expressed in millions of dollars, others in billions—each year from 2010 to 2014, as well as the total effects over those five years and over the 2010–2019 period. (Estimated year-by-year effects on spending and revenues for the 2015–2019 period will be available with the Web version of this report at [www.cbo.gov](http://www.cbo.gov).) The subsequent discussion provides general background information; describes the policy change envisioned in the option;



**Figure 1-2.**

## The Relationship Between Quality of Care and Medicare Spending, by State, 2004

(Composite measure of quality of care, 100 = maximum)



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services and from the Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Quality Report, 2005* (December 2005), Data Tables Appendix, available at [www.ahrq.gov/qual/nhqr05/index.html](http://www.ahrq.gov/qual/nhqr05/index.html).

Notes: The composite measure of the quality of care, based on Medicare beneficiaries in the fee-for-service program who were hospitalized in 2004, conveys the percentage who received recommended care for myocardial infarction, heart failure, or pneumonia.

Spending figures convey average amounts by state.

identifies whether it would affect mandatory spending, discretionary spending, or revenues; and summarizes arguments for and against the change. When appropriate, the discussion includes references to related options elsewhere in this volume and to other relevant CBO publications.

For options that deal with mandatory spending, CBO estimated the budgetary effects relative to baseline levels of spending that are estimated to occur under current law. For options affecting discretionary spending, the changes

were calculated relative to the 2009 appropriations specified in the Continuing Resolution (Public Law 110-329), as adjusted for inflation. In all cases, the effects on spending were estimated by CBO. For most of the revenue options, budgetary effects were estimated by the staff of the Congress's Joint Committee on Taxation, which is responsible for estimating the impact of changes to the Internal Revenue Code. CBO estimates other revenue effects that do not involve changes to the tax code.

In general, estimates assume that a particular option would be enacted near the end of fiscal year 2009. The estimates take into account the time needed to implement each policy and the time needed for the effects to be fully phased in. For some options, implementation would be straightforward and could happen quite rapidly. Other options might take at least a few years to start or multiple years to be fully phased in. Thus, the effects of some options on federal spending over 10 years may seem modest because of small effects in the initial years. Effects for later years within the 10-year projection period may be instructive about how large the budgetary effects would be over a longer time period.

### Caveats

The estimates in this volume rely on CBO's current analysis of and judgment about the response of individuals, firms, and providers to changes in the health care system. These estimates are informed by the available economic and health research literature and by CBO's own work and analysis in this area. Many options rely on CBO's Health Insurance Simulation Model to generate the estimate.<sup>1</sup> When possible, CBO has estimated an option's impact on the number of individuals (presented as an average for a particular year) who have health insurance or who would participate in federal programs.

Every option involves some trade-off or redistribution between parties, whether individuals, businesses, providers, or the government (state or federal). Some options would yield significant federal savings but would represent dramatic changes for individuals or providers—for example, reducing the cost of a federal program but at the expense of its beneficiaries. Conversely, spending options

1. A more detailed description of the model can be found in Congressional Budget Office, *CBO's Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007).

might expand access to health insurance but do so inefficiently or with secondary effects on the system that policymakers might find unacceptable.

The budgetary effects of each option in this volume are estimated without reference to any other options. Those effects for a group of options cannot be added together to yield combined costs or savings because there could be significant interactions when options are combined. For example, a change in cost sharing for home health services covered by Medicare could also affect an option related to Medicare payments for home health, but the estimates provided here are for each option as a stand-alone proposal. A legislative package of several health options would almost surely result in interactions that would affect the budgetary results.

Throughout this document, CBO uses the term “mandate” to describe federal requirements regarding health care. The use of that term should not be interpreted to indicate that CBO has concluded those requirements meet the definition of “mandate” specified in the Unfunded Mandates Reform Act (UMRA). Some of the options that would affect state, local, or tribal governments or the private sector might involve federal mandates subject to UMRA. That act requires CBO to estimate the costs of any mandates that would be imposed by new legislation. The discussions of the options in this volume, however, do not address the costs of potential mandates to the entities that are subject to those mandates, nor do they attempt to quantify the impact of options on state spending. In addition, many options in this volume include assumptions about state responses to policy changes, which can be difficult to predict and can change over time in response to the fiscal condition of states and other factors.

The estimates of spending and savings presented in this volume are based primarily on CBO’s March 2008 baseline, except in instances where CBO was able to incorporate the effects of new data or legislation that substantially modified assumptions underlying that baseline. (For example, Medicare’s payments to physicians were altered by the Medicare Improvements for Patients and Providers Act of 2008, Public Law 110-275). CBO will update its baseline projections early in 2009. For all spending options, the budget estimate period is fiscal years 2010 through 2019, corresponding to the 10-year projection period that will be used during the next session of the Congress. Estimates prepared by the Joint Committee on Taxation are based on CBO’s March 2008 baseline and are for the period from 2009 through 2018; therefore, no 2019 effect is included for any revenue option.

Subsequent cost estimates by CBO or later revenue estimates by the Joint Committee on Taxation for legislative proposals that resemble these options may differ from the estimates shown here. One reason is that the policy proposals on which those later estimates would be based might not precisely match the options in this volume. Also, more detailed analysis in the future or the availability of additional data or research results could cause changes in the estimates. In addition, the baseline budget projections against which such proposals would ultimately be measured may differ because of legislative or administrative actions or because of other changes in CBO’s estimates. Finally, in some cases, CBO has not yet developed specific estimates of secondary impacts for some options that would primarily affect mandatory spending or revenues but that could also have other, less direct effects on the budget.

## The Private Health Insurance Market

In 2009, roughly 160 million people under the age of 65—or about three out of every five nonelderly Americans—are expected to obtain health insurance through an employer or another job-related arrangement, such as a plan offered through a labor union. That figure includes active workers, workers' spouses and dependents who are covered by family policies, and nonelderly retirees. About 70 million people, roughly a quarter of the nonelderly population, will not have access to employment-based coverage (because neither they nor a family member is offered such coverage). Most of those people are members of families whose income is less than two times the federal poverty level—that is, less than about \$40,000 for a family of four. (The average cost of health insurance premiums for employment-based policies for such a family is roughly \$13,000 per year.) About 10 million nonelderly individuals, in the Congressional Budget Office's estimation, will obtain insurance coverage through the individual insurance market. The great majority of those people do not have access to employment-based coverage.

Compared with the individual market, employment-based coverage offers several advantages, particularly for employees of larger firms. First, as discussed in Chapter 3, the tax treatment of employment-based insurance provides a subsidy from the government that substantially reduces the net cost of health insurance that is employment based. Second, administrative costs per enrollee can be reduced because of economies of scale. Sales and marketing costs for insurers are relatively fixed, so as the number of enrollees covered by an employer's policy increases, those fixed costs can be spread over a larger number of enrollees. As a result, the average premium needed to purchase a given amount of coverage is lower for employees of larger firms than for those of smaller firms, and premiums for a given amount of coverage are lower for employees of small firms than for people who purchase insurance individually.

Regulation of private health plans by federal and state governments differs for individually purchased insurance and employment-based plans and, among employment-based plans, for large firms and small firms (generally defined as those with 50 or fewer employees). State governments for the most part are responsible for regulating the business of insurance; as a result, any policy that an individual or a firm buys from an insurance company is regulated at the state level. (In general, state law also governs medical malpractice and the adjudication of malpractice claims.)

In some cases, however, federal legislation has established provisions that supersede or limit states' regulatory efforts. In particular, federal law exempts from state regulation any coverage that is offered by an employer that chooses to bear the financial risk of providing health insurance to its employees and their dependents; in those instances, the employer effectively serves as the insurer. Although any employer could make that choice, it is much more common among larger firms—those that have enough employees to form a more certain estimate of the costs they are likely to incur for an enrollee in such insurance.

As a result of that regulatory distinction, policies for individuals and most small employers must comply with requirements that vary by state regarding the benefits they must cover, the degree to which an insurer may vary the premiums it charges different people or firms and the factors that may be used to adjust those premiums, and other aspects of the policies. Health coverage provided through larger firms, by contrast, typically faces fewer regulatory or legal constraints regarding its benefits and premiums. Some federal rules do apply, however, including rules that prohibit an employer from varying the share of premiums that employees pay on the basis of their health status, that limit employers' use of exclusions for preexisting conditions, that require coverage of certain benefits, and that provide for a continuing offer of cover-

age to employees and family members who separate from an employer under certain circumstances.

2

In principle, anyone may purchase coverage in the individual insurance market—coverage for a single person or a family—but in practice, that option may be more attractive to some people than to others. (Such coverage is sometimes called nongroup insurance to distinguish it from group coverage, which is primarily employment based.) The potential for adverse selection, whereby an insurer ends up with a pool of enrollees who have unexpectedly high health care costs, may be greater in the individual market than in the employment-based market, in part because people can apply for individual insurance at any time—and may therefore wait until a health problem arises before seeking coverage—and in part because applicants do not have to be healthy enough to work. To address those possibilities, insurers usually “underwrite” the policy, a process by which they assess the health risk of applicants. Although most applicants are offered a standard premium rate (which usually varies by age), underwriting may result in adjustments to premiums or benefits (for example, to exclude coverage of known health conditions) or in denials of coverage. Some states, though, prohibit or limit those practices—which generally has the effect of reducing the premiums charged to older or less healthy applicants, compared with what they otherwise would have been, and raising the premiums charged to younger and healthier applicants. Many states have also established so-called high-risk pools, which offer subsidized insurance to people who have been denied coverage in the private market because of their health problems.

About 45 million people, or roughly 17 percent of the nonelderly population, will be uninsured at a point in

time in 2009, by CBO’s most recent estimates. (Those estimates for 2009 do not reflect the recent deterioration in economic conditions, however, which could result in a larger uninsured population.) The highest rates of uninsured—about 30 percent—are found among households whose income is below 200 percent of the federal poverty level. Among the households in that group that have insurance, those with income below the poverty line are much more likely to have public coverage, whereas households with income above the poverty line are more likely to have private insurance. Only about 12 percent of households below the poverty line have private coverage; that rate rises to more than 40 percent for those with income between 100 percent and 200 percent of the poverty level. By contrast, for households whose income is between 200 percent and 400 percent of the poverty level, about 75 percent have private coverage, and 16 percent are uninsured. Among households with income greater than 400 percent of the poverty level, over 90 percent have private coverage, and about 4 percent are uninsured.

This chapter presents options that address issues related to the cost of and access to health insurance (both group and nongroup) through the private market. It includes options that would potentially expand coverage by creating incentives for individuals to purchase coverage and for firms to offer coverage. In some cases, options could be adjusted to include greater or lesser subsidies or penalties so as to change both the number of people with insurance coverage and the federal costs of such interventions. Some of the options also examine issues associated with the regulation of health insurance at the state and federal levels and how changes to those regulatory structures might aim to lower costs and increase coverage.

**Option 1****Foster the Formation of Association Health Plans**

| (MILLIONS OF DOLLARS)                        | 2010     | 2011     | 2012     | 2013      | 2014      | Total     |            |
|--|----------|----------|----------|-----------|-----------|-----------|------------|
|  |          |          |          |           |           | 2010-2014 | 2010-2019  |
| Change in Mandatory Spending                 | 0        | -70      | -140     | -220      | -320      | -750      | -2,740     |
| Change in Revenues <sup>a</sup>              | 0        | -70      | -140     | -230      | -340      | -780      | -2,960     |
| <b>Net Effect on the Deficit<sup>b</sup></b> | <b>0</b> | <b>0</b> | <b>0</b> | <b>10</b> | <b>20</b> | <b>30</b> | <b>220</b> |
| Change in Discretionary Spending             |          |          |          |           |           |           |            |
| Budget authority                             | 0        | 5        | 10       | 16        | 16        | 47        | 137        |
| Outlays                                      | 0        | 5        | 10       | 16        | 16        | 47        | 137        |

- a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.
- b. Estimates exclude the potential effect of changes in discretionary spending.

The market for employment-based health insurance differs significantly for small and large employers. Small employers (generally defined as having 50 or fewer employees) typically purchase health insurance from carriers licensed by the state in which the firm is located. The coverage offered by such carriers is subject to state insurance regulations, both in terms of the benefits that must be offered and the premiums that can be charged. Large employers might also purchase coverage from licensed carriers, but they are far more likely to self-insure—assume the financial risk of their employees' health care costs—which allows them to avoid many state insurance regulations. Such regulations vary considerably from state to state.

In addition to being subject to state regulations, small employers generally incur higher costs when offering health insurance because they have fewer employees over which to spread the fixed costs associated with managing health insurance benefits. As such, they typically offer fewer benefits to their employees at higher cost than do large employers.

Under this option, health insurance carriers would be able to sell coverage to small employers through federally certified association health plans (AHPs). AHPs could be established by industry, professional, and trade associations as a vehicle for providing health care benefits to employees of businesses that are association members. Generally, AHPs would not have to cover state-mandated benefits and would be only partially subject to state rules that restrict the extent to which health insurance premi-

ums can vary within a state's small-group market. (That is, because they would only have to make their plans available to members of the association, state rules on premium variation would in general not apply to as broad a range of firms as is the case for traditional insurers that must follow statewide premium-rating rules in the small-group market.) Many firms would be able to pay lower health insurance premiums by purchasing coverage through AHPs rather than through the traditional small-employer health insurance market, where premiums reflect the full extent of state insurance regulations.

In the Congressional Budget Office's estimation, this option would boost the number of workers covered by employment-based health insurance. That increase in coverage would translate into higher spending for employers, which would be partly offset by a decrease in the average per capita cost of employment-based insurance (because policies would cover fewer mandated benefits). The net impact of those two changes would be a loss of federal tax revenues as compensation shifted from taxable wages to nontaxable fringe benefits. Enacting this option would reduce federal revenues by an estimated \$780 million over the 2010–2014 period and by about \$3.0 billion from 2010 to 2019.

At the same time, the new coverage would be extended to some workers and their dependents who would otherwise have been covered by Medicaid. As a result, the option would reduce federal spending on Medicaid by \$750 million over the 2010–2014 period and by about \$2.7 billion over the 2010–2019 period. The option's

combined effects on revenues and federal Medicaid spending would produce a small net increase in the federal deficit.

2 The main advantage of this option is that, by lowering the price of health insurance paid by some small employers, it would lead to an increase in the number of people with health insurance coverage—specifically, about 600,000 people would obtain employment-based coverage who otherwise would have been uninsured in 2014. In addition to encouraging otherwise uninsured people to purchase health insurance, it would also reduce the average price of coverage paid by people who enrolled in those plans but who were already insured through

small employers. That price reduction would be accomplished by offering less generous insurance benefits through AHPs (less generous than those a licensed insurance carrier would be required to offer) and by reducing the administrative costs of that insurance.

The main disadvantage of this option is that premiums in the regulated market would be somewhat higher than under current law because a disproportionate share of enrollees with lower-than-expected health care costs would leave the regulated market to obtain insurance through an AHP, thereby increasing the average expected health care costs of those remaining in the regulated market.

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**Option 2****Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State**

| (MILLIONS OF DOLLARS)            | 2010     | 2011        | 2012        | 2013        | 2014        | Total         |               |
|----------------------------------|----------|-------------|-------------|-------------|-------------|---------------|---------------|
|                                  |          |             |             |             |             | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending     | 0        | 10          | 20          | 30          | 50          | 110           | 380           |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>190</u>  | <u>400</u>  | <u>640</u>  | <u>910</u>  | <u>2,140</u>  | <u>7,810</u>  |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-180</b> | <b>-380</b> | <b>-610</b> | <b>-860</b> | <b>-2,030</b> | <b>-7,430</b> |

2

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Under current law, issuers of individual health insurance must be licensed in the state in which they offer such policies, and those policies must comply with the laws and regulations of that state. States have a variety of such restrictions that apply to individual health insurance, including protections for consumers; required coverage of specific services or benefits; and rules affecting the offer, sale, rating (or pricing), issuance, and renewal of those policies. States' laws and regulations can affect, for example, the extent to which premiums are allowed to vary on the basis of a person's age or health status, what benefits must be covered, how insurers may adjust premiums from year to year, and who, if anyone, may be denied coverage outright.

This option would permit an insurance carrier to choose one state in which to become licensed. As long as the carrier's individual health insurance policies complied with the insurance laws and regulations of that state, the carrier would be permitted to sell those policies in other states and to be exempted from the laws and regulations of those other states.

The option would have different effects depending on whether individuals were expected to spend a great deal or a small amount for health care and whether their own states' laws tightly or loosely restricted the rating and other features of health insurers' policies. For example, under this option, individuals who had a low risk of incurring substantial health care costs and who lived in states that restricted insurers' ability to price plans on the basis of their relatively healthy status might find better-priced health plans sold by out-of-state carriers. In addition, individuals who expected to use fewer health care services might be more likely to seek insurance from carriers licensed in states that had few requirements about benefits and covered services. Conversely, individuals who expected to have a significant need for health care

might prefer insurance sold in states that had laws ensuring that certain benefits and services would be covered. Such individuals might also prefer to buy those policies in states that restricted carriers from basing the price of a plan on an individual's health status. That dynamic could lead to conditions in which states that strictly regulated insurers attracted a more costly mix of enrollees than did states that had looser or fewer laws and regulations. In some instances, the rising premiums in those former states, to account for the more costly case mix, would result in a loss of coverage for some people. Over time, insurers located in those highly regulated states might need to raise their premiums or might consider leaving the market. As a result, highly regulated states might consider loosening their regulations in an attempt to reduce premiums for healthy enrollees and to retain insurers. (Whether they did so or not, premiums for individuals with high expected health care spending would be higher under the option.)

The net result of those responses would be more relaxed regulations overall, higher premiums for high-cost enrollees in tightly regulated states and lower premiums for low-cost enrollees in those states. Those changes could spur an increase in coverage by 2014 of an estimated 600,000 people among those with low expected spending and a decrease in coverage of 100,000 among those with high expected spending.

This option would also have an impact on the employment-based health insurance market. The new opportunities for some workers to purchase nongroup insurance in loosely regulated states might cause some employees to shift to the nongroup market, particularly employees in small firms located in highly regulated states. And some firms might be driven to drop their employment-based plans altogether. Some employees of those firms would obtain coverage in the nongroup market, but the Con-

gressional Budget Office estimates that, under the option, roughly 100,000 employees and their dependents would become uninsured by 2014. Those shifts in coverage would decrease the number of uninsured individuals overall, on net, by roughly 400,000 in 2014, once the effects of the option were fully realized.

The federal budget—specifically revenues—would be directly affected by those changes in coverage. Tax receipts would rise, on balance, mainly because of the net movement from the employment-based market to the nongroup market, which would include a shift in some compensation from nontaxable fringe benefits to taxable wages. The estimated gain in revenues would be \$2.1 billion between 2010 and 2014 and \$7.8 billion over the 10-year period from 2010 to 2019.

Federal outlays would rise by about \$400 million over the 2010–2019 period because a small number of individuals who would otherwise have been covered by employment-based insurance would be expected to enroll in the Med-

icaid program. Overall, this option would reduce the deficit by \$2.0 billion over the 2010–2014 period and by \$7.4 billion over the 2010–2019 period.

A rationale for this option is that state restrictions on premiums charged in the nongroup market make health care coverage more expensive for some individuals, thereby diminishing access to health insurance. This option would reduce the cost of coverage for those individuals by allowing insurers located in highly regulated states to choose to be regulated in states that had fewer or less restrictive rules. A second rationale is that the option could increase the number of insured individuals in the United States without using additional federal resources.

The option's main drawback is that it would weaken the ability of states to regulate their own health insurance markets. It also would lead to higher premiums for people who are expected to incur substantial health care costs.

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**Option 3****Impose a “Pay-or-Play” Requirement on Large Employers**

| (MILLIONS OF DOLLARS)            | 2010     | 2011          | 2012          | 2013          | 2014          | Total          |                |
|----------------------------------|----------|---------------|---------------|---------------|---------------|----------------|----------------|
|                                  |          |               |               |               |               | 2010-2014      | 2010-2019      |
| Change in Mandatory Spending     | 0        | -40           | -80           | -120          | -170          | -410           | -1,470         |
| Change in Revenues <sup>a</sup>  | 0        | 1,200         | 2,500         | 4,000         | 5,600         | 13,300         | 46,800         |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-1,240</b> | <b>-2,580</b> | <b>-4,120</b> | <b>-5,770</b> | <b>-13,710</b> | <b>-48,270</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

In 2009, about 160 million nonelderly individuals (people younger than 65 years old) are expected to be covered by health insurance offered by their employer, or a family member's employer, making employment-based insurance the leading source of health care coverage in the United States. Approximately 63 percent of employers offered health care benefits to their employees in 2008. Small employers were less likely than large employers to offer coverage. For instance, some 60 percent of employers with 50 or fewer workers offered coverage in 2008, compared with 94 percent of employers with between 50 and 200 workers and 99 percent of employers with more than 200 workers.

Under this option, employers with more than 50 employees would be required either to *pay* a set monthly fee, offsetting some of the government's costs of providing health care to the uninsured, or *play*, by offering their employees health insurance coverage that met a minimum standard. This option is similar to the pay-or-play requirement that Massachusetts established in July 2007, which compels employers with 11 or more employees to make a “fair and reasonable” contribution toward health insurance in order to meet the play requirement. Employers in Massachusetts that do not contribute to their employees' health insurance coverage must pay the government up to \$295 annually per employee.

Under this option, in order to meet the play requirement, large employers would have to offer their employees health insurance that met or exceeded a minimum actuarial standard and to contribute at least 50 percent of the total premium cost of both single and family coverage. Employers would have to offer coverage to both part-time and full-time workers. Employers that did not meet those requirements would be required to pay \$500 annually per employee to a federal agency. For illustrative purposes,

that fee is assumed to grow at the rate of inflation as measured by the consumer price index for all urban consumers. This option includes only a fee and does not subsidize any part of the pay-or-play requirement. Although employers could choose to offer more-generous policies, qualifying health insurance coverage would have to be at least as generous as a high-deductible health insurance policy combined with a tax-sheltered savings account that enrollees could use to finance out-of-pocket costs for health care services. For 2010, the maximum deductible would be \$1,100 for single coverage and \$2,200 for family coverage. Maximum out-of-pocket costs would be \$5,500 for single policies and \$11,000 for family policies.

This option would increase federal revenues by an estimated \$13 billion over the 2010–2014 period and by \$47 billion over the 2010–2019 period. That net increase would result from fees collected from employers that either did not offer coverage or offered coverage but did not pay at least 50 percent of the premium. Among employees working part- or full-time at firms with more than 50 employees, approximately 18 percent would not be offered employment-based health insurance coverage if the option took effect. Another 6 percent would be offered coverage, but their employers would contribute less than 50 percent of the cost of an individual policy, in the Congressional Budget Office's estimation. Two factors would offset part of that increase: lost revenues from additional people who were offered and took up employment-based coverage under the option (for whom compensation would be shifted from taxable wages to nontaxable fringe benefits); and lost revenues to the extent that employers paid lower wages than they otherwise would have to offset the fees they had to pay. The option would also reduce federal mandatory spending by an estimated \$1.5 billion over the 2010–2019 period because of decreased enrollment in Medicaid.

In 2014, the option would be expected to result in approximately 330,000 fewer uninsured individuals and about 90,000 fewer individuals enrolled in Medicaid.

2

That reduction in the number of uninsured people represents about 3 percent of the roughly 10 million individuals and dependents who are uninsured and work for (or are dependents of someone who works for) firms that would be directly affected by the mandate. If the fee was large enough to approach the cost of providing coverage, most firms would offer coverage. In that case, the reduction in the number of uninsured individuals would be much larger, and the net reduction in the deficit would be smaller.

An argument in support of this option is that it would probably increase the number of employers that offered health benefits—which is what happened in Massachu-

setts following implementation of that state's pay-or-play requirement. (In Massachusetts, however, the pay-or-play mandate was implemented along with an individual mandate to obtain insurance coverage.) Increasing the number of people who had access to employment-based insurance would reduce the number of people who were uninsured. Of people with access to employment-based insurance, about 8 percent are uninsured; among those without access, nearly 40 percent are uninsured.

An argument against this option is that it would impose a new cost on employers, even if their employees valued higher wages more than health insurance. Employers who chose to pay the fee rather than offer health benefits would be likely to offset at least some of those costs by paying lower wages or employing fewer people.

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**Option 4****Establish a National High-Risk-Pool Program**

| (MILLIONS OF DOLLARS)            | 2010     | 2011       | 2012       | 2013         | 2014         | Total        |               |
|----------------------------------|----------|------------|------------|--------------|--------------|--------------|---------------|
|                                  |          |            |            |              |              | 2010-2014    | 2010-2019     |
| Change in Mandatory Spending     | 0        | 500        | 1,000      | 1,600        | 2,300        | 5,400        | 19,600        |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>100</u> | <u>200</u> | <u>300</u>   | <u>400</u>   | <u>1,000</u> | <u>3,600</u>  |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>400</b> | <b>800</b> | <b>1,300</b> | <b>1,900</b> | <b>4,400</b> | <b>16,000</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Currently, 33 states have established high-risk pools that provide health insurance coverage to people who have difficulty obtaining coverage in the individual, or nongroup, health insurance market. In contrast to the employment-based group insurance market, where insurers provide coverage to a mix of people, regardless of whether they anticipate high or low levels of spending, nongroup market insurers (when allowed by state law) frequently assess the health status of applicants before deciding what premiums to charge or even whether to offer coverage at all. That practice mainly stems from the concern that people who seek nongroup insurance do so specifically because they anticipate high levels of health care spending. Features such as annual enrollment periods and employer subsidies, which do not exist under nongroup coverage, help minimize that phenomenon in employment-based insurance. To those in good health, nongroup insurers usually offer coverage at the standard premium rate (the average rate for applicants' age and sex). For less healthy applicants, insurers typically offer policies that exclude coverage for certain preexisting conditions or that have higher premiums—in some cases, up to twice the standard rate. For applicants in poor health, insurers may deny coverage altogether.

State-based high-risk pools generally offer subsidized health insurance to those who meet one or more of three criteria: those who have been denied coverage by one or more nongroup insurers; those who received offers of coverage only from nongroup insurers that charged a premium above a given percentage of the standard rate; and those individuals with certain "presumptive conditions"—such as AIDS—that would make them uninsurable in the nongroup market. To make the cost of coverage more affordable for participants, high-risk pools typically cap enrollees' premiums at 125 percent to 150 percent of the standard rate (although some high-risk pools charge up to 200 percent).

Because high-risk pools do not charge enough in premiums to cover the costs of the claims they pay, they require additional funds. In 2006, high-risk pools paid approximately \$600 million more in claims than they collected in premiums. To make up the difference, states usually subsidize their high-risk pools with state revenues, often from assessments on insurance companies. Since 2004, the federal government has provided additional subsidies to state high-risk pools that meet certain criteria, such as charging no more than 200 percent of the standard rate and requiring that enrollees have a choice of two or more coverage options within the pool. Those subsidies, in the form of seed grants for starting new high-risk pools and operating grants that cover pool losses, are relatively small, consisting of less than \$100 million in a given year.

This option would require that all states establish high-risk pools and provide full federal subsidies for each enrollee. Eligibility would be based on the three criteria noted above used by existing state pools. Enrollees would be responsible for paying premiums of up to 150 percent of the standard rate (adjusted for the enrollee's age and sex), and the federal government would pay for all excess premium costs above that amount. Because states with community-rated nongroup markets would not typically be eligible for those funds—because people in poor health can receive policies in community-rated states at the standard rate—this option would offer those states subsidies to lower the premiums for all nongroup enrollees. Subsidies to states would take the form of capped allotments determined by a formula based on the estimated number of uninsured individuals residing in the state who are in poor health.

This option would increase outlays by an estimated \$5.4 billion over the 2010–2014 period and by \$19.6 billion over the 2010–2019 period. Because some individuals with employment-based coverage would choose to

enroll in the risk pools provided under this option, tax revenues would increase as compensation shifted from nontaxable fringe benefits to taxable wages. As a result, the option would increase tax revenues by an estimated \$1.0 billion over the 2010–2014 period and by \$3.6 billion over the 2010–2019 period. The net effect would be to increase deficits by an estimated \$4.4 billion over the 2010–2014 period and by \$16.0 billion over the 2010–2019 period. The option would result in a net 175,000 additional people obtaining coverage in 2014 who otherwise would have been uninsured; that net change includes roughly 50,000 people who would lose coverage under the option as a result of their employers' ceasing to offer health insurance. About two-thirds of the federal subsidy would go to people who would have already had nongroup coverage (some of whom would also have been in high-risk pools) or who would have had employment-based coverage under current law.

A rationale for federally financed high-risk pools administered at the state level would be to expand insurance coverage options for those who were not eligible for either employment-based or public coverage and who would have had difficulty purchasing individual coverage because of their poor health status. Individuals in poor

health arguably are in the greatest need of health insurance and the access to care it could provide. Although a federal grant program currently exists to defray the start-up and operating costs of pools, only five states have begun high-risk pools since the grants became available, suggesting that additional federal financing might be needed to expand high-risk pools in more states. Finally, the subsidies provided for high-risk individuals could result in slightly lower premiums for non-high-risk-pool enrollees to the extent that premiums for such individuals were increased to make up for insurers' losses for higher-risk individuals (some of whom would now be receiving high-risk-pool subsidies).

Conversely, federally financed high-risk pools are costly and would substitute for spending currently undertaken by 33 states, thus subsidizing individuals in those states who already have coverage. Federal costs could be reduced if states with existing high-risk pools were required to maintain their current level of financing or if states were required to pay a specified matching percentage, as is the case with Medicaid and the State Children's Health Insurance Program.

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**Option 5****Establish a National Reinsurance Program to Provide Subsidies to Insurers and Firms for Privately Insured Individuals**

2

| (BILLIONS OF DOLLARS)   | 2010     | 2011        | 2012        | 2013        | 2014        | Total        |              |
|---|----------|-------------|-------------|-------------|-------------|--------------|--------------|
|   |          |             |             |             |             | 2010-2014    | 2010-2019    |
| <b>Subsidize Insurance for All Privately Insured High-Cost Individuals</b>              |          |             |             |             |             |              |              |
| Change in Mandatory Spending  | 0        | 26.0        | 56.0        | 88.0        | 125.0       | 295.0        | 1,044.0      |
| Change in Revenues <sup>a</sup>   | <u>0</u> | <u>7.0</u>  | <u>16.0</u> | <u>25.0</u> | <u>35.0</u> | <u>83.0</u>  | <u>292.0</u> |
| <b>Net Effect on the Deficit</b>  | <b>0</b> | <b>19.0</b> | <b>40.0</b> | <b>63.0</b> | <b>90.0</b> | <b>212.0</b> | <b>752.0</b> |
| <b>Subsidize Only Nongroup and Small-Firm Group Insurance for High-Cost Individuals</b> |          |             |             |             |             |              |              |
| Change in Mandatory Spending  | 0        | 9.0         | 18.0        | 29.0        | 41.0        | 97.0         | 342.0        |
| Change in Revenues <sup>a</sup>   | <u>0</u> | <u>2.0</u>  | <u>4.0</u>  | <u>7.0</u>  | <u>9.0</u>  | <u>22.0</u>  | <u>77.0</u>  |
| <b>Net Effect on the Deficit</b>  | <b>0</b> | <b>7.0</b>  | <b>14.0</b> | <b>22.0</b> | <b>32.0</b> | <b>75.0</b>  | <b>265.0</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Private health insurers and firms that self-insure by directly paying for medical claims themselves typically purchase reinsurance, which is available from private reinsurance companies, to limit their costs for covered individuals whose medical bills exceed a defined threshold. Reinsurance pays all or a portion of an individual's remaining medical claims once a threshold dollar value of claims is exceeded. In that way, it reduces the variability in a business's health care costs from year to year, but it does not reduce the overall amount that reinsured firms pay in the long run—the firms must pay premiums to the reinsurer that, on average, cover the claims' costs. Under current law, the federal government does not provide direct financial assistance for reinsurance to firms that have employees or retirees with large medical bills. The objective of this option would be to reduce the portion of premiums that individuals and employers must pay, thereby encouraging more firms to offer coverage and more individuals to take up coverage.

Under one alternative of this option, the federal government would reimburse all insurers and firms that self-insure for 75 percent of their medical claims above \$50,000 in one year for any single worker or retiree, or for their dependents. (After 2010, that figure would be indexed to the projected growth in premiums per capita for employment-based insurance.) The government would extend such subsidies to all privately insured individuals in both group and nongroup (individually purchased) plans. About 2 million privately insured individ-

uals are expected to incur health expenditures of more than \$50,000 in 2010; those expenditures will account for roughly 15 percent of all private health care expenditures in that year.

This version of the option would increase outlays by an estimated \$295 billion over the 2010–2014 period and by \$1.0 trillion over the 2010–2019 period. Those estimated costs would be net of savings to the Medicaid program because approximately 500,000 enrollees would obtain employment-based insurance who otherwise would have had Medicaid coverage. Those savings to Medicaid would be \$4.0 billion over the 2010–2014 period and \$10.0 billion over the 2010–2019 period. In addition, because this alternative would lower health insurance premiums for employers, tax revenues would increase as compensation shifted from nontaxable fringe benefits to taxable wages. The option would boost tax revenues by an estimated \$83 billion over the 2010–2014 period and by \$292 billion over the 2010–2019 period. The net effect would be to increase deficits by an estimated \$752 billion over the 2010–2019 period. In 2014, roughly 2.6 million people who otherwise would have been uninsured would obtain private coverage.<sup>1</sup>

An alternative version of this option would provide the same subsidy but only to insurers in the nongroup market

1. That estimate incorporates the assumption that insurers providing coverage through the Federal Employees Health Benefits program would not receive subsidies for reinsurance.

and to firms in the group market with fewer than 100 employees. This version of the option would increase outlays by much less—an estimated \$97 billion over the 2010–2014 period and \$342 billion over the 2010–2019 period. That cost is net of savings to the Medicaid program, which are estimated to be \$3.0 billion over the 2010–2014 period and \$8.0 billion over the 2010–2019 period. The option would increase tax revenues by an estimated \$22 billion over the 2010–2014 period and by \$77 billion over the 2010–2019 period. The net effect would be to increase deficits by an estimated \$265 billion over the 2010–2019 period. That estimate does not take into account the potential budgetary effects of firms’ reorganizing to become eligible for the subsidy offered to firms with fewer than 100 employees. Under this alternative, roughly 2.1 million people who otherwise would have been uninsured would obtain private coverage in 2014.

A rationale for a federally financed program of subsidies for privately insured individuals with high medical costs is that it would reduce premiums for private health insurance and lessen the variability in those premiums for companies and their employees. In contrast to private

reinsurance, which is funded through the premiums paid by those who purchase the coverage, the federal subsidies to be provided under this option would be paid for through general revenues. Premiums for health insurance would thus be lower because the 75 percent of health care costs that exceeded the specified threshold would be paid for with government funds and would not need to be covered by premiums. In particular, the option would help smaller businesses and firms by substantially reducing the potential for very high insurance costs incurred by one or a few employees with very large health expenditures in a given year. As noted above, this option would increase insurance coverage among individuals who otherwise would have been uninsured.

An argument against the option is that a program of federal subsidies for individuals with high medical expenses would be costly and would displace purchases of reinsurance in the private market. In addition, because the subsidies would pay for medical costs above a specified threshold, the option might lessen the incentive that insurers and firms have to control such costs.

«CBO»

**Option 6****Require States to Use Community Rating for Small-Group Health Insurance Premiums**

| (MILLIONS OF DOLLARS)            | 2010     | 2011        | 2012        | 2013        | 2014        | Total         |               |
|----------------------------------|----------|-------------|-------------|-------------|-------------|---------------|---------------|
|                                  |          |             |             |             |             | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending     | 0        | 20          | 40          | 70          | 100         | 230           | 830           |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>160</u>  | <u>340</u>  | <u>530</u>  | <u>740</u>  | <u>1,770</u>  | <u>5,930</u>  |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-140</b> | <b>-300</b> | <b>-460</b> | <b>-640</b> | <b>-1,540</b> | <b>-5,100</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Currently, the way that states regulate their small-group health insurance markets—which typically pertain to employers with 50 or fewer employees—varies considerably. One aspect of that variation is the extent to which states allow insurers to charge different groups of employees different rates on the basis of their age, health status, or other characteristics. Although several states allow insurers to charge premiums with essentially no restrictions, most use “rate bands” to limit the extent to which premiums may vary across groups (for instance, no more than 25 percent above or below the state average for a given insurance product for reasons related to the health status of the group). Some states limit premium variation further by prohibiting insurers from using health characteristics (though they might still allow the use of age) as a basis for varying premiums. A few states mandate pure community rating—that is, they require that insurers charge all groups the same premium for a given health insurance policy (allowing for an adjustment based on geographic considerations).

This option would require that all states employ pure community rating for their small-group markets, allowing variations in premiums only on the basis of geography. In states with little or no such regulation currently, the option would result in small groups of employees with low expected health care use being charged higher rates and groups with relatively high expected health care use being charged lower rates. This option would have a smaller effect in states that already had limits on premium variation in their small-group markets.

Under this option, total enrollment in the small-group health insurance market would fall by about 400,000 people, or about 1 percent of current enrollment, by 2014. That drop in enrollment would reflect the combined effect of two developments: an increase in

enrollment of about 300,000 employees and their dependents with high expected health care spending who would see premiums decline as a result of the new policy; and a larger decrease in enrollment of workers and dependents with low expected health care spending who would see premiums increase. The net decrease in enrollment would be larger in later years because the initial changes in overall enrollment would lead to a pool of enrollees in each state with somewhat higher levels of health care spending, requiring insurers to subsequently raise premiums on average, resulting in further net declines in enrollment. Of those employees who would have been insured in the small-group market under current law, approximately 45 percent would be uninsured, 30 percent would be enrolled in the nongroup market, 20 percent would have employment-based insurance through a spouse, and 5 percent would be enrolled in public coverage or other options.

The option would increase federal revenues by about \$6 billion over 10 years (2010 to 2019). That amount is the net effect of a \$11 billion increase in federal revenues from individuals who leave employment-based coverage to become uninsured or take up coverage in the nongroup market, and a \$5 billion decrease in revenues related to people who gain employment-based coverage. Gaining employment-based coverage reduces federal revenues because some compensation is shifted from taxable wages to nontaxable fringe benefits. Losing employment-based health insurance would have the opposite effect. In addition, federal outlays would rise by about \$800 million over 10 years because a small number of those individuals otherwise covered by employment-based insurance would be expected to enroll in the Medicaid program. Overall, this option would reduce the deficit by \$1.5 billion over the 2010–2014 period and by \$5.1 billion over the 2010–2019 period.

Arguments in favor of this option are that it would reduce the price of health insurance for those who, it could be argued, most need it—those who are unhealthy. Workers in poor health also have lower incomes, on average, than those in better health; thus, this option would make insurance more affordable for those less able to afford coverage.

2

An argument against this option is that it would reduce overall coverage in the small-group market. The option also would preempt existing state laws, which are likely to reflect variation in attitudes about how much less-healthy people should pay for insurance relative to more-healthy people.

«CBO»



**Option 7****Create a Voucher Program to Expand Health Insurance Coverage**

| (MILLIONS OF DOLLARS)            | 2010     | 2011         | 2012         | 2013         | 2014         | Total         |               |
|----------------------------------|----------|--------------|--------------|--------------|--------------|---------------|---------------|
|                                  |          |              |              |              |              | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending     | 0        | 2,000        | 4,110        | 6,330        | 8,660        | 21,100        | 68,000        |
| Change in Revenues <sup>a</sup>  | 0        | 70           | 140          | 220          | 310          | 740           | 2,520         |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>1,930</b> | <b>3,970</b> | <b>6,110</b> | <b>8,350</b> | <b>20,360</b> | <b>65,480</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

To extend health insurance coverage to uninsured people, policymakers have proposed various options, including offering direct subsidies or tax-related inducements to individuals who purchase coverage or to firms who offer it to their employees; expanding Medicaid and the State Children's Health Insurance Program (SCHIP); changing the rules that regulate private insurance; and requiring employers to offer coverage.

This option would create vouchers that uninsured people could use to purchase coverage in the individual health insurance market that meets a minimum coverage standard. The voucher would pay as much as 70 percent of the total cost of insurance premiums for such coverage, not to exceed \$1,500 for an individual and \$3,000 for a family in 2010. (Those amounts would be indexed for general price inflation in subsequent years.) The vouchers would be available to people whose household income was below 250 percent of the federal poverty level. (The value of the voucher would be phased out for people with income between 200 percent and 250 percent of the federal poverty level). The vouchers would be provided in the same year in which the individual or family was covered by a qualified plan, often referred to as being "advanceable," and would not be available to individuals who were enrolled in Medicare, Medicaid, or SCHIP.

Under this option, the estimated cost of the vouchers would be about \$21 billion over the 2010–2014 period and roughly \$68 billion over the 2010–2019 period. However, the effect on the federal deficit would be slightly smaller than those amounts because of an increase in revenues (\$2.5 billion over the 10-year period) owing to a small shift that the subsidy would generate from employment-based coverage to coverage in the individual market. The increase in tax revenues would occur as compensation for those individuals shifted from nontaxable

fringe benefits to taxable wages. (Under the option, self-employed individuals could continue to deduct the unsubsidized portion of their premiums from their taxable income.)

Of the roughly 4 million people who would use the voucher in a typical year, about 1.6 million would already have had coverage in the individual health insurance market without the voucher. Of the remaining 2.4 million people, about 2.3 million would have been uninsured without the subsidy, and about 100,000 would have had employment-based coverage. The net reduction in the number of uninsured people under this option would be about 2.2 million in 2014—because approximately 100,000 people would become newly uninsured as some small employers elected not to offer insurance because of the new subsidy. Because of the subsidy, health insurance in the individual market would become less expensive, and as a result, some firms would opt to provide their employees with higher cash wages rather than offer health insurance. Although such a change might benefit a firm's employees on average, some previously insured employees could face higher premiums in the individual market (perhaps because of adverse health conditions) and consequently might forgo insurance coverage altogether.

A rationale for this option is that it would increase the affordability of health insurance—particularly for the roughly 27 million people who have income below 250 percent of the federal poverty level and no access to Medicaid, SCHIP, or employment-based insurance, about 20 million of whom are uninsured. Moreover, subsidies for the purchase of insurance in the individual market would address an imbalance in the current health insurance marketplace: the favorable tax treatment currently accorded employment-based health insurance and insurance bought by self-employed people.

A potential drawback of this option is that nearly half of the funds would go to people who otherwise would have had insurance coverage even without the subsidy. In addition, although the option would expand health insurance coverage overall, it would reduce coverage for a small number of workers whose employers would drop their coverage because of the new subsidy. Moreover, by providing a subsidy in the form of a fixed-dollar amount, the voucher would provide less assistance on a percentage basis for people with higher expected health care costs, who are often charged higher premiums in the individual market because of preexisting or chronic medical conditions.

The estimates presented here incorporate the assumption that an effective method of distributing the vouchers could be developed. Nevertheless, another set of concerns

relates to how much program participation would depend on the mechanism used to distribute the vouchers and when the funds would become available. For example, an eligibility criterion based on household income would most likely be difficult to administer, and participation could be impeded if the application and eligibility determination process for obtaining the vouchers was burdensome. Because lower-income households would be more likely to have trouble financing the cost of the premiums up front, participation might also be limited if voucher funds were not available until the individual or household filed an income tax return for the prior year. However, one concern about an “advanceable” voucher option is that some lower-income families might be reluctant to participate if they were unsure that their household income in the coming year would remain low enough to allow them to qualify for the program.

RELATED CBO PUBLICATIONS: *The Price Sensitivity of Demand for Nongroup Health Insurance*, August 2005; and *CBO's Health Insurance Simulation Model: A Technical Description*, October 2007

**Option 8****Limit Awards from Medical Malpractice Torts**

| (MILLIONS OF DOLLARS)                        | 2010       | 2011        | 2012        | 2013        | 2014        | Total         |               |
|--|------------|-------------|-------------|-------------|-------------|---------------|---------------|
|  |            |             |             |             |             | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending <sup>a</sup>    | 0          | -360        | -370        | -370        | -480        | -1,580        | -4,320        |
| Change in Revenues                           | 30         | 80          | 100         | 120         | 130         | 460           | 1,310         |
| <b>Net Effect on the Deficit<sup>b</sup></b> | <b>-30</b> | <b>-440</b> | <b>-470</b> | <b>-490</b> | <b>-610</b> | <b>-2,040</b> | <b>-5,630</b> |
| Change in Discretionary Spending             |            |             |             |             |             |               |               |
| Budget authority                             | 0          | -10         | -10         | -10         | -20         | -50           | -160          |
| Outlays                                      | 0          | -10         | -10         | -10         | -20         | -50           | -160          |

a. Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.

b. Estimates exclude the potential effect of changes in discretionary spending.

Under common law, individuals may pursue civil claims against physicians and other health care providers for alleged torts, or breaches of duty that result in personal injury. That system of tort law has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for losses they incur (including lost wages, medical expenses, and pain and suffering) as the result of an injury caused by negligence. Malpractice claims are generally pursued through the state courts, and states have established various rules by which those claims are adjudicated. Nearly all health care providers obtain malpractice insurance to protect against the risk of having to pay a very large malpractice claim. Ultimately, the cost of that insurance results in higher medical costs because, in order to pay for the premiums, providers must charge their patients higher fees. In addition, some research suggests that providers may engage in “defensive medicine”—providing services that are unnecessary but that may help reduce the risk of litigation. The evidence, however, is not conclusive, and whether limits on malpractice torts have an impact on the practice of medicine has been subject to some debate. (The Congressional Budget Office has examined the issue by looking at the experience of states that implemented limits on torts and has not found sufficient evidence to conclude that practicing defensive medicine has a significant effect on health care spending.)<sup>1</sup>

1. See Congressional Budget Office, *Medical Malpractice Tort Limits and Health Care Spending* (April 2006).

This option would impose certain nationwide curbs on medical malpractice torts. Many states have enacted some or all of these limits, whereas others have very few restrictions on malpractice claims. The tort limits include caps on noneconomic damages (also known as pain and suffering) and on punitive damages; a shortened statute of limitations; restrictions on the use of joint-and-several liability; and changes to rules regarding collateral sources of damages.<sup>2</sup> Specifically, the limits would be as follows:

- A cap of \$250,000 on awards for noneconomic damages;
- A cap of \$500,000 (or two times the value of awards for economic damages) for punitive damages;
- A statute of limitations of one year from the date of discovery of the injury for adults, and three years in the case of children;
- The joint-and-several liability rule would be replaced by the fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to that defendant’s share of responsibility for the injury; and

2. Under the joint-and-several liability rule, all of the defendants in a lawsuit are individually responsible for the entire amount of the award. An example of a collateral source of income is the amount paid by a plaintiff’s health insurer to cover health care services provided to a patient as a result of an injury resulting from malpractice.

- Evidence of income from collateral sources (such as life insurance payouts and health insurance) would be allowed to be introduced at trial.

**2** Imposing limits on malpractice torts could reduce health care spending, though the magnitude of that reduction is subject to some debate. By reducing the average size of malpractice awards, tort limits would ultimately reduce the cost of malpractice insurance premiums. But in CBO's estimation, the effect would be relatively small—less than 0.5 percent of total health care spending. Because premiums paid by employers for health insurance are excluded from employees' taxable income, reducing such premiums would, on average, increase the share of employees' compensation that was taxable and thereby increase federal tax revenues. The effect on tax revenues would be an increase of an estimated \$460 million over the 2010–2014 period and of \$1.3 billion over the 2010–2019 period. By reducing overall health care spending, this option would also reduce the cost of some federal programs, including Medicare, Medicaid, and the Federal Employees Health Benefits program. The total amount of savings in mandatory spending from those programs would be approximately \$1.6 billion over the 2010–2014 period and about \$4.3 billion over the 2010–2019 period. Discretionary savings would amount to about \$50 million over the 2010–2014 period and nearly \$160 million over the 2010–2019 period, if the amounts

appropriated for federal agencies were reduced accordingly.

Proponents of limits on malpractice torts believe that such limits could reduce health care spending by much more than CBO's estimate, perhaps by as much as 7 percent to 9 percent, primarily because of the reduction in the practice of defensive medicine. Advocates also argue that tort limits would ease concerns about whether the number of physicians in certain areas of the country, especially those with high malpractice premium costs, is adequate. For example, annual malpractice premiums for obstetricians exceed \$100,000 in some areas. Such high premiums probably deter some physicians from practicing in those areas.

An argument for not making this change is that tort limits could relax health care providers' incentive to avoid making mistakes that could injure patients. Reducing the amount of money that could be collected in the case of a medical injury might cause providers to exercise less caution, resulting in an increase in the number of medical injuries attributable to negligence. In addition, those who suffered substantial harm as a result of medical negligence might not be able to obtain full compensation for their injuries.

«CBO»

## The Tax Treatment of Health Insurance

**H**ealth insurance provided through employment is the most common source of coverage for people in the United States who are under the age of 65. In 2009, about 160 million nonelderly Americans, including workers, their spouses, and dependents, are expected to receive health insurance through employment. In 2008, on average, employers contributed 73 percent of the cost of a family policy for their employees and 84 percent of the cost of an individual policy. Although employer-paid premiums for health insurance are considered part of employees' total compensation, they are exempt from individual income taxes and payroll taxes and are thus excluded from employees' taxable income. In addition, employees of firms that offer "cafeteria plans"—plans that allow employees to choose between taxable cash wages and nontaxable fringe benefits—may pay their share of premiums for employment-based health insurance with pretax earnings. The tax-preferred treatment of employment-based insurance is effectively a subsidy that is larger for individuals who are subject to the highest marginal tax rate (that is, whose last dollar of income is taxed at the highest rate). The exclusion of premiums for employment-based health insurance resulted in a tax expenditure (that is, forgone revenues) of \$246 billion in 2007, of which \$145 billion and \$101 billion were attributable, respectively, to individual income tax and payroll tax receipts.

Self-employed individuals who purchase health insurance on their own also enjoy preferential tax treatment but to a

lesser extent than those with employment-based insurance: Premiums paid by self-employed workers may be deducted from income that is subject to individual income taxes but not from income that is subject to payroll taxes.

This chapter comprises options that would change the current tax treatment of health insurance. For example, some options would limit the tax preference for employment-based health insurance, whereas others would extend a tax deduction to all who purchased insurance, regardless of whether they purchased it through their employer.

Several of the options that affect the tax treatment of employment-based insurance may also affect Social Security benefits. Those benefits are based on taxable wages, and if one or more of the options was implemented, the amount of compensation that workers received in the form of wages would most likely change. The Congressional Budget Office estimates that the effects of those options on spending would be small relative to their effects on revenues; as a result, CBO has not reported such spending effects in this volume.

The Joint Committee on Taxation provided estimates of the budgetary effects of the options in this chapter. Those estimates cover the 10-year period from 2009 to 2018; no figures for 2019 are available for these options.

**Option 9****Reduce the Tax Exclusion for Employment-Based Health Insurance and the Health Insurance Deduction for Self-Employed Individuals**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | -0.7 | 13.7 | 24.6 | 31.4 | 39.1 | 108.1     | 452.1     |

Source: Joint Committee on Taxation.

Note: Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Although employer-paid premiums for health insurance are part of many employees' total compensation, those premiums are exempt from individual income taxes and payroll taxes. Employees at firms offering "cafeteria plans"—plans that allow employees to choose between taxable cash wages and nontaxable fringe benefits—can pay their share of premiums for employment-based health insurance with pretax earnings. In addition, employees' contributions to flexible spending accounts (FSAs) and employers' contributions to health savings accounts (HSAs) are not subject to income and payroll taxes. Health insurance premiums paid by self-employed individuals also receive favorable tax treatment: People who are self-employed can take an "above-the-line" deduction from their adjusted gross income for such premiums, even if they do not itemize other deductions.

This option would limit the extent to which employer-paid health insurance premiums and contributions to FSAs and HSAs could be excluded from income and payroll taxation. Specifically, it would include in employees' taxable income any contributions that employers or employees made for health insurance and for health care costs (through FSAs or HSAs) that together exceeded \$1,440 a month for family coverage or \$565 a month for individual coverage. Those limits, which are based on the 75th percentile for health insurance premiums paid by or through employers in 2010, would be indexed for inflation. The limits would also apply to the deduction for health insurance available to self-employed individuals.

Such a restriction would increase revenues from income and payroll taxes by a total of \$108 billion over the 2009–2013 period and by \$452 billion over the 2009–2018 period. The increase in Social Security payments resulting from including employers' contributions for health care coverage in employees' taxable income—and

thus in the wage base on which Social Security benefits are calculated and in the indexing of the benefit formula—is not included in those estimates. By raising the after-tax price of health insurance, this option would increase the number of uninsured individuals by more than 3.2 million in 2014.

Many analysts believe that the tax preference for employment-based health insurance distorts the markets for health insurance and health care. Current tax law provides incentives for health insurance plans to cover routine expenses as well as large, unexpected costs because routine charges are subsidized (through the tax exclusion) only if they are paid for through an insurance plan (or FSA). In contrast, under this option, employees and their employers would have an incentive to buy less expensive insurance and to reduce contributions to FSAs and HSAs for health care spending—which could diminish upward pressure on prices for health care and encourage the use of more-cost-effective types of care.

An argument against this option is that it would increase the number of uninsured Americans because it would discourage employers from offering insurance to their workers. Another argument against the option is that the effects of setting fixed dollar limits on excluded health care spending would differ among workers, depending on their location or on the age and health status of their firm's workforce. For example, the additional costs that would be subject to taxation under the option would be greatest for workers who lived in areas where health care was more expensive and for workers who were employed by firms that offered generous health benefits; costs would also be larger for employees of firms that had higher premiums because of the age or poor health of their employees.

**Option 10****Replace the Income Tax Exclusion for Employment-Based Health Insurance with a Deduction**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | -0.4 | 28.0 | 45.4 | 51.4 | 57.1 | 181.5     | 552.2     |

Source: Joint Committee on Taxation.

Note: Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Taxpayers currently may be eligible for one or more tax benefits that effectively reduce the cost of their health insurance. Although employer-paid premiums are part of many employees' total compensation, those premiums are exempt from individual income taxes and payroll taxes. Employees at firms offering "cafeteria plans"—plans that allow employees to choose between taxable cash wages and nontaxable fringe benefits—can pay their share of premiums for employment-based health insurance with pretax earnings. In addition, employees' contributions to flexible spending accounts (FSAs) and employers' contributions to health savings accounts (HSAs) are not subject to income and payroll taxes. Self-employed individuals can take an "above-the-line" deduction for health insurance premiums. (Above-the-line deductions are those that taxpayers can claim along with their standard deduction even if they do not itemize other deductions.)

Under this option, a single above-the-line deduction for health insurance premiums would replace both the current income tax exclusion for employer-paid premiums and the deduction for self-employed individuals with health insurance.<sup>1</sup> Employer-paid premiums for health insurance, as well as contributions to FSAs and HSAs, would continue to be excluded from payroll taxes. Employees' contributions to FSAs and employers' contributions to HSAs would be deductible under the option. The deduction would phase out for taxpayers with income above a certain point.

Under this option, the deduction would begin to phase out at the following income levels: \$80,000 for unmarried filers and \$160,000 for married couples filing jointly.

1. Because the option would replace the exclusion in effect under current law with a deduction, adjusted gross income would include premiums paid by employers or by employees through cafeteria plans.

Beyond that point, each additional dollar of adjusted gross income (AGI) would reduce the deduction incrementally by 25 cents until the deduction was completely phased out. Those limits would be indexed for inflation. With that structure, the deduction would raise revenues by about \$182 billion over the 2009–2013 period and by \$552 billion over the 2009–2018 period. The increase in Social Security payments that results from including employers' contributions for health care coverage in taxable income—and thus in the wage base on which Social Security benefits are calculated—is not included in that estimate. Because the option would increase the after-tax price of health insurance for higher-income taxpayers, it is estimated to increase the number of uninsured people by 1.5 million in 2014.

One rationale for this option is that it would increase consumers' awareness of the costs of health insurance. The current tax treatment of health insurance premiums creates an incentive for employees and self-employed individuals to purchase more insurance than they would if they had to pay the full cost themselves. By comparison, the option would encourage taxpayers whose health insurance payments were no longer exempt from the individual income tax to purchase less expensive health care. Taxpayers whose tax benefit was unchanged might also become more cost-conscious. If the option was implemented, employers would be required to report the health insurance premiums they paid for each employee on the employee's W-2 form. That, too, would increase workers' awareness of the total costs of health insurance, possibly encouraging workers to purchase less costly coverage.

Another rationale for the option would be to enhance the equity of the tax system. Current provisions link the size of the tax benefit to a taxpayer's marginal tax rate (the rate on the last dollar of income), which generally results in

higher subsidies for people with higher income. The option would reduce the subsidy for higher-income taxpayers while maintaining the same level of subsidy for taxpayers of low or moderate income.

3 An argument against this option is that it would increase the number of uninsured individuals, in part because it would lead some employers to stop offering health insurance coverage. However, many firms would probably maintain their current health care plans because the majority of their workers would retain all or most of the tax advantages they receive from acquiring health insurance through the workplace.

Another argument against the option is its complexity. Under the option, employers who self-insured would be required to determine the cost of providing single and family plan health insurance and to inform employees of those amounts—bookkeeping responsibilities that could prove burdensome. Taxpayers would have to report those amounts on their tax returns, and if their income fell within the deduction's phaseout range, they would also have to compute the amount of the deduction that they were allowed to claim.

«CBO»



**Option 11****Replace the Income and Payroll Tax Exclusion with a Refundable Credit**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | -0.8 | 32.8 | 51.9 | 58.2 | 63.6 | 205.7     | 606.0     |

Source: Joint Committee on Taxation.

Note: Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Certain tax benefits effectively reduce the cost of health insurance for some taxpayers. For example, employer-paid premiums are exempt from individual income taxes and payroll taxes, and employees at firms that offer “cafeteria plans”—which allow employees to choose between taxable cash wages and nontaxable fringe benefits—can pay their share of premiums for employment-based health insurance with pretax earnings. Nontaxable forms of compensation do not affect eligibility for or the amount of other tax benefits (for instance, the earned income tax credit) that are based on earnings or adjusted gross income. Other tax benefits include an “above-the-line” deduction for health insurance premiums that self-employed individuals can take. (Taxpayers can claim above-the-line deductions along with their standard deduction even if they do not itemize other deductions.) For other individuals who buy health insurance through the nongroup (individual) market, premiums may be deducted only if those taxpayers itemize their deductions and their medical expenses exceed 7.5 percent of their adjusted gross income.

Under this option, a refundable tax credit for health insurance premiums would replace the current income and payroll tax exclusion for employer-paid premiums and the deduction for self-employed individuals with insurance. Taxpayers could claim the credit—which would equal 25 percent of the premium—even if they did not work for an employer that offered health insurance. The credit would be refundable, which means that people could receive the full amount even if they had little or no income tax liability.

The refundable tax credit for health insurance that this option would implement would phase out for taxpayers with income above a certain point. The starting point for the phaseout range for the credit would be \$80,000 for unmarried filers and \$160,000 for married couples who filed jointly. Beyond that point, each additional dollar of adjusted gross income would reduce the credit by

25 cents. Under that structure, replacing the current-law tax exclusion with the more limited credit would increase revenues by \$206 billion over the 2009–2013 period and by \$606 billion over the 2009–2018 period. The net increase in uninsured persons would be an estimated 2.6 million people in 2014. This option would shift revenue from the general services account in the budget to the Medicare and Social Security trust funds because employer-paid health insurance would now be subject to payroll taxes. For example, the trust funds would gain \$102 billion in 2013.

Taxpayers with income below the phaseout range could receive the full credit in advance. They could claim the advance credit on their prior year’s tax return, using their income and filing status in that year to determine eligibility for the advance credit. The advance credit payment would be transferred directly to their insurer to pay for the taxpayer’s health insurance premiums.

A potential advantage of this option is that, for those who did not work for an employer that offered health insurance, the expanded credit would create an incentive to purchase health insurance in the private market. Moreover, weakening the link between employment and health insurance would allow individuals greater flexibility in choosing a job and the health insurance plan best suited to their particular needs.

Another rationale for the option is that it would foster equitable treatment in the tax system. Currently, excluding employer-paid premiums from taxation allows workers whose employers purchase health insurance for them to pay less tax than those who receive the same total compensation but must buy their own health insurance. Replacing the exclusion with a credit would provide taxpayers who received the same amount of compensation with the same tax benefits, whether or not their employer provided health insurance. In addition, the present income tax exclusion for health insurance premiums

provides a larger subsidy to higher-income taxpayers because they generally have higher marginal tax rates (the rate on the last dollar of income). This option would reduce the subsidy to higher-income taxpayers while potentially increasing the subsidy for those who do not have any income tax liability.

3

An argument against this option is that it would lead to more uninsured people, partially because it would cause some employers to stop offering health insurance coverage and partially because it would raise the after-tax price of health insurance for higher-income taxpayers. Employers' decisions to offer coverage are affected by changes in the relative attractiveness of their employees' other insurance choices, including plans available through the nongroup market. By lowering the after-tax cost of insurance in the nongroup market, this option would make it less likely that firms would offer coverage to their employees.

An additional concern is whether low-income individuals would receive refundable credits in time to pay their insurance premiums during the year. Although this option would allow filers to claim the credit in advance, some low-income individuals (especially those who generally do not file tax returns) might find that process burdensome.

Another argument against the option is its complexity. Under the option, employers would be required to determine the cost of providing individual- and family-plan health insurance and to inform employees of those amounts; such bookkeeping responsibilities could prove burdensome. Also, taxpayers would have to report those amounts on their tax returns, and if their income fell within the credit's phaseout range, they would have to compute the amount of the credit that they were allowed to claim.

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**Option 12****Allow Self-Employed Workers to Deduct Health Insurance Premiums from Income That Is Subject to Payroll Taxes**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | -0.8 | -3.2 | -3.4 | -3.6 | -3.8 | -14.8     | -37.2     |

Source: Joint Committee on Taxation.

Note: Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Employer-paid premiums and certain contributions by employees to employment-based health insurance plans are not subject to individual income taxes or payroll taxes. Premiums that self-employed workers pay for health insurance are deductible from income that is subject to individual income taxes; however, such premiums remain subject to payroll taxes, which fund the Social Security trust funds and Medicare's Hospital Insurance Trust Fund. In tax year 2006, approximately 3.8 million self-employed taxpayers paid payroll taxes on their health insurance premiums.

This option would exclude health insurance premiums paid by self-employed individuals from income that is subject to self-employment payroll taxes, thus treating premiums paid by employers and those paid by self-employed individuals in a comparable manner. The exclusion would reduce revenues by about \$15 billion over the 2009–2013 period and by \$37 billion over the 2009–2018 period.

By reducing payroll taxes, this option would reduce revenues to the Social Security and Hospital Insurance Trust Funds, as does the current exclusion from payroll taxes that applies to employer-paid premiums. Another alternative approach that would keep payroll tax revenues unchanged would be to implement this option as an income tax credit equal to the payroll taxes that self-employed workers paid on their premiums. To achieve the same effect as that produced by excluding the premiums from earnings subject to payroll taxes, the credit would have to be refundable. (Workers might owe payroll taxes but have no individual income tax liability, and for such workers, a nonrefundable individual income tax credit would provide no benefit.)

By excluding health insurance premiums paid by self-employed workers from payroll taxes, this option would give self-employed workers the same tax benefit received by those who purchase health insurance through employment-based plans. The current differential tax treatment makes insurance relatively more expensive for self-employed individuals than for people who have employment-based plans, a disparity in price that may discourage some individuals from choosing to become self-employed. By ending the disparity, this option would remove a potential distortion in people's decisions about employment. Moreover, by effectively lowering the price of insurance for the self-employed, a group with many uninsured individuals, the exclusion could potentially expand health insurance coverage.

This option might not be the most efficient way to expand coverage because self-employed workers who had already chosen to purchase insurance would receive the tax benefit without any change in their insurance-purchasing behavior. Moreover, this option would not treat everyone's insurance premiums in the same way for tax purposes. Premiums for insurance purchased by unemployed people or by employees whose employers did not offer coverage would still not be deductible from income subject to individual income taxes unless those taxpayers itemized their deductions and their medical expenses exceeded 7.5 percent of their adjusted gross income. In addition, the premiums for those groups would not be deductible from income subject to payroll taxes. Furthermore, some employers sponsor insurance plans but do not offer so-called cafeteria plans that include a premium-conversion feature, which allows employees to pay their share of health insurance premiums with pretax earnings. In such cases, employees pay both income and payroll taxes on that premium share.

«CBO»

**Option 13****Expand Eligibility for an “Above-the-Line” Deduction for Health Insurance Premiums**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | -1.2 | -4.2 | -5.7 | -6.7 | -6.4 | -24.2     | -65.2     |

Source: Joint Committee on Taxation.

Current tax law treats payments for health insurance premiums in different ways. Premiums for employment-based health insurance—often referred to as group insurance—are exempt from both individual income taxes and payroll taxes. Insurance premiums paid by self-employed individuals are exempt from income taxes but not from payroll taxes. The law allows self-employed people to take an “above-the-line” deduction on their tax returns for the amount of their health insurance premiums, subtracting that amount from their adjusted gross income. (Above-the-line deductions are those that taxpayers can claim along with the standard deduction even if they do not itemize other deductions.) Premiums paid by other people who buy health insurance through the nongroup, or individual, insurance market are exempt from income taxes in certain circumstances—that is, if they itemize their deductions and their medical expenses exceed 7.5 percent of their adjusted gross income.

This option would expand eligibility for the above-the-line deduction to include all individuals who purchase health insurance in the nongroup market. As is the case under current law, taxpayers who did not itemize could nevertheless claim that deduction in addition to the standard deduction. Individuals with employment-based insurance (whose premiums are excluded from income and payroll taxes) would not be eligible for the benefit. The expansion of eligibility that the option would put in place would reduce revenues by \$24 billion over the 2009–2013 period and by \$65 billion over the 2009–2018 period. The net reduction in uninsured persons would be an estimated 700,000 people in 2014.

Implementing this option could offer several advantages. For people who did not work for an employer who offered health insurance, the expanded deduction would create an incentive to purchase insurance. Moreover, by loosening the ties between employment and health insurance, this option would give individuals greater flexibility in choosing both a job and health insurance coverage that met their particular needs.

Such an approach could have disadvantages as well. Implementing the option could lead some employers to stop offering health insurance coverage altogether. Employers’ decisions about whether to offer coverage are affected by changes in the relative attractiveness of their employees’ other insurance choices, including plans available through the nongroup market. By lowering the after-tax cost of insurance in that market, this option could make it less likely that firms would offer coverage to their employees. However, because workers would still receive a larger tax benefit—that is, the exemption from payroll taxes—by purchasing health insurance through their employers, firms would be less likely to drop coverage than if the deduction replaced the current-law tax benefit for employment-based insurance. Key factors in evaluating the effects of this option on employment-based insurance coverage would be whether alternative insurance plans would develop outside the context of the workplace and the scope of the coverage those plans would provide.

«CBO»

**Option 14****Disallow New Contributions to Health Savings Accounts**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | 0.5  | 0.8  | 1.0  | 1.1  | 1.1  | 4.5       | 10.5      |

Source: Joint Committee on Taxation.

In 2003, federal law was changed to authorize health savings accounts (HSAs) for people who enroll in high-deductible health plans (HDHPs). For 2009, participants in qualified HDHPs are required to pay the first \$1,150 of their medical expenses (\$2,300 for family coverage) before insurance benefits begin. Conventional insurance plans, whose participants cannot contribute to HSAs, typically have deductibles of about one-third that amount. Qualified HDHPs must also limit out-of-pocket expenses to no more than \$5,800 for individual policies and \$11,600 for family coverage.

Policyholders' contributions to HSAs are deducted when calculating their adjusted gross income (that is, their taxable income before personal exemptions and either the standard deduction or itemized deductions are subtracted); employers' contributions are exempt from both income and payroll taxes. Investment returns within the accounts accumulate tax-free, and distributions that are applied to eligible medical expenses are not taxed. Distributions applied to ineligible expenses are included in adjusted gross income and are subject to a 10 percent penalty if received prior to age 59½. Contributions are limited in 2009 to \$3,000 for taxpayers with individual HDHP coverage and to \$5,950 for those with family HDHP coverage. Individuals who are aged 55 and older can contribute an additional \$1,000.

This option would disallow any further contributions to HSAs but would allow existing HSAs to continue to accumulate tax-free earnings and make nontaxable

distributions for qualifying expenses. If implemented, the option would increase revenues by an estimated \$4.5 billion over the 2009–2013 period and by \$10.5 billion over the 2009–2018 period.

An argument for adopting this option is that it would, in theory, enhance the viability of the conventional insurance market. HDHPs are attractive primarily to relatively healthy people. By selecting HDHPs, those people leave the conventional insurance market with a less robust risk pool, thereby forcing insurance companies to raise premiums for non-HDHP plans. (The plans are too new, however, to determine how HSAs have actually affected conventional premiums.) Furthermore, by eliminating the subsidy inherent in the tax benefits provided by HSAs, the option would encourage greater spending discipline among those remaining in HDHPs. Finally, the option would prevent higher-income taxpayers who could afford to pay medical expenses with non-HSA funds from using HSAs as a vehicle for wealth accumulation.

An argument against disallowing further HSA contributions is that it would increase costs for many employers, probably prompting some to stop providing health insurance to their employees. Furthermore, without the HSA alternative, some employees might choose to forgo available coverage rather than pay their share of conventional premiums. Finally, employees reverting to conventional plans would no longer be subject to the same level of spending discipline that HDHPs impose.

RELATED CBO PUBLICATION: *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes*, December 2006

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**Option 15****Allow Health Insurance Plans with Coinsurance of at Least 50 Percent to Qualify for the Health Savings Account Tax Preference**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | *    | *    | *    | *    | *    | 0         | -0.3      |

Source: Joint Committee on Taxation.

Note: \* = less than \$50 million.

Health savings accounts (HSAs) allow individuals who are enrolled in high-deductible insurance plans to accumulate tax-preferred savings to cover their out-of-pocket medical expenses. The tax code permits such individuals to deduct contributions to HSAs from the income they receive that is subject to individual income taxes even if they do not itemize deductions. In addition, current tax law exempts employers' contributions to their workers' HSAs from individual income taxes and payroll taxes; it also excludes from account holders' taxable income any accumulated interest earnings on contributions to HSAs and distributions from the accounts for qualified medical expenses.

To qualify for the preference in 2009, a high-deductible health plan must have a deductible of at least \$1,150 for individual coverage or \$2,300 for family coverage; the plan must also limit the amount that an enrollee pays out of pocket to \$5,800 for individual coverage and \$11,600 for family coverage. (The thresholds for the deductible and the out-of-pocket limits are adjusted for inflation each year.) Individuals are not eligible for an HSA if they are covered by another health plan—including Medicare.

This option would expand the definition of an HSA-qualified health plan. Plans would qualify if they met all of the current restrictions of a high-deductible health plan with one exception: in lieu of the plans' satisfying the requirement of a minimum deductible, they would require enrollees to pay at least 50 percent in coinsurance for their medical expenses. Allowing those plans to be eligible to offer HSAs would encourage taxpayers to set up such accounts, thereby reducing revenues by \$300 million over the 2009–2018 period.

Proponents of this option argue that allowing plans with high rates of coinsurance to qualify for the tax preference would make consumers more cost-conscious. Under current law, enrollees in high-deductible plans generally do not have an incentive to pay attention to the cost of health care services after they reach the limit that their plan places on out-of-pocket expenses. In contrast, under this option, enrollees in plans that had a coinsurance rate of 50 percent would pay half the costs of their medical care up to a higher dollar limit (\$11,600 in medical care for an individual with self-only coverage). Another argument in support of this option is that it might encourage more individuals to participate in HSAs, particularly consumers who did not anticipate large medical expenses. Those individuals would generally find a plan with a 50 percent coinsurance rate to be more attractive than a plan with a high deductible.

An argument against this option is that it might result in higher health insurance premiums for some individuals by inducing relatively healthy people to switch from conventional health plans to HSAs. For some healthy individuals, a health insurance plan with a 50 percent coinsurance rate, combined with a tax subsidy for out-of-pocket spending, might be less expensive than a conventional health plan. However, shifting healthy people out of more comprehensive employment-based insurance plans could have an adverse effect on premiums for workers who were likely to remain in those plans—in particular, workers who were older or who had chronic health problems.

**Option 16****Levy an Excise Tax on Medigap Plans**

| (BILLIONS OF DOLLARS)           | 2009       | 2010       | 2011       | 2012       | 2013       | Total      |             |
|---------------------------------|------------|------------|------------|------------|------------|------------|-------------|
|                                 |            |            |            |            |            | 2009-2013  | 2009-2018   |
| Change in Mandatory Spending    | -0.1       | -0.1       | -0.1       | -0.2       | -0.2       | -0.7       | -1.7        |
| Change in Revenues <sup>a</sup> | <u>0.5</u> | <u>0.8</u> | <u>0.9</u> | <u>0.9</u> | <u>1.0</u> | <u>4.1</u> | <u>10.4</u> |
| Net Effect on the Deficit       | -0.6       | -0.9       | -1.0       | -1.1       | -1.2       | -4.8       | -12.1       |

a. Changes in revenues were estimated by the Joint Committee on Taxation.

About a third of Medicare beneficiaries who receive care through the traditional fee-for-service (FFS) program—which consists of services covered under Part A and Part B—buy medigap insurance policies that are designed to cover most or all of the cost sharing Medicare requires. Some medigap policies also cover a limited number of benefits that Medicare does not offer. By reducing or eliminating beneficiaries' out-of-pocket costs for Medicare services, medigap insurance reduces enrollees' incentive to make cost-effective health care decisions and encourages enrollees to use more medical services. That, in turn, causes Medicare's spending to rise. Since 1992, federal law has required that any newly issued medigap policy take the form of one of a specified number of standard benefit plans (currently there are 12). However, insurers have been permitted to renew nonstandard medigap policies that were issued prior to 1992. Premiums for medigap policies vary geographically and by type of plan. Under current law, medigap insurance premiums are considered a qualified medical expense for itemizing deductions on individual income tax returns.

This option would levy an excise tax on medigap insurance plans equal to 5 percent of the premium for each policy purchased. The insurer would pay the tax to the Internal Revenue Service on a quarterly basis, and revenues from the tax would be deposited in Medicare's

Hospital Insurance Trust Fund. If this option was implemented, revenues would increase by \$4.1 billion over the 2009–2013 period and by \$10.4 billion over the period 2009 to 2018. The reduction in demand for medigap insurance would lead to a reduction in Medicare spending. In the Congressional Budget Office's estimation, federal spending on Medicare would be reduced by \$700 million over the 2009–2013 period and by \$1.7 billion over the next 10 years.

A potential advantage of this option is that by reducing the incentive for enrollees to purchase supplemental insurance and encouraging beneficiaries to purchase less comprehensive policies, the imposition of an excise tax on medigap policies would encourage Medicare beneficiaries to be more sensitive to the cost of health care services, thereby dampening demand for health care they perceived to be of marginal benefit. In addition, the excise tax could partially compensate the Medicare trust funds for the increased federal spending that medigap policies cause.

An argument against this option is that the increased cost of medigap insurance could discourage individuals from purchasing such coverage, which could cause some beneficiaries to forgo necessary health care.

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## Changing the Availability of Health Insurance Through Existing Federal Programs

**T**he federal government finances or furnishes health insurance for more than 100 million individuals. Some individuals are covered by government health programs because they meet certain eligibility criteria (for example, age, disability, income); others receive health insurance through federal employment, both civilian and military. This chapter examines options that would change the circumstances under which individuals may become eligible for federal programs. Some options would expand access to federal health insurance; others would tighten programs' rules for eligibility.

### Medicare

Approximately 44 million individuals are enrolled in Medicare. Eligibility for the program is linked to age, work history, and disability. Individuals who are age 65 or older and who have paid into the Health Insurance (HI) Trust Fund through payroll taxes for at least 10 years are entitled to benefits under Part A (which finances inpatient hospital care and other services provided by institutions). Individuals who lack 10 years of work experience may enroll in Part A by paying a monthly premium. The vast majority of Medicare beneficiaries are entitled to Part A.

At age 65, people may also enroll in Part B (which covers the costs of physicians' services and other outpatient care) and Part D (the outpatient drug benefit). They pay a monthly premium for each program, and each premium is set to equal roughly 25 percent of the program's expected costs per enrollee. People with disabilities are entitled to Part A and may enroll in Medicare before the age of 65 if they have been eligible to receive disability payments under Social Security for at least 24 months. The 24-month waiting period is waived for individuals who have end-stage renal disease (that is, permanent kidney failure) or amyotrophic lateral sclerosis (Lou Gehrig's

disease). Medicare beneficiaries may choose to enroll in Medicare Advantage (Medicare Part C), in which case they receive their A and B benefits from a private health plan. Most Medicare Advantage plans also offer drug coverage.

### Medicaid and the State Children's Health Insurance Program

On average, about 53 million people were enrolled in Medicaid and the State Children's Health Insurance Program (SCHIP) in 2007, which are operated jointly by the federal and state governments. On average, the federal government pays about 57 percent of the costs of Medicaid, although that share varies from state to state. To participate in Medicaid, states must cover certain groups and individuals, referred to as mandatory populations, which comprise low-income children and parents, pregnant women, disabled people, and elderly individuals. Within federal guidelines, states may choose to cover additional individuals whose income or assets (or both) may exceed the levels that apply to mandatory populations. Those additional individuals are referred to as optional populations. Nonpregnant able-bodied individuals who have no children are generally not eligible for Medicaid.

As is the case for Medicaid, states determine eligibility for SCHIP within the federal guidelines. On average, the federal government pays about 70 percent of the costs of SCHIP. The federal funding process for that program differs from the process for Medicaid, however, because the total amount of federal funds available for SCHIP each year is fixed by law. Children who are eligible for the program are generally from low-income families whose income is above the eligibility threshold for Medicaid.

In both Medicaid and SCHIP, states may use waivers to expand eligibility to populations that do not fall within

the existing categorical eligibility groups. For example, a state might seek waiver authority to expand eligibility for Medicaid to nonpregnant able-bodied childless adults.

## TRICARE

TRICARE is the federal health care program that covers current members of the armed forces and military retirees, as well as their families and survivors. In total, more than 9 million beneficiaries are eligible to use TRICARE. Care is provided through government-owned and -operated hospitals, medical clinics, dental clinics, and contracts with networks of private-sector providers. Most of the costs incurred by TRICARE are funded by discretionary appropriations to the Department of Defense. However, once military retirees become eligible for Medicare, all costs incurred on their behalf by both the Medicare and TRICARE programs are treated as mandatory outlays. (That is, they do not require annual appropriations, and the available funding is not limited.)

## The Veterans Health Administration

The Veterans Health Administration (VHA), part of the Department of Veterans Affairs, provides health care to former members of the armed forces through a nationwide network of more than 1,000 government-operated hospitals, outpatient clinics, and nursing homes. Although most veterans are eligible to use VHA services, access to care is determined in accordance with a rating system that gives priority to veterans with service-con-

nected disabilities and lower income. Of the roughly 23 million current veterans, almost 8 million are enrolled with VHA. VHA is funded through discretionary appropriations, and care is provided with little or no out-of-pocket cost to most enrolled veterans.

## The Federal Employees Health Benefits Program

The Federal Employees Health Benefits (FEHB) program is the primary health program for about 8 million federal civilian employees and annuitants, and their family members. Under the program, eligible beneficiaries enroll in approved private-sector health plans, and then share the cost of the premiums with the government. The Office of Personnel Management oversees the program on behalf of the federal government.

The government's contribution to premiums for an active worker is paid by the agency that employs him or her out of the agency's appropriated funds. That spending is categorized as discretionary. By contrast, the federal government's contributions to premiums for annuitants are classified as mandatory outlays and are drawn from the Treasury's general fund. The U.S. Postal Service's contributions to premiums for its active and retired workers are categorized as off-budget outlays. (That is, although they are part of the unified budget, they are not counted in the totals for certain purposes.)

**Option 17****Raise the Age of Eligibility for Medicare to 67**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014   | Total     |           |
|------------------------------|------|------|------|------|--------|-----------|-----------|
|                              |      |      |      |      |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending |      |      |      |      |        |           |           |
| Medicare                     | 0    | 0    | 0    | 0    | -3,300 | -3,300    | -85,600   |
| Social Security              | 0    | 0    | 0    | 0    | -300   | -300      | -6,800    |

The age of eligibility for Medicare benefits is 65, although people may qualify for coverage earlier if they have been eligible for disability benefits under Social Security for at least 24 months or if they have end-stage renal disease or amyotrophic lateral sclerosis. Because of increases in life expectancy, the average length of time that people are covered by Medicare has risen steadily since the program began in 1965. That trend, which boosts the program's costs, is expected to continue.

This option would raise the age of eligibility for Medicare by two months every year beginning in 2014 until the eligibility age reached 67 in 2025, where it would stay indefinitely. Those increases are similar to increases currently scheduled for the normal retirement age (NRA) in Social Security, which is the age at which workers become eligible for full retirement benefits. Workers may receive a reduced retirement benefit as early as age 62, and many workers have chosen to take such early retirement benefits, with a vast majority of the eligible population choosing to do so before reaching Social Security's NRA. The eligibility age for Medicare would remain below Social Security's NRA until 2019, when both would be age 66; from that point on, the two would be identical. (The rise in Social Security's NRA started sooner and included a 12-year period during which the NRA remained at 66.)

Under the option, Medicare's spending would decline by \$3.3 billion in 2014 and by \$85.6 billion over the 2010–2019 period, the Congressional Budget Office estimates.<sup>1</sup> Outlays for Social Security retirement benefits (an off-budget item) would fall by \$0.3 billion in 2014 and by \$6.8 billion from 2010 to 2019. The increase in the age

1. The decrease in spending for Medicare under this option would be partially offset by a modest rise in spending for Medicaid, the Federal Employees Health Benefits program, and Social Security disability benefits. At this time, CBO has not estimated those budgetary effects.

of eligibility for Medicare would reduce outlays for Social Security retirement benefits because some workers would delay retiring to maintain their employment-based health insurance coverage until they became eligible for Medicare.

By 2050, Medicare's spending under this option would have fallen by about 3 percent—or, measured relative to the size of the economy, from 8.6 percent of gross domestic product (GDP) to 8.4 percent. In 2009, outlays for Medicare are projected to be about 2.9 percent of GDP; thus, this option would have little effect on the trajectory of Medicare's long-term spending. (Medicare's spending would fall by less than its enrollment because younger beneficiaries are healthier and thus less costly than the program's average beneficiary.) By contrast, an option that raised the age of eligibility for Medicare by two months every year until it reached 70 in 2043 (where it would stay indefinitely) would reduce Medicare's spending by 10 percent by 2050. Yet even under that more extensive change, outlays for Medicare would rise to 7.7 percent of GDP by 2050.

A rationale for this option is that it would adjust the eligibility age for Medicare to account for increases in life expectancy and thereby restrain the growth of spending for Medicare. In addition, a higher age threshold for Medicare eligibility would reinforce incentives created by increases in Social Security's NRA that encourage people to delay retiring. Disability among elderly people has declined over time, and jobs are generally less physically demanding, suggesting that a larger fraction of the population might be capable of working beyond age 65. Many who would do so might have access to employment-based insurance.

An argument against this option is that many workers retire before age 65 and raising the age of eligibility for Medicare would lengthen the time those early retirees

might be at risk of having no health insurance. That risk would be greatest for low-income retirees who did not have access to coverage through a former employer or a spouse's employer, and who either might have difficulty affording coverage in the individual insurance market or might be denied coverage because of poor health. Fur-

thermore, increasing the age of eligibility for Medicare would shift costs that are now paid by that program to individuals and to employers that offered health insurance to their retirees. Those higher costs might lead more employers to reduce or eliminate such coverage.

RELATED CBO PUBLICATION: *The Long-Term Budget Outlook*, December 2007

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**Option 18****Create a Medicare Buy-In Program for Individuals Ages 62 to 64**

| (MILLIONS OF DOLLARS)                     | 2010     | 2011     | 2012      | 2013      | 2014       | Total      |              |
|---|----------|----------|-----------|-----------|------------|------------|--------------|
|   |          |          |           |           |            | 2010-2014  | 2010-2019    |
| Change in Mandatory Spending <sup>a</sup> | 0        | 10       | 60        | 120       | 180        | 370        | 1,590        |
| Change in Revenues                        | 0        | 10       | 10        | 30        | 40         | 90         | 400          |
| <b>Net Effect on the Deficit</b>          | <b>0</b> | <b>0</b> | <b>50</b> | <b>90</b> | <b>140</b> | <b>280</b> | <b>1,190</b> |

a. Estimates represent an increase in Social Security outlays, which are classified as off-budget.

Medicare provides health insurance coverage to people ages 65 and older and to people who have been eligible for Social Security disability benefits for at least 24 months or who have end-stage renal disease or amyotrophic lateral sclerosis. Like other adults, people between the ages of 62 and 64 who do not have employment-based or public health insurance coverage must rely on the individual (nongroup) market for private insurance, in which many people who have health problems are denied coverage altogether or are offered policies that exclude coverage for preexisting conditions. Because the prevalence of health problems increases with age, people ages 62 to 64 in many cases have greater difficulty than do younger adults in obtaining insurance in the nongroup market.

This option would allow people in the 62-to-64 age group who did not have employment-based health insurance or Medicaid coverage to enroll voluntarily in Medicare. Open enrollment would begin on January 1, 2011. After that initial enrollment opportunity, events that would qualify individuals for enrollment would include turning 62 or losing employment-based coverage; at either of those points, a person would have 63 days in which to enroll in the buy-in program. In estimating the budgetary effect of this option, the Congressional Budget Office assumed that participants in the buy-in program would enroll as well in Medicare's prescription drug benefit (Part D) and receive all other benefits covered by Medicare.

People who participated in the program would pay a premium equal to the expected average cost of benefits for the program's participants plus an administrative fee of 5 percent. The premium for the buy-in program would be higher than if the entire eligible population was enrolled because the program would be likely to experience adverse selection (that is, people who enrolled would

probably be heavier users of health care services, on average, than those who did not enroll). CBO estimates that the annual premium for single coverage in 2011 would be about \$7,600 (that figure includes the cost of Part D coverage). Premiums would be updated annually.

If the actual costs incurred by Medicare exceeded the premiums collected for a particular cohort of enrollees (that is, for people who entered the program in a particular year), individuals in that cohort would be required to pay an additional premium once they reached the normal age of eligibility for Medicare, and they would continue paying it until they reached age 85. The additional premium would be set at an amount that would recapture, over the expected life span of enrollees, the amount by which the cost of their benefits during the buy-in years exceeded the premiums that they paid. Conversely, if the actual costs of benefits plus the administrative fee were less than the premiums a particular cohort of enrollees paid during those years, the individuals in that group would receive a rebate on their Medicare premiums once they reached the normal Medicare eligibility age. Thus, measured over the lifetime of participants in the buy-in program, the program would have no direct effect on Medicare's spending.

CBO assumed that the government could set a premium that would cover the costs of the program's participants during the buy-in years. Under that assumption, the program would not require any new outlays during the 2010–2019 period. However, outlays for Social Security retirement benefits under this option would increase by \$370 million over the 2010–2014 period and by \$1.6 billion over the 2010–2019 period because the availability of the Medicare buy-in program would induce some people to retire sooner than they otherwise would have (because they would no longer need insurance from their employer). Over longer periods, however, the effects on

outlays should be minimal, because earlier retirement results in lower annual benefits.

At the same time, federal revenues would increase by \$90 million over the 2010–2014 period and by \$400 million over the 2010–2019 period because some self-employed individuals who otherwise would have had private nongroup coverage would enroll in the Medicare buy-in program and thus lose the favorable tax treatment ordinarily accorded their health insurance premiums. (Self-employed individuals may deduct premiums for nongroup health insurance coverage from their adjusted gross income on their tax returns. This option incorporates the assumption that premiums for the Medicare buy-in program would be ineligible for deduction, which is consistent with how premiums for the government's other health care programs are treated under current law.)

In 2014, according to CBO's estimates, about 300,000 people would be participating in the Medicare buy-in program, of whom 200,000 otherwise would have had private nongroup coverage, 80,000 would have been uninsured, and 20,000 would have remained employed and had employment-based coverage. The participants who otherwise would have been uninsured represent approximately 9 percent of the uninsured population ages 62 to 64.

An advantage of this option is that it would provide health insurance coverage to some people who without it would have been uninsured. In addition, the option would reduce the cost of insurance for some individuals who otherwise would have had private nongroup coverage. Another advantage of the option is that the buy-in

program would provide better insurance coverage for many individuals than would private nongroup policies because it would not include any restrictions on coverage for preexisting conditions. Providing such insurance coverage for so-called near-elderly individuals who otherwise would have been uninsured could lead to improvements in their health—for example, through better management of chronic diseases. (CBO did not estimate the potential budgetary effect of such improvements in health status, although better health could reduce Medicare's spending for those individuals after they turned 65. However, such improvements in health status might also reduce the number of people who died before turning 65, which would increase outlays for Medicare. Little information is available on the net effect of those countervailing factors.)

A disadvantage of this option is that the ability to buy Medicare coverage at age 62 would encourage some people to retire earlier than they otherwise would have. Some of those early retirees could face financial hardship in later years because many people underestimate the financial resources needed for retirement. In addition, because the cost of the coverage would not be subsidized, many low-income near-elderly people would continue to be uninsured. A potential problem with this option is that the amount of adverse selection that the program experienced could be greater than anticipated, which would put upward pressure on premiums and in turn reduce participation. (The potential for adverse selection would be limited in that the program would be offered only to individuals ages 62 to 64, who are more similar to each other in their health status and attitudes toward insurance than are individuals in the general population.)

«CBO»

**Option 19****Eliminate or Reduce Medicare's 24-Month Waiting Period for Recipients of Social Security Disability Benefits**

| (BILLIONS OF DOLLARS)  | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|--|------|------|------|------|------|-----------|-----------|
|  |      |      |      |      |      | 2010-2014 | 2010-2019 |
| <b>Eliminate the Waiting Period</b>  |      |      |      |      |      |           |           |
| Change in Mandatory Spending   | 0    | 6.9  | 10.5 | 11.6 | 12.4 | 41.4      | 113.3     |
| Change in Revenues <sup>a</sup>  | 0    | 0.1  | 0.2  | 0.3  | 0.4  | 1.0       | 3.3       |
| <b>Reduce the Waiting Period to 12 Months</b>                                      |      |      |      |      |      |           |           |
| Change in Mandatory Spending   | 0    | 3.7  | 6.1  | 6.7  | 7.2  | 23.7      | 64.8      |
| Change in Revenues <sup>a</sup>  | 0    | 0.1  | 0.2  | 0.2  | 0.3  | 0.8       | 2.4       |
| <b>Eliminate the Waiting Period for People Without Access to Private Insurance</b> |      |      |      |      |      |           |           |
| Change in Mandatory Spending   | 0    | 3.8  | 5.6  | 5.9  | 6.0  | 21.3      | 55.6      |
| <b>Eliminate the Waiting Period for People Without Access to Any Insurance</b>     |      |      |      |      |      |           |           |
| Change in Mandatory Spending   | 0    | 1.6  | 2.5  | 2.8  | 3.0  | 9.9       | 27.7      |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Medicare provides health insurance to disabled individuals who are younger than age 65 and who qualify for benefits under the Social Security Disability Insurance (SSDI) program. Under current law, most disabled beneficiaries do not become eligible for Medicare until 24 months after they become eligible for SSDI benefits. People cannot become eligible for SSDI benefits until 5 months after the onset of their disability, so the total waiting period for coverage by Medicare is 29 months. (However, there are exceptions to the Medicare waiting period for individuals with end-stage renal disease or amyotrophic lateral sclerosis.)

As of December 2007, approximately 1.8 million SSDI beneficiaries were in the 24-month waiting period for coverage under Medicare. Studies have found that about a fifth to a third of such individuals are uninsured. Some disabled individuals have private coverage during the Medicare waiting period, which may include coverage under a spouse's employment-based plan or a retiree plan, or continued coverage through an employee's work-based insurance plan under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, former workers of employers with more than 20 employees are entitled to continue their employment-based coverage for up to 18 months under some circumstances (or for as long as 29 months if they

are disabled). Such coverage is expensive, though, because employers can charge former employees 102 percent of the total premium for the first 18 months and 150 percent of the premium after 18 months. (The average total annual premium for single coverage under employment-based plans in calendar year 2008 was about \$4,700.) Individuals whose income and assets are low enough and who meet states' tests for disability can qualify for coverage under Medicaid while they are in the waiting period for coverage under Medicare. In addition, a small percentage of disabled individuals may obtain care during the Medicare waiting period from medical facilities operated by the Department of Veterans Affairs or the Department of Defense.

This option comprises four alternatives for eliminating or reducing the 24-month waiting period for Medicare coverage of SSDI recipients. The first alternative would eliminate the waiting period entirely, thereby making eligibility for Medicare simultaneous with eligibility for SSDI. That alternative would increase federal outlays by about \$41 billion over the 2010–2014 period and by \$113 billion over the 2010–2019 period. Those amounts reflect a decrease in federal spending for Medicaid of about \$32 billion over the 2010–2019 period because some of the SSDI recipients who would gain Medicare coverage would otherwise have been covered by Medicaid. In

addition, because the alternative would lower health insurance costs for employment-based plans, tax revenues would increase as compensation shifted from nontaxable fringe benefits to taxable wages. As a result, the option would boost tax revenues by about \$1 billion over the 2010–2014 period and by \$3 billion over the 2010–2019 period. The net budgetary effect would be to increase the deficit by \$110 billion over the 2010–2019 period.

The second alternative would reduce the Medicare waiting period from 24 months to 12 months and would thus be less costly than the first alternative. It would increase federal spending by \$65 billion over the 2010–2019 period; that amount reflects a decrease in Medicaid spending of about \$24 billion over the 10-year period. The alternative would boost tax revenues by about \$2 billion over the 2010–2019 period. The net budgetary effect would be to increase the deficit by \$62 billion over the 10-year period.

The third alternative would retain the 24-month waiting period for Medicare coverage for individuals who had access to private insurance (including COBRA coverage) that met or exceeded a specified actuarial standard. However, it would eliminate the waiting period for individuals who did not have access to such coverage. This alternative would increase federal spending by about \$56 billion over the 2010–2019 period. That amount reflects a decrease in Medicaid spending of about \$32 billion over that time.

The fourth alternative would eliminate the 24-month waiting period only for uninsured individuals, retaining the 24-month period for people who had access to private insurance or to Medicaid coverage. That alternative would increase federal spending by \$28 billion over the 2010–2019 period.

Most disabled individuals are awarded SSDI benefits at some point after they initially become eligible because of delays in applying for the program or because of the time required to adjudicate applications for disability benefits. (On average, disability insurance benefits are awarded 11 to 12 months after the date of eligibility; the median wait is 7 to 8 months.) A small percentage of SSDI recipients are awarded benefits more than 24 months after they become eligible. Under current law, those individuals are awarded benefits retroactively under Medicare for the period that began 24 months after they became eligible for SSDI benefits. Medicare reimburses those individuals or their providers (at the program's rates) for medical

services furnished during the period of retroactive eligibility.

Each of the alternatives included in this option would substantially increase the number of beneficiaries eligible for retroactive coverage under Medicare. Under the option's design, Medicare would provide such coverage to all beneficiaries for services under Part A (which includes inpatient hospital care as well as skilled nursing, home health, and hospice care). Medicare would also provide retroactive coverage only to Medicaid beneficiaries for services covered under Part B (including services provided by physicians and other practitioners, hospital outpatient departments, and suppliers of medical equipment). The option is designed to provide those retroactive Part B benefits only to Medicaid beneficiaries because of the administrative complexity of retroactively collecting Part B premiums from individuals.

An argument in favor of this option is that it would provide insurance coverage to disabled individuals who otherwise would have been uninsured. Research has shown that many SSDI beneficiaries who are uninsured during the Medicare waiting period have limited access to health care services as a result of financial constraints. Better access to medical care might improve the health of some individuals enough to enable them to leave SSDI and return to work. (The budgetary effect of that potential outcome is not estimated here. Currently, a very small percentage of SSDI recipients leave the program because of their medical recovery.) In addition, eliminating or reducing the Medicare waiting period would ease the financial burden on disabled individuals with private insurance who otherwise would have paid the premiums for that more expensive coverage.

An argument against this option is that coverage under Medicare would displace private coverage for some individuals—particularly under the two alternatives that would eliminate or reduce the waiting period for all SSDI beneficiaries, regardless of whether they had access to private coverage. Another disadvantage of the option is that by making participation in SSDI more valuable, it would increase by a modest amount the number of people who applied for those benefits and therefore boost federal spending for the program. (That budgetary effect also is not estimated here but is likely to be small.) A further argument against the option is how complex it would be to administer the retroactive Medicare coverage that would be extended to individuals who were awarded



SSDI benefits after the date of their eligibility for Medicare. Such a change would require that affected individuals keep their medical bills and submit them to Medicare at a later date; it would also require Medicare to retroactively coordinate benefits with Medicaid and other insurers. Another disadvantage of the alternative that

would eliminate the waiting period for individuals who did not have access to private insurance is that it would require a new—and costly—administrative mechanism to verify those individuals' lack of access to coverage.

«CBO»

**Option 20****Create a Medicaid Buy-In Program**

| (MILLIONS OF DOLLARS)            | 2010     | 2011       | 2012       | 2013       | 2014       | Total        |              |
|----------------------------------|----------|------------|------------|------------|------------|--------------|--------------|
|                                  |          |            |            |            |            | 2010-2014    | 2010-2019    |
| Change in Mandatory Spending     | 0        | 300        | 600        | 1,000      | 1,400      | 3,300        | 11,800       |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>100</u> | <u>200</u> | <u>400</u> | <u>500</u> | <u>1,200</u> | <u>4,000</u> |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>200</b> | <b>400</b> | <b>600</b> | <b>900</b> | <b>2,100</b> | <b>7,800</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

4

More than 44 million people in the United States lacked health insurance at a point in time in 2008. Although uninsured people constitute a diverse population, more than 80 percent of them have income of less than 300 percent of the federal poverty level. (The federal poverty level for a family of three in 2008 is \$17,600.) Federal and state policymakers have proposed a variety of approaches for reducing the number of people who lack insurance, including proposals that would establish or alter regulations governing the range of premiums that can be charged or the terms under which individuals and groups may purchase insurance as well as proposals that would expand Medicaid.

States administer their Medicaid programs under federal guidelines that specify a minimum set of services that must be provided to certain low-income individuals. Not all low-income individuals are eligible, however. Children in families with income below 200 percent of the federal poverty level qualify for public coverage in most states. At a minimum, Medicaid specifies that states must cover children under age 6 in families with income below 133 percent of the federal poverty level and older children in families whose income is below the poverty level. However many states opt to cover children in families whose income is higher. Furthermore, the State Children's Health Insurance Program (SCHIP) provides coverage for children in families with income of as much as 200 percent of the federal poverty level or 50 percentage points above the income threshold for Medicaid eligibility that was in effect before the enactment of SCHIP. In contrast, adults without a qualifying disability and adults without children are generally not eligible for Medicaid.

This option would create a buy-in program that would allow uninsured individuals who had family income of up to 300 percent of the federal poverty level to purchase Medicaid coverage for acute care services. States would be

required to expand eligibility to individuals who chose to participate. Covered benefits provided to enrollees in the buy-in program and cost sharing would be required to be equal to the standard acute care benefits and cost sharing offered to current Medicaid enrollees. However, unlike the current Medicaid program, this option would not include a direct federal subsidy for premiums. Rather, the cost to an individual would be based on the per capita costs for existing Medicaid populations (that is, for non-disabled children and adults) in that person's state. Charging one premium for all child enrollees and another premium for all adult enrollees who bought into the program would permit cross-subsidization of costs among enrollee groups (within the child and the adult categories) so that individuals in poor health would not be charged prohibitively high premiums. As a result, healthier individuals would pay a premium above their expected per capita costs. The federal government and the states would be responsible for any additional costs—with the federal government contributing the matching rate in effect in each state—that exceeded the premiums collected.

Federal outlays under this option would increase by an estimated \$3.3 billion over the 2010–2014 period and by \$11.8 billion over the 2010–2019 period. Of the roughly 1.7 million people who would obtain Medicaid coverage in 2014, about 1.1 million would otherwise have been uninsured. Of the remaining 600,000 people, about 100,000 would otherwise have had employment-based coverage, and 500,000 would otherwise have had coverage in the individual health insurance market. Higher cash wages resulting from lower rates of employment-based coverage would generate increased revenues of about \$1.2 billion over the 2010–2014 period and \$4 billion over the 2010–2019 period. The federal deficit under this option would increase by an estimated \$2.1 billion over the 2010–2014 period and by \$7.8 billion over the 2010–2019 period.

A rationale for this option is that uninsured individuals who previously had no access to private insurance or did not find private insurance affordable could obtain coverage. Some people do not have access to employment-based insurance or have been denied coverage in the individual (nongroup) market because of their poor health. Individuals denied coverage have only a limited set of options for obtaining it; as an example, high-risk pools established by the states and designed to cover people who are denied policies in the direct-purchase market exist in only 33 states, and they typically have restrictions on covering people with preexisting conditions. This option would provide Medicaid benefits with limited cost sharing regardless of an enrollee's health status.

An argument against this option is that some employers might be less inclined to offer health insurance coverage to their workers because the perceived demand for insurance would be diminished by the introduction of the new coverage alternative. Some of the employees in those firms could end up uninsured if the Medicaid buy-in

option was less affordable relative to more heavily subsidized employment-based insurance or if their family income was above 300 percent of the federal poverty level. Another argument against the option is that without direct subsidies or other means of offsetting the high cost of the program, revenues from premiums would not cover the full expenditures of the state and federal governments for providing benefits and paying administrative costs—because individuals who anticipated higher-than-average costs for health care would be more likely than others to enroll. Moreover, the administrative burden that enrolling in Medicaid poses for people and the stigma generally believed to be associated with the low-income program could deter some individuals from enrolling. In addition, the Medicaid program generally has a more limited network of providers than that available in the private insurance market—because of Medicaid's low rates of reimbursement for services—and networks of providers that are too small can impede access to care, partially offsetting the benefits of insurance coverage.

«CBO»

**Option 21****Require States to Adopt Premium Assistance Programs for Medicaid Enrollees**

| (MILLIONS OF DOLLARS)            | 2010       | 2011       | 2012       | 2013        | 2014        | Total       |               |
|----------------------------------|------------|------------|------------|-------------|-------------|-------------|---------------|
|                                  |            |            |            |             |             | 2010-2014   | 2010-2019     |
| Change in Mandatory Spending     | -100       | -250       | -440       | -710        | -1,080      | -2,580      | -12,260       |
| Change in Revenues <sup>a</sup>  | -80        | -190       | -350       | -570        | -870        | -2,060      | -10,170       |
| <b>Net Effect on the Deficit</b> | <b>-20</b> | <b>-60</b> | <b>-90</b> | <b>-140</b> | <b>-210</b> | <b>-520</b> | <b>-2,090</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

4

Through Medicaid, states may establish premium assistance programs that help enrollees who have access to employment-based (group) health insurance purchase such coverage—but only when it is cost-effective to do so. Under section 1906 of the Social Security Act, premium assistance is considered cost-effective if the reduction in Medicaid’s expenditures for each individual who enrolled in a group health plan would be greater than the expenditures for premiums and cost sharing that the state would pay on the individual’s behalf under the group health plan. Under current law, states that offer premium assistance instead of regular benefits under Medicaid must ensure that Medicaid beneficiaries enroll only in group health plans that have benefits and cost sharing comparable to Medicaid’s. If the features of a group health plan are not comparable, the state may provide benefits that “wrap around” those of the health plan to ensure comparable coverage. Those requirements are designed to protect Medicaid enrollees from reductions in benefits or increases in cost sharing.

To promote the use of premium assistance, the federal government would require states to mandate that instead of enrolling in regular Medicaid, individuals eligible for Medicaid who also have access to employment-based insurance must enroll in their state’s premium assistance program under this option. States would be required to provide premium assistance to Medicaid-eligible individuals who had access to employment-based insurance (if an employer paid at least 50 percent of the total premium) without having to ensure that the benefits or cost sharing under the private health plans equaled what Medicaid would have provided. A state would be eligible to receive federal matching payments that it could use to pay the employee’s contribution toward the private coverage. In estimating the budgetary effects of this option, the Congressional Budget Office assumed that all Medicaid-eligible individuals who had access to such insurance

would also be eligible for premium assistance but that individuals’ acceptance of offers of employment-based coverage would never reach 100 percent. (The latter assumption derives from the administrative complexity such a program would face as well as the effects of changes in labor-market participation and in the eligibility of potential enrollees in public programs.)

To enroll an individual in such a program, states would first need to verify whether he or she had access to employment-based coverage. Therefore, under this option, the federal government would require that employers with Medicaid-eligible employees report to the state’s Medicaid program the health insurance benefits for which those employees are qualified and the insurance plans in which they are enrolled. The option would decrease the federal deficit by an estimated \$0.5 billion over the 2010–2014 period and by \$2.1 billion over the 2010–2019 period. That change is the net result of a reduction in Medicaid’s outlays that is mostly offset by a decrease in federal revenues. The reduction of \$12.3 billion in Medicaid’s spending over 10 years is the net result of a decrease in Medicaid payments to providers for services furnished to individuals who, under the option, would be covered by their employer’s plan and an increase in premium payments for participants in the premium assistance program who might be enrolled in Medicaid, covered by employment-based coverage, or uninsured under current law. The decrease in revenues results from individuals who otherwise would have been uninsured or had coverage through Medicaid and who now would be receiving employment-based coverage, which would mean that some compensation would shift from taxable wages to nontaxable fringe benefits. In 2014, the first year that this option would be fully phased in, an estimated 1.2 million individuals would newly enroll in an employment-based plan, and the majority of those individuals would otherwise have been covered by Medicaid.

An argument in support of this option is that states would have more flexibility to encourage the expansion of private employment-based coverage. The requirement that employers provide data on their health insurance plans could increase enrollment in premium-assistance arrangements. (Many states maintain that enrollment remains low because of the difficulty of getting employers to provide such information.) In addition, the employers' reporting requirement would lessen the administrative burden that states currently face in verifying a Medicaid enrollee's access to employment-based coverage. Additional arguments in support of the option are that states and the federal government could use the employer's contribution to defray the costs of providing coverage and that the approach could reduce the number of uninsured people (primarily by requiring that Medicaid-eligible individuals who had access to employment-based coverage enroll in those plans and receive subsidized private coverage rather than go without insurance). In CBO's estimation, about 100,000 individuals who otherwise

would have been uninsured would gain employment-based coverage in 2014 when this option was fully phased in.

An argument against the option is that if individuals took up employment-based coverage and that coverage was less comprehensive than benefits provided under Medicaid, those individuals could lose their entitlement to some benefits offered through the public program. Because cost sharing under many of the states' Medicaid programs is nominal, enrollees would probably face higher out-of-pocket costs for medical care through an employment-based plan than they would under Medicaid. Another argument against this option is that it would increase costs for employers who would be required to provide insurance for individuals who otherwise would have been covered by Medicaid. Some employers would probably drop their health insurance coverage rather than pay the employer's share of the premium for their Medicaid-eligible employees—who without this option could receive their health benefits entirely from Medicaid.

«CBO»

**Option 22****Expand Eligibility for Medicaid Family Planning Services**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 10   | 10   | -10  | -30  | -30  | -50       | -160      |

4 According to a recent study, close to half of all pregnancies in the United States are unplanned.<sup>1</sup> (About half of those end in abortions and the other half result in live births or miscarriages.) Moreover, the rate of unplanned pregnancies among low-income women is four times greater than that among women at higher income levels. In general, Medicaid not only covers prenatal care for women with low income who qualify for such services; it also covers family planning services for those women for 60 days as part of their postpartum care. The Centers for Medicare and Medicaid Services has granted waivers to about half of all states, which give them the option to provide family planning services to certain populations who otherwise would not qualify for coverage under Medicaid. The majority of the waivers are income based—covering women who are not pregnant and have income between the Medicaid income eligibility levels and 200 percent of the federal poverty level (\$35,200 for a family of three in 2008). Many women whose household income is 200 percent of the federal poverty level are eligible, if they become pregnant, for Medicaid-funded prenatal, delivery, and postpartum care.<sup>2</sup>

1. Lawrence B. Finer and Stanley K. Henshaw, “Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001,” *Perspectives on Sexual and Reproductive Health*, vol. 38, no. 2 (June 2006).
2. States must provide Medicaid coverage to pregnant women with family income below 133 percent of the federal poverty level. The majority of states, however, have elected to expand the income-eligibility thresholds beyond 133 percent of the federal poverty level. The federal poverty level for a family of three in 2008 is \$17,600—133 percent of the federal poverty level for such a family would equal \$23,408.

This option would require states to cover family planning services for all women between the ages of 15 and 44 who were not pregnant and whose family income was up to 200 percent of the federal poverty level. That targeted expansion of coverage under Medicaid would give eligible individuals improved access to family planning services to avoid unplanned pregnancies. The new requirement would provide coverage to 2.3 million low-income women in 2014, resulting in a decrease in unplanned pregnancies that would reduce federal outlays, after accounting for the cost of the program, by \$50 million over the 2010–2014 period and by \$160 million over the 2010–2019 period.

The main argument for this option is that it would reduce the number of unplanned pregnancies while resulting in savings to the states and the federal government. A number of benefits are associated with lowering the rate of unplanned pregnancies. Women with unplanned pregnancies are less likely to recognize early signs of pregnancy and thus delay the use of prenatal services until later in their pregnancies, possibly increasing the risk of birth complications. In addition, motherhood among young women tends to result in lower educational attainment and higher reliance on public assistance. Finally, reducing unplanned pregnancies could reduce the adverse health consequences of closely spaced births.

An argument against this option is that it could cause some individuals to enroll in Medicaid who otherwise might have access to other sources of health coverage. Some opponents of this option might also argue against government-funded family planning services for young women, preferring instead an abstinence-based approach to reducing unintended pregnancies.

**Option 23****Expand Medicaid Eligibility to Include Young Adults with Income Below the Federal Poverty Level**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012  | 2013  | 2014  | Total     |           |
|------------------------------|------|------|-------|-------|-------|-----------|-----------|
|                              |      |      |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 400  | 800  | 1,300 | 1,900 | 2,500 | 6,900     | 21,900    |

As a result of expansions in eligibility for the Medicaid program since its inception and the enactment of the State Children's Health Insurance Program (SCHIP), the majority of children in families with income below 200 percent of the federal poverty level (\$35,200 for a family of three in 2008) are now eligible for either Medicaid or SCHIP. That coverage, which is based on family income, typically ends for young adults when they turn 19. In addition, most low-income young adults cannot qualify for public coverage on their own because eligibility is generally limited to children, parents, disabled and aged adults, and pregnant women. Furthermore, income-eligibility requirements for adults are generally more restrictive than they are for children.

Children who receive health care coverage as a dependent under the private or employment-based insurance policy of a parent or legal guardian also typically lose coverage at age 19 unless they qualify for certain exemptions (for example, being a full-time student). Those exemptions usually end upon the child's graduation or attainment of a specified age. In recent years, however, several states have extended the length of time during which a child may be eligible for health insurance under the policy of a parent or legal guardian.

This option would require states to expand eligibility for their Medicaid program to young adults ages 19 to 23 who had income below the federal poverty level, which is \$10,400 for a single person in 2008 and \$17,600 for a family of three. Income-eligibility levels for a young adult

would be based on family income if he or she was still considered a dependent by a parent or guardian, or on individual income if the young person was considered independent. The option would provide coverage to an estimated 1.1 million low-income young adults in 2014; it would increase federal outlays by about \$7 billion over the 2010–2014 period and by \$22 billion over the 2010–2019 period.

A rationale for this option is that it would increase the currently low rates of health insurance coverage for low-income young adults (in 2007, 44 percent of those individuals were uninsured). Low-income young adults generally have less access to employment-based health insurance than other adults because many of them work part-time or for employers that do not offer coverage. Expanding Medicaid eligibility to young adults with income below the federal poverty level would increase their access to preventive care and lower their risk of incurring large expenditures in the case of unforeseen illness.

An argument against this option is that an expansion of Medicaid would increase the program's expenditures at a time when it already faces budgetary pressures at both the federal and state level. In addition, this option could cause some young adults to enroll in Medicaid who otherwise would have been covered as dependents under their parents' private insurance policies or under their own private insurance coverage.

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**Option 24****Expand Medicaid Eligibility to Include Parents with Income Below the Federal Poverty Level**

| (MILLIONS OF DOLLARS)        | 2010 | 2011  | 2012  | 2013  | 2014  | Total     |           |
|------------------------------|------|-------|-------|-------|-------|-----------|-----------|
|                              |      |       |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 600  | 1,300 | 2,200 | 3,100 | 4,200 | 11,400    | 37,500    |

4 In low-income families, children are much more likely than adults to qualify for public health insurance. As a result of expansions to the Medicaid program that began in the late 1980s and the enactment of the State Children's Health Insurance Program (SCHIP) in 1997, a majority of children in families with income below 200 percent of the federal poverty level (\$35,200 in 2008 for a family of three) are now eligible for either Medicaid or SCHIP. For parents, however, states generally limit Medicaid eligibility to those whose income is substantially below the federal poverty level. (That restriction notwithstanding, as of 2006, 16 states had expanded eligibility for public coverage to include parents whose income is above the federal poverty level using Section 1115 waiver authority granted by the Centers for Medicare and Medicaid Services.) In 2007, roughly 42 percent of low-income parents were uninsured.

Under this option, states would be required to expand Medicaid eligibility to include all parents whose income was below the federal poverty level (which is \$17,600 for a family of three in 2008) and who had children currently enrolled in or children who were eligible for but not enrolled in Medicaid. That new requirement—which would provide coverage to approximately 1.4 million parents with income below 100 percent of the federal poverty level in 2014—would increase federal outlays by about \$11 billion over the 2010–2014 period and by \$38 billion over the 2010–2019 period.

An advantage of this option is that it would present an opportunity for uninsured parents of limited financial

means to obtain health insurance coverage for themselves and, in some cases, for their children. Coverage for newly eligible parents would boost participation for children who are currently eligible for, but not enrolled in, Medicaid or SCHIP because parents and their children would be covered under the same insurance. The Congressional Budget Office estimates that, under this option, approximately 700,000 children would obtain health insurance as a result of their parents' enrollment in Medicaid in 2014. (The costs associated with enrolling those children in Medicaid are reflected in the estimate.)

A potential drawback of this option is that expanded eligibility would lead some parents to drop private insurance to obtain coverage through public insurance. Moreover, employers with a disproportionate number of lower-income workers might be less inclined to offer health insurance to their workforce as a whole because the perceived demand would be lessened by the availability of Medicaid coverage. Nevertheless, those effects are expected to be small because the target population—parents with income below the poverty level—is less likely to have private insurance compared with individuals who have higher income. Less than 5 percent of the parents who would obtain coverage under this option would otherwise have had private insurance, CBO estimates. Another disadvantage of this option is that the increased amounts it would require states to spend could lead some states to make cuts to other parts of their Medicaid program.

«CBO»



**Option 25****Establish a Medicaid Outreach Program with Mandatory Funds**

| (MILLIONS OF DOLLARS)        | 2010      | 2011      | 2012       | 2013       | 2014       | Total      |              |
|------------------------------|-----------|-----------|------------|------------|------------|------------|--------------|
|                              |           |           |            |            |            | 2010-2014  | 2010-2019    |
| Change in Mandatory Spending |           |           |            |            |            |            |              |
| Outreach Funds               | 20        | 50        | 80         | 90         | 100        | 340        | 500          |
| Medicaid                     | 70        | 280       | 550        | 730        | 840        | 2,470      | 6,320        |
| SCHIP                        | <u>20</u> | <u>90</u> | <u>180</u> | <u>240</u> | <u>280</u> | <u>810</u> | <u>2,090</u> |
| Total                        | 110       | 420       | 810        | 1,060      | 1,220      | 3,620      | 8,910        |

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

Medicaid and the State Children's Health Insurance Program (SCHIP) finance health insurance coverage for millions of low-income adults and children, and disabled and elderly people in the United States. Both programs are administered by the states and receive federal funding based on the federal medical assistance percentage (FMAP) for Medicaid and an enhanced FMAP for SCHIP. In 2007, approximately 48 million people—adults and children, and aged, blind, and disabled individuals—were enrolled in Medicaid, on average. SCHIP served about 5 million low-income children, on average, during 2007. Even so, of the approximately 43 million Americans who lacked health insurance at a point in 2007, about 20 percent were eligible for, but not enrolled in, Medicaid or SCHIP.

This option would provide \$100 million in mandatory funds annually for five years to finance outreach and enrollment campaigns directed at those individuals who are eligible for but not enrolled in Medicaid. The outreach campaigns would be administered by state Medicaid programs, Native American tribes or tribal consortiums, and other national, state, or local community-based public or nonprofit private organizations. (Outreach efforts would also be likely to reach individuals who were eligible for but not currently covered by SCHIP and would encourage them to enroll; but those efforts would not specifically target that group because funding for SCHIP is capped under law.) Funds would be distributed through grants that would be awarded on the basis of applications submitted to the Centers for Medicare and Medicaid Services (CMS). Unspent funds allotted in any given year within the five-year window would remain available in subsequent years until spent. No state match would be required to access grant funds. However, the funds would be intended to supplement, not supplant,

current outreach programs, so funds would be available only if a state met a maintenance-of-effort requirement based on outreach spending that occurred in the year prior to implementation of this option. To ensure that the annual funding was being used specifically for outreach and enrollment activities, states and other organizations using the grant money would be required to submit an annual report to CMS indicating the amount of money spent on outreach, the outreach activities for which that money was allocated, and an estimated number of children or adults enrolled in Medicaid or SCHIP as a result of those activities.

In the Congressional Budget Office's estimation, on the basis of the increase in outreach funding provided under this option, an additional 320,000 individuals would be enrolled in Medicaid or SCHIP in 2014, boosting federal outlays by approximately \$3.6 billion over the 2010–2014 period and by \$9 billion over the 2010–2019 period.

A rationale for this option is that outreach and enrollment funding would provide states with an opportunity to reduce the number of uninsured individuals without expanding the eligibility criteria for public insurance programs. In addition, should states face budget difficulties and need to choose between paying for services and paying for administrative activities, such as outreach, this option would provide a new stream of funding that could be used for outreach. Finally, making funds available to community-based and other nongovernmental organizations (which may be more effective than governmental efforts in reaching certain segments of the Medicaid and SCHIP populations) would further improve the likelihood of increasing the number of individuals with health insurance and expanding access to health care services.

An argument against this option is that the federal government already spends a significant amount on outreach through Medicaid and SCHIP and ultimately defers to states on how best to identify and enroll beneficiaries. Moreover, state Medicaid agencies, in collaboration with other state agencies and community organizations, could

reach those eligible individuals under current program funding rules. Finally, as reflected in the estimate, each eligible individual who was enrolled as a result of this outreach funding would present an additional cost to the states and to the federal government once services began to be delivered.

«CBO»

**Option 26****Permanently Extend the Transitional Medical Assistance Provision in Medicaid**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014  | Total     |           |
|------------------------------|------|------|------|------|-------|-----------|-----------|
|                              |      |      |      |      |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 500  | 800  | 800  | 900  | 1,000 | 4,000     | 10,000    |

Medicaid provides transitional medical assistance (TMA) to certain beneficiaries who otherwise would lose eligibility because of increased earnings. The beneficiaries who qualify for TMA are usually former recipients of funds from the Temporary Assistance for Needy Families program, which generally provides, for a limited time, cash assistance, child care, and training opportunities to low-income families with dependent children. Through TMA, both the parents and children in those families qualify for at least 6 months and up to 12 months of medical assistance if their family income rises above the level established for Medicaid eligibility for families, but remains below 185 percent of the federal poverty level. This mandatory eligibility category is currently authorized through June 30, 2009, and will expire after that date.

This option would permanently extend the TMA eligibility category. The Congressional Budget Office estimates that the option would increase federal spending by \$4 billion over the 2010–2014 period and by about \$10 billion over the 2010–2019 period. In 2014, there would be an estimated 570,000 people covered under this Medicaid eligibility category.

A rationale for a permanent extension of TMA is that such action would provide low-income working families with health insurance as their income rose above levels that otherwise would make many of them ineligible for Medicaid. In the absence of such action, eligibility for

Medicaid would be lost as family incomes rose. Although those individuals have joined the workforce, a significant percentage of them might not work in jobs that offered employment-based health insurance, or they might be unable to afford such insurance if it was offered. Given the importance of health insurance to many low-income families, the loss of Medicaid could provide a disincentive for them to increase their earnings by working additional hours or obtaining higher-paying jobs. Even though extending the TMA category would not eliminate that disincentive, it would move up the point at which the disincentive occurred to 185 percent of the poverty level.

An argument against this option is that certain individuals who would qualify for TMA could be eligible for employment-based insurance and therefore TMA would serve as a disincentive for enrollment in available private coverage. According to the Census Bureau's Current Population Survey, about 10 percent of adults and 18 percent of children whose family income is below the poverty line are covered by employment-based insurance. Although coverage rates in those instances are lower than they are for groups with higher income, they indicate that employment-based insurance would be available and affordable for some potential TMA enrollees. Enrollment in such insurance, though often more costly for individuals than Medicaid, typically affords better access to providers and could involve less stigma for enrollees.

«CBO»

**Option 27****Allow People and Firms to Buy Health Insurance Plans Through the Federal Employees Health Benefits Program**

| (MILLIONS OF DOLLARS)            | 2010        | 2011        | 2012        | 2013        | 2014        | Total         |               |
|----------------------------------|-------------|-------------|-------------|-------------|-------------|---------------|---------------|
|                                  |             |             |             |             |             | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending     | -50         | -120        | -190        | -280        | -380        | -1,020        | -3,440        |
| Change in Revenues <sup>a</sup>  | <u>-110</u> | <u>-230</u> | <u>-380</u> | <u>-530</u> | <u>-710</u> | <u>-1,960</u> | <u>-6,200</u> |
| <b>Net Effect on the Deficit</b> | <b>60</b>   | <b>110</b>  | <b>190</b>  | <b>250</b>  | <b>330</b>  | <b>940</b>    | <b>2,760</b>  |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

The Federal Employees Health Benefits (FEHB) program, administered by the Office of Personnel Management (OPM), offers health benefits to current and former federal employees and their families. As of 2007, the FEHB program managed approximately 300 health plans that provided health coverage to about 8 million enrollees. Eligible employees, retirees, and their dependents have a choice of plans, including several nationwide fee-for-service plans and, depending on the region, one or more managed care products. The government contributes a defined amount toward the premiums of FEHB plans—72 percent of the national average premium but only up to 75 percent of an individual plan's premium. OPM has the authority to negotiate premiums and benefits with private insurers and to oversee insurers' compliance with consumer protection and other federal laws.

This option would allow individuals and private firms not affiliated with the federal government to purchase coverage through the FEHB program. Unlike federal employees, who receive contributions from their employer, individual purchasers in this new insurance market would be directly responsible for the full cost of the premium, and individuals whose employer purchased coverage through an FEHB plan would be responsible for any costs in excess of their employer's contribution. The new program would constitute a separate insurance risk pool for nonfederal enrollees, and their premiums would not be the same as those for federal employees. However, premiums would be the same for all nonfederal enrollees within each plan in a particular geographic area and would be based on the expected medical claims of the plan's enrollees. To reduce the likelihood that some individuals would avoid enrolling in the program until they needed health care services, this option would introduce an annual open-enrollment period similar to the provision for such a period in the current FEHB program.

Subject to applicable laws, plans could exclude coverage of certain preexisting health conditions for a specified period but could not deny coverage altogether. To ensure that insurers would participate, OPM could require them to offer coverage to nonfederal enrollees as a condition of participating in the FEHB program.

In calculating the budgetary effects of this option, the Congressional Budget Office assumed that the benefits and cost-sharing features of the plans offered through the new program would resemble those offered through the current FEHB program. CBO also assumed that the premiums for nonfederal enrollees would be structured so that they covered any new administrative costs that OPM might incur, including fixed costs related to setting up the program and negotiating additional contracts with insurers, as well as costs related to enrolling new beneficiaries, collecting premiums, and resolving disputes between enrollees and insurers. As a result, the option as structured would not lead to any new outlays by the federal government.

Implementing this option would reduce federal revenues by an estimated \$2.0 billion over the 2010–2014 period and by \$6.2 billion over the 2010–2019 period. Federal revenues would decrease because an estimated 900,000 individuals would gain employment-based insurance through employers who purchased FEHB plans and compensation would shift from taxable wages to nontaxable fringe benefits. In 2014, an estimated 2.3 million individuals would purchase a plan through the expanded FEHB program if offered the opportunity—1.3 million who otherwise would have been uninsured and 800,000 individuals who would have purchased individual private insurance policies but who would switch to coverage through the FEHB program.

Federal outlays would decrease by approximately \$1.0 billion over the 2010–2014 period and by \$3.4 billion over the 2010–2019 period because approximately 200,000 individuals who would obtain employer-purchased FEHB coverage would otherwise have had coverage under Medicaid. Because revenues would decline more than outlays would, the net effect would be an increase in the federal deficit.

The above estimates reflect an assumption that individuals who enrolled in the expanded FEHB program would have greater-than-average health risks, which would lead to higher premiums and greater growth in premiums than if the entire eligible population had enrolled in the program. The estimates of budgetary effects do not include the costs of brokers' fees that some employers and individuals would pay to purchase coverage in the expanded FEHB market. Hence, the option effectively assumes that some of the revenue from premiums would be directed toward advertising as well as Internet and telephone enrollment systems—which would obviate the need for brokers. Nonetheless, because many small firms and individuals may find brokers' services valuable, policymakers might consider allowing such services to be used in conjunction with this option, albeit at a higher effective premium.

Proponents of this type of option argue that the FEHB program is well suited to serve as a vehicle for expanding coverage because it offers a wide range of health plans that compete directly for enrollees. In addition, a well-established system is in place for administering such a program. Proponents also maintain that opening up the FEHB program to nonfederal enrollees would extend an additional health insurance option to individuals and firms that might view their existing options as unattractive, as well as an option to individuals who could not obtain coverage because of previous health conditions. (In contrast to some insurance plans, FEHB plans cannot selectively deny applicants coverage on the basis of their health status, although this option would allow FEHB insurance carriers in the nonfederal program to deny coverage for certain preexisting conditions.) Another argument in support of the option is that for individuals and small-employer groups, the administrative costs of insurance purchased in a larger pool might be lower than

those purchasers could have obtained in the market for private insurance. (Such costs include those associated with developing and disseminating information about the plans and the FEHB program, and insurers' costs for assessing the health risks of potential enrollees.)

An argument against the option is that there is a significant risk that the premiums for plans in the expanded FEHB program might not be attractive enough to draw a large and stable pool of enrollees. The feature of the program that guarantees coverage would be particularly attractive to individuals and firms that had a greater-than-average risk of incurring large medical expenses, and their enrollment in large numbers would put upward pressure on the premiums in the new program. Further, because carriers in the new FEHB program would be wary of underestimating the degree to which their plan would attract enrollees with greater-than-average expected health costs, actual premiums could be even higher than those anticipated in this estimate, which were calculated so that premium revenues would approximately equal expected costs plus administrative fees. Such a response by insurers would cause lower enrollment than suggested above and, if premiums did not fall in later years as insurers competed for enrollees, would increase the likelihood that the program would be unstable over the long term. A related concern stems from the fact that insurers have not offered this option voluntarily—which could indicate that charging a single premium regardless of health risk might not be viable in the health insurance marketplace (except in states where other insurers face the same requirement). Moreover, the wide array of plans in the FEHB program might be a problem if sicker enrollees chose more generous or more flexible plans—choices that would lead to higher premiums for those plans and further discourage healthier enrollees from selecting them. Another argument against this option is that some insurers might leave the existing FEHB program if they found the conditions of participation under this option burdensome or unprofitable. Recognizing the above concerns, policymakers could consider additional incentives to encourage people to enroll, such as providing direct subsidies to the program or allowing the adjustment of premiums for the age of enrollees or their expected health spending.

**Option 28****End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8**

| (MILLIONS OF DOLLARS)            | 2010   | 2011   | 2012   | 2013   | 2014   | Total     |           |
|----------------------------------|--------|--------|--------|--------|--------|-----------|-----------|
|                                  |        |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending     | 2,300  | 2,400  | 2,400  | 2,500  | 2,600  | 12,200    | 26,100    |
| Change in Discretionary Spending |        |        |        |        |        |           |           |
| Budget authority                 | -4,700 | -4,900 | -5,000 | -5,100 | -5,300 | -25,000   | -53,600   |
| Outlays                          | -4,300 | -4,800 | -5,000 | -5,100 | -5,200 | -24,400   | -52,800   |

Note: Discretionary savings accrue to the Department of Veterans Affairs; increases in mandatory outlays are projected for the Medicare program.

Veterans who seek medical care from the Department of Veterans Affairs (VA) are enrolled in one of eight priority care groups that are defined on the basis of income, disability status, and other factors. Veterans in Priority Group 8 are those without service-connected disabilities whose income and assets are above both a means-tested threshold that is updated each year by VA and a geographic income index established and updated by the Department of Housing and Urban Development (HUD). Veterans who are enrolled in Priority Group 7 have no service-connected disabilities; their incomes are above the VA threshold but below the HUD geographic index. About 2.3 million veterans who have enrolled for VA medical services are in Priority Groups 7 and 8.

Veterans in those groups make copayments for their care, and if they have private health insurance, VA bills those insurance plans. Copayments and private-plan billings cover about 21 percent of the cost of those veterans' care. For 2008, VA anticipated \$3.4 billion in net spending for those patients, or about 12 percent of the department's total budget for medical care. When the priority system was established in 1999, the Secretary of Veterans Affairs was charged with deciding how many priority groups VA could serve each year. Since then, VA's medical costs have more than doubled, and in 2003, the department cut off new enrollment of veterans in Priority Group 8. Veterans who were already enrolled were allowed to remain in the program.

This option would close enrollment for Priority Group 7 veterans and disenroll all veterans in Priority Groups 7 and 8, thus curtailing VA's health care spending for veterans who are not poor and who do not have service-related medical needs. To be eligible for VA medical services

under this option, a veteran would have to qualify for a higher priority group by demonstrating a service-connected disability, by documenting income that was below the means-tested threshold, or by qualifying under other criteria (such as exposure to Agent Orange, status as a Purple Heart recipient or former prisoner of war, eligibility for Medicaid, or catastrophic non-service-connected disability). Disenrolling all Priority 7 and Priority 8 veterans would reduce discretionary outlays on net by an estimated \$24 billion over the period from 2010-2014 and by \$53 billion between 2010 and 2019, under the assumption that appropriations were reduced accordingly. Implementing this option, however, would increase mandatory spending for Medicare by an estimated \$12 billion from 2010 to 2014 and by \$26 billion from 2010 to 2019.

An advantage of this option is that it would refocus VA's attention and services on its traditional group of patients. Higher-income veterans without service-connected disabilities gained access to the VA system only in the mid-1990s, when the federal budget was under less strain and experiencing less demand for services by higher-priority veterans. In 2007, 90 percent of enrollees in Priority Groups 7 and 8 had other health care coverage, most notably Medicare and private health insurance. As a result, the vast majority of the veterans who would lose VA coverage under this option would have access to other sources of care.

A disadvantage of the option is that veterans enrolled in Priority Groups 7 and 8 who have come to rely on VA for at least part of their medical care might find their health care disrupted by the change in enrollment rules. Some of those veterans—particularly those whose income was just

above the threshold and the HUD index—might have difficulty identifying or affording high-quality health care from other sources. A possible alternative to this option would be to allow veterans in Priority Groups 7 and 8 to

enroll in VA health care if they could demonstrate that they did not have access to other health insurance coverage. Such an alternative would reduce the estimated savings under the option.

RELATED CBO PUBLICATIONS: Statement of Allison Percy, Principal Analyst, before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, *Future Medical Spending by the Department of Veterans Affairs*, February 15, 2007; *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs*, Letter to the Honorable Larry E. Craig, July 14, 2006; and *The Potential Cost of Meeting Demand for Veterans' Health Care*, March 2005

«CBO»

**Option 29****Reopen Enrollment for VA Medical Care Among Priority Group 8 Veterans for Five Years**

| (MILLIONS OF DOLLARS)            | 2010  | 2011  | 2012  | 2013  | 2014  | Total     |           |
|----------------------------------|-------|-------|-------|-------|-------|-----------|-----------|
|                                  |       |       |       |       |       | 2010-2014 | 2010-2019 |
| Change in Discretionary Spending |       |       |       |       |       |           |           |
| Budget authority                 | 1,400 | 2,200 | 3,000 | 3,100 | 3,200 | 12,900    | 29,700    |
| Outlays                          | 1,200 | 2,000 | 2,900 | 3,000 | 3,200 | 12,300    | 29,000    |

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Veterans who enroll in the health care system administered by the Department of Veterans Affairs (VA) are assigned to one of eight priority care groups on the basis of such factors as income and extent of disability. Each year, the Secretary of Veterans Affairs announces which enrollment categories of veterans will be eligible to receive VA health care in the following year. That determination is based on estimates of health care costs and VA's available resources.

Since January 2003, VA has accepted no new enrollments in Priority Group 8, which comprises veterans who have no service-connected disability and whose income is above certain geographically adjusted thresholds. This option would require VA to accept enrollments from that group during the 2010–2014 period but would restore the freeze on new enrollments from that group after 2014. However, between 2010 and 2014, many Priority Group 8 veterans would enroll, and if VA's resources were stretched to capacity, providing care for those veterans would affect the volume of services available for veterans in Priority Groups 1 through 7.

Advocates of this option note that it would allow access to VA medical services for the 10 million veterans that in VA's estimation fall into Priority Group 8 but who are not currently enrolled. Although most of those individuals would probably not seek care from the VA system, a number of them might enroll, perhaps to reduce their out-of-pocket costs for pharmaceuticals and medical services, to gain access to specialty services (such as treatment for spinal cord injury or mental health services) for which VA is well known, or to take advantage of VA's approach to health care (which strives to ensure that patients' care meets recognized clinical guidelines).

If this option was implemented, VA would probably experience a substantial influx of new enrollees. One

potential negative result would be that veterans in both Priority Group 8 and higher priority groups would face longer waiting times for many services if VA did not have sufficient existing capacity or could not expand its network of clinics to meet the increased demand for services. VA has enacted scheduling rules to ensure that patients with service-connected disabilities receive priority when appointments are scheduled. However, under this option many patients might face delays or referrals to distant facilities in order to meet the expanded demand for VA services.

Data from VA about the population of potential Priority Group 8 enrollees suggest that implementing this option would result in the enrollment of about 1.7 million new Priority Group 8 veterans in the VA health care system by 2012. The Congressional Budget Office assumed for its estimates that VA would incur the same costs for the care received by those veterans that it incurs for the care it provides to veterans who are currently enrolled in Priority Group 8; under that assumption, annual net costs for an additional enrollee would average an estimated \$1,580 in 2010. (The net cost equals the cost of care minus copayments and third-party reimbursements.) That estimate assumes that the expansion of services would not entail large-scale expenditures for construction or difficulties in hiring sufficient medical personnel. The option would increase VA's health care costs—providing the funds were appropriated—by about \$12 billion over the 2010–2014 period and \$29 billion from 2010 through 2019. Those discretionary spending totals, which include an adjustment for anticipated inflation, represent an increase in annual spending of approximately 8 percent compared with VA's 2009 appropriation for medical care.

Some of the newly eligible veterans who enrolled in Priority Group 8 would also be eligible for Medicare. If VA received sufficient funds to serve those new enrollees, its



care might substitute for care that otherwise would be provided under Medicare.<sup>1</sup>

In estimating spending under this option, CBO assumed that most Priority Group 8 veterans would not enroll in the VA health system and that the veterans who did enroll

would rely on other health care coverage for most of their needs, seeking less than a quarter of their care from VA. CBO also assumed that VA could provide care for the new enrollees at the same average cost as the care received by current enrollees in Priority Group 8. However, expanding access to VA medical care by 1.7 million new enrollees without increasing waiting times would probably entail costs for new construction and other expenditures related to expansion, which would require more discretionary funding than is estimated for this option.

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1. Those potential effects on Medicare spending are not estimated here because they would be contingent on provisions enacted in subsequent appropriation acts.

RELATED CBO PUBLICATIONS: *Cost Estimate for S. 1233, the Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007*, August 23, 2007; Statement of Allison Percy, Principal Analyst, before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, *Future Medical Spending by the Department of Veterans Affairs*, February 15, 2007; *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs*, Letter to the Honorable Larry E. Craig, July 14, 2006; and *The Potential Cost of Meeting Demand for Veterans' Health Care*, March 2005



## The Quality and Efficiency of Health Care

**T**he quality of health care in the United States has long been of concern to policymakers. Despite spending more per capita than other nations, the United States lags behind lower-spending nations on several metrics, including life expectancy and infant mortality.<sup>1</sup> In addition, many experts believe that the health care delivery system is ill suited to meet current and future health care needs, particularly with respect to the treatment of chronic conditions. Although many treatments undoubtedly save lives and improve health—and the aggregate benefits from health care spending probably exceed the costs—evidence also indicates that much spending is not cost-effective and in many cases does not even improve health. Those concerns have generated calls to increase the efficiency of the health care system.

Together, Medicare and Medicaid account for a large share of total health care costs and are thought to influence health care delivery in the broader health care system; therefore, changes in those two programs would have a ripple effect throughout the system. In recent years, interest has grown in reducing incentives for providers to perform services of marginal benefit and increasing incentives for them to improve quality. Evidence that those approaches would lead to long-term changes in the rate of growth in health care costs is, however, lacking in many cases. In addition, the process of converting innovative ideas into successful programmatic changes would probably require some experimentation and would take a number of years.

Medicare, which is largely financed by the federal government within mostly uniform national policies on cover-

age and payments, offers opportunities to develop and test strategies to reduce costs and improve the quality of care. Several current Medicare initiatives, such as Hospital Compare, enable the government to collect data and evaluate the performance of providers. Medicare has also begun to explore ways to link payments more explicitly to the quality of the care that beneficiaries receive.

In the case of Medicaid, states have the primary responsibility for administering the program, so improving the quality of the care that Medicaid provides can be more challenging. To date, states have taken the initiative in pursuing ways to improve quality in Medicaid, and the effects of their efforts have varied widely from state to state.

Policymakers have also expressed a strong interest in encouraging providers to adopt health information technology (health IT) to improve both the quality of care and the efficiency with which it is delivered. (Health IT refers to information technology applications specifically designed for the practice of clinical medicine, including electronic health records, personal health records, health information exchange, computerized physician order entry, clinical decision support systems, and electronic prescribing.)

Most of the options in this chapter focus on ways to improve the quality of the care provided to Medicare and Medicaid beneficiaries. Some options are broader and would affect the larger health care system. In addition, two options would consolidate federal funding that supports medical education and helps pay for uncompensated care. (Medicare and Medicaid both make payments to support medical education and relieve hospitals of the burden of uncompensated care.)

1. See, for example, Gerard F. Anderson and Bianca K. Frogner, “Health Spending in OECD Countries: Obtaining Value Per Dollar,” *Health Affairs*, vol. 27, no. 6 (November/December 2008), pp. 1718–1727.

**Option 30****Bundle Payments for Hospital Care and Post-Acute Care**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 0    | -200 | -500 | -700      | -18,600   |

The Medicare fee-for-service program pays health care providers fixed amounts for each service provided to beneficiaries. Medicare's definition of the unit of service varies depending on the setting where treatment is provided. In hospitals, the unit is a discharge; in skilled nursing facilities, the unit is a day; and in home health care settings, the unit is a 60-day "episode." For example, a Medicare beneficiary who is hospitalized and then discharged to a skilled nursing facility generates one payment to the hospital plus additional payments for each day spent in the facility.

Payments are referred to as bundled when the unit of payment includes multiple individual services. For instance, hospitals receive a single bundled payment from Medicare for each discharge; that payment covers all of the services provided by the hospital during the stay, including nursing, room and board, operating room fees, and so on. In general, bundled payments offer providers an incentive to reduce the costs of the services within each component of the bundle and to increase the efficiency with which they provide medical care.

Under this option, the unit of payment for acute care provided in hospitals would be redefined and expanded to include post-acute care provided both in acute care hospitals and nonhospital settings. Hospitals would receive a single bundled payment from Medicare for such services. The new bundled payment rates would initially be set equal to the rate currently paid for each Medicare severity diagnosis-related group (MS-DRG)—the current method of categorizing inpatient Medicare cases on the basis of diagnosis—plus the average costs across all post-acute care settings for treating patients in that MS-DRG. Hospitals would receive the full bundled payment regardless of whether a specific patient received post-acute care. Medicare would no longer make separate payments for post-acute care services following an acute care inpatient hospital stay. Those services would be provided directly by the hospital or by other providers under contractual arrangements with the discharging hospital. Post-acute

care would be defined as any service that was initiated within 30 days of a patient's discharge from an acute care inpatient hospital and that was provided by a home health agency, a skilled nursing facility, an inpatient rehabilitation facility, a long-term care hospital, or a hospital-based outpatient rehabilitation facility. Beneficiaries would continue to face cost-sharing requirements for post-acute care based on current law. Bundled payments would be applied beginning in 2013 to hospital discharges accounting for at least one-third of post-acute care admissions (to be determined by the Secretary of Health and Human Services) and would apply to all admissions beginning in 2015. Those changes would reduce federal outlays by an estimated \$0.7 billion over the 2010–2014 period and by almost \$19 billion over the 2010–2019 period.

Under this option, hospitals would probably reduce the cost of post-acute care services for Medicare beneficiaries, relative to the cost that otherwise would have occurred. Such savings could occur through reductions in the volume or intensity of post-acute care, or through hospitals' contracting with lower-cost providers. Medicare's annual update factors (annual increases in base payment rates determined in part on the basis of increases in the prices for various "inputs," such as labor and equipment, that medical providers use to produce medical services) for hospitals would be adjusted downward so as to recapture 80 percent of the anticipated reductions in the costs of post-acute care. Those adjustments would enable hospitals, in the aggregate, to retain approximately 20 percent of the anticipated savings they produced.

An advantage of this option is that hospitals would become more involved in coordinating post-discharge care and in arranging post-acute care. Further, hospitals would have an incentive to be economical in making those arrangements. They would have flexibility in determining whether and how the costs of post-acute care should be reduced. An argument against this option is that hospitals might reduce medically beneficial

post-acute care services, which could be detrimental to beneficiaries' health outcomes. In addition, because of geographic differences in current patterns in the use of post-acute care, some hospitals could reap large financial windfalls without changing their practice patterns or improving patients' outcomes.

An alternative approach to bundling would be to combine payments for inpatient hospital care with payments for concurrent physicians' services (meaning those provided during inpatient hospital stays). Hospitals, under this alternative, would receive a single payment from Medicare for each discharge, a portion of which would be intended to cover the cost of physicians' services provided during the stay. A rationale for that type of bundling is that it would give hospitals and physicians incentives to

coordinate care and to provide care efficiently. In particular, hospitals would have an incentive to eliminate unnecessary physician consultations provided during hospital stays. That form of bundling could, however, carry the risk that appropriate physicians' services would be limited or withheld.

The bundling of hospital and physician payments for selected surgical procedures is discussed in Option 34. The Congressional Budget Office did not estimate the budgetary impact of a broader alternative for bundling physician and hospital payments; however, in principle, hospital and physician bundling has the potential to spur gains in efficiency that could be recouped at least in part by the Medicare program.

«CBO»

**Option 31****Reduce Medicare Payments to Hospitals with High Readmission Rates**

| (MILLIONS OF DOLLARS)                                      | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|--|------|------|--------|--------|--------|-----------|-----------|
|  |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending                               |      |      |        |        |        |           |           |
| Hospitals with readmission rates above the 50th percentile | 0    | 0    | -1,000 | -1,000 | -1,100 | -3,100    | -9,700    |
| Hospitals with readmission rates above the 75th percentile | 0    | 0    | -800   | -800   | -900   | -2,500    | -8,100    |

5 Medicare compensates hospitals for providing acute care through the Inpatient Prospective Payment System, which determines hospital payments on the basis of the following: patients' diagnoses and the severity of their illness or injury; geographic variations in hospital costs; and other hospital- and patient-specific factors. Under that system, hospitals receive full payment for patient readmissions, regardless of whether the readmission was preventable, related to the initial admission, or the result of insufficient post-acute care coordination. The Medicare Payment Advisory Commission (MedPAC) stated that in 2005, about 18 percent of Medicare's acute care hospital admissions resulted in readmissions within 30 days of the patients' discharge.<sup>1</sup> According to that report, a large share of those readmissions may have been "potentially preventable," although in practice, patients may have experienced complications or relapses that were beyond the hospitals' control; therefore, some portion of those readmissions were probably unavoidable.

This option would have two components: requiring the public reporting of readmission rates and the implementation of payment reductions for hospitals with excessive readmission rates. Hospitals with excessive readmission rates would be defined as those with a high readmission rates relative to their expected readmission rate. The latter would be defined as the median hospital readmission rate for certain conditions or procedures and would be based on data collected from hospitals after adjusting for the severity of patients' conditions. Instead of recalculating expected rates on an annual basis, those original expected readmission rates would be used as a baseline in each subsequent year the policy was in effect. Such an approach would provide hospitals with a fixed and stable target.

1. See Medicare Payment Advisory Commission, *Report to the Congress: Promoting Greater Efficiency in Medicare* (June 2007).

Although not assumed as part of this option, policymakers might choose to recalculate the target in the future if it became evident that wide variation in readmission rates and quality of care remained.

Under this option, the Centers for Medicare and Medicaid Services would, starting in 2011, analyze hospital-level data on acute care readmissions that occurred during 2009 and 2010. On the basis of that initial analysis, the Secretary of Health and Human Services would designate the targeted categories of conditions and procedures and use that information to identify potentially preventable readmissions. That analysis would be used to determine which hospitals would be at risk for reduced payments beginning in 2012. The estimate underlying this option incorporates the effects of reduced payments for excessive readmissions related to eight condition and procedure groups.

Beginning in 2012, hospitals with excessive readmission rates for a targeted condition or procedure would be subject to a withholding of payment for patients admitted within the identified Medicare severity diagnosis-related group (MS-DRG). If the patient was readmitted to an acute care hospital within 30 days of discharge because of a complication or related diagnosis, Medicare would keep the withheld funds; otherwise, the hospital would receive the withheld amount. Hospitals would not receive a reduced payment for readmissions for unrelated hospitalizations, planned readmissions, or for readmissions of cancer and burn patients. Beginning in 2013, data on readmissions would be made available to the public.

Under this option, Medicare would reduce payments to hospitals with risk-adjusted readmissions above either the median or the 75th percentile for each targeted condition or procedure. Reducing payments by 20 percent to

hospitals with readmission rates above the median for a targeted condition or procedure would lower federal outlays by about \$3 billion over the 2010–2014 period and by almost \$10 billion over the 2010–2019 period. Using the 75th percentile to define excessive readmission rates and applying a 30 percent reduction would reduce Medicare’s spending by about \$2.5 billion over the 2010–2014 period and by about \$8 billion over the 2010–2019 period. Those estimates are based on an analysis that classifies certain readmissions as “potentially preventable”; actual savings would depend on the classification system used and how the thresholds were set. The estimates also assume savings from hospitals’ taking action to reduce readmissions, some of which would be offset by additional use of post-acute care services.

An argument in favor of reducing payments to hospitals with high readmission rates is that such action would provide a financial incentive for hospitals to offer higher-quality care. Implementing the option could result in better coordination of care between the hospital and post-acute care facility, including improved communication

between the patient, the hospital, and any providers of post-acute care or other caretakers. Further, this option could reduce the wasteful spending associated with preventable readmissions.

An argument against this option is that high readmission rates may be due, in part, to factors beyond a hospital’s control, including patients’ or caretakers’ lack of adherence to discharge orders or the quality of care provided at a post-acute care facility. Moreover, accurately identifying preventable readmissions is a complex and potentially subjective exercise that could be burdensome for Medicare administrators to implement. Another argument against this option is that some hospitals might try to avoid the risk of readmissions by increasing patient discharges to post-acute facilities, thus potentially offsetting any savings from reducing readmissions. (One method for addressing that issue is included in Option 30.) Also, payment reductions could deter hospitals from treating patients with the targeted conditions, which could impede some enrollees’ access to care.

«CBO»

**Option 32****Expand the Hospital Quality Incentive Demonstration to All Hospitals**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -300 | -300 | -300 | -300 | -1,200    | -2,900    |

5 In 2003, the Centers for Medicare and Medicaid Services launched the Hospital Quality Incentive Demonstration (HQID), a project that offers participating hospitals financial incentives to provide high-quality health care. Participating hospitals report data on the quality of care provided to patients who receive treatment for selected clinical conditions (heart attack, heart failure, or pneumonia) or undergo certain procedures (specifically, hip or knee replacement or coronary bypass graft surgery). That information is used to calculate a composite quality score for each hospital. Hospitals with the highest scores receive bonuses of 1 percent to 2 percent of standard Medicare payments for patients with the selected conditions; hospitals that fail to meet a baseline quality measure (established during the program's first year) face reductions in standard payments of 1 percent to 2 percent. About 250 hospitals in 36 states participate in the demonstration project.

Under this option, all hospitals would receive reduced Medicare payments for inpatient hospital care for the five selected clinical conditions. The reduction would be based on estimates of productivity growth consistent with those used in the calculation of the Medicare economic index (typically estimated to be between 1.0 and 1.5 percentage points per year). This option would also implement quality incentives similar to those used in the HQID. On the basis of the data on quality that they submitted, top-performing hospitals would receive bonus payments of between 0.75 percent and 1.50 percent. (No additional payment reductions would be made for

hospitals that provided lower-quality care once the initial payment reduction was made.) On the basis of the reduction in Medicare payments, the Congressional Budget Office estimated that this option would reduce federal outlays by \$1.2 billion over the 2010–2014 period and by \$2.9 billion over the 2010–2019 period. Savings could be greater if quality improvements led to reductions in either hospital readmissions or the use of other medical services. Additional savings could result from varying the option, including reducing payments to hospitals that reported the lowest quality scores.

Proponents of a quality-based hospital payment system—also known as a pay-for-performance system—argue that it would improve upon Medicare's standard payment methods by adding a quality-improvement incentive to the cost-cutting incentive that now exists under the acute hospital inpatient prospective payment system. During the HQID's first three years of operation, quality measures rose in participating hospitals in all five clinical categories.

An argument against this option is that many hospitals currently lack the data collection and reporting capabilities that participating in the program would require. Investing in the necessary technology could pose financial difficulties for those hospitals, which, in turn, could actually intensify the challenges associated with improving quality of care.

«CBO»



**Option 33****Deny Payment Under Medicaid for Certain Hospital-Acquired Conditions**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -5   | -5   | -5   | -5   | -20       | -45       |

Under Medicaid, states have significant flexibility in determining how and how much to pay hospitals for caring for Medicaid enrollees. In contrast, the Medicare program uses a prospective payment system (PPS) to pay hospitals for operating costs that are tied to providing inpatient services to beneficiaries. Under that system, Medicare pays hospitals on a per-case basis according to preset rates—which are determined by taking a base rate for a given diagnosis and adjusting it to reflect local labor costs, the clinical characteristics of the patient involved, and other factors. Thus, Medicare often pays a higher rate for a case in which more than one medical condition is present because multiple conditions add to the complexity of the care required.

Under current law, however, Medicare is required to deny payment for some of those complicating secondary diagnoses if they are not present when a patient is admitted to the hospital. Specifically, the law requires the Secretary of Health and Human Services to identify certain “hospital-acquired conditions” (HACs) on the basis of three characteristics: The costs for treating the condition are high or the condition is particularly prevalent, or both; the condition as a secondary diagnosis results in a higher payment for the hospital; and the condition could reasonably have been prevented if the hospital had followed evidence-based guidelines in caring for the patient. Medicare will not pay a hospital for the costs incurred in treating one of those identified HACs if the condition is the sole secondary diagnosis responsible for a higher payment. To date, the Secretary has identified 12 such conditions and has the authority to modify the list of conditions in the future.<sup>1</sup> The HACs now on the list include such condi-

tions as pressure ulcers, falls and trauma, and certain infections of surgical sites.

This option would apply Medicare’s HAC rules to payments to hospitals for inpatient care covered by Medicaid. Under the option, states would be prohibited from paying hospitals for the same hospital-acquired conditions that the Secretary of Health and Human Services had identified for the Medicare program. That change would save an estimated \$20 million over the 2010–2014 period and \$45 million over the 2010–2019 period.

The HAC provision was intended to help improve the quality of health care and reduce medical errors by giving hospitals a financial incentive to avoid preventable conditions. Under this option, hospitals would be responsible for treating a patient who acquired one of the identified conditions after admission, but Medicaid would not pay the hospital for the costs of the care provided (although Medicaid would pay for treating the patient’s primary diagnosis). Hospitals would not therefore receive payment for certain medical errors, a restriction that might lead them to enhance the controls they maintained to monitor the quality of their care and so reduce the incidence of identified HACs.

A potential drawback of the option is that it does not take into account that in certain circumstances and for certain patients, hospitals could not reasonably be expected to prevent some of the identified conditions. The provision of medical care at times requires subjective judgments. The imprecise nature of those judgments and the complexity of some patients’ conditions may make prevention impossible in certain cases. Nevertheless, under this option, hospitals in those situations would be denied payment for treating those conditions, which could lower revenues for hospitals and potentially strain their budgets.

1. Estimates for this option do not include the impact of the new national coverage determinations announced on December 2, 2008, that will prevent Medicare from paying for three additional medical errors.

**Option 34****Establish Regional Centers of Excellence for Selected Surgical Procedures Covered by Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -30  | -30  | -40  | -40  | -140      | -450      |

5 Medicare pays hospitals and physicians separately for services provided during an inpatient stay. Acute care hospitals, which are paid under Medicare's prospective payment system, receive a fixed, predetermined amount for each admission based on the patient's diagnosis and other factors. Providing additional services or more intensive treatment does not generally mean greater payments, so hospitals have a strong incentive to contain costs for each admission (in some cases, additional payment is available for high-cost "outlier" patients). Physicians, by contrast, generally are paid on the basis of a fee schedule for each individual service they provide and therefore do not have the same incentive that hospitals do to restrain costs.

In the 1990s, Medicare conducted a demonstration project to assess the feasibility of combining payments to both hospitals and physicians into a single bundled payment for one particular procedure—coronary artery bypass surgery—performed at selected hospitals. Discounted bundled payment rates were established through negotiations with participating hospitals in conjunction with teams of physicians. This option would establish a similar negotiated bundled payment arrangement for joint-replacement surgery as well as for bypass surgery at selected hospitals known for the quality of their care; the Secretary of Health and Human Services would designate an appropriate number of hospitals per region as Medicare centers of excellence for those procedures. Under this option, hospitals identified as centers of excellence would refund half of the inpatient deductible amount for a designated procedure to beneficiaries. Medigap coverage would be modified to allow beneficiaries to keep the refund, and the Medicaid program would receive the refund for any dually eligible individuals.

In the Congressional Budget Office's estimation, implementing this option would save the federal government \$140 million over the 2010–2014 period and \$450 million over the 2010–2019 period. That estimate reflects an

assumption that participating centers will negotiate bundled payment rates that constitute 90 percent of what the total Medicare payment per admission—the hospital payment plus physicians' fees—would be under the standard payment policy. That assumption is consistent with estimates from the coronary bypass surgery demonstration in the 1990s. Unlike that demonstration project, however, this option would give patients a financial incentive to seek treatment at participating centers; in exchange for more patient volume, participating centers might offer larger discounts, which could lead to greater savings. Also, savings could rise over time by expanding the policy to additional services and geographic areas that the Secretary of Health and Human Services deemed appropriate.

Advocates of this option argue that aligning hospitals' and physicians' financial incentives would facilitate greater efficiency in the delivery of health care. Furthermore, in addition to the budgetary savings it offered, this option could offer the prospect of improved care for many patients. Medical researchers have found that patient outcomes from bypass surgery are superior in centers that perform many such procedures; currently, however, Medicare patients frequently undergo bypass surgery in centers where relatively few are performed. By channeling more patients to centers of excellence—high-volume hospitals with superior outcomes—this option could improve care for Medicare patients.

A potential drawback of this option is that hospitals that are not designated centers of excellence could experience a significantly reduced volume of patients. If that led to a deterioration in hospitals' expertise in bypass surgery or joint-replacement surgery, quality of care could decline for patients who underwent those procedures at non-participating hospitals. But on average, patient outcomes among all Medicare beneficiaries would probably improve.

**Option 35****Convert Medicare and Medicaid Disproportionate Share Hospital Payments into a Block Grant**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -4,800 | -5,600 | -6,700 | -7,800 | -24,900   | -84,600   |

Hospitals that serve a disproportionately large number of low-income patients can qualify for higher payment rates under Medicare than other hospitals do. Since being introduced in 1986, Medicare's disproportionate share hospital (DSH) adjustment has been seen as a way to protect low-income patients' access to care by providing financial support to hospitals that serve a large share of people from that population. Between 1992 and 1997, annual outlays for Medicare's DSH payments rose from \$2.2 billion to \$4.5 billion. Restrictions established by the Balanced Budget Act of 1997 caused those outlays to decline for a few years, but by 2000, growth in such outlays had resumed. The Medicare Modernization Act of 2003 further modified the payment formulas to increase DSH payments to rural and small urban hospitals. According to the Congressional Budget Office's estimates, Medicare's DSH payments are expected to grow to \$9.8 billion in 2009.

Disproportionate share hospitals can also receive additional funds from Medicaid if they meet certain federal criteria. States have some discretion in deciding which hospitals receive Medicaid DSH payments and the size of those payments. During the late 1980s and early 1990s, many states engaged in funding transfers, using the DSH program to obtain increased federal funding for Medicaid without raising net spending on DSH hospitals—effectively boosting their federal medical assistance percentage above that specified in law. To rein in that practice, lawmakers enacted a series of restrictions on Medicaid's DSH payments during the 1990s that included setting fixed ceilings on DSH payments to each state. The Medicare Modernization Act raised those ceilings by \$1.2 billion in 2004 and by smaller amounts in later years. CBO estimates that federal outlays for Medicaid's DSH payments will be \$9.1 billion in 2009 and that total federal outlays

for all DSH payments—combining Medicare's and Medicaid's—will be approximately \$18.9 billion that year.

This option would convert federal DSH payments from both Medicare and Medicaid into a single block-grant payment to each state. (The option would incorporate a maintenance-of-effort requirement to ensure that states' spending for disproportionate share hospitals would continue at existing levels.) Block-grant payments would be set at 90 percent of the state's current annual level of federal DSH funding (a figure that is derived by using the estimated sum of Medicare's DSH payments to hospitals in a given state and the federal DSH allotments for Medicaid for 2009) indexed to the increase in the consumer price index for all urban consumers minus 1 percentage point. Those changes would decrease federal outlays by about \$25 billion between 2010 and 2014 and by about \$85 billion over the 2010–2019 period. About half of those savings would be attributable to no longer counting Medicare DSH payments in setting payment rates for Medicare Advantage plans.

One rationale for converting all DSH payments into a block grant is that the increased latitude provided to the states could result in more appropriate and equitable DSH spending targeted toward providers that serve low-income populations. For example, states would have greater flexibility to use DSH funds to support outpatient clinics and other providers that treat low-income patients in nonhospital settings. Another argument for the option is that all federal DSH payments would be coordinated.

A potential drawback of this option is that hospitals (and health care providers in general) would receive less in federal subsidies and consequently might not be able to offer the same level of care.

«CBO»

**Option 36****Consolidate Medicare and Federal Medicaid Payments for Graduate Medical Education Costs at Teaching Hospitals**

| (MILLIONS OF DOLLARS)  | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|--|------|--------|--------|--------|--------|-----------|-----------|
|  |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending   |      |        |        |        |        |           |           |
| Set payments equal to 90 percent of total mandatory GME funding inflated by the CPI-U minus 1 percentage point                                 | 0    | -1,900 | -2,000 | -2,300 | -2,700 | -8,900    | -30,100   |
| Calculate IME payments using a 2.2 percent adjustment factor plus DGME and Medicaid GME funding inflated by the CPI-U minus 1 percentage point | 0    | -4,800 | -4,900 | -5,200 | -5,600 | -20,500   | -57,300   |

Note: GME = graduate medical education; CPI-U = consumer price index for all urban consumers; IME = indirect medical education; DGME = direct graduate medical education.

Under Medicare's prospective payment system for inpatient medical services, hospitals with teaching programs receive additional funds for costs related to graduate medical education. One component of that additional funding, direct graduate medical education (DGME), covers a portion of a teaching hospital's costs for residents' compensation and institutional overhead. DGME payments are based on a hospital's 1984 costs per resident (indexed for changes in consumer prices), the number of residents, and Medicare's share of total inpatient days at that hospital. The other component, indirect medical education (IME), is intended to cover teaching-related costs that are not attributable either to residents' compensation or to other direct costs of running a residency program. Examples of IME costs are the added demands placed on staff as a result of teaching activities and the greater number of tests and procedures ordered by residents. IME payments also compensate teaching hospitals for the larger proportion of severely ill patients that they tend to treat. Under current law, for every increase of 0.1 in the ratio of full-time residents to the number of beds, the IME adjustment provides teaching hospitals with about 5.5 percent more in payments; however, the Medicare Payment Advisory Commission (MedPAC) has estimated that an increase of 2.2 percent would more closely reflect the actual indirect teaching costs that hospitals incur.<sup>1</sup>

1. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2007).

Teaching hospitals also receive graduate medical education (GME) payments from both the federal government and the states through the Medicaid program. The Congressional Budget Office estimates that in 2008, total mandatory federal spending for hospital-based graduate medical education was approximately \$9.5 billion—\$8.7 billion for Medicare and \$0.8 billion for Medicaid.

This option would consolidate all mandatory federal spending for hospital-based graduate medical education into a block grant to teaching hospitals. Payments would be apportioned according to the number of residents at a hospital and the portion of the hospital's inpatient days accounted for by Medicare or Medicaid patients. Total funds available for distribution as block grants would be determined in one of two ways.

- Under the first alternative, total funding for 2011 would be set at 90 percent of the estimated total mandatory federal payments for graduate medical education in 2009 with an adjustment for inflation. That alternative would save about \$9 billion over the 2010–2014 period and \$30 billion over the 2010–2019 period.
- Under the second alternative, total funding for 2011 would be set based on a reduction of the IME adjustment to 2.2 percent in 2009—an amount that MedPAC has estimated would more accurately reflect indirect costs—plus the 2009 levels of Medicaid GME

and DGME as adjusted for inflation. That alternative would save approximately \$21 billion over the 2010–2014 period and \$57 billion over the 2010–2019 period.

Under both alternatives, total funding for the block grants would grow with inflation as measured by the consumer price index for all urban consumers minus 1 percentage point. If the discretionary funds for graduate medical training currently provided by the Health Resources and Services Administration of the Department of Health and Human Services were also included in the grant pool, the total available funding would rise by an estimated \$0.7 billion in 2011.<sup>2</sup>

An argument for reducing the subsidy for graduate medical education is that federal payments under current law exceed hospitals' actual teaching costs. As a result, a smaller subsidy would create savings for the federal bud-

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2. CBO's estimated savings under the option could change (by less than \$1 billion over the 2010–2019 period) depending on whether a notice of proposed rulemaking from the Centers for Medicare and Medicaid Services to eliminate GME payments for Medicaid became a final rule.

get without unduly affecting hospitals' teaching activities. A smaller subsidy would also remove an incentive for hospitals to have a greater number of residents than is necessary. If hospitals responded to the reduction in the subsidy by lowering residents' compensation, residents would bear more of the cost of their medical training, which might deter some people from entering the medical profession. However, medical training enables individuals to earn a higher income in the future, and market incentives appear to be sufficient to encourage people to become physicians.

An argument against this option is that reducing the federal subsidy for graduate medical education could lead some teaching hospitals to train fewer residents or devote less time and fewer resources to beneficial educational activities. Also, to the extent that some teaching hospitals use a portion of their additional payments to fund charity care, reducing those payments could reduce the number of patients that hospitals treated or lower the quality of care that they provided. Another argument against the option is that states could lose some discretion to direct GME payments to hospitals since the federal government would be administering the block grant.

**Option 37****Allow Physicians to Form Bonus-Eligible Organizations and Receive Performance-Based Payments**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 0    | -50  | -270 | -320      | -5,300    |

5 In Medicare's fee-for-service (FFS) program, providers have little or no financial incentive to coordinate the care that their patients receive across different treatment settings; to assume accountability for the costs and quality of that care; or to deliver care in an efficient, cost-effective manner. Instead, providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists. Not only can the lack of coordination be confusing to patients, but inadequate coordination can also lead to inefficient, lower-quality care. For example, poor coordination could result in duplicated or unnecessary services leading to higher-cost care that contained no additional benefit for patients.

Under this option, groups of providers meeting certain qualifications would have the opportunity to participate, on a voluntary basis, in Medicare as bonus-eligible organizations (BEOs). The concept of BEOs is similar to the accountable care organization models proposed by some researchers. In general, a group of providers, in order to qualify as a BEO, would have to be able to work together to manage and coordinate care for patients. BEOs could consist of physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community-based coalitions of providers. Each FFS beneficiary would be automatically assigned to a primary care provider (PCP). That assignment would be based on the physician from whom the beneficiary received the most primary care in the preceding year and would affect payments only if the beneficiary's PCP elected to participate in a BEO.

Medicare would continue to pay providers under the current FFS system, but providers in participating BEOs would be eligible for bonuses if they met certain quality measures and if spending was below a benchmark. Beneficiaries would continue to be able to see providers both

in and outside of their BEO, but PCPs, in order to have more control over the costs and quality of care delivered, would have an incentive to keep as much of the beneficiary's care within the BEO as possible. The benchmark for each BEO would be set using the most recent three years of total per-beneficiary spending for beneficiaries assigned to the BEO; that amount would then be updated by the projected rate of growth in national per capita spending for the original Medicare FFS program, as projected (using the most recent three years of data) by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS).

BEOs would be eligible to receive a bonus only if they met a set of quality performance measures and if their patients' average Medicare expenditures over a two-year period were at least 2 percent below the average benchmark for the corresponding two-year period; the BEO bonus share would be half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark. The bonus, in dollars, would equal the bonus share multiplied by the benchmark for the most recent year. For example, if a BEO's benchmark was \$9 million in the first year and \$11 million in the second year, and the BEO's actual expenditures were \$8 million in the first year and \$10 million in the second year, then the average benchmark would equal \$10 million, and the average actual expenditure would equal \$9 million. The BEO bonus share in the second year would equal half of the difference between 90 percent (\$9 million divided by \$10 million) and 98 percent (the bonus threshold), which is equal to 4 percent. The bonus amount in the second year, in dollars, would equal 4 percent of \$11 million, or \$440,000.

To qualify as a BEO, the organization would have to meet the following criteria. First, the BEO must have a formal legal structure that would allow the organization to receive and distribute bonuses to participating

providers. Second, the BEO must include the PCPs of at least 5,000 Medicare beneficiaries and must be willing to become accountable for the overall care of all the Medicare beneficiaries assigned to those PCPs. Third, the organization must provide CMS with a list of primary care and specialist physicians participating in the BEO in order to support beneficiary assignment, the implementation of performance measures, and the determination of bonus payments. Additionally, to qualify as a BEO, organizations must have the following: contracts in place with a core group of key specialist physicians; a leadership and management structure; and processes in place to promote evidence-based medicine, to report on quality measures, and to coordinate care.

In estimating the budgetary effects of this option, the Congressional Budget Office assumed that approximately 20 percent of FFS Medicare beneficiaries would be assigned to PCPs participating in a BEO by 2014, and 40 percent would be assigned by 2019. This option would reduce Medicare spending by an estimated \$0.3 billion from 2010 to period and by \$5.3 billion over the 2010–2019 period.

The savings to Medicare from this option would decline over the 2010–2019 period, CBO expects. The decline in savings reflects two factors. First, over time, the share of BEOs that met the quality requirements—and, therefore, would be eligible to receive bonuses—would grow, which would increase bonus payments. Second, this option would reduce somewhat the volume of Medicare-covered physicians' services and services "incident to" physicians' services. Because of the sustainable growth rate (SGR) mechanism that Medicare uses to determine physician fees, such volume reductions would lead to increased Medicare physician fees at the end of the period—which would reduce the savings to Medicare from this option. (The option would specify that the anticipated reductions in the volume of physicians' services as a result of the bonus payments would not be treated as "law and regulation" changes for the purposes of calculating spending targets under the SGR.)

The nationwide implementation of BEOs would be new to the Medicare program, and estimates of the effects of such an arrangement are therefore particularly uncertain. One area of uncertainty lies in the details of how CMS would implement such an arrangement. Designating BEOs would require that CMS perform a number of new and complex functions, including the assignment of ben-

eficiaries to PCPs, the projection of spending benchmarks for BEOs, the measurement of quality for BEOs (to determine eligibility for receiving bonuses), and the disbursement of bonus payments. CBO assumed that CMS would be able to implement this option beginning on January 1, 2013, but the date of implementation could be changed depending on the administrative difficulties encountered. The second area of uncertainty relates to providers' behavioral responses to BEOs. CBO assumed that providers, in response to the financial incentives under a shared-savings program, would reduce somewhat the volume and intensity of services provided to their patients. Additional modifications to this option, such as penalties for nonparticipation or for spending above the benchmark, could make savings more likely. A pilot or demonstration project that evaluated BEOs could provide valuable insights into the effects of alternative designs and the magnitude and nature of providers' responses.

An argument in favor of this option is that it would provide a stronger incentive than currently exists for providers to treat Medicare patients in a coordinated and cost-effective manner. If this option was implemented, providers would have incentives to develop coordinated systems for delivering care and would be rewarded to the extent that those activities reduced beneficiaries' overall spending. By encouraging providers to begin developing more coordinated, more efficient systems for delivering care, this option could be an initial step toward changing providers' current systems of delivering care and could pave the way for greater changes in the future. Another argument in favor of this option is that its performance and reporting requirements would encourage the development of higher quality, evidence-based care. Not only would providers need to meet a quality standard to be eligible for bonuses, but the information they reported could be used to further refine performance measures. Finally, because of the voluntary nature of this option, it would be minimally disruptive to existing provider–patient and provider–provider relationships. Providers finding it difficult to join a BEO would not be required to do so.

An argument against this option is that there is a substantial and somewhat unpredictable degree of variation in the growth of Medicare's spending from year to year, even among large groups of Medicare beneficiaries. Thus, Medicare would be paying bonuses, in some cases, for slowdowns in spending growth that would occur even in

the absence of the policy change. Additionally, because of the voluntary nature of the option, providers able to anticipate performing at a more efficient level would be more likely to choose to participate. Another argument against this option is that providers participating in a BEO might object to their remuneration being tied to decisions made by patients (for instance, their deciding to

see a specialist outside of a BEO), which they might feel are beyond their control. Finally, if the performance and quality measures were inadequate, providers might not offer adequate care, leading to a decline in the overall quality of care.

«CBO»



**Option 38****Pay Primary Care Physicians in Medicare Using a Partial-Capitation System, with Bonuses and Penalties**

| (MILLIONS OF DOLLARS)           | 2010     | 2011     | 2012     | 2013        | 2014          | Total         |                |
|---------------------------------|----------|----------|----------|-------------|---------------|---------------|----------------|
|                                 |          |          |          |             |               | 2010-2014     | 2010-2019      |
| Change in Mandatory Spending    |          |          |          |             |               |               |                |
| Payments to physicians          | 0        | 0        | 0        | 0           | 400           | 400           | 9,200          |
| Payments to all other providers | <u>0</u> | <u>0</u> | <u>0</u> | <u>-500</u> | <u>-1,100</u> | <u>-1,600</u> | <u>-14,400</u> |
| Total                           | 0        | 0        | 0        | -500        | -700          | -1,200        | -5,200         |

Under a full-capitation system, physicians receive a fixed payment for each patient assigned to them (a grouping known as a “panel”), and the payment does not vary with the quantity or intensity of medical services provided. By contrast, in Medicare’s fee-for-service (FFS) program, physicians who treat Medicare patients are paid separately for each service they provide. Providing separate payments for each service encourages physicians to provide a higher volume of services than they would under capitation arrangements. In addition, there is no designation of primary care providers as coordinators of care for individual Medicare beneficiaries.

This option would assign each beneficiary who participates in fee-for-service Medicare to a primary care physician (PCP) and change Medicare’s payment system for PCPs from a fee-for-service model to partial capitation. Under the partial-capitation system, PCPs would receive approximately three-fourths of their Medicare payments on a per-service basis and approximately one-fourth of their Medicare payments through capitation; they would also receive bonuses or face penalties, depending on the total spending incurred by each physician’s panel of assigned beneficiaries. This option is projected to result in savings to Medicare of about \$1 billion over the 2010–2014 period and about \$5 billion over the 2010–2019 period.

Under this option, each FFS beneficiary would be automatically assigned to the PCP who provided most of their care in the preceding year. Beneficiaries would be notified of their assignment and would have the option of selecting a different PCP. Physicians in a range of specialties—including general practice, family practice, and internal medicine, as well as cardiology, gynecology, and oncology—would be eligible to be PCPs. Beneficiaries who

were not automatically assigned to a PCP (for example, those newly eligible for Medicare) would be able to designate their PCP or have a PCP designated for them by the Centers for Medicare and Medicaid Services (CMS).

Under this option, physicians in specialties eligible to be PCPs would receive three separate types of payment from Medicare:

- A payment for each office visit equal to 75 percent of the fee schedule amount under current law. That reduced fee schedule payment would apply to all services provided by physicians in PCP-eligible specialties, regardless of whether the services were being provided to a patient in the PCP’s own panel.
- A capitation (“per beneficiary per month”) payment for each beneficiary in the PCP’s panel. In the aggregate, the capitation payments would approximately equal the 25 percent reduction in fee schedule payments described above. The capitation amount would vary on the basis of patients’ health status (a risk-adjustment methodology determined by the Secretary of Health and Human Services would be used) and on the basis of local prices for “inputs” (such as labor and equipment used in the production of medical services) in the geographic area in which the PCP’s primary practice was located.
- Bonuses and penalties that would be calculated separately for each PCP on the basis of “relative spending” among the PCP’s panel of Medicare patients. Relative spending would equal Medicare-covered spending for all services among a PCP’s panel divided by a target spending amount. That target amount, like the capitation amount, would be based on the health status of

the patients in the PCP's panel and on local prices for inputs. A PCP whose panel underspent relative to the target could receive a bonus, whereas a PCP whose panel overspent by more than 5 percent would face a penalty. To be eligible to receive a bonus, the PCP would have to meet certain quality of care and reporting requirements, as determined by CMS. Bonuses and penalties for each PCP would be capped at plus or minus 80 percent of the capitation amount the PCP received. Penalties would be deducted from future capitation payments.

5 Under this option, Medicare would facilitate PCPs' coordination of care by providing monthly reports to them on the utilization of Medicare-covered services among patients in their panel; the lag in reporting would be no more than several months. PCPs would probably try to reduce spending in several ways—for example, by limiting referrals to specialists, increasing the prescribing of generic medications, and reducing hospitalizations for discretionary procedures. Groups of PCPs could also engage in risk-sharing arrangements and develop cooperative agreements with hospitals and with specialists who are not eligible to be PCPs.

CMS does not currently pay PCPs or any other physicians on the basis of partial capitation. CBO's estimate of the effect of such an arrangement is therefore uncertain. One area of uncertainty lies in the details of how CMS would implement such an arrangement. Partial capitation would require that CMS perform a number of new and complex functions, including the assignment of beneficiaries to PCPs; the measurement of the quality of care delivered by individual PCPs (to determine eligibility for bonuses); and the disbursement of capitation payments, bonuses, and penalties. The Congressional Budget Office assumed for this option that CMS would implement partial capitation beginning on January 1, 2013, but the date of that implementation could change depending on the administrative difficulties that were encountered. CBO also assumed that CMS would facilitate PCPs' behavioral responses by distributing up-to-date information on spending among their panels of patients. If CMS was unable to collect and distribute information in a timely

manner, the behavioral response of PCPs could be dampened. The second area of uncertainty relates to providers' behavioral responses to partial capitation. CBO assumed that PCPs, in response to the financial incentives in the partial-capitation system, would reduce somewhat the volume and intensity of services provided to their patients. Given the significant uncertainty associated with this approach, a pilot or demonstration program of partial capitation could provide valuable insights into the magnitude and nature of such responses.

An argument in favor of this option is that it would provide a stronger incentive than currently exists for Medicare patients to be treated in a cost-effective manner. For example, under the current FFS program, if primary care physicians lengthen their visits with patients, help coordinate or manage their care to eliminate unnecessary or duplicated services, or encourage preventive care activities that result in long-run savings that outweigh their costs, neither they nor other health care providers directly benefit financially—and many actually fare worse because the time spent on those activities could otherwise be spent performing more highly remunerative procedures. Under this option, however, PCPs would be rewarded to the extent that those activities reduced overall spending by beneficiaries. The quality of care delivered could also improve if the additional time spent on the coordination of care enhanced quality to a greater degree than did the activities that otherwise would have been performed.

An argument against this option is that PCPs could be placed in an adversarial position with respect to specialists and other health care providers. Furthermore, primary care physicians might object to their remuneration being tied to decisions made by patients, which they might feel were beyond their control (for instance, when patients chose to visit a specialist without a referral). Finally, a partial-capitation system could lead to suboptimal care in some cases if there were insufficient safeguards to prevent stinting on necessary care, or if beneficiaries were unable to avoid PCPs that they felt were not providing an adequate level of necessary services.

«CBO»

**Option 39****Pay for a Medical “Home” for Chronically Ill Beneficiaries in Fee-for-Service Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 260  | 420  | 450  | 490  | 530  | 2,150     | 5,610     |

Medicare beneficiaries who have chronic illnesses, such as diabetes and congestive heart failure, consume more of the program’s resources than do beneficiaries who are in better health. Approximately 75 percent of Medicare spending pays for care for beneficiaries who have five or more chronic conditions and see an average of 14 different physicians each year. Research has shown that care for beneficiaries with chronic conditions is often fragmented, with little communication or coordination among the multiple physicians who care for them. Five percent of Medicare beneficiaries account for 43 percent of the program’s overall spending, and the costliest 25 percent of beneficiaries account for about 85 percent of outlays. An intervention that focused on coordinating care for those beneficiaries could both improve their health and reduce Medicare spending.

Some experts have proposed the concept of a medical “home” as a source of care for chronically ill individuals. Although definitions vary, the Medicare Payment Advisory Commission has characterized a medical home as “a clinical setting that serves as a central resource for a patient’s ongoing medical care.” The Tax Relief and Health Care Act of 2006 mandated that the Centers for Medicare and Medicaid Services (CMS) establish a medical-home demonstration project. That project is expected to begin in January 2010; the results are expected to be available in December 2013.

This option illustrates the costs of implementing a medical-home benefit on a national basis rather than waiting for the results of the demonstration project. Under such an approach, Medicare beneficiaries with at least two chronic conditions could designate a qualified physician as their medical home. Physicians, group practices, or clinics could qualify as medical-home providers by documenting that they had the systems and infrastructure in place to provide coordinated and timely high-quality care. The option would use qualification standards

developed by CMS for the medical-home demonstration project, including two tiers of medical-home services. Tier 1 would require physicians or practices to have 17 specific capabilities, and Tier 2 would require 19 capabilities plus any three of a group of capabilities the CMS lists as optional.<sup>1</sup> Because the requirements to become a medical home would be demanding, only about 1 percent of physicians would be likely to meet the requirements initially; however, in the Congressional Budget Office’s estimation, participation would increase over time.

Physicians who qualified as medical homes would receive a monthly payment for each beneficiary who designated them as such. The prospective monthly payment would compensate the physician for the additional time and other costs associated with managing more comprehensive care for some patients. In 2010, the payment would average about \$34 per month per beneficiary, and it would be adjusted annually by the percentage change in the update to Medicare’s physician fee schedule.<sup>2</sup> The average medical home is projected to have 250 beneficiaries. Giving beneficiaries with multiple chronic conditions the option to choose a medical home would cost an estimated \$2.2 billion over the 2010–2014 period and \$5.6 billion over the 2010–2019 period.

1. For specific medical-home capabilities, see Centers for Medicare and Medicaid Services, “Design of the CMS Medical Home Demonstration,” October 3, 2008, [www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome\\_DesignReport.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_DesignReport.pdf).
2. CMS set the average payment rates for 2009 for Tier 1 and Tier 2 services at \$40 and \$52, respectively. Adjusting those fees by the percentage change in the update to the physician fee schedule, which includes reductions as a result of the sustainable growth rate mechanism, and weighting the fees to reflect Tier 1 versus Tier 2 medical homes results in an average initial fee of \$34 for 2010. Projected updates to the physician fee schedule (and to the fees used in estimating this option) would result in further annual reductions for most of the projection period.

The medical-home concept has the potential to improve the health and health care of chronically ill Medicare beneficiaries. In some cases, improving care could reduce spending by eliminating duplicated services, making more appropriate use of specialists, and averting serious complications from chronic conditions through better medical management. In other cases, improving care could lead to increases in spending for chronically ill patients who were not receiving all recommended care. CBO cannot estimate whether the net result of those effects would be to increase or decrease spending for the Medicare program.

5 Studies that support the medical home's potential for reducing spending have not directly assessed a complete version of the approach but rather certain elements of it. Another caveat relating to studies of medical homes is that they have been conducted in such settings as Medicaid programs, publicly funded clinics, pediatric clinics, and integrated care systems (typically large health care organizations that provide a wide range of services, including hospital and physician care, in a coordinated manner).<sup>3</sup> Some preliminary evidence indicates that a highly developed medical home that focused on selected conditions could produce savings.<sup>4</sup> Generalizing results from those types of studies to chronically ill Medicare beneficiaries across a wide variety of physicians' practice settings is difficult. The lack of readily applicable evidence of the effects of a broadly implemented medical-

home model in the chronically ill Medicare population is a good argument for demonstration projects or pilot studies to determine whether the approach is an effective way to improve care and reduce costs.

Demonstration projects or pilot studies could also be used to test different methods of payment—such as having physicians bear more of the risk of patients' incurring high costs or granting physicians more flexibility in controlling patients' utilization of services or use of specialists. Different payment approaches could have an impact on whether or not the medical-home approach resulted in overall savings for Medicare. Likewise, such studies could shed light on the extent to which the use of electronic health records, the practice of evidence-based medicine, and care coordination are necessary infrastructure for generating savings.

An argument in support of this option is that it would provide resources to physicians that they could invest in systems and staff to provide higher-quality care. In addition, the option would provide an opportunity for improving the coordination of care for chronically ill Medicare beneficiaries.

An argument against the option is that if Medicare adopted the medical-home approach on a broad scale, it might pay more for care that had not been proven to improve health outcomes for patients or reduce the program's costs. Implementing the medical-home model on a nationwide basis could also interfere with CMS's ability to define a clear comparison group for use in studies to assess differences in the costs attributable to a medical-home model of care versus other approaches.

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3. Jaan Sidorov, "The Patient-Centered Medical Home for Chronic Illness: Is It Ready for Prime Time?" *Health Affairs*, vol. 27, no. 5 (2008), pp. 1231–1234.

4. Martha L. Sylvia and others. "Guided Care: Cost and Utilization Outcomes in a Pilot Study," *Disease Management*, vol. 11, no. 1 (2008), pp. 29–36.

**Option 40****Require Medicare Carriers to Provide Information About Peer Profiling to Physicians**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -70  | -120 | -160 | -350      | -1,710    |

A significant share of Medicare's spending for physicians' services is associated with a relatively small number of providers who generate higher costs for the program than do other physicians in the same specialty because their patients use (in some combination) more services in general and more relatively high-cost services. The Medicare Payment Advisory Commission estimates that in 2005, a small percentage of physicians—less than 2 percent of those who treat Medicare patients—accounted for \$4.6 billion in outlays, or 7.5 percent of all payments under Medicare Part B, the part of the program that covers physicians' and other outpatient services. (Those estimates reflect adjustments for physicians' caseloads under Medicare and for geographic differences in payments.)

Identifying such "outlier" physicians and targeting their use of health care resources is an increasingly common strategy for containing costs among private health plans. Many plans create "peer profiles"—which compare the pattern of services that one physician provides with the patterns of other physicians in the same specialty. Typically, those comparisons use "episode groupers"—software that combines separate but clinically related services into a so-called episode. In some cases, private health care plans use information gained from peer profiling to select participants for preferred networks or candidates for bonus payments. In other cases, plans provide the information as feedback to physicians, who then may alter the number and kinds of services they provide if they notice that their patterns of practice are unusual. Research has shown that providing such feedback has a small downward effect on the use of health care.

This option would require Medicare to develop an open-source (that is, publicly available) episode grouper to measure physicians' use of health care resources. It would also require Medicare carriers—organizations that process claims for Medicare Part B—to reduce payments to physicians whose use of resources was excessively high relative to that of their peers. Comparisons would be made

between physicians in the same specialty and market area and would be adjusted to account for differences in the health status of physicians' patients. Over time, comparisons could be made across larger geographic areas to reduce cross-national variation in resource use.

The first reduction in payments under the option would not occur until 2012. In 2010, the Centers for Medicare and Medicaid Services (CMS) would analyze data from Medicare claims to generate episode-based, risk-adjusted comparisons of practice patterns for physicians by specialty. During 2011, physicians would receive reports that compared their use of resources with that of their peers. The peer group would include only physicians who had a sufficient number of episodes to construct valid comparisons. Physicians whose use of resources was above the 90th percentile for their peer group would be notified that their fees would be reduced by 5 percent in 2012. (The Congressional Budget Office's estimates of the budgetary effects of this option incorporate the assumption that physicians whose use of resources was near the threshold would change their practices so as to bring their usage below it.) This option would reduce federal outlays by an estimated \$350 million over the 2010–2014 period and by \$1.7 billion over the 2010–2019 period. Those estimates reflect savings for Part B only; total reductions in outlays could be greater if the utilization of hospital services was also affected by changes in physicians' patterns of practice because of peer profiling reports.

An advantage of this option is that it would provide physicians with useful information about how their patterns of practice compared with those of their peers. That information might make it easier for physicians to follow professional norms regarding clinical practice; for example, peer profiling information provided to a cardiologist might show that his or her use of imaging services was much greater than that of peers for patients with coronary artery disease. Such information might also provide a useful defense against charges of malpractice. Another

advantage of this option is that it would target potentially inappropriate uses of health care resources without interfering directly in physicians' decisions about how to practice medicine. Peer profiling could also create a useful infrastructure for reducing geographic variation in the use of resources as well as differential practices by specialty in treating the same condition.

Opponents of peer profiling suggest that it can present a misleading picture of the appropriateness of providers' clinical decisions. Many such decisions are based on nuanced information about patients' health that physicians obtain when they examine patients, information that may be absent from claims data provided to

Medicare carriers. As a result, peer profiling reports that are based on those data may not always permit reliable comparisons between practitioners. In addition, professional norms do not always follow evidence-based standards of best practice, and in different markets, peer groups may have substantially different practice norms. Thus, a disadvantage of this option is that it could discourage physicians from providing evidence-based care that used a high level of resources even when that level of care was of better quality than the norm in a particular market. A final issue is that the option would impose an additional administrative burden on Medicare carriers.

«CBO»

**Option 41****Require Prior Authorization for Imaging Services Under Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -20  | -40  | -70  | -90  | -220      | -1,090    |

Imaging services are one of the fastest growing areas of spending in the Medicare program. From 2000 to 2006, outlays for such services doubled, rising from \$7 billion to \$14 billion, for an average annual rate of growth of 13 percent. Spending for advanced imaging procedures, such as magnetic resonance imaging and computed tomography scans, grew even faster, at an annual pace averaging 17 percent. The Government Accountability Office, among others, has recommended that, in addition to the retrospective controls on payments that are now in place, the Centers for Medicare and Medicaid Services (CMS) begin to use prospective approaches to manage the growth of payments for imaging services.

This option would institute a policy of requiring prior authorization for the use of and payment for advanced imaging services in the Medicare program. Many private health plans now use such an approach, which requires physicians to obtain approval before ordering a specified service, but Medicare has not used prior authorization before with respect to physicians' services. Under this option, the Medicare program would hire radiology benefit managers (RBMs) to make decisions on its behalf about whether to approve payment for a specific imaging service ordered by a physician. Those decisions would be based on criteria formulated from recommended guidelines for clinical practice, including guidelines developed by medical specialty societies, and Medicare would not pay for services that were not approved. Under typical contracts with RBMs in the private sector, managers are paid a monthly fee per covered beneficiary in exchange for managing the use of imaging services. According to unpublished data, many private plans that employ RBMs have noted that immediately after implementing a prior authorization approach, the use of imaging services declines initially but that as physicians adapt to the new procedures, utilization picks up, and in many cases the

growth of spending returns to its previous pace. (Nevertheless, spending remains below the level that would have occurred without the RBM intervention.) The savings shown for this option—a reduction in net federal outlays of \$220 million over the 2010–2014 period and about \$1 billion over the 2010–2019 period—take those findings into account and include outlays by the Medicare program to RBMs as well as savings from a lower rate of utilization of imaging services.

An argument for this option is that it would reduce the number of advanced imaging services provided to Medicare beneficiaries that are of little or no clinical benefit, thereby reducing the program's expenditures. Moreover, the health insurance carriers that currently administer payments to imaging providers on Medicare's behalf are often the same private health plans that make frequent use of prior authorization in managing their own enrollees' use of services. That fact, coupled with the availability of radiology benefit managers, would probably ease any shift by Medicare to requiring prior authorization for imaging.

An argument against this option is that prior authorization (particularly when the approach involves paying a monthly fee per beneficiary) is unprecedented in the fee-for-service component of Medicare, in which carriers review claims for payment after procedures have been performed. CMS would have difficulty approving procedures and payments on a prior authorization basis and then determining subsequently, during a postpayment or fraud-and-abuse review, that the claim should not have been paid. However, instead of paying a monthly fee per beneficiary, CMS could gain similar savings by using another means to control utilization, including improving providers' incentives to deliver quality care.

«CBO»

**Option 42****Encourage Wider Use of Patient Shared-Decision Aids by Physicians in Medicare**

5 Deciding on an appropriate medical treatment can sometimes be challenging for patients and their physicians. Even where adequate evidence exists about the effectiveness of certain treatments, there may be trade-offs, depending on the patient's values and tolerance for risk and other considerations. For example, evidence may show that expected outcomes after five years are the same for a particular condition whether a patient has surgery or follows a medical management regimen. Available evidence may also show that patients choosing the surgical option have faster symptom relief but an elevated risk of stroke from the surgery. For some patients, the faster symptom relief may be worth the higher risk; other patients will prefer to follow the less risky path even knowing that their symptoms may last longer.

In cases where two or more “medically reasonable” alternatives exist, some experts recommend counseling patients in a process known as shared clinical decision-making. Such counseling involves providers “communicating personalized information on options, outcomes, probabilities, and scientific uncertainties, and patients communicating the personal value or importance they place on benefits versus harms so that agreement on the best strategy can be reached.” Evidence-based shared patient decision aids (PtDAs) have been developed to assist providers and patients in this process.

Studies indicate that decision aids improve patients' understanding of available treatment alternatives and the associated risks and benefits, decrease the uncertainty attached to a particular procedure or treatment, and increase patients' overall satisfaction with their care. In addition, some studies have shown that decision aids reduce the use of aggressive surgical procedures in favor of more conservative options, without affecting health outcomes. In spite of the benefits that PtDAs can convey to patients and providers, their use is not widespread. Studies suggest that barriers to physicians' adoption of PtDAs include their being unaware that decision aids exist for a particular situation, the cost of training and support systems, and their judgment that using PtDAs will not be compatible with their style of practicing medicine.

Research on patient shared decisionmaking shows that it might be a promising avenue for the Centers for Medicare and Medicaid Services (CMS) to pursue to improve quality and reduce costs in Medicare. However, designing a policy that promotes the use of shared decisionmaking

by physicians where appropriate will be challenging. Some questions that must be answered in designing a workable policy include the following: Which provider should be responsible for engaging in shared decision-making—the primary care physician or a specialist? Should it be the primary care physician or a specialist? At what point in the process of care should shared decision-making occur? How should Medicare pay for the resource cost of providing shared decisionmaking? Should a system of bonuses and penalties be used? Should there be a flat fee or an office visit code for shared decisionmaking? Should patient shared decisionmaking be used as a performance or quality measure? Which patients should be eligible for shared decisionmaking services? How would appropriate use of decision aids be measured? Identifying procedures where decision aids are available is possible, but how should cases where the procedure is not done (but might have been) be identified? Should CMS limit payment for shared decisionmaking services to major procedures, or should Medicare pay for the use of all credible tools? Should the cost-effectiveness of using shared decisionmaking be considered in determining in which instances CMS should modify payment incentives?

In addition to uncertainty about how to appropriately design a payment policy for patient shared decision-making, there is uncertainty about how spending would be affected by greater use of that approach. Studies of the tools have shown reductions in the use of more invasive procedures; however, in some cases, less invasive procedures cost more. In addition, those studies have not focused on the Medicare population and so the effects observed in them might not be generalizable to the Medicare program. The Congressional Budget Office cannot estimate the effects of greater use of shared decision-making on Medicare's spending at this time because of the uncertainty about how to set detailed design parameters and how those parameters would affect the use of decision aids by patients and physicians, the utilization of less invasive alternatives and, ultimately, Medicare's spending. Given that uncertainty, policymakers might want to direct CMS to experiment with different policy designs to determine how best to encourage appropriate use of patient shared decisionmaking and to assess its likely effect on spending for Medicare. Development of a successful strategy in Medicare might also lead to greater use of shared decisionmaking among all patients.



**Option 43****Expand Medicare's Least Costly Alternative Policy to Include Viscosupplements**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -20  | -40  | -50  | -50  | -50  | -210      | -490      |

Osteoarthritis is a degenerative joint disease in which bone-cushioning cartilage wears away and synovial fluid (a thick liquid that reduces friction between bones) starts to thin and lose its ability to lubricate a joint. In many people with the disease, the degradation of cartilage and the reduction in synovial lubrication lead to pain, stiffness, loss of motion, and swelling. About 21 million Americans have osteoarthritis, typically in the weight-bearing joints of their knees.

Viscosupplements treat osteoarthritis by replacing some of the lubrication normally provided by the synovial fluid. Five such products have been approved by the Food and Drug Administration (FDA), all based on hyaluronic acid (one of the two components of natural synovial fluid). Although viscosupplementation does not cure osteoarthritis, it can improve a person's mobility and reduce pain; thus, it is indicated for patients who have not found relief from other therapies, such as exercise, orthotics, and over-the-counter medicines. The FDA has approved the supplements solely for use in the knee.

Medicare covers the cost of viscosupplements under Part B (which covers physicians' and other outpatient services) because the agents are administered via an injection during a visit to a physician. In 2007, Medicare spent about \$180 million for the use of viscosupplements. Payments are set for such products by using the average sales price (ASP) methodology, in which Medicare's reimbursement reflects an average of the prices that the manufacturer has charged for sales of its product exclusive of certain discounts. Medicare pays physicians for drugs they administer at the rate of the ASP plus 6 percent, or 106 percent of the manufacturer's average sales price.

Under this option, Medicare's payments for viscosupplements would be subject to a least costly alternative (LCA)

policy. Medicare's LCA policy limits the payment for a given product or service to the amount paid for the lowest-cost of the equivalent products in the category. Currently, Medicare applies its LCA policy to payments for certain drugs for treating prostate cancer. The rationale is that the program should not pay more for one product when a similar product can be used to treat the same condition and produce the same outcome but at a lower cost. If the LCA standard was applied to viscosupplements, Medicare's payment would be limited to the product with the lowest ASP in that class of drugs. The option would save about \$200 million over the 2010–2014 period and almost \$500 million over the 2010–2019 period.

An argument for this option is that it encourages physicians to consider cost when choosing among treatment options. Although each product differs slightly, they are all approved by the FDA for the same indication—osteoarthritis—and work through the same mechanism of clinical action. Medicare, it could therefore be argued, should not pay more for one product than another if both are likely to have the same effect in a patient when prescribed for the same condition.

An argument against the option is that differences do exist between products in terms of how they are derived and produced. Each also has a different molecular weight (or concentration of the active ingredient) and a different dosage strength (for example, 20, 16, or 30 milligrams). Those differences may warrant a clinical judgment on the part of physicians to prescribe one product rather than another. The LCA policy could therefore impose a financial penalty on physicians who used a more costly alternative on the basis of their clinical judgment and expertise.

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**Option 44****Require Drug and Device Manufacturers to Disclose Their Relationships with Physicians Who Participate in Medicare**

Under this option, pharmaceutical and device manufacturers would be required each year to disclose to the Centers for Medicare and Medicaid Services (CMS) all relationships with physicians who participated in the Medicare program. All contacts would be subject to disclosure, and CMS would publish the information on its Web site.<sup>1</sup> Contacts would include support for continuing medical education and relationships in which physicians were paid to lecture about specific drugs or devices. A manufacturer that failed to disclose a contact or provided an incomplete report would be fined \$10,000 per violation.

At this time, the Congressional Budget Office cannot estimate how this option might affect spending for Medicare but believes that, over time, disclosure has the potential to reduce spending. For example, hospitals and health plans could use the data collected under this option to ensure that relationships between physicians and manufacturers did not influence decisions about which drugs became part of a formulary (a list of preferred drugs) or were recommended in practice guidelines. Public reporting and disclosure of industry–physician relationships might also encourage physicians to monitor and modify their own behavior. The reporting system that this option would implement and the data that would be collected as a result could become a building block for further regulations that might reduce future costs below the level that they otherwise would attain.

Manufacturers of prescription drugs and medical devices interact with physicians in many ways—for example, during sales visits, in supporting continuing medical education, and in establishing formal relationships in which physicians act as consultants to manufacturers. One

recent study estimated that in 2003 and 2004, about 94 percent of practicing physicians had some sort of relationship with a drug company.<sup>2</sup>

As the U.S. health care system is now structured, some of those relationships are probably unavoidable, and some of the contacts may prove beneficial to patients. For example, manufacturers' sales representatives visit physicians to market their products and often provide free samples. Doctors, in turn, may learn about new pharmaceuticals during those visits and sometimes use the samples to assist patients who have trouble affording a prescription or who need to start on a medicine as quickly as possible. With respect to medical devices, manufacturers may be the best sources of training for physicians in the use of a new product.

Research indicates, however, that relationships between physicians and manufacturers may also have unintended and unfortunate effects on health care utilization and spending. One study found that physicians' interactions with drug companies or their representatives were associated with rapid prescribing of newer, more expensive drugs and more limited prescribing of less expensive generic medicines.<sup>3</sup> Another study found that physicians who had had contacts with a drug company were more likely than other physicians to request that the company's drug be added to a hospital's formulary, even when the drug offered no therapeutic advantage over pharmaceuticals that were already on the list.<sup>4</sup>

An argument in support of this option is that Medicare could use the information it would provide to better understand and evaluate relationships between physicians and device and drug manufacturers. When choosing a

1. The Medicare Payment Advisory Commission, in its June 2008 publication *Report to the Congress: Reforming the Delivery System*, examined some of the issues surrounding physicians' relationships with drug and device manufacturers, including consideration of a federal reporting system. In November 2008, the commission recommended that the Congress direct drug and device manufacturers to disclose their relationships with physicians and hospitals, as well as other stakeholders, such as patient organizations and pharmacists. The commission also recommended that the Congress direct the Secretary of Health and Human Services to post the information on a public Web site.

2. E.G. Campbell and others, "A National Survey of Physician–Industry Relationships," *New England Journal of Medicine*, vol. 356, no. 17 (April 26, 2007), pp. 1742–1750.

3. J. Lexchin, "Interactions Between Physicians and the Pharmaceutical Industry: What Does the Literature Say?" *Canadian Medical Association Journal*, vol. 149, no. 10 (November 15, 1993), pp. 1401–1407.

4. A. Wazana, "Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift?" *Journal of the American Medical Association*, vol. 283, no. 3 (January 19, 2000), pp. 373–380.

physician, Medicare beneficiaries could consider a doctor's relationships with the pharmaceutical and medical-device industries and could select a physician, at least in part, on the basis of those relationships. CMS could use the information, in combination with data from claims, to improve its understanding of physicians' practice patterns and trends in the utilization of drugs and devices.

An argument against the option is that it could be administratively burdensome. Although manufacturers might

have ready access to some of the information that would be required—such as consulting contracts—they might find other data more difficult to collect. In addition, CMS would need to set up a process for gathering and reviewing the disclosures and then publishing them in a way that would be easily available to and understood by the public.

«CBO»

**Option 45****Fund Research Comparing the Effectiveness of Treatment Options**

| (MILLIONS OF DOLLARS)            | 2010      | 2011      | 2012      | 2013       | 2014       | Total      |            |
|----------------------------------|-----------|-----------|-----------|------------|------------|------------|------------|
|                                  |           |           |           |            |            | 2010-2014  | 2010-2019  |
| Change in Mandatory Spending     | 20        | 50        | 80        | 140        | 200        | 490        | 1,120      |
| Change in Revenues <sup>a</sup>  | <u>0</u>  | <u>0</u>  | <u>*</u>  | <u>10</u>  | <u>10</u>  | <u>20</u>  | <u>260</u> |
| <b>Net Effect on the Deficit</b> | <b>20</b> | <b>50</b> | <b>80</b> | <b>130</b> | <b>190</b> | <b>470</b> | <b>860</b> |

Note: \* = less than \$5 million.

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

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Patients with a given disease or medical condition often have several treatment options available to them, but rigorous evaluation of the relative effectiveness of those options is rarely available to them or their doctors. Drugs and medical devices must be certified as safe and effective before they can be marketed, but with limited exceptions the regulatory process for approving those products does not evaluate them relative to alternatives. Meanwhile, medical procedures—which account for a much larger share of total health care spending—can achieve widespread use without a systematic review of their impact. Estimates about the current situation vary widely, but some experts believe that less than half of all medical care utilization is based on adequate evidence about its effectiveness.

Under this option, the federal government would provide mandatory funding for research on the comparative effectiveness of alternative medical treatments. Funding would begin at \$100 million in 2010, grow to \$400 million in 2014, and remain at that level through 2019. The results of that research would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States by an estimated \$8 billion over the 2010–2019 period (or by less than one-tenth of 1 percent). Reductions in federal spending on health care—primarily for Medicare, Medicaid, and the Federal Employees Health Benefits program—would total about \$100 million over the 2010–2014 period and about \$1.3 billion over the 2010–2019 period. Because any cost-saving benefits of research would occur after the spending on that research, the net effect on mandatory spending resulting from increased funding for research and reductions in federal spending for health benefits would thus be an increase of \$490 million over 5 years

and \$1.1 billion over 10 years. By the end of the 10-year period, however, the annual reduction in health care spending is estimated to be slightly larger than the increased spending on research.

Reductions in health care costs that are covered by employment-based health insurance plans would lead to small shifts in compensation from nontaxable health benefits to taxable wages, resulting in a revenue increase of about \$260 million over the 2010–2019 period.<sup>1</sup> Overall, in the Congressional Budget Office's estimation, implementing this option would increase the federal deficit by \$860 million over the 2010–2019 period.

The estimates here assume that there is an effective way to target research funds toward studies that are likely to produce savings. Predicting the effect that additional information about comparative effectiveness could have on health care spending is difficult, however, because it is hard to know what that research would show. As a general rule, however, the fee-for-service payment system by which most health care in the United States is currently financed typically provides financial incentives for doctors and hospitals to adopt new and more expensive treatments and procedures even if evidence about their effectiveness is not available. Further, some analyses have found that clinical trials sponsored by drug manufacturers and device makers are more likely than independent studies to find favorable results. Nevertheless, over the long term, generating additional objective information about the relative costs and benefits of treatments thus seems more likely to reduce total health care spending

1. The reduction in private health insurance premiums could also have a small effect on federal discretionary spending for employee health insurance costs; however, those reductions would be subject to appropriations committee action and are not included here.

than to raise it, especially if combined with new incentive structures for physicians that reflected that information.

A potential advantage of this option is that it would increase the information available for providers, payers, and consumers to use in making decisions about medical care and, over the long term, could lead to a reduction in health care costs while maintaining or improving the health of Americans. Proponents of this option note that the private sector is unlikely to fund as much research in this area as society would value because the knowledge it generates has many characteristics of a public good—so it is difficult for the sponsors of the research to capture all of its benefits. Another advantage of this option is the potential gains from a larger federal role in funding comparative effectiveness research. That larger role would enhance the federal government’s ability to ensure a greater degree of coordination and would aid in eliminating redundancy in research and assist in developing appropriate research standards.

One disadvantage of accelerating research on comparative effectiveness is that negative results from early studies might discourage the use of a promising treatment before it had been adequately tested. That might prevent the reinvention and improvement of certain medical

technologies that often occur once a treatment has been introduced. For example, during the course of clinical practice, physicians significantly improved the outcomes of coronary-stent placement after developing new techniques in stent insertion and anticoagulation therapy. Without the widespread use of coronary-stent insertion, such improvements and innovations might not have occurred. Additionally, if treatments were withheld in anticipation of the results of comparative effectiveness research, patients, especially those with severe or rare illnesses, could miss out on potentially beneficial and life-saving interventions. Some observers have also argued that greater emphasis on comparative research reviews in medical practice or in decisions about insurance coverage could limit the adoption of certain drugs and medical devices and could discourage manufacturers from developing new, innovative treatments. Another concern is that research examining the average effects of treatments might overlook subgroups of patients for whom the benefits might be more substantial. Opponents also argue that increased government funding might simply displace research efforts financed by the private sector. Moreover, critics of this option raise the concern that government-sponsored research might be biased toward conclusions that reduce federal spending—or at least might be perceived in that way by the medical community.

RELATED CBO PUBLICATION: *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role*, December 2007

**Option 46****Create Incentives in Medicare for the Adoption of Health Information Technology**

| (MILLIONS OF DOLLARS)  | 2010     | 2011      | 2012       | 2013       | 2014       | Total      |               |
|--|----------|-----------|------------|------------|------------|------------|---------------|
|  |          |           |            |            |            | 2010-2014  | 2010-2019     |
| <b>5 Percent Bonus for Adoption, Primary Care Physicians Only</b>        |          |           |            |            |            |            |               |
| Change in Mandatory Spending   | 0        | 60        | 100        | 110        | 110        | 380        | 1,170         |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>*</u>  | <u>*</u>   | <u>5</u>   | <u>5</u>   | <u>10</u>  | <u>75</u>     |
| <b>Net Effect on the Deficit</b>   |          | <b>60</b> | <b>100</b> | <b>105</b> | <b>105</b> | <b>370</b> | <b>1,095</b>  |
| <b>2 Percent Bonus for Adoption, All Participating Physicians</b>        |          |           |            |            |            |            |               |
| Change in Mandatory Spending   | 0        | 50        | 70         | 80         | 90         | 290        | 880           |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>*</u>  | <u>*</u>   | <u>*</u>   | <u>5</u>   | <u>5</u>   | <u>55</u>     |
| <b>Net Effect on the Deficit</b>   | <b>0</b> | <b>50</b> | <b>70</b>  | <b>80</b>  | <b>85</b>  | <b>285</b> | <b>825</b>    |
| <b>5 Percent Penalties for Nonadoption, All Participating Physicians</b> |          |           |            |            |            |            |               |
| Change in Mandatory Spending   | 0        | 0         | 0          | -20        | -40        | -60        | -4,620        |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>0</u>  | <u>0</u>   | <u>*</u>   | <u>5</u>   | <u>5</u>   | <u>130</u>    |
| <b>Net Effect on the Deficit</b>   | <b>0</b> | <b>0</b>  | <b>0</b>   | <b>-20</b> | <b>-45</b> | <b>-65</b> | <b>-4,750</b> |
| <b>Combined Penalties and Bonuses, All Participating Physicians</b>      |          |           |            |            |            |            |               |
| Change in Mandatory Spending   | 0        | 50        | 70         | 80         | 70         | 270        | -4,240        |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>*</u>  | <u>*</u>   | <u>5</u>   | <u>10</u>  | <u>15</u>  | <u>160</u>    |
| <b>Net Effect on the Deficit</b>   | <b>0</b> | <b>50</b> | <b>70</b>  | <b>75</b>  | <b>60</b>  | <b>255</b> | <b>-4,400</b> |

Note: \* = less than \$5 million.

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

By helping health care providers manage information, health information technology (health IT) has the potential to significantly improve providers' efficiency and the quality of care they offer. Ultimately, such improvements could reduce costs and improve health care outcomes. Health IT refers to information technology applications specifically designed for the practice of clinical medicine, including electronic health records (EHRs), personal health records, health information exchange, computerized physician order entry, clinical decision support systems, and electronic prescribing.

Proponents of health IT have argued that adopting it on a nationwide basis could result in significant reductions in health care spending. Those reductions would be realized by, among other things, reducing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of

adverse events resulting from medical errors. Health IT could also improve the quality of care provided to patients by improving the information available to clinicians at the time of treatment, by encouraging the use of evidence-based medicine, and by helping physicians manage patients with complex, chronic conditions. Conversely, the savings associated with health IT could be offset by improved adherence to treatment protocols, which could increase the amount of care provided.

In spite of such advantages, few physicians have adopted health IT; only about 5 percent have adopted comprehensive systems, according to a recent survey.<sup>1</sup> In response to the low rate of adoption, the federal govern-

1. Catherine M. DesRoches and others, "Electronic Health Records in Ambulatory Care—A National Survey of Physicians," *New England Journal of Medicine*, vol. 359, no. 1 (July 3, 2008), pp. 50–60.

ment has undertaken several different efforts to encourage providers to use health IT, including recognizing an EHR certification process; setting standards for interoperability (enabling different health IT systems to communicate with each other); providing grants and loans for providers to purchase the technology; and, through the Medicare program, offering financial incentives that both reward adoption and penalize nonadoption. Barriers to the adoption of health IT still remain, however—primarily financial ones. High-quality systems can cost \$20,000 to \$25,000 per physician, not including implementation and annual maintenance costs. Overall, startup costs can exceed \$40,000 per physician. Currently, large group practices find health IT the most attractive, and the Congressional Budget Office expects that they will continue to have the highest adoption rates over the 2010–2019 period. CBO projects that under current law, about 40 percent of physicians will have adopted health IT systems by 2019, with near-universal adoption anticipated over the next quarter century. Health IT initiatives could affect the degree of health care spending by speeding the adoption of such technologies; however, any such effects would diminish in later years, when the use of health IT was more pervasive.

This option would create an incentive program through Medicare to increase providers' use of health IT. The option comprises four alternatives that have several common features. To meet the requirements for any of the incentive programs, the provider would have to first purchase a "qualifying electronic health record" system with a standard package of functionalities. (Those capabilities would include, for example, clinical notes with medical history and follow-up, computerized physician order entry for diagnostic and other services, electronic prescribing, management of diagnostic testing results, and clinical decision support.) The product would have to be certified by the Certification Commission for Healthcare Information Technology (CCHIT) as having met the current-year requirements for interoperability.<sup>2</sup> Each incentive mechanism considered here would have a potentially different effect on adoption and a different budgetary impact. Although adoption would be encouraged through Medicare's payment incentives, all health

2. CCHIT is the only organization recognized by the Department of Health and Human Services as qualified to certify the capabilities of health IT products. More information is available at [www.cchit.org](http://www.cchit.org).

care spending—both public and private—would be affected by the increased use of health IT.

The mechanisms considered here through which the adoption of health IT could be accelerated are as follows:

- **Bonuses for Primary Care Physicians.** Under this alternative, CMS would pay participating primary care physicians that use a qualifying health IT system a bonus of 5 percent on top of the amount it would otherwise pay for an office visit by a Medicare beneficiary. (The bonus calculations would not apply to fees for injections, X-rays, or any other services that are provided in an office setting but billed separately from the office visit itself.) By the end of the 10-year budget window, CBO estimates, this alternative would increase the share of primary care physicians who adopted electronic health record systems by 12 percentage points over the adoption rate projected under current law (and would increase by 5 percent the share of all physicians adopting health IT). The net cost of this option over the 2010–2014 period would be an estimated \$370 million (including increases in spending for bonus payments, decreases in spending resulting from reduced utilization of services, and increases in federal revenues because of the reduction in private health insurance premiums); the net cost over the 2010–2019 period would be \$1.1 billion.
- **Bonuses to Support Adoption.** Under this alternative, CMS would pay all participating physicians that used a qualifying health IT system a bonus of 2 percent on top of the amount it would otherwise pay for each office visit. (The bonus calculations would not apply to other services that were provided in an office setting but billed separately from the office visit itself.) By the end of the 2010–2019 period, CBO estimates, this alternative would lead an additional 5 percent of all participating physicians to adopt electronic health record systems. The net cost of this alternative would be an estimated \$285 million over the 2010–2014 period and \$825 million over the 2010–2019 period.
- **Penalties for Nonadoption.** Under this alternative, CMS would penalize physicians who participated in the Medicare program but did not use a qualifying health IT system, beginning 5 years after the policy was enacted. The penalty would be implemented by reducing payments for office visits by 5 percent. (The penalty calculations would not apply to other services

that are provided in an office setting but billed separately.) In CBO's estimation, this alternative would spur an additional 14 percent of all participating physicians to adopt electronic health record systems compared with the number who would adopt them under current law. The net savings of this option would be an estimated \$65 million over the 2010–2014 period and \$4.8 billion over the 2010–2019 period.

- 5** ■ **Combined Penalties and Bonuses.** Under this alternative, CMS would pay all participating physicians that used a qualifying health IT system a bonus of 2 percent on top of the amount it would otherwise have paid for an office visit during the first five years following the alternative's implementation; during the next five-year period, physicians that did not use a qualifying health IT system would be assessed a 5 percent penalty. By the end of the 10-year period from 2010 to 2019, by CBO's estimates, this alternative would lead an additional 15 percent of all participating physicians to adopt electronic health record systems compared with the number projected under current law. The net cost of this alternative over the 2010–2014 period would be an estimated \$255 million, and the net savings over the 2010–2019 period would be an estimated \$4.4 billion. This alternative would produce somewhat fewer savings than would the penalty-only approach. Although adoption of health IT would be slightly greater, the savings in efficiency and utilization from that additional increment of adoption would be offset by the loss of penalty payments.

Creating incentives to adopt health IT would produce savings by increasing the efficiency with which care is delivered and by reducing the utilization of unnecessary services. However, the magnitude of those savings would

be overshadowed by the impact of the bonuses and penalties. Options that relied solely on bonuses to boost adoption would produce net costs, not savings. Options that used penalties would produce net savings—but primarily because of the application of the penalties. A key reason for that outcome is the lack of financial incentives for providers to control utilization and deliver health care efficiently. For example, in the fee-for-service component of Medicare, providers are paid for each service they provide. There is no benefit to them from eliminating unnecessary care, and, in fact, doing so causes them financial harm. That basic incentive problem is not affected by whether or not a provider uses a health IT system.

Each of the incentive mechanisms described above would have different advantages. Encouraging greater adoption of health IT through the use of penalties would result in the lowest federal expenditures, although most of the savings would come from reducing physicians' payment rates rather than from changes in the utilization of services. But providers would have to bear the full cost of adopting the technology, and many providers have not adopted health IT because the cost of doing so is greater than the potential savings in lower office costs or increased revenues. Bonuses, in contrast, would shift much of the cost of adoption to the government, with the net effect being an increase in expenditures. The combination of bonuses and penalties would strike the middle ground between the two extremes. Directing larger bonuses to primary care physicians might produce the greatest improvements in efficiency because such physicians may spend more time than do specialists in managing patient care. Moreover, because they are among the lowest paid of physicians, primary care providers may be least likely to adopt health IT without bonuses.



**Option 47****Require the Use of Health Information Technology as a Condition of Participation in Medicare**

| (MILLIONS OF DOLLARS)            | 2010     | 2011        | 2012          | 2013          | 2014          | Total         |                |
|----------------------------------|----------|-------------|---------------|---------------|---------------|---------------|----------------|
|                                  |          |             |               |               |               | 2010-2014     | 2010-2019      |
| <b>Physicians</b>                |          |             |               |               |               |               |                |
| Change in Mandatory Spending     | 0        | -60         | -240          | -490          | -970          | -1,760        | -9,620         |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>10</u>   | <u>30</u>     | <u>80</u>     | <u>150</u>    | <u>270</u>    | <u>1,540</u>   |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-70</b>  | <b>-270</b>   | <b>-570</b>   | <b>-1,120</b> | <b>-2,030</b> | <b>-11,160</b> |
| <b>Hospitals</b>                 |          |             |               |               |               |               |                |
| Change in Mandatory Spending     | 0        | -280        | -780          | -1,210        | -1,670        | -3,940        | -17,680        |
| Change in Revenues <sup>a</sup>  | <u>0</u> | <u>70</u>   | <u>210</u>    | <u>350</u>    | <u>490</u>    | <u>1,120</u>  | <u>5,130</u>   |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-350</b> | <b>-1,000</b> | <b>-1,560</b> | <b>-2,170</b> | <b>-5,080</b> | <b>-22,800</b> |

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

To participate in the Medicare program, providers must meet certain requirements, such as holding licensed certification in their field of practice and agreeing not to bill Medicare beneficiaries for more than the amount specified under Medicare. The requirements are intended to ensure, among other things, that beneficiaries have access to health care services of a reasonable level of quality and at an appropriate price. Because of the positive effect that health information technology (health IT) is believed to have on the quality and efficiency of care, Medicare also could require that providers use electronic health record systems as a condition of participation.

This option would require that physicians and hospitals adopt and use health IT as a condition of participation in Medicare beginning in 2015. As described in related health IT options in this volume, to meet the requirements for participation in Medicare, the hospital or physician would have to purchase a “qualifying electronic health record” system with a standard package of capabilities. For physicians, the standard package would include, for example, clinical notes with medical history and follow-up, computerized physician order entry for diagnostic and other services, electronic prescribing, management of diagnostic testing results, and clinical decision support. For hospitals, the standard package would most likely include clinical systems for the major ancillary services (laboratory, pharmacy, and radiology), a clinical data repository, clinical documentation (including nurses’ and physicians’ notes), clinical decision support, and

computerized physician order entry. Products would have to be certified by the Certification Commission for Healthcare Information Technology (CCHIT) as having met the commission’s current-year requirements for interoperability.<sup>1</sup>

The Congressional Budget Office expects that, if implemented, this option would lead virtually all hospitals and physicians to adopt electronic health record systems. By reducing both administrative overhead and unnecessary utilization of services (including inappropriate tests and procedures) as well as adverse events resulting from preventable medical errors, the option, in CBO’s estimation, would produce savings in major federal health care financing programs, including both Medicare and Medicaid. Nearly universal adoption of health IT by physicians and hospitals would also lower health insurance premiums in the private sector, thereby shifting some compensation from tax-advantaged premiums to taxable wages and salaries. As a result, federal tax revenues would increase.

The new condition for participation in Medicare for physicians would reduce federal deficits by about \$2 billion over the 2010–2014 period and by \$11 billion over the 2010–2019 period. Applying the requirement to hospi-

1. CCHIT is the only organization recognized by the Department of Health and Human Services as qualified to certify the capabilities of health IT products. More information is available at [www.cchit.org](http://www.cchit.org).

tals would reduce deficits by about \$5 billion over the 2010–2014 period and by \$23 billion over the 2010–2019 period. Those estimates include both reductions in expenditures for Medicare and Medicaid, arising from the reduced utilization of services, and increased federal revenues, resulting from the reduction in private health insurance premiums.

The savings included in the table reflect only those that would be achieved without any other change in federal law. Under Medicare’s current payment rules, the only savings in Medicare’s expenditures from the adoption of health IT would be from reducing some types of utilization, such as by reducing the probability of hospital admissions resulting from preventable adverse medical events. Health IT also helps hospitals reduce their internal operating costs by, among other things, improving nurses’ productivity, lowering the cost of maintaining patients’ medical charts, and reducing the utilization of unnecessary prescription drugs and diagnostic services. However, because Medicare pays for inpatient care on a per-admission basis, those savings would not result in lower expenditures for the Medicare program. Those savings would only be captured by reducing the annual updates to payment rates under the inpatient prospective payment system, which would require legislative action. If the updates were changed to reflect lower operating

costs for hospitals, the total savings related to the requirement that hospitals adopt health IT as a condition of Medicare participation would be \$14.0 billion over the 2010–2014 period and \$60.6 billion over the 2010–2019 period. Similarly, improvements in efficiency in physicians’ offices would not accrue to Medicare unless physician payment updates were changed to take those lower operating costs for physicians into account. If those changes were made, total savings related to the requirement that physicians adopt health IT as a condition of participation in Medicare would be \$2.7 billion over the 2010–2014 period and \$14.3 billion over the 2010–2019 period.

An advantage of this option is that the expanded use of health IT would be likely to improve both the quality of health care services and health outcomes, perhaps markedly so. A disadvantage of this option is that it would impose a large cost on providers. In particular, many small practices would be hard-pressed to find the financial resources to purchase a health IT system. In addition, implementing this option would create a surge in demand for health IT systems, thereby bidding up the price of IT specialists and of the systems themselves. Thus, this option could create a strong incentive for providers to favor low-cost health IT systems over high-quality systems.

**Option 48****Support Development of VistA to Meet Standards and Encourage Adoption**

| (MILLIONS OF DOLLARS)                   | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|---|------|------|------|------|------|-----------|-----------|
|   |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Discretionary Spending        |      |      |      |      |      |           |           |
| Budget authority                        | 530  | 210  | 220  | 220  | 230  | 1,410     | 2,670     |
| Outlays                                 | 450  | 260  | 220  | 220  | 230  | 1,380     | 2,630     |
| <b>Memorandum:</b>                      |      |      |      |      |      |           |           |
| Nonscorable Budget Effects <sup>a</sup> |      |      |      |      |      |           |           |
| Change in mandatory spending            | 0    | -10  | -190 | -270 | -340 | -810      | -2,350    |
| Change in revenues                      | 0    | 0    | 20   | 30   | 50   | 100       | 480       |

a. Any savings from the adoption of the Veterans Health Information Systems and Technology Architecture would depend on appropriation of the necessary funding. Following Congressional budget-scoring rules (scorekeeping rule 3), such estimated savings are not counted in recording the budgetary impact of an appropriation act.

The Veterans Health Information Systems and Technology Architecture (VistA), one of the most widely used electronic health records (EHRs) in the world, is a health care information management system found in the hospitals, outpatient clinics, and nursing homes of the Veterans Health Administration (VHA), the medical system of the Department of Veterans Affairs (VA). In addition to its EHR, which allows providers to electronically review and update a patient's health record, VistA also has such additional capabilities as computerized order entry, electronic prescribing, and decision support that encourages adherence to clinical guidelines. The source code for the software is freely available and has been used to develop several other open-source (that is, publicly available) versions of VistA. Two of those adaptations have been certified by the Certification Commission for Healthcare Information Technology (CCHIT) as CCHIT Certified Ambulatory EHR products for 2006: the WorldVistA EHR VOE/1.0 and Document Storage Systems' vxVistA V1.0. Some VistA adaptations have been installed in hospitals and networks of clinics outside the VHA system.

This option would support the development or enhancement of adaptations of VistA that were intended for use by physicians outside the VHA. (The federal government could also support the upgrading of VistA adaptations intended for use by other providers, such as hospitals, but this option focuses only on physicians.) The VistA adaptations developed under the option would be open source in character and would meet the latest certification standards for health information technology (health IT)

products as determined by the Secretary of Health and Human Services. Under the assumption that appropriated funds were available, the costs for developing and enhancing VistA would total about \$1.4 billion over the 2010–2014 period, the Congressional Budget Office estimates, and \$2.6 billion over the 2010–2019 period. Moreover, this option, which would result in an additional 18 percent of physicians adopting electronic health record systems compared with the number projected under current law, would save \$910 million over the 2010–2014 period and \$2.8 billion over the 2010–2019 period (including both reductions in expenditures for federal programs and increased revenues). After the first few years, CBO anticipates, the cost savings to the federal government would exceed the annual costs for VistA.

As with other options that would increase adoption of health IT, those savings would come from improved efficiency in providing health care, such as reducing the number of unnecessary services and decreasing administrative costs. That increased efficiency would help reduce expenditures for federal health financing programs, such as Medicare and Medicaid, and lower premiums for private health insurance. Lowering private premiums would shift some income away from tax-advantaged fringe benefits (employment-based health insurance) to taxable compensation, thereby increasing federal tax revenues. However, the projected savings would depend on the availability of appropriation actions undertaken to fund the VistA upgrades.

Supporters of this option argue that a certified VistA product would offer a relatively inexpensive option for providers who otherwise would be unable to pay the high price asked for a proprietary health IT system. VistA already has one of the highest rates of adoption by providers of any single EHR because its use in the VHA system has created a strong base of support for physicians outside that system to begin using the product. Many providers may feel overwhelmed by the variety of health IT products currently on the market; having a single government-sponsored, open-source system could simplify their decisionmaking with regard to adoption. Another argument in support of this option is that VistA's open-source platform would allow individuals and firms in the public and private sectors to create updates and add-ons that could improve the system.

Critics of this option argue that a government-sponsored system might undermine the significant investments made by the private sector in developing health IT products, some of which might offer advantages or features that VistA may not provide. Moreover, although the offering of VistA as an open-source product would reduce the cost of an EHR, it would not reduce that cost to zero. Providers that adopted VistA would still have to pay for training, implementation, and interfaces for exchanging data with other entities, and they would still experience a reduction in productivity for two to three months when the system was first installed.

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**Option 49****Sponsor Regional Markets for Health Information Technology**

| (MILLIONS OF DOLLARS)            | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|----------------------------------|------|------|------|------|------|-----------|-----------|
|                                  |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Discretionary Spending |      |      |      |      |      |           |           |
| Budget authority                 | 50   | 50   | 50   | 60   | 60   | 270       | 270       |
| Outlays                          | 40   | 50   | 50   | 50   | 60   | 250       | 270       |
| <b>Memorandum:</b>               |      |      |      |      |      |           |           |
| Nonscorable Budget Effects       |      |      |      |      |      |           |           |
| Change in mandatory spending     | 0    | -10  | -10  | -20  | -30  | -70       | -360      |
| Change in revenues               | 0    | *    | *    | 5    | 5    | 10        | 70        |

Notes: Any savings from sponsoring regional markets for health information technology would depend on appropriation of the necessary funding. Following Congressional budget-scoring rules (scorekeeping rule 3), such estimated savings are not counted in recording the budgetary impact of an appropriation act.

\* = less than \$5 million.

Despite the benefits that may be gained from adopting health information technology (health IT) systems, many providers have not purchased such systems. (For a fuller discussion of health IT, see Option 46.) Under this option, the Secretary of Health and Human Services would put out for bid the responsibility for sponsoring regional markets for health IT systems. The primary function of organizational entities that won contracts to sponsor a market would be to address some of the barriers that providers face in adopting health IT—in particular, by narrowing the choices of systems for providers, reducing the prices that they face, and coordinating the development of common interfaces and implementation guides to facilitate the electronic exchange of health information both regionally and nationally. Those entities, or regional sponsors, would be regionally based organizations with the demonstrated ability to accomplish the objectives of this option. Sponsors of regional health IT markets would ultimately offer providers a selection of several qualifying electronic health records (EHRs) that would include the following: both stand-alone and application service provider (ASP) systems, several hosting services for those systems, interfaces and implementation guides for the most common connection needs, and an EHR implementation model using Web-based support services.<sup>1</sup> The Office of the National Coordinator of Health Information Technology (which manages federal activities to develop health IT standards for achieving interoperability) would be required to ensure that interoperability and reporting were uniformly carried out

and that implementation guides for interoperability were standardized. (Interoperability refers to the capacity of one health IT application to share information with another in a computable format.)<sup>2</sup>

Sponsors under this option would solicit bids from health IT vendors and from Web-hosting services to simplify providers' decisions about purchasing a system. That process, in turn, by providing the potential for greater sales and use of standard formatting, might lead vendors to offer lower prices than they currently do. Vendors would be required to offer a standard package of EHR functionalities—for example, one that included a capacity for clinical notes with medical history and follow-up, computerized physician order entry for diagnostic and other services, electronic prescribing, management of diagnosis

1. A stand-alone system is one that is purchased outright and entirely housed within a provider's office. In an application service provider system, providers access the system remotely from their offices by using an Internet connection; an ASP system is typically paid for through a monthly fee. Implementation guides are technical specifications that provide standardized data requirements and content to allow all users to achieve interoperability between information systems.
2. EHR systems that meet requirements for interoperability specified by the Certification Commission for Healthcare Information Technology (which has contracted with the federal government to develop and evaluate certification criteria and create an inspection process) have the capability to be interoperable but can only achieve it if they follow the appropriate implementation guide.

tic testing results, and clinical decision support—in stand-alone and ASP systems. To be certified by the Certification Commission for Health Information Technology (CCHIT), the product would have to meet CCHIT’s most recent requirements, including those for interoperability. Sponsors would accept bids from several qualified vendors that offered the lowest prices for the standard package.

To maximize competition among the vendors, sponsors would submit a standard request for proposal with enough detailed specifications to ensure that each vendor’s product was comparable with those of competitors. Sponsors would also solicit bids for Web-hosting services for both ASP and EHR systems that would be required to host products with CCHIT’s most recent certification and to accommodate all current federal incentive programs for electronic reporting of health data. In addition, sponsors would coordinate the development of standard interfaces to facilitate the transmission of data in a computable format between physicians and ancillary service providers. Finally, sponsors could provide Web-based training for facets of the systems’ implementation that were common across all health IT vendors.

Providing such Web-based training could help lower the costs to providers of purchasing an EHR, given that expenditures for training and implementation make up a significant share of the total cost of acquiring an EHR system. Vendors estimate that about 25 percent of training in the use of electronic health records is similar among vendors. Rather than requiring each vendor to offer what could be duplicated training, the sponsor could contract with a single training entity to offer a Web-based curriculum at a significantly lower cost than would be possible if each vendor offered or provided training. Sponsors could lower any costs for vendor-specific training by offering training regionally or through Web-based technology.

The effects of this option would come mainly from lowering the prices that providers would pay for health IT systems and simplifying their decisions about such pur-

chases, thereby increasing adoption. Sponsors could cover their costs by charging fees to provide training and support for implementation, but they would probably require some initial “seed money.” Assuming the availability of appropriated funds, the Congressional Budget Office estimated that expenditures for sponsors would be \$50 million per year (adjusted for inflation) for the first five years after the option’s implementation. By CBO’s calculations, this option could ultimately lower prices for health IT by about 15 percent below what they otherwise would have been. The lower prices would encourage an additional 3 percent of physicians (beyond those that would have adopted it anyway) to adopt health IT, which would increase the benefits that flowed from that adoption.

Increasing the adoption of health IT would most likely reduce health care costs by, among other things, decreasing the number of duplicated diagnostic tests, diminishing the likelihood of adverse outcomes of treatment as a result of missing or inaccurate information (outcomes that in turn might require costly treatment to remedy), and, in the long run, improving the quality of health care.

The main advantage of this option is that it could boost health care providers’ adoption of health IT by simplifying their decisions about whether to invest in the technology and by helping lower prices below what they otherwise would have been. Such price reductions would follow from the competitive bidding process for vendors and from the provision, at a lesser cost, of some of the training that health IT vendors typically provide with purchases.

The main disadvantage of this option is that sponsors might be reluctant to participate without the promise of more predictable compensation. (Their compensation under the option would consist primarily of initial start-up funding and then the fees they would charge for training and other services in connection with their sponsorship responsibilities.)

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## Geographic Variation in Spending for Medicare

**H**ealth care spending per capita varies widely across the United States, and spending in the Medicare program is no exception. Researchers affiliated with the Dartmouth *Atlas of Health Care* have analyzed groups of Medicare beneficiaries who appear to have similar medical conditions. They found that beneficiaries who lived in high-spending geographic areas received approximately 60 percent more services than those who lived in low-spending areas.<sup>1</sup> Because Medicare is financed through federal tax revenues, high spending in one area is, in effect, funded largely by taxpayers in other areas.

Previous research by the Congressional Budget Office has shown that the degree of geographic variation in Medicare spending has lessened over time.<sup>2</sup> Major changes in Medicare's payment policies appear to be linked to some of that reduced variation; those changes include the

introduction of prospective payment systems for hospitals and post-acute care facilities, and the introduction of the physicians' fee schedule.

The amount of spending involved is quite large—one report indicated that Medicare spending would fall by 29 percent if spending in medium- and high-spending regions were the same as that in low-spending regions.<sup>3</sup> But policies that reduce spending in high-spending areas would not necessarily lead to increased efficiency—and could result in worse health outcomes for patients—unless the reductions targeted ineffective or harmful treatments.

The options in this chapter offer alternatives that would further reduce existing regional variations in Medicare's spending. The mechanisms discussed in the options encompass incentives for both providers and beneficiaries.

1. Elliott S. Fisher and others, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (February 18, 2003), pp. 273–287.
2. Congressional Budget Office, *Geographic Variation in Health Care Spending* (February 2008).

3. John E Wennberg and others, "Geography and the Debate Over Medicare Reform," *Health Affairs*, Web Exclusive (February 13, 2002), pp. W96–W114.

**Option 50****Reduce Medicare's Fees for Physicians in Areas with Unusually High Spending**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013   | 2014   | Total     |           |
|------------------------------|------|------|------|--------|--------|-----------|-----------|
|                              |      |      |      |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -400 | -900 | -1,500 | -2,100 | -4,900    | -5,300    |

Each year, Medicare sets fees for physicians' services using the "sustainable growth rate" (SGR) mechanism. That mechanism establishes a cumulative target for Medicare's spending for physicians' services (including those furnished "incident to" a visit to a physician, such as diagnostic laboratory or imaging services). The target is updated annually to reflect inflation, overall economic growth, the increase in the number of Medicare enrollees in the fee-for-service program, and any changes in Medicare's outlays that stem from new laws or regulations (such as the addition of newly covered preventive services). If actual spending for Medicare-covered physicians' services increases faster than the target, the SGR mechanism is designed to reduce payment rates for those services so that cumulative spending and the cumulative target eventually converge. (The reverse happens when spending is below the target.)

In principle, the SGR mechanism gives physicians, as a group, an incentive to limit the volume of the Medicare-covered services they provide. Reductions in volume, if they could be achieved through coordinated efforts by physicians, would, under the SGR mechanism, eventually increase the payment rate that a physician received for each service. Any single physician or group practice acting alone, however, has essentially no ability to influence the overall volume of services—any unilateral reductions in volume would, from an individual physician's perspective, lead to a drop in income. The lack of a coordinated attempt by physicians to restrain the volume of Medicare-covered physicians' services is apparent in historical trends. Since 2002, the volume of such services has grown more rapidly than the expenditure target; consequently, the SGR mechanism has called for reductions in the fees for physicians' services each year. (Policymakers have repeatedly overridden those reductions through legislation.)

Under this option, local spending targets for each microregion of the country (discussed below) would be set and used as the basis for reducing fees in microregions

with unusually high spending. A cumulative spending target for Medicare-covered physicians' services would continue to be set at the national level using the SGR mechanism. The local spending targets would be used to adjust fees downward in areas in which spending substantially exceeded those targets. This option would reduce Medicare's outlays by about \$5 billion over both the 2010–2014 and 2010–2019 periods.

Microregions would be defined on the basis of hospital service areas, or HSAs. (HSAs are aggregations of zip codes that represent local health care markets.) Many HSAs contain 10,000 or more Medicare beneficiaries; those service areas are sufficiently large that each would constitute a separate microregion. In the case of HSAs that had fewer than 10,000 beneficiaries, multiple nearby HSAs would be combined to create microregions that each comprised at least 10,000 beneficiaries.

The spending target for each microregion would be based on the number of Medicare beneficiaries in the area and their health status, together with the local prices of inputs (for example, the cost of office space or professional labor). Adjustments for health status would be based on Medicare's hierarchical condition categories, which are used to adjust payment rates for Medicare Advantage plans. An additional adjustment would be made for regional migration patterns in the use of health care services. Areas such as Boston that had persistent net inflows of patients would receive higher spending targets to reflect that migration.

The Centers for Medicare and Medicaid Services (CMS) would calculate a local adjustment factor annually for each microregion by comparing the cumulative local target with cumulative local spending, and would apply the local adjustment factor to all physicians whose primary practice location was in that microregion. The local adjustment factor would equal zero unless the ratio of local spending to the local target exceeded the 90th percentile among all microregions. In such cases, the local



adjustment factor would equal the percent difference between the 90th percentile ratio and the ratio in the microregion. CMS would phase in the local adjustment factors: The share of fees determined by the factor would increase from 20 percent in calendar year 2011 to 100 percent in calendar year 2015. Initially, CMS would set the local adjustment factors solely on the basis of projections of the number of beneficiaries in the region and patterns of local spending for health care. In future years, those projections would be updated with actual data on enrollment and spending, as the information became available. The coinsurance that beneficiaries paid would continue to be determined by current law.

This option specifies that the reduction in fees from applying the local adjustment factors would not be treated as a “law-and-regulation” change and therefore would not reduce the national SGR target. That provision would result in increased Medicare physician fees in 2018 and 2019 in areas that do not have high spending—an outcome that would substantially reduce the savings from the option. If the local adjustment factors were instead treated as a law-and-regulation change, the option would reduce federal outlays by roughly \$20 billion over the 2010–2019 period.

Under this option, CMS would provide regular reports to state medical associations showing how it calculated the local adjustment factors. The reports would provide information on patterns of health care utilization by detailing the total allowable charges for Medicare-covered services and listing them separately by microregion and provider.

An advantage of this option is that it would create a degree of financial accountability among physicians within local areas, which could spur them to engage in coordinated efforts to reduce the wasteful use of health care resources. If, for example, an individual physician or

imaging center in a high-spending area was submitting an excessive number of claims to Medicare for payment, the physicians who worked in the same microregion would have a direct financial incentive to monitor, detect, and discourage such behavior—that incentive exists under the current SGR but would be much more direct under this option. (CMS’s regular reports on patterns of utilization of services in each local area would facilitate such monitoring.) The self-monitoring by physicians and related providers that this option would put in place could lead to reductions in the volume of Medicare-covered physicians’ services. The option would also reduce the degree of geographic variation in Medicare’s spending over the short run by lowering physicians’ fees in high-spending areas. In addition, because the SGR would remain in effect at the national level, reductions in spending in high-spending microregions over the long term would result in increases of about 10 percent in physicians’ fees in microregions that had low or average spending.

One potential drawback to this option is that Medicare’s fees for physicians’ services in some high-spending areas would be reduced dramatically. For example, in 2015 (the first year in which the local adjustment factors would be fully phased in), this option would reduce physicians’ fees in Miami by more than 30 percent. Even when phased in over five years, changes of that magnitude could disrupt health care markets. Moreover, even with the option in place, physicians might fail to act in a coordinated fashion to constrain the growth in the volume of Medicare-covered services. In addition, Medicare beneficiaries might face difficulties in obtaining certain medical services if providers became less willing to offer them. Reduced access in the fee-for-service sector could cause some beneficiaries to enroll in Medicare Advantage plans. The budget effects of such a switch are not included in these estimates.

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**Option 51****Reduce Medicare's Payment Rates for Hospitals in Areas with a High Volume of Elective Admissions**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -60  | -140 | -220 | -420      | -2,580    |

6 Researchers have documented wide variation across geographic areas in Medicare's spending per beneficiary, and most of that variation does not appear to be explained by measurable differences in the health status of beneficiaries. Substantial differences appear specifically in the use of certain types of hospital care, including such surgical procedures as spine surgery and knee joint replacements, as well as in hospital admissions for such conditions as chronic obstructive pulmonary disease. In explaining such variation, researchers have pointed to "gaps in medical science and professional uncertainty about the implications of alternative treatments."<sup>1</sup> Some researchers have also questioned whether beneficiaries in high-spending areas experience improvements in health outcomes that are commensurate with the greater volume of services they receive.

Under this option, the Centers for Medicare and Medicaid Services (CMS) would designate certain Medicare severity diagnosis-related groups (MS-DRGs) as elective (that is, as subject to substantial uncertainty and discretion in clinical decisionmaking) and would group those elective MS-DRGs into clinically related groups. The set of elective MS-DRGs would have to be broad enough to account for at least 8 percent of current Medicare spending on short-stay hospitals. CMS would then measure the rate of hospital admissions in a geographic area for each group of elective MS-DRGs. Areas would be defined by using the Office of Management and Budget's list of designated metropolitan statistical areas (MSAs) as a starting point, with each MSA constituting an area for the purposes of this option. All of the nonmetropolitan regions of a state (those not part of an MSA) would together constitute an area. CMS would adjust admission rates on the basis of the demographics of the local population.

1. Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Quality of Medical Care in the United States: A Report on the Medicare Program* (1999), [www.dartmouthatlas.org/atlas/99Atlas.pdf](http://www.dartmouthatlas.org/atlas/99Atlas.pdf), p. 144.

If, after adjusting for demographics, CMS identified an area as having an unusually high volume of admissions for a specific group of elective MS-DRGs, hospitals located in that area would have their payment rates reduced for that group of MS-DRGs. High-volume metropolitan areas would be defined as those in which the rate of admissions per Medicare beneficiary, after adjusting for age, sex, and race, exceeded 120 percent of the national average. (Roughly 20 percent to 30 percent of areas, depending on the type of admission, would currently exceed that threshold.) The payment rate for each MS-DRG group would be reduced by half of the difference in percentage points between the MSA's risk-adjusted admission rate and 120 percent of the national average; the maximum rate reduction would be set at 20 percent. CMS would phase in the reduction in payment rates in high-volume areas over five years. This option would reduce spending for Medicare by an estimated \$0.4 billion over the 2010–2014 period and by \$2.6 billion over the 2010–2019 period.

An argument in support of this option is that it would reduce the degree of geographic variation in Medicare's outlays for hospital services. The option would also draw the attention of hospitals and other providers to their local area's rates of admissions for the selected MS-DRGs and could spur efforts either to justify those rates or to change them.

An argument against this option is that once the payment reductions took effect, Medicare beneficiaries might face difficulties in obtaining medical services if providers became unwilling to serve them. Because some providers would receive less revenue from Medicare, they would either have to cut their operating expenses or earn smaller margins on their services to Medicare patients. By reducing the revenue of providers, this option might also limit the level of care and amenities they were able to deliver.

**Option 52****Reduce Medicare's Payment Rates Across the Board in High-Spending Areas**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -1,000 | -2,200 | -3,500 | -5,000 | -11,700   | -50,900   |

In some parts of the country, Medicare's spending per beneficiary is unusually high, a circumstance that appears to be attributable primarily to differences in local patterns of medical practice and professional norms, and not to higher local prices for "inputs" (goods and services used in the production of services, such as professional labor, office space, and so forth) or to unusually sick populations. Researchers have questioned whether the additional services provided in such high-spending areas produce improvements in patients' health that are commensurate with their cost.

In parts of the country where per-beneficiary spending unusually high, this option would apply across-the-board reductions to Medicare payment rates in the fee-for-service sector for services covered under Parts A and B of the program. The first step in determining those reductions would be to define the geographic areas to be used for measuring and comparing per-beneficiary spending. (The size of such areas has a substantial effect on the amount of the change in mandatory spending that the option might bring about.) The Office of Management and Budget's list of designated metropolitan statistical areas (MSAs) would serve as a starting point in that definition process; each MSA would constitute an area for the purposes of this option. Then, in each state, all non-metropolitan regions (that is, all parts of the state not included in an MSA) would constitute a single additional area.

Payment rates for the fee-for-service program would depend on each area's "relative spending"—defined as the spending per beneficiary in that area, adjusted to reflect the price of inputs and the health status of the local population, divided by the average spending per beneficiary nationwide. (Adjustments for health status would be based on Medicare's hierarchical condition categories, which are currently used to adjust payment rates for Medicare Advantage plans.) Fee-for-service payment rates under this option would be reduced in areas where relative spending exceeded 1.1—that is, where spending

was 10 percent or more above the national average; reductions would equal one-half of the difference between the region's relative spending and the threshold of 1.1. (For example, a region with relative spending of 1.2—that is, spending 20 percent above the national average—would experience reductions in Medicare payment rates amounting to 5 percent, or 1.2 minus 1.1 divided by 2.)

The reduction in payment rates in high-spending areas would be phased in over five years and capped at 20 percent. It would apply to all payments—including those to hospitals, physicians, and providers of post-acute care—made on the basis of a fee schedule. Moreover, the reduction in fee-for-service payment rates would indirectly reduce Medicare's payments to private Medicare Advantage plans by reducing the benchmark payment rates for those plans. If implemented, this option would reduce Medicare spending by an estimated \$12 billion over the 2010–2014 period and by \$51 billion over the 2010–2019 period.

An argument in favor of this option is that it would bring about more interregional equity in Medicare's spending and might encourage initiatives in high-spending areas to reduce the utilization of health care resources, especially services thought to have only marginal benefits for patients. This option also would reduce the federal government's outlays for Medicare as compared with levels under current law. Reductions in Medicare's Part B expenditures would also lower beneficiaries' premiums and out-of-pocket payments.

An argument against this option is that it would not target specific medical providers or specific types of services. In high-spending areas, all medical providers would face reductions in payment rates, regardless of whether their practice patterns contributed to the area's unusually high level of spending. Thus, payments for all services, regardless of a service's value to a patient, would be reduced, and once those reductions took effect, Medicare benefi-

ciaries might face difficulties in obtaining certain medical services if providers became less willing to offer them. Reduced access in the fee-for-service sector could cause some beneficiaries to enroll in Medicare Advantage plans; however, the budgetary effects of such changes in enrollment are not included in these estimates.

Another argument against the option involves providers' responses. Because providers would receive less revenue

from Medicare, they would either have to reduce their operating costs or accept a smaller profit on services to Medicare patients. By reducing the revenue of providers, this option might also limit their ability to provide high-quality care. In addition, reductions in Medicare's payments to Medicare Advantage plans would result in beneficiaries' paying higher premiums for those plans or receiving a smaller benefit package. Moreover, some plans might withdraw from the Medicare program as a result.

RELATED PUBLICATION: *Geographic Variation in Health Care Spending*, February 2008

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**Option 53****Impose a Surcharge on Medicare Cost Sharing in High-Cost Areas and Prohibit Medigap Plans from Covering the Surcharge**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|------|--------|--------|--------|-----------|-----------|
|                              |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -1,600 | -2,300 | -2,400 | -6,300    | -20,900   |

Researchers have documented wide geographic variations in per-beneficiary Medicare spending, and most of that variation does not appear to be explained by measurable differences in beneficiaries' health status. Some researchers have questioned whether beneficiaries in areas with high spending experience improvements in health outcomes commensurate with the higher volume of services they receive.

Under this option, Medicare beneficiaries living in areas with unusually high levels of spending would face a cost-sharing surcharge for services covered under the program. Areas with high spending would be defined as those in which per-beneficiary spending in the Medicare fee-for-service program exceeded by 10 percent or more the national average per-beneficiary spending, after adjusting for differences in enrollees' health status and the price of local "inputs" (goods and services used in the production of services, such as professional labor and office space). Areas would be defined by using the Office of Management and Budget's list of designated metropolitan statistical areas (MSAs) as a starting point, with each MSA constituting an area for the purposes of this option. All of the nonmetropolitan regions of a state (that is, all those not included in an MSA) would together constitute an area. The cost-sharing surcharge in a high-spending area would depend on the region's "relative spending"—defined as regional per-beneficiary spending, adjusted to reflect the prices of inputs and the health status of the local population and divided by the national average. (Adjustments for health status would be based on Medicare's hierarchical condition categories, which are currently used to adjust payment rates for Medicare Advantage plans.) Surcharges would be applied only in areas with relative spending exceeding 1.1 (that is, 10 percent above the national average) and would vary depending on the excess above 1.1. For example, in an area with relative spending equal to 1.2 (20 percent above the national average), the surcharges would be equal to one-quarter of current

cost-sharing amounts; in areas with relative spending equal to 1.3 (30 percent above the national average), the surcharges would be equal to half of the current cost-sharing amounts. (Surcharges would be capped at half of the current cost-sharing amounts.) The surcharge would be imposed in addition to the cost sharing required under current law and would be applied to all services that currently require cost sharing. Medigap plans would not be permitted to cover the surcharge, although public supplemental coverage for low-income beneficiaries (provided through state Medicaid agencies) would cover the surcharge.

This option would reduce federal outlays by an estimated \$6.3 billion over the 2010–2014 period and by \$20.9 billion over the 2010–2019 period. The change in outlays would be attributable primarily to reductions in Medicare's spending but also would reflect increases in federal spending for Medicaid to cover the surcharges for low-income beneficiaries.

An argument in favor of this option is that it would create incentives for beneficiaries in areas with high spending to reduce their use of Medicare-covered services, some of which may be excessive or clinically inappropriate. The option would also help beneficiaries compare local spending for Medicare with the national average; in high-spending areas, the option could spur coordinated efforts either to justify those spending levels or reduce them.

An argument against this option is that the cost-sharing surcharge would not be targeted toward services that provided little clinical benefit. Moreover, applying a surcharge could prompt beneficiaries to forgo beneficial medical services. Also, larger cost-sharing requirements in the fee-for-service program could cause some beneficiaries to switch to Medicare Advantage plans. (Estimates include the budgetary effects of such a switch.)



## Paying for Medicare Services

**T**he Medicare program comprises four separate components that finance care for about 44 million elderly and permanently disabled individuals. In general, Medicare Part A finances services furnished by hospitals, nursing facilities, and other institutional providers. Medicare Part B finances visits to physicians and other physicians' services, outpatient hospital care, the purchase of durable medical equipment, and other ambulatory services. Part C of Medicare delivers Part A and Part B benefits through private plans, and Part D finances outpatient prescription drugs.

### Part A

Medicare pays for most Part A services delivered in the fee-for-service sector of the program using prospective payment systems that vary according to the type of service furnished. For hospitals, Medicare makes a payment for each discharge; for inpatient rehabilitation facilities and long-term care hospitals, a payment for each stay; for skilled nursing facilities and hospices, a payment for each day of care; and for home health services, a payment for each 60-day episode of care.

Medicare's prospective payment systems generally set a base payment, then adjust that base payment for variables like the severity of illness and geographic variation in input prices to yield the provider's total compensation for a given service, like a hospital stay. The prospective payment approach is designed to promote efficiency, because payments are predetermined and do not depend on the costs that providers incur.

### Part B

Medicare pays for most Part B services using fee schedules. Medicare's fee schedule for physicians' services is based on a relative-value scale that is intended to reflect the relative costs of the inputs that are used to provide physicians' services. The annual updates to physicians'

payments are determined under the "sustainable growth rate" (SGR) mechanism, which establishes annual and cumulative targets for Medicare's combined spending for physicians' services and for those services furnished "incident to" (in connection with) a visit to a physician (for instance, diagnostic laboratory tests, or a physician's administration of certain drugs). If spending on Medicare-covered physicians' services increases rapidly, the SGR mechanism is designed to reduce the rates of payment to physicians each year, so that cumulative spending and the cumulative target eventually converge. (The reverse happens when spending is below the target.) The Congressional Budget Office estimates that under current law, physicians will receive about a 21 percent reduction in payment rates in 2010. However, in most recent years, legislation has been enacted to prevent reductions in payment rates that would have been triggered by the SGR mechanism.

Most other Part B providers, including clinical laboratories, dialysis facilities, and hospital outpatient departments, are paid using fee schedules or other systems of administered pricing. Payments for drugs furnished incident to a physician's service are based on the average sales price (ASP), which serves as a proxy for the physician's acquisition cost. Medicare's payment equals the average sales price plus 6 percent.

Many drugs covered under Part B of Medicare are biologics (pharmaceuticals derived from living organisms), which are not as easily characterized or replicated as are traditional chemical drugs. The Food and Drug Administration's regulatory authority for the approval of most biologics comes from the Public Health Service Act. To encourage innovation, the nation's system of patent protection provides innovative drugs (such as new chemical compounds) and biologics with a market advantage. The Hatch-Waxman Act of 1984 established an abbreviated regulatory approval process for drugs originally approved under the Federal Food, Drug, and Cosmetics Act to

encourage the entry of generic drugs into the market after patents (on the original drug) have expired. However, there is no comparable pathway for biologics that are regulated under the Public Health Service Act.

For both Part A and Part B of Medicare, the Centers for Medicare and Medicaid Services (CMS) updates the payment rules and rates annually, using notice-and-comment rulemaking. In general, the update factor that CMS applies is meant to capture inflation in providers' costs (including labor) during the previous year.

### Part C

Part C, or Medicare Advantage (MA), uses private health plans to furnish the full package of Medicare services to beneficiaries. Private plans submit bids indicating the per capita payment for which they are willing to provide Medicare's covered benefits. The government's maximum payment per enrollee—which is called a benchmark and varies by county—is established by statutory rules and made public each year before the plans submit their bids. Medicare pays plans the amount of their bids (up to the benchmark) plus 75 percent of the amount by which the benchmark exceeds their bid. Plans must return that 75 percent to enrollees as additional benefits or as rebates on their Medicare premiums. Thus, the lower a plan's bid relative to the benchmark, the greater the additional benefits and premium rebates it can offer to attract enrollees. Plans whose bids are above the benchmark are required to charge enrollees the full difference between the bid and the benchmark as an additional premium for the Medicare benefit package that the plans provide. Medicare's payments to plans are adjusted to account for differences in plans' expected costs that are associated with the health status of their enrollees. The government pays more to Medicare Advantage plans for delivering Medicare benefits than it would pay if the plans' enrollees had remained in the traditional fee-for-service program. In 2008, benchmarks for the Medicare Advantage program were 17 percent higher, on average, than projected fee-for-service spending per capita nationwide.

### Part D

Medicare's outpatient prescription drug benefit, Medicare Part D, also uses private health plans to furnish coverage for prescription drugs to beneficiaries who receive the rest of their care (inpatient stays at hospitals, physicians' visits, and so forth) through the traditional fee-for-service portion of Medicare. Like MA plans, prescription drug plans (PDPs) submit bids that indicate the per capita cost for which they are willing to offer the standard drug benefit or an acceptable alternative.<sup>1</sup> The federal payment to the plans reflects two components: a direct subsidy, which is a capitated amount per enrollee based on the national average of plans' bids; and government reinsurance for costs that exceed the catastrophic threshold in place for the Part D benefit. In addition, Medicare limits plans' losses and gains on their drug spending and makes additional payments for low-income beneficiaries.

Most MA plans offer a prescription drug (MA-PD) plan that includes drug coverage under Part D in the benefits they provide to enrollees. In that case, the MA plan's bid has two parts: one for drug coverage and one for all other Medicare services. For both MA plans and Part D, the government does not mandate the amounts that plans pay providers; instead, plans negotiate those rates. As part of its review process, CMS ensures that bids are actuarially sound and realistic for the given package of services. Under the Medicare Modernization Act, CMS is specifically prohibited from involving itself in negotiations between PDPs or MA-PD plans and drug companies. Plans directly negotiate payment rates with pharmacies and rebates from drug manufacturers.

In addition to subsidizing the cost of prescription drugs covered by PDPs and MA-PD plans, Part D also subsidizes those costs for Medicare enrollees covered by certain employer- and union-sponsored plans.

This chapter's options encompass a broad range of policies related to Medicare's payments to providers in the fee-for-service sector and its payments for Medicare Advantage and Part D.

1. Prescription drug plans may offer the statutorily defined benefit (the standard drug benefit) or an alternative benefit design as long as it offers the same benefit value to enrollees.



**Option 54****Reduce Annual Updates in Medicare Fee-for-Service Payments to Reflect Expected Productivity Gains**

| (BILLIONS OF DOLLARS)   | 2010 | 2011 | 2012 | 2013  | 2014  | Total     |           |
|---|------|------|------|-------|-------|-----------|-----------|
|   |      |      |      |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending  |      |      |      |       |       |           |           |
| Reduce update factors by half of expected productivity gains              | 0    | -1.6 | -3.5 | -5.8  | -8.0  | -18.9     | -101.8    |
| Reduce update factors by the entire amount of expected productivity gains | 0    | -3.2 | -7.1 | -11.4 | -15.9 | -37.6     | -200.7    |

Medicare's fee-for-service (FFS) payment policy covers a broad range of services provided by physicians and other caregivers at a variety of facilities, including acute care hospitals, home health agencies, hospices, inpatient rehabilitation centers, inpatient psychiatric facilities, long-term care hospitals, outpatient facilities, and skilled nursing facilities. Payment for those services is determined according to preset fee schedules. Medicare's base payment rates are updated annually to reflect changes in the prices of various "inputs" (such as labor and equipment) that are used to provide medical services. The prices of those inputs are measured by market-basket indexes (MBIs), which combine various price increases into a single update factor for each type of provider. Each MBI is designed to approximate the changes in costs that providers incur as a result of changes in input prices, assuming that the quantity, quality, and mix of those inputs remain constant. To the extent that providers increase their productivity over time (perhaps, in part, in response to the incentives created by Medicare's FFS payment systems), MBIs overstate actual increases in providers' costs. For example, providers can increase their productivity by using fewer inputs or a less expensive mix of inputs to deliver care or by adopting new technologies.

The market basket component of the update mechanism for physicians' services, known as the Medicare economic index (MEI), is adjusted under current law to exclude productivity gains. This option would apply a similar adjustment to update factors for acute care hospitals, home health agencies, hospices, inpatient rehabilitation centers, inpatient psychiatric facilities, long-term-care hospitals, outpatient facilities, and skilled nursing

facilities. The option would use the same measure of productivity improvement—the 10-year moving average of all-factor productivity—that is incorporated in the MEI. In particular, this option would implement an annual update beginning in 2011 that is equal to the MBI minus half of the expected productivity gains. By adjusting for only half of such gains, this option would allow providers to share the savings associated with productivity gains. The Congressional Budget Office estimates that this option would reduce Medicare outlays by about \$19 billion over the 2010–2014 period and by about \$102 billion over the 2010–2019 period. Reducing the MBIs by the entire amount of expected productivity gains (as is done in setting the MEI) would reduce Medicare outlays by an estimated \$38 billion over the 2010–2014 period and by \$201 billion over the 2010–2019 period.

A rationale for this option is that setting payment updates equal to the full increase in the MBIs overcompensates FFS providers. Implementing this option would reinforce the incentives contained in Medicare's prospective payment systems for providers to deliver care efficiently.

An argument against this option is that reducing the payment updates might cause some providers to lower the quality of care they provided or to stop serving Medicare beneficiaries altogether. In addition, different types of health care services may be more capable of achieving such productivity increases than others are. If so, this option could cause considerable hardship for providers that are not able to increase their productivity by the amount assumed in the update.

«CBO»

**Option 55****Reduce the Update Factor for Hospitals' Inpatient Operating Payments Under Medicare by 1 Percentage Point**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -1,500 | -3,100 | -5,000 | -7,000 | -16,600   | -92,900   |

The Medicare program uses a prospective payment system (PPS) to compensate acute care hospitals for operating costs that are tied to providing inpatient services to beneficiaries. Under that system, payments are determined on a per-case basis, according to preset rates that vary with a patient's diagnosis and the characteristics of the hospital. Medicare adjusts those payment rates each year using an update factor that is determined in part by the projected rise in the hospital market-basket index (MBI) as projected by the Centers for Medicare and Medicaid Services. That index is intended to reflect the effect of inflation on hospitals' costs per case.

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This option would reduce by 1 percentage point Medicare's PPS update factor for acute inpatient hospital services as compared to the factor that would be established under current law. The lower rate would take effect in 2011 and continue through at least 2019. The Congressional Budget Office estimates that savings from this option would total about \$17 billion over the 2010–2014 period and about \$93 billion over the 2010–2019 period.

Supporters for reducing the PPS update argue that granting the full MBI update factor overcompensates hospitals for average growth in their operating costs. To the extent that the MBI is intended to approximate how much providers' costs would rise if the quantity, quality, and mix of "inputs" (such as labor and equipment) they used to provide care remained constant, the MBI will generally overstate cost inflation because it does not reflect improvements in productivity (such as the tendency of providers to adopt cost-saving technological advances in response

to the fixed payments established under the PPS). In its March 2008 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) found that relatively efficient hospitals have positive Medicare margins (that is, Medicare payments exceed the costs incurred by the hospitals).<sup>1</sup> Moreover, MedPAC found that hospitals that consistently have very low Medicare margins generally have positive total margins—often relatively large total margins. Those findings suggest that the financial pressure for hospitals to improve their efficiency is limited. That lack of pressure to control costs may be exacerbated by Medicare updates that overcompensate hospitals for the increases in their operating costs.

Critics of this approach contend that Medicare's payments for inpatient services should not be reduced without carefully evaluating the adequacy of payments for other services that hospitals provide (such as outpatient care). For hospitals covered by the prospective payment system, the overall Medicare margin—which reflects the difference between hospitals' Medicare payments and the costs for services provided to Medicare beneficiaries—decreased continuously between 2000 and 2006, falling to -4.8 percent in 2006. MedPAC estimates that the margin rose to -4.4 percent in 2008. Further reductions in the update factor, critics maintain, could impose a financial burden on hospitals.

1. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2008).

**Option 56****Reduce the Update Factor for Payments to Providers of Post-Acute Care Under Medicare by 1 Percentage Point**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|------|--------|--------|--------|-----------|-----------|
|                              |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -700 | -1,600 | -2,700 | -3,900 | -8,900    | -54,200   |

Medicare's coverage of post-acute care generally is limited to patients who require skilled nursing care or rehabilitation. Post-acute care is offered by four types of providers: skilled nursing facilities, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities. The Congressional Budget Office estimates that outlays for post-acute care currently account for approximately one-sixth of total spending under Medicare's fee-for-service program. In each of the four post-acute care settings, providers are paid by Medicare under prospective payment systems in which payments reflect "base" rates. The payment for a specific case equals the base rate adjusted to reflect differences in local practice costs, the clinical characteristics of the patient, and other factors.

Annual increases in Medicare's base payment rates are referred to as update factors. Under current law, update factors generally are determined by increases in the prices of various "inputs" (such as labor and equipment) that medical providers use to produce medical services. Those increases in input prices are measured by market-basket indexes, which gauge the prices of a grouping of goods or services in a particular market by combining the various price increases into a single number for each type of provider.

This option would change the update factors for each type of post-acute care provider to equal the rise in the market-basket index minus 1 percentage point for each year beginning in 2011. This option would reduce

Medicare outlays by about \$9 billion over the 2010–2014 period and by \$54 billion over the 2010–2019 period.

An argument in favor of this option is that Medicare's payment rates for post-acute care have been found, in general, to be more than adequate relative to providers' costs. The Medicare Payment Advisory Commission (MedPAC) came to that conclusion in its March 2008 report to the Congress. MedPAC recommended that the Congress reduce or eliminate the update to payment rates for all types of post-acute care providers for 2009 and stated that doing so would be unlikely to harm beneficiaries' access to post-acute care. Another possible advantage of this option is that it could provide stronger incentives for post-acute care providers to increase efficiency and reduce operating costs.

An argument against this option is that reduced federal payments might increase the incentive of post-acute care providers to avoid treating patients with complex conditions who require costly care. Reducing update factors, therefore, might lead to difficulties for certain patients who tried to obtain post-acute care. To the extent that patients faced limited access to such care, they might remain in a short-stay hospital longer, be discharged to receive long-term care in a facility not covered by Medicare, or return home without receiving post-acute care at all. By reducing providers' revenue, this option might also limit their ability to provide high-quality care.

«CBO»

**Option 57****Eliminate Inflation-Related Updates to Medicare's Payment Rates for Home Health Care for Five Years**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -300 | -1,200 | -2,300 | -3,500 | -5,000 | -12,300   | -50,300   |

In 2007, Medicare paid about \$15 billion for home health services, which include skilled nursing care, physical and speech therapy, and services provided by home health aides for beneficiaries deemed to be homebound. Medicare's spending for such services grew rapidly in the late 1980s and early 1990s, when home health agencies were reimbursed separately for each home health visit, but spending fell sharply after a new payment system was implemented under the Balanced Budget Act of 1997. Since 2000, however, Medicare's spending for home health care has again been increasing rapidly.

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Home health agencies currently receive a single payment from Medicare for providing all covered services to an individual beneficiary for a 60-day period (known as a home health episode). The Centers for Medicare and Medicaid Services (CMS) sets the payment rates for different types of episodes prospectively, which means that the rates are set in advance to reflect the expected costs of each episode and are not determined by the costs that home health agencies actually incur. The payment for each episode is equal to a national base payment rate combined with an adjustment to account for differences in patients' medical conditions and functional status (or "case mix") and for geographic variation in the prices of inputs (such as differences in wages across labor markets). For calendar year 2009, CMS has set the base payment per home health episode at \$2,272. Under current law, that amount is updated annually, partly on the basis of the projected increase in the home health market-basket index, which reflects increases in the prices of inputs.

The Medicare Payment Advisory Commission, or MedPAC, has calculated that among freestanding home health agencies, the aggregate Medicare margin—the excess of Medicare's payments over providers' costs expressed as a percentage of payments—was high in 2006, at about 15 percent. (MedPAC did not report the aggregate Medicare margin for hospital-based agencies in 2006.) MedPAC has projected that the aggregate Medicare margin will remain high (11 percent) in 2008, even though the base payment rate for home health care has increased by only 0.25 percent in that year. (That increase is the net effect of the market-basket update of

3.0 percent required by law and a reduction of 2.75 percent to the base rate to compensate for changes in agencies' coding practices in prior years that led to increases in reported case mixes that were not attributable to actual increases in the severity of patients' conditions.)

This option would eliminate the adjustment of the base payment for each home health episode by the home health market basket index for 2010 through 2014, with the goal of gradually narrowing the gap between payments and costs. That change would reduce federal outlays by an estimated \$12 billion over the 2010–2014 period and by \$50 billion over the 2010–2019 period.

A rationale for this option is that margins for home health care are likely to remain high under current law. Although under current law CMS will adjust the base payment rates downward over the next four years—by a total of -10.5 percent—to compensate for changes in agencies' coding practices in prior years, that adjustment coincides with Medicare's introduction of a new system for adjusting payments on the basis of an agency's case mix, a change that could lead to agencies' receiving larger payments per episode. MedPAC estimates that home health agencies' costs per episode have grown by an amount slightly smaller than the market-basket update in the past year. If that trend continued and at the same time agencies were able to increase the payments they received per episode under the new case-mix adjustment system, home health agencies would still receive adequate margins under this option.

A drawback of the option is that it could reduce access to home health services for some Medicare beneficiaries. Home health agencies that had substantially higher costs than the average and that could not reduce their operating expenses sufficiently would probably cease participating in the program. As a result, some beneficiaries might have difficulty in obtaining home health services. Moreover, smaller payments could lead some home health agencies to reduce the amount or quality of the services they provided.

**Option 58****Reduce the Update Factor for Medicare's Payments for Skilled Nursing Facilities by 1 Percentage Point**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013   | 2014   | Total     |           |
|------------------------------|------|------|------|--------|--------|-----------|-----------|
|                              |      |      |      |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -300 | -700 | -1,200 | -1,800 | -4,000    | -24,000   |

In 2007, Medicare's outlays for services provided in skilled nursing facilities (SNFs) totaled about \$21 billion. Medicare's spending for such care grew rapidly in the early and mid-1990s, during which time SNFs were paid by Medicare on the basis of their incurred costs. As required by the Balanced Budget Act of 1997, Medicare implemented a prospective payment system for SNF services in 1998. Medicare payment rates now are set in advance to reflect SNFs' expected costs; they are no longer determined by the costs that SNFs actually incur. In the years immediately following the BBA, Medicare's spending for SNF services fell substantially. Since 2000, however, such spending has been growing at an average annual rate of nearly 11 percent.

Skilled nursing facilities currently receive a daily payment from Medicare for providing all covered services to an individual beneficiary. To be eligible for a Medicare-covered stay in such a facility, an individual must have been hospitalized for at least three days, and Medicare only covers SNF stays of up to 100 days. Services covered during a stay include nursing care, rehabilitation services, and other treatments, such as medications. Room and board are also included in the SNF daily rate. The Centers for Medicare and Medicaid Services sets the payment rates prospectively, and those rates are adjusted on the basis of patients' medical conditions and functional status. Medicare payment rates for SNF services are updated yearly to reflect the projected increase in the SNF market basket index, which is a national measure of changes in the prices of various "inputs" (such as labor

and equipment) used to produce SNF services. This option would set the update factor for SNFs equal to the market basket index minus 1 percentage point for each year from 2011 through at least 2019. Implementing the option would reduce Medicare's outlays by about \$4 billion over the 2010–2014 period and by \$24 billion over the 2010–2019 period.

An argument in favor of this option is that Medicare's payment rates for skilled nursing facilities have been found to be more than adequate relative to providers' costs. The Medicare Payment Advisory Commission has calculated that among freestanding SNFs (those not located within a hospital), the aggregate Medicare margin—the excess of Medicare payments over SNF costs as a share of payments—has been over 10 percent since 2001 and will continue to be greater than 10 percent in 2008. In addition, SNF spending for fee-for-service enrollees has grown faster than overall program spending since 2000.

An argument against this option is that it could reduce access to SNF services for Medicare beneficiaries. Operating costs vary widely among SNFs, and those facilities that have substantially higher costs than average and cannot reduce their operating expenses sufficiently could cease participating in the program. As a result, some beneficiaries might have difficulty finding a skilled nursing facility to accommodate them.

«CBO»

**Option 59****Modify the Sustainable Growth Rate Formula for Updating Medicare's Physician Payment Rates**

| (BILLIONS OF DOLLARS)  | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|--|------|------|------|------|------|-----------|-----------|
|  |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending   |      |      |      |      |      |           |           |
| Freeze physician payment rates through 2019  | 10.0 | 17.0 | 20.0 | 24.0 | 29.0 | 100.0     | 318.0     |
| Replace the SGR mechanism with annual updates based on the MEI   | 13.0 | 21.0 | 26.0 | 32.0 | 38.0 | 130.0     | 439.0     |
| Replace the SGR mechanism with annual updates based on the MEI and include a hold-harmless provision for Part B premiums | 16.0 | 27.0 | 33.0 | 40.0 | 48.0 | 164.0     | 556.0     |

Note: MEI = Medicare economic index; SGR = sustainable growth rate.

Each year, Medicare updates fees for physicians' services using the sustainable growth rate (SGR) mechanism. That mechanism establishes both yearly and cumulative targets for Medicare's combined spending for physicians' services and those services furnished "incident to" (in connection with) a visit to a physician (for instance, diagnostic laboratory services or physician-administered drugs). Those targets are updated annually to reflect inflation, overall economic growth, the increase in the number of Medicare enrollees in the fee-for-service sector (which includes Parts A and B), and any changes in Medicare outlays that stem from new laws or regulations. If spending exceeds the target (measured on both an annual and a cumulative basis), as it currently does, the SGR mechanism is designed to reduce payment rates to physicians each year so that cumulative spending and the cumulative target eventually converge. (The reverse would happen if spending was below the target.)

Since 2002, Medicare spending for physicians' services has consistently been above the targets established by the formula; consequently, the SGR mechanism has called for reductions in physician payment rates. In 2003, physicians were scheduled to receive a negative 4.4 percent update, after having seen a drop in payment rates of 4.8 percent in 2002. Lawmakers responded to that imminent reduction by boosting the cumulative target, thereby producing a 1.6 percent increase in payment rates for physicians' services for 2003. Since then, legislation has overridden scheduled payment reductions each year, further widening the gap between the target for cumulative

spending and actual cumulative spending. Most recently, the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA (Public Law 110-275), replaced a 10.6 percent reduction in payments, scheduled to take effect in July 2008, by maintaining current rates for the remainder of 2008 and increasing rates by 1.1 percent for 2009. As a result, payment rates under the physician fee schedule are due to fall by about 21 percent in 2010 and by about 5 percent annually for at least several years thereafter.<sup>1</sup>

Given that the SGR formula's results have been overridden in each of the past seven years, there is interest among policymakers in considering other payment mechanisms. The option considered here presents three alternatives: One would provide temporary relief from projected payment cuts by freezing payment rates at their 2009 levels through 2019; one would repeal the SGR mechanism and instead increase payment rates each year in accordance with the Medicare economic index, or MEI; and one would repeal the SGR mechanism, increase payment rates each year using the MEI, and include a hold-harmless provision for premiums.

1. An additional provision in MIPPA changes the application of the budget-neutrality adjuster used in the calculation of payment rates under the Medicare physician fee schedule from the relative value units (RVUs) to the conversion factor, beginning in 2009. Although, on average, that provision will probably result in a lower conversion factor and higher RVUs, fees that are weighted more toward work—such as primary care—will increase, whereas other fees will decrease.

- Alternative 1 would freeze physician payment rates at their 2009 levels through 2019, essentially disregarding the SGR mechanism for those years. Returning to the SGR mechanism after a 10-year freeze—starting in 2020—would require payment rates to be reduced by about 5 percent each year for well over a decade thereafter. This alternative would increase net federal outlays by an estimated \$100 billion from 2010 to 2014 and by \$318 billion from 2010 to 2019.
- Alternative 2 would fully replace the SGR targets with annual updates based on changes in the prices of inputs that are used to provide physicians' services, minus a productivity adjustment (as measured by the MEI). Instead of declining by about 21 percent in 2010 and by about 5 percent annually for at least several years thereafter, payment rates would rise by about 2 percent annually. Those updates would not be subject to further adjustments, and excess spending, as defined by the SGR, would not be recouped through subsequent reductions in payment rates. This alternative would increase net federal outlays by an estimated \$130 billion over the 2010–2014 period and by \$439 billion from 2010 to 2019.
- Alternative 3 expands on Alternative 2 by including a hold-harmless provision for premiums. Under this alternative, Medicare's Part B premiums would not be adjusted to reflect changes in spending that resulted from changes in physicians' payment rates following the repeal of the SGR formula. Because that hold-harmless provision would uncouple premiums from program costs, this alternative would increase federal costs relative to that projected under Alternative 2. In particular, this alternative would boost net federal outlays by an estimated \$164 billion from 2010 to 2014 and by about \$556 billion from 2010 to 2019.

Proponents of modifying the SGR mechanism argue that the current system is flawed because, as a national target, the SGR does not provide incentives for individual physicians to control the volume of services they provide. In addition, if the projected negative fee updates were to

actually occur, they might lead to a reduction in the number of physicians who were willing to accept Medicare patients. (The Medicare Payment Advisory Commission is following this issue closely and to date has not found significant problems with physician participation. It should be noted, however, that the projected reductions in payment rates will be different from past reductions, as they are expected to be larger in magnitude and to persist over a period of several years.)

The alternatives presented in this option address some of the limitations of the SGR formula. Alternative 1 would temporarily lift the fee reductions scheduled under the SGR mechanism by setting an update of zero from 2010 through 2019, thus avoiding large and persistent cuts in fees that could compromise access to care. However, because this alternative would retain the SGR mechanism, future payment rates would still be reduced to recoup spending already incurred in excess of the SGR targets. Alternatives 2 and 3—both of which would use the MEI to set fee updates rather than the SGR mechanism—would also address potential access-to-care concerns posed by the decreasing payment rates projected under current law. Those alternatives, nonetheless, would be costlier.

An argument against modifying the SGR is that, although imperfect, it is useful in drawing attention to the growth in Medicare's spending for physicians' services. In addition, a continuation of the SGR, to the extent that the mechanism was allowed to operate, would guarantee that past spending in excess of the target would be recouped in future years, thus avoiding additional pressures on the already substantial long-term costs of the Medicare program. Another argument against modifying the SGR mechanism is that all of the alternatives would result in higher spending by Medicare for physicians' services, thus boosting federal spending and requiring cuts elsewhere in the budget, higher taxes, or larger deficits. In addition, except under Alternative 3, beneficiaries would face higher cost-sharing obligations and higher Medicare Part B premiums, which are set at 25 percent of the program's average costs.

RELATED CBO PUBLICATIONS: *Factors Underlying the Growth in Medicare's Spending for Physicians' Services*, June 2007; *The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates*, Issue Brief, September 7, 2006; and Statement of Donald B. Marron, Acting Director, Congressional Budget Office, before the House Subcommittee on Health, Committee on Energy and Commerce, *Medicare's Physician Payment Rates and the Sustainable Growth Rate*, July 25, 2006

**Option 60****Create Service-Specific Updates for Medicare's Physician Payment Rates**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 10.0 | 15.0 | 15.0 | 16.0 | 17.0 | 73.0      | 184.0     |

Medicare updates fees for physicians' services on an annual basis using the sustainable growth rate (SGR) mechanism. Payment rates under the physician fee schedule are due to fall by about 21 percent in 2010 and by about 5 percent annually for at least several years thereafter.

As an alternative to modifying the sustainable growth rate formula for updating Medicare's physician payment rates (see Option 59), this option would use the existing SGR methodology to create service-specific spending targets and calculate separate annual updates to payment rates for each of those categories of services. Physicians' services would be grouped into five categories: anesthesia; evaluation and management; imaging and tests; major procedures; and minor procedures.<sup>1</sup> Services "incident to" (in connection with) a visit to a physician (for instance, diagnostic laboratory services or physician-administered drugs) would be assigned to each category according to that category's share of total expenditures in any given year.

Following the existing SGR formula, annual updates to payment rates for each category of services would be based on a comparison of actual spending and target spending, measured on both an annual and cumulative basis, with 1998 designated as the initial year for calculating cumulative spending. Target spending would be based on actual spending in 1998 for each category and updated annually by the SGR applicable in subsequent years. To calculate cumulative target spending, the Congressional Budget Office assumed a uniform SGR for the five service categories through 2010; however, beginning in 2011, each category's target would be adjusted to reflect the effects of laws and regulations that were applicable to that type of service. To the extent that actual spending in a given type-of-service category was higher than target spending for that category, the SGR mechanism would reduce payment rates for services in that category each year, so that cumulative spending and the

cumulative target would eventually converge. (The reverse would happen if actual spending was lower than target spending.)

This option would freeze 2010 payment rates at the 2009 level—thus avoiding the 21 percent reduction in 2010—and apply the five separate updates to payment rates starting in 2011. If implemented, the option would increase outlays by an estimated \$73 billion over the 2010–2014 period and by \$184 billion over the 2010–2019 period. Spending for each category would be higher than under current law.

Figure 7-1 shows projected cumulative spending under the option relative to the SGR target for each type of service. If this option was put into effect, cumulative spending for anesthesia services and major procedures would be below target spending and therefore would be eligible for positive updates throughout the 10-year budget period considered in this option. Cumulative spending on evaluation and management services would exceed projected target spending initially, which would result in a reduction in payment rates for those services. However, the SGR formula is designed to bring spending in line with the expenditure targets over time. Consequently, those services would receive a positive update by the end of the projection period.

Because projected spending on minor procedures and imaging and testing under this option would be above the projected spending target, payment updates for those services would be negative throughout the 10-year period. In fact, those negative payment updates would be equal to the maximum allowable reduction of about 5 percent (the update would equal the Medicare economic index, which generally is about 2 percent, minus the maximum reduction factor of 7 percent).<sup>2</sup> Although the SGR formula would reduce spending for those services, updates to payment rates of lesser magnitude than the maximum reduction would occur outside the 2010–2019 period.

1. The categories are based on the Berenson-Eggers type-of-service categories from the Centers for Medicare and Medicaid Services, which are available at [www.cms.hhs.gov/HCPCSReleaseCodeSets/20\\_BETOS.asp](http://www.cms.hhs.gov/HCPCSReleaseCodeSets/20_BETOS.asp).

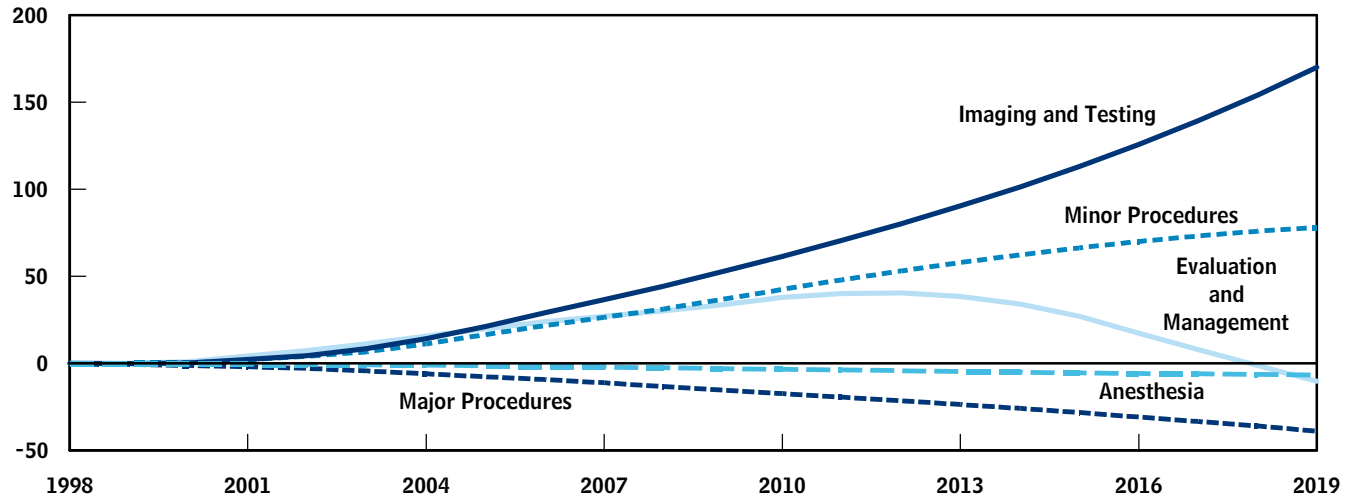
2. The Medicare economic index measures changes in the prices of "inputs" (such as physicians' salaries and practice expenses) that are used to provide physicians' services, minus an adjustment for changes in productivity.



**Figure 7-1.**

## Cumulative Spending Over or Under the Category's Sustainable Growth Rate Target

(Billions of dollars)



Source: Congressional Budget Office.

Note: The lines on the figure represent the difference between projected spending for each category under the option and the target for that category. In general, payment updates are expected to be negative for services with cumulative spending over the target and positive for services with cumulative spending under the target.

Payments for major procedures and anesthesia would increase throughout that time span, and payments for evaluation and management services would increase during part of the 10-year period.

An advantage of this option is that it would address an inherent shortcoming in the current SGR mechanism—the fact that it treats all physicians identically, regardless of their contribution to the spending target. The introduction of service-specific targets could signal that high-volume growth in a given type of service indicates that Medicare's payments for those services are too high relative to the cost of furnishing them. Another advantage

could be that specialty societies might have incentives to provide guidelines and encourage physicians' adherence to either justify or reduce growth in the volume of services.

A disadvantage of this option is the possibility that physicians would substitute services with larger payment updates (and possibly lower medical value) for services with smaller updates. Also, for some physicians—radiologists, for example—fee updates would not be driven by their own behavior but rather by the behavior of referring physicians.

«CBO»

**Option 61****Use the Medicare Economic Index to Update Physician Payment Rates for Evaluation and Management Services and Create Four Service-Specific Updates for Remaining Services**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 10.0 | 16.0 | 18.0 | 21.0 | 23.0 | 88.0      | 253.0     |

Each year, Medicare updates fees for physicians' services using the sustainable growth rate (SGR) mechanism. (For information on the physician payment system and the sustainable growth rate mechanism, see Option 59.) Payment rates under the physician fee schedule are due to fall by about 21 percent in 2010 and by about 5 percent annually for at least several years thereafter. Although those updates are applied to all physicians' services uniformly, recent growth in spending for different types of physicians' services has varied widely. For example, from 2000 to 2005, growth ranged from 18 percent for evaluation and management services to 61 percent for imaging services.

As an alternative to modifying the SGR (see Option 59 and Option 60), this option would use the Medicare economic index (MEI) to update physicians' fees for evaluation and management services beginning in 2011. (The option also incorporates the assumption that payment rates for all services on the physician fee schedule would be frozen in 2010 at the 2009 level.) The MEI, as calculated by the Center for Medicare and Medicaid Services, measures changes in the prices of inputs used to provide services (such as physicians' salaries and expenses related to a physician's practice), minus an adjustment for changes in productivity. Services classified as evaluation and management include visits in physicians' offices as well as in other settings, such as hospitals and nursing homes, but not tests or other services that are furnished during those visits. The SGR mechanism would continue to be used to update fees for all other services, but it would be applied to four distinct groups of services: major procedures, minor procedures, anesthesia, and imaging and tests. Updates for those services would be computed by the method described in Option 60. This

option would increase federal outlays by an estimated \$88 billion over the 2010–2014 year period and by \$253 billion over the 2010–2019 year period.

Proponents of this option argue that the update to payment rates for evaluation and management services should be predictable and not subject to the volatility inherent in the SGR mechanism. They also maintain that the option would boost the compensation of primary care physicians—because evaluation and management services account for a large share of the payments those physicians receive from Medicare—and might result in a greater supply of primary care doctors. A number of studies have found that the Medicare physician fee schedule undervalues primary care services, which could explain the rising proportion of medical students who choose to specialize rather than establish a primary care practice. If an increase in fees for evaluation and management services resulted in a substantial shift in career choice from specialist to primary care physician, patients might receive care that was not only more coordinated but also of better quality. (Research suggests that geographic areas that have a larger number of specialists per person are associated with higher levels of spending and, in many cases, a lower quality of care.)

An argument against this option is that it would boost the federal government's outlays for the Medicare program by comparison with what they would have been under current law. As a result, beneficiaries would face larger cost-sharing obligations and higher premiums for Part B of Medicare. (Premiums are set at 25 percent of the program's average costs.)

**Option 62****Modify the Equipment Utilization Factor for Advanced Imaging in Calculating Physicians' Fees in Medicare**

| (MILLIONS OF DOLLARS)   | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|---|------|------|------|------|------|-----------|-----------|
|   |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending                                  |      |      |      |      |      |           |           |
| Increase the utilization factor from 50 percent to 75 percent | -130 | -210 | -220 | -210 | -200 | -970      | -1,940    |
| Increase the utilization factor from 50 percent to 95 percent | -200 | -320 | -320 | -310 | -300 | -1,450    | -2,870    |

The Medicare program pays physicians for the services they provide to Medicare beneficiaries according to a schedule of fees that reflect the relative costs that physicians are expected to incur in providing each service. The fees are based on so-called relative value units (RVUs), which are national, uniform calculations established for components of three categories of resources involved in providing a service: physicians' work (for example, the cost of the physician's time), practice expense (such as the salaries of nurses and other staff in the physician's practice and the cost of supplies, including equipment), and malpractice (the cost of insurance premiums). Basically, RVUs from the three categories are summed (together with a factor that adjusts for geographic location) to produce the fee that Medicare pays for a particular service.

To determine the practice-expense RVUs for services that involve equipment—such as magnetic resonance imaging (MRI) or computed tomography (CT) machines—the methodology governing the fee schedule requires the Centers for Medicare and Medicaid Services (CMS) to make assumptions about how frequently the equipment is used. In determining practice expense, CMS assumes that equipment, including imaging equipment, is used 50 percent of the time. The use of a higher utilization factor would spread the cost of the equipment over more units of service, resulting in a smaller payment per service. Likewise, the use of a lower utilization factor would spread the cost of the equipment over fewer units of service, resulting in a larger payment. If the utilization factor used in the calculation is less than the actual use of the equipment, then the payment for that equipment would be too high. Thus, the utilization factor that CMS uses in the methodology has a direct effect on the size of Medicare's payments.

Services that are overpaid tend to exhibit rapid growth, such as Medicare is experiencing in advanced imaging (spending for MRI and CT services grew at an annual pace averaging 17 percent between 2000 and 2006). The Medicare Payment Advisory Commission (MedPAC) has suggested that Medicare may be overpaying for advanced imaging services (that is, MRI and CT) because of the rapid growth in the use of such services. This option has two alternatives: The first would increase the utilization factor for such services from 50 percent to 75 percent; the second alternative would increase the utilization factor for those services to 95 percent. Both alternatives are based on current law; that is, they take into account the scheduled drops in payment rates under the physician fee schedule of about 21 percent in 2010 and approximately 5 percent annually for at least several years thereafter.<sup>1</sup> Because changes to practice-expense RVUs (which cover imaging equipment) are budget neutral, any savings from the alternatives would be redistributed to other physicians' services unless the legislative language implementing the option explicitly stated that the budget-neutrality provision did not apply. These estimates assume that provision does not apply. The Congressional Budget Office estimates that Alternative 1 would decrease federal outlays by about \$970 million over the 2010–2014 period and by about \$1.9 billion over the 2010–2019 period. Alternative 2 would decrease outlays by about

1. The Deficit Reduction Act of 2005 (DRA) requires that the payment rate for such services be the lower of the amount determined by the physician fee schedule or rates set under the Medicare outpatient prospective payment system. Both alternatives take into account the interaction of rates set by the DRA and physician fee schedule; thus, changes to payment rates for physicians' services could cause changes in the savings associated with increasing the utilization factor.

\$1.5 billion over the 2010–2014 period and by \$3 billion over the 2010–2019 period.

Proponents of increasing the utilization factor for imaging services maintain that, whenever possible, RVUs should reflect actual prices and patterns of use. Updating the utilization factor for advanced imaging to reflect physicians' actual use of the equipment would be a step in that direction. The current utilization factor of 50 percent was set in 1997 in the absence of specific information about equipment utilization. However, the high cost of much of that equipment gives providers a financial incentive to minimize the amount of time that the equipment lies idle. MedPAC noted in its June 2006 report to the Congress that it estimated (on the basis of a survey of

imaging providers) that the average rate of use of MRI machines was 91 percent and the average rate of use of CT machines was 73 percent.<sup>2</sup>

An argument against revising the utilization factor is that the lower payment rates that would result could discourage rural practitioners from providing imaging services because they might not use the equipment often enough to cover the capital costs they would incur in purchasing it.

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2. See Medicare Payment Advisory Commission, *Report to Congress: Increasing the Value of Medicare* (June 2006).

**Option 63****Set the Benchmark for Private Plans in Medicare Equal to Local Per Capita Fee-for-Service Spending**

| (BILLIONS OF DOLLARS)        | 2010 | 2011  | 2012  | 2013  | 2014  | Total     |           |
|------------------------------|------|-------|-------|-------|-------|-----------|-----------|
|                              |      |       |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -11.0 | -13.0 | -15.0 | -16.0 | -55.0     | -157.0    |

Medicare beneficiaries may receive their benefits through the traditional fee-for-service program or they may enroll in a private health plan under the Medicare Advantage program. Plans that choose to participate in the program submit bids reflecting the per capita payment they will accept for providing benefits covered by Medicare. The government compares those bids with benchmarks that are determined in advance through statutory rules. Plans are paid their bids (up to the benchmark), which are adjusted for differences in expected costs based on the health status of each beneficiary. If the bid is less than the benchmark, plans also receive 75 percent of the amount by which the benchmark exceeds their bid. However, they must return that 75 percent to beneficiaries in the form of additional benefits or rebates on their Medicare premium. Plans whose bids are above the benchmark are required to charge enrollees the full difference between the bid and the benchmark as an add-on to their regular Medicare premium. (Private plans submit separate bids for providing Medicare's prescription drug benefit under Part D; this option pertains to bids for providing all other Medicare benefits.)

Benchmarks are established for each county and are required to be at least as high as local per capita spending in Medicare's fee-for-service (FFS) program. In nearly all counties, the benchmark is higher than per capita FFS spending, in some cases substantially so. Benchmarks were derived from a payment mechanism for private plans that was established in the Balanced Budget Act of 1997 and modified through subsequent legislation.

This option would set the benchmark in each county so that it equaled projected local per capita spending for Medicare's FFS program. That change would reduce spending for Medicare by about \$55 billion over the 2010–2014 period and by about \$157 billion over the 2010–2019 period. (In developing its estimate, the

Congressional Budget Office assumed that this change would not be implemented until 2011, given the schedule for the publication of benchmarks under current law.) Alternatively, setting the benchmark in each county equal to 95 percent of local per capita FFS spending (the level at which Medicare set payment rates for private plans prior to 1998) would reduce Medicare spending by \$66 billion over the 2010–2014 period and by \$186 billion over the 2010–2019 period.

An argument in favor of this option is that the Medicare program should be neutral as to whether beneficiaries decide to enroll in private plans or remain in the FFS sector. (Most beneficiaries—about 79 percent—are enrolled in the FFS program.) The current payment system gives an advantage to private plans because they can operate in areas where their bids exceed FFS spending levels and, if their bids are less than the benchmark, provide additional benefits to attract enrollees. Under that system, Medicare pays more for enrollees in some private plans than it would have paid if they had remained in the FFS sector.

An argument against this option is that because it would reduce the revenue that private plans in many geographic areas receive from Medicare, it could lead many plans to limit the benefits they offer, raise their premiums, or withdraw from the program. Another argument is that private plans should not be expected to provide Medicare services in all markets at a cost that is less than per capita FFS spending because Medicare may be able to use its market power to set FFS payment rates at levels below those determined by private-market forces. Below-market payments to health care providers could result in a less-efficient allocation of resources than would be achieved if more beneficiaries were enrolled in private plans that paid providers at rates determined in the market.

«CBO»

**Option 64****Convert Medicare to a Premium Support System**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013  | 2014  | Total     |           |
|------------------------------|------|------|------|-------|-------|-----------|-----------|
|                              |      |      |      |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -9.0 | -16.0 | -19.0 | -44.0     | -161.0    |

Nearly 80 percent of Medicare beneficiaries receive their health care through the program's traditional fee-for-service (FFS) sector—sometimes referred to as original Medicare—which pays providers for each service or bundle of services they furnish. The remaining participants are enrolled in private health plans (termed Medicare Advantage plans) that assume responsibility for, and the financial risk of, providing Medicare benefits. Private plans submit bids indicating the per capita payment they are willing to accept for providing the benefits covered by Medicare.

7 The government's maximum payment per Medicare Advantage enrollee—called a benchmark—is established by statute and made public each year before the plans submit their bids. The benchmark varies by county. Medicare pays plans their bids up to the benchmark plus 75 percent of any amount by which the benchmark exceeds their bid. Plans must return that 75 percent to enrollees in the form of additional benefits or rebates on their Medicare premium. Thus, the lower a plan's bid relative to the benchmark, the greater the additional benefits and premium rebates it can offer to attract enrollees. Plans whose bids are above the benchmark are required to charge enrollees the full difference between the bid and the benchmark as an additional premium for the Medicare benefit package. Medicare's payments to plans are adjusted to account for differences in the health status and demographic characteristics of their enrollees.

Benchmarks for Medicare Advantage plans are based in part on a payment system that was established by statute in 1997 and modified through subsequent legislation. The benchmarks, which are required to be at least as great as local per capita spending in the fee-for-service program, are higher than FFS spending in nearly all counties. In 2008, benchmarks were 17 percent higher, on average, than projected per capita FFS spending nationwide.

This option would convert Medicare to a premium support system, in which the federal government would

contribute an amount that beneficiaries could use toward the purchase of Medicare coverage either through the traditional FFS program or through a private plan. Such a system could be designed in various ways. Under the design specified for this option, the government would construct a benchmark for each county that was equal to the average bid of the plans serving that county. The fee-for-service program would be regarded as one of the bidding plans, and its bid would be the projected per capita FFS expenditures in the county. Each plan's bid would be weighted by its enrollment in the previous year.

Medicare would pay plans their bids up to the benchmark and would adjust those payments to account for differences in enrollees' health status and demographic characteristics. Beneficiaries who enrolled in a plan (including the FFS program) whose bid was equal to the benchmark would pay the same premium for their Medicare coverage that they would pay under current law. Beneficiaries who enrolled in a plan whose bid was below the benchmark would receive the full difference between the bid and the benchmark in the form of additional benefits or a rebate on their Medicare premium. Those who enrolled in a plan whose bid was above the benchmark would be required to pay the full difference between the two as an additional premium for their Medicare coverage. (This option pertains only to bids and benchmarks for care provided under Medicare Part A and Part B. It is assumed that the payment system for the prescription drug benefit, or Part D, would continue as specified under current law. An alternative design, which has not been estimated, would be for the FFS program to offer a drug benefit and compete with private plans on that basis as well.)

This option would reduce Medicare spending by an estimated \$44 billion over the 2010–2014 period and by \$161 billion over the 2010–2019 period. (The Congressional Budget Office assumed that this option would not be enacted in time to be implemented before 2012, given

the schedule for the submission of bids under current law and the logistical changes that would be needed.)

A key way in which this option would differ from current law is that the Medicare premium for beneficiaries who enrolled in the fee-for-service program would vary across geographic areas, depending on how the FFS program's bid compared with the benchmark. The premium for FFS enrollees would tend to be higher in areas with higher per capita FFS spending. Private plans can generally deliver Medicare benefits at a lower cost than the FFS program can in areas where FFS spending is high, so private plans' bids (and hence benchmarks) would be lower than the FFS bid in such areas. In contrast, the FFS program can deliver Medicare benefits at a lower cost than private plans can in areas where FFS spending is low, so private plans' bids would be higher than the FFS bid in such areas. In many such areas, there would most likely be a substantial shift in enrollment from private plans to the FFS program, resulting in benchmarks that were approximately equal to the FFS bid.

A rationale for implementing this option is that it would reduce federal spending on Medicare and could lead to

more efficient delivery of services by stimulating greater price competition among plans and making beneficiaries more cost-conscious in their choice of plans. (CBO based its analysis on the bids that private plans submit under the Medicare Advantage program and did not assume that this option would cause them to reduce their bids. If plans did reduce their bids, federal savings would be greater than those estimated here.)

An argument against the option is that beneficiaries who live in areas where per capita spending in the traditional FFS program is very high would see their Medicare premiums increase sharply if they chose to remain in that program. Another issue is that the FFS program might attract the least healthy enrollees, which could raise the average beneficiary's premium for that program if methods of adjusting the government's contribution to account for differences in beneficiaries' health status were inadequate. Opponents might also object to the fact that much of the estimated federal savings arising from this option would come from increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery.

RELATED CBO PUBLICATION: *Designing a Premium Support System for Medicare*, December 2006

«CBO»

**Option 65****Establish Benchmarks for the Medicare Advantage Program Through Competitive Bidding**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013  | 2014  | Total     |           |
|------------------------------|------|------|------|-------|-------|-----------|-----------|
|                              |      |      |      |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -8.0 | -12.0 | -15.0 | -35.0     | -158.0    |

The federal government's maximum payment per enrollee in the Medicare Advantage program—known as a benchmark—is set for each county through statutory rules (see Option 63). This option would replace that mechanism with a system in which benchmarks would be determined solely from plans' bids, which reflect the per capita payment they will accept for providing benefits covered by Medicare. In particular, the benchmark for each county would be the average bid of the plans that served that county, with each plan's bid weighted by its enrollment the previous year. However, benchmarks would be constrained so they did not exceed the benchmarks that would have existed under current law.

Beneficiaries who enrolled in a plan whose bid was below the benchmark would receive the full difference between the bid and the benchmark in the form of additional benefits or as a rebate on their Medicare premiums. Beneficiaries who enrolled in a plan whose bid was above the benchmark would be required to pay the full difference between the two as an additional premium for their Medicare coverage. This option differs from a premium-support approach (see Option 64) in that it would not treat the fee-for-service (FFS) sector of Medicare as a bidding plan and would determine the Part B premium for beneficiaries who received their care through the FFS program in the same manner as under current law. The option would reduce outlays for Medicare by about \$35 billion over the 2010–2014 period and by about \$158 billion over the 2010–2019 period. (Those estimates rest on the assumption that the option would be implemented beginning in 2012, given the schedule for the submission of bids under current law and the changes needed in methods for the government to determine benchmarks from bids.)

An argument in favor of this option is that it would reduce the per capita amount paid for benefits for enrollees in Medicare Advantage plans to levels determined by the plans' bids. The option might also encourage private plans to compete more strongly on the basis of price. (The Congressional Budget Office based its analysis on the bids that private plans have submitted under the Medicare Advantage program and did not assume that this option would cause plans to reduce their bids. If plans did reduce their bids, the budgetary savings would be greater than those estimated here.)

An argument against this option is that it would not establish a level playing field between private plans and the FFS sector of Medicare. Determining benchmarks on the basis of bids from private plans, with no consideration given to local per capita spending in the FFS program, would not establish incentives for beneficiaries (in their choice of whether to enroll in a private plan or the FFS sector) that would reflect the different systems' costs of delivering Medicare benefits. In particular, the additional benefits and premium rebates that private plans could offer to attract enrollees (or the additional premiums they would be required to charge) would depend on how their bids compared with the average bid of other plans in their local market area. Those added features would not depend on how plans' bids compared with spending in the FFS program. For example, a plan with a bid above the average bid of private plans in its market would be required to charge enrollees an additional premium for their Medicare coverage even if that plan's bid was lower than local per capita spending in the FFS program.

«CBO»



**Option 66****Eliminate the One-Sided Rebasing Process for Establishing Benchmarks for Medicare Advantage Plans**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -4.0 | -5.0 | -6.0 | -6.0 | -21.0     | -61.0     |

About 21 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans, which assume the responsibility for and the financial risk of providing benefits to those individuals. The government's maximum payment, or benchmark, for an enrollee in such a plan is established for each county and updated annually. Benchmarks are derived from a set of payment rates for private plans that were in effect in 2004; under that system, the rate for each county was required to be at least as great as projected local fee-for-service (FFS) spending per capita, and in many counties the rates were greater than the FFS spending. Beginning in 2005, the benchmark in each county is equal to the previous year's benchmark updated either by the projected national growth in Medicare's spending per capita or by 2 percent, whichever is greater. That approach to setting benchmarks is modified in years during which the government reestimates (or "rebases") FFS spending per capita for every county, which it is required by law to do at least once every three years. In those years, the benchmark in each county is the greater of the new projection of local FFS spending or the previous year's benchmark updated in the usual manner.

The current-law method of updating benchmarks in rebasing years is one-sided because, under that method, a county's benchmark can increase at a pace faster than the projected national growth in Medicare's per capita spending but never slower than the growth in the national rate. Over time, that circumstance has caused benchmarks to increase relative to FFS spending, an effect that can be seen most clearly in the 27 percent of counties in which payment rates for Medicare Advantage plans in 2004 were equal to local per capita FFS spending. By 2008, after the government had rebased county-level FFS spending three times, the benchmarks in those counties were, on average, 10 percent higher than local FFS spending. That gap appeared because the counties where local FFS spending was projected to grow less rapidly than Medicare's spending nationally received an update to their benchmarks that was based on the national average,

whereas counties where local FFS spending was projected to grow more rapidly than the national average received an update based on their projected local spending.

This option would eliminate the one-sided mechanism for updating benchmarks in rebasing years. Instead, the benchmark in those years would be set equal to local per capita FFS spending for any county in which the payment rate for Medicare Advantage plans was equal to local FFS spending in 2004 as well as for any county whose benchmark was subsequently set equal to local FFS spending in a rebasing year. Thus, under this option, any county that benefited from the requirement that benchmarks be at least as great as local FFS spending would have its benchmark set equal to local FFS spending in all future rebasing years. The option would reduce spending for Medicare by about \$21 billion from 2010 to 2014 period and by about \$61 billion from 2010 to 2019. (For those calculations, the Congressional Budget Office assumed that the option would take effect in 2011 and that the government would rebase the benchmarks for that year.)

A rationale for this option is that it would eliminate a feature of the Medicare Advantage payment system that has caused benchmarks to rise more quickly than FFS spending. Moreover, by lowering benchmarks, it would reduce outlays for the Medicare program. A drawback of the option is that plans that serve counties whose benchmarks were lowered would have to reduce the additional benefits or premium rebates they offered to their enrollees (see Option 63 for a discussion of the program's requirements regarding those additional benefits or rebates). To avoid the disruption that would arise if potentially large reductions in benchmarks occurred in a single year, the option could be phased in—for example, by adding a requirement that benchmarks in the affected counties would not fall from one year to the next. (However, such a phase-in was not an assumption used for the estimates given here.)

«CBO»

**Option 67****Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Medicare Part D**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014  | Total     |           |
|------------------------------|------|------|------|------|-------|-----------|-----------|
|                              |      |      |      |      |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -6.0 | -8.0 | -9.0 | -10.0 | -33.0     | -110.0    |

Medicare's voluntary outpatient drug benefit, known as Part D, began in 2006, and as of January 2008, about 25 million Medicare beneficiaries were enrolled. The benefit is delivered through a combination of stand-alone prescription drug plans (PDPs) and prescription drug plans associated with Medicare Advantage plans (MA-PDs). Overall, the federal government subsidizes about 75 percent of beneficiaries' premiums for the plans (both PDPs and MA-PDs) and provides additional assistance for beneficiaries who have low income. In 2009, the Congressional Budget Office estimates, federal spending for Part D will total \$49 billion. (That amount covers federal subsidies to Part D but does not include subsidies to employers for prescription drug coverage provided by their retiree health plans or offsetting payments from states.)

PDPs and MA-PDs help reduce the cost of the Part D benefit by managing beneficiaries' use of prescription drugs (for example, by encouraging the use of generic and more-cost-effective brand-name drugs) and by negotiating payment rates with pharmacies and rebates from manufacturers of brand-name drugs. The size of a manufacturer's rebate is based in part on the ability of the prescription drug plan to favor one brand-name drug over another in its formulary—the list of prescription drugs that the plan covers. Most formularies place drugs in different tiers and tie lower copayments for beneficiaries to the use of drugs in the “preferred” tiers. A 2007 report by the House Committee on Oversight and Government Reform found that in 2006, manufacturers' rebates under Medicare Part D averaged 8.1 percent of spending.<sup>1</sup>

This option would require manufacturers of brand-name drugs to pay the federal government a rebate equaling 15 percent of the average manufacturer price. Using Medicaid's rebate policy as a model, manufacturers

would apply a basic rebate to the average price that a manufacturer received on sales to retail and mail-order pharmacies, plus an additional rebate for increases in a drug's price that exceeded inflation. The rebate would apply to purchases of brand-name drugs by all Part D beneficiaries. Manufacturers would be required to participate in the rebate program in order for their drugs to be covered by Parts B and D of Medicare, by Medicaid, and by the Veterans Health Administration. Each year, the Centers for Medicare and Medicaid Services (CMS) would retrospectively calculate the rebate that each manufacturer owed on the basis of data that CMS collects. (PDPs and MA-PDs submit data based on drug claims under the Medicare Part D program, and drug manufacturers report their average manufacturer prices under Medicaid's rebate program.) The amounts of the rebates would be calculated at the unit level of a drug (such as a 20-milligram tablet) and then summed across all drugs to arrive at the total amount that a manufacturer owed for drugs purchased by Part D beneficiaries in a given year.

Under this option, which would initially be implemented in calendar year 2011, manufacturers would continue to have an incentive to provide rebates to PDPs and MA-PDs in exchange for the plans' designation of those manufacturers' products as “preferred” in their formularies. However, the rebates that those plans negotiated would probably decline to some degree relative to their current amounts. The savings to the federal government under this option would be an estimated \$33 billion over the 2010–2014 period and about \$110 billion over the 2010–2019 period.

An advantage of this option is that Medicare could pay lower prices for currently available brand-name drugs purchased by Part D beneficiaries largely without interfering with the discounted prices negotiated by private purchasers (other than PDPs and MA-PDs). For example, the option would not affect the prices paid for drugs by employment-based plans covering the under-65 popu-

1. House Committee on Oversight and Government Reform, “Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage” (October 2007).

lation. The structure of this option parallels Medicaid's rebate program but lacks the best-price provision. (That provision gives Medicaid access to some of the lowest prices paid in the private sector and consequently may affect private-sector pricing.) Previously, manufacturers paid a rebate to Medicaid for drugs purchased by the dual-eligible population before those beneficiaries began receiving the Medicare Part D benefit, so there is a precedent for the federal government (and states) to collect rebates related to prescriptions for that population.<sup>2</sup>

A disadvantage of this option is that over time, manufacturers could partially offset the rebates they were required to pay by charging higher prices for new drugs—particularly for a “breakthrough” drug (the first drug that uses a new mechanism to treat an illness). Manufacturers could also introduce new strengths and dosages for existing drugs and set the initial prices of those products somewhat higher in anticipation of the Part D rebate they would have to pay. (Those higher prices need not affect all purchasers. For example, employment-based plans that covered people under 65 could negotiate for larger rebates to offset the higher launch prices, but Medicaid programs would pay a higher price for breakthrough drugs. This estimate reflects such costs.) Nevertheless, competition from drugs already on the market would limit the extent to which manufacturers could charge higher initial prices for new drugs, particularly those that were merely different formulations and strengths. Another disadvantage of this option is that premiums

2. Dual eligibles are persons who qualify in some way for coverage under both Medicare and Medicaid. Medicare covers their acute care, and Medicaid covers their Medicare premiums and cost sharing, and—for those of a certain health status who meet specific income and asset thresholds—long-term care.

could increase as a result of a decrease in the rebates negotiated by the plans.

Another possible disadvantage of the option is that because manufacturers could not fully offset the required rebates with higher prices for new drugs, the option might reduce the amount of funds that manufacturers invested in research and development of new products. The option would not significantly reduce the incentive to develop breakthrough drugs, however, and those drugs could be launched at higher prices that would largely offset the rebate.

This option would generate substantial savings because it would require manufacturers to pay a rebate on brand-name drugs purchased under Medicare Part D or forgo participation in that program as well as in other federal programs that pay for prescription drugs. It has been suggested that the Secretary of Health and Human Services could negotiate drug prices as an alternative strategy for reducing prescription drug costs under Part D. The Congressional Budget Office has concluded that negotiations by the Secretary would produce small if any savings, because the Secretary would not have sufficient leverage in such negotiations to secure significant discounts on most drugs beyond those already obtained by the PDPs and MA-PDs. The Secretary might be able to negotiate small savings for single-source drugs that had no close substitutes on the market by persuading manufacturers to reduce prices for a few drugs. Or such negotiations might produce small savings if they were paired with techniques for utilization management (for example, requiring prior authorization for drugs for which no additional rebate was provided). However, many PDPs and MA-PDs already manage utilization, so the ability of the Secretary to negotiate further discounts is likely to be limited.

RELATED CBO PUBLICATIONS: *Cost Estimate for S. 3, Medicare Prescription Drug Price Negotiation Act of 2007*, April 16, 2007; *Issues Regarding Drug Price Negotiation in Medicare*, Letter to the Honorable Ron Wyden, April 10, 2007; *Cost Estimate of Draft Legislation That Would Change Medicare's Prescription Drug Program*, Letter to the Honorable Max Baucus, April 10, 2007; *Authority to Negotiate Prices for Single-Source Drugs for Medicare Beneficiaries*, Letter to the Honorable Ron Wyden, March 3, 2004

**Option 68****Establish an Abbreviated Approval Pathway for Follow-On Biologics**

| (MILLIONS OF DOLLARS)   | 2010     | 2011     | 2012     | 2013     | 2014        | Total       |                |
|---|----------|----------|----------|----------|-------------|-------------|----------------|
|   |          |          |          |          |             | 2010-2014   | 2010-2019      |
| <b>Establish an Abbreviated Approval Pathway</b>  |          |          |          |          |             |             |                |
| Change in Mandatory Spending <sup>a</sup>   | 0        | 0        | 0        | *        | -100        | -100        | -8,100         |
| Change in Revenues <sup>b</sup>   | <u>0</u> | <u>0</u> | <u>0</u> | <u>*</u> | <u>*</u>    | <u>*</u>    | <u>1,100</u>   |
| <b>Net Effect on the Deficit<sup>c</sup></b>  | <b>0</b> | <b>0</b> | <b>0</b> | <b>*</b> | <b>-100</b> | <b>-100</b> | <b>-9,200</b>  |
| Change in Discretionary Spending <sup>d</sup>   |          |          |          |          |             |             |                |
| Budget authority  | 0        | 0        | 0        | *        | *           | *           | -1,000         |
| Outlays   | 0        | 0        | 0        | *        | *           | *           | -1,000         |
| <b>Establish an Abbreviated Approval Pathway and<br/>Modify Medicare Part B Payment Rates</b> |          |          |          |          |             |             |                |
| Change in Mandatory Spending <sup>a</sup>   | 0        | 0        | 0        | *        | -200        | -200        | -10,600        |
| Change in Revenues <sup>b</sup>   | <u>0</u> | <u>0</u> | <u>0</u> | <u>*</u> | <u>*</u>    | <u>*</u>    | <u>1,400</u>   |
| <b>Net Effect on the Deficit<sup>c</sup></b>  | <b>0</b> | <b>0</b> | <b>0</b> | <b>*</b> | <b>-200</b> | <b>-200</b> | <b>-12,000</b> |
| Change in Discretionary Spending <sup>d</sup>   |          |          |          |          |             |             |                |
| Budget authority  | 0        | 0        | 0        | *        | *           | *           | -1,100         |
| Outlays   | 0        | 0        | 0        | *        | *           | *           | -1,100         |

Note: \* = between -\$50 million and \$50 million.

- Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.
- Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.
- Estimates exclude the potential effect of changes in discretionary spending.
- Estimates exclude costs to the Food and Drug Administration for administering the program.

In recent years, total spending on biologics—drug products derived from living organisms—has grown in the United States, exceeding \$40 billion in 2007. About three-quarters of that spending is for brand-name biologic products that could potentially lose patent protection over the next 10 years. For prescription drugs that are approved under the federal Food, Drug, and Cosmetic Act (usually developed from nonbiologic, or chemical, sources), an abbreviated regulatory process exists for approving generic alternatives once a patent expires. As a result, following the expiration of a patent, a number of firms are typically prepared to enter the market and produce a generic form of the brand-name chemical drug, especially one that generates high sales. By contrast, such competition is absent in the market for biologics because there is no comparable abbreviated regulatory process for licensing “follow-on” products. (Generic drugs contain the same active chemical ingredient that the original patented drug contains,

whereas follow-on biologics are copies of much more complex molecules.)

This option would establish an abbreviated regulatory pathway for approving follow-on biologics under the Public Health Service Act. In approving a follow-on biologic, the Food and Drug Administration (FDA) would be allowed to rely, in part, on literature and data from clinical trials that were submitted during the approval process for the original product. Therefore, the manufacturer of the follow-on biologic would not be required to duplicate all of the clinical trials conducted by the manufacturer of the brand-name drug. By streamlining the approval process, multiple manufacturers of follow-on biologics would be likely to enter the market, particularly for top-selling products; such competition would put downward pressure on prices and help lower expenditures on biologic products for both the federal government and private purchasers of health insurance.

If implemented, this option would establish standards for FDA approval of follow-on biologics and permit the agency to issue guidance to potential producers of follow-on biologics describing the approval process and the agency's requirements. This option would grant brand-name biologics 12 years of exclusivity during which time no follow-on biologic could be approved. Nonetheless, in cases in which the patent on the brand-name biologic expired after the 12-year exclusivity period, the patent could then determine the timing of the follow-on product's entry into the market. The option would also create a process to facilitate the resolution of patent disputes, and that patent-resolution process would run concurrently with the FDA's approval process.

A modification of this option would require that the Centers for Medicare and Medicaid Services place follow-on biologics in the same billing code as their brand-name counterparts for making payments under Medicare Part B. That modification would financially penalize physicians who did not dispense follow-on biologics, when available, to patients enrolled in Medicare Part B. Because the payment rate would be calculated as a weighted average of the prices paid to manufacturers for all drugs within the same billing code, that rate would not fully cover the cost of dispensing a brand-name biologic if a follow-on biologic was available. At the same time, physicians would benefit financially from using follow-on biologics because they would be less expensive and physicians would be allowed to retain the difference between the acquisition cost of the biologic and Medicare's payment. As a follow-on biologic became more widely used, the payment rate under Medicare Part B would decline, and savings to the program would increase. Without this modification in Part B payment rates, the market share of follow-on biologics would be smaller, as would be the savings under this option.

Because follow-on biologics would be priced lower than their brand-name counterparts, drug spending in federal health programs would be reduced. As a result, implementing this option without any modification to the Medicare Part B payment system would save mandatory health programs such as Medicare and Medicaid about \$8.1 billion over the 2010–2019 period.<sup>1</sup> In the Congressional Budget Office's estimation, spending for discretionary health programs, such as those administered by the Veterans Health Administration and the Department of Defense, would decrease by \$1 billion over the

2010–2019 period under the assumption that appropriations reflect the reduced costs to the programs.<sup>2</sup> In addition, this option would reduce costs for private health insurance plans and lower insurance premiums for employers by almost 0.2 percent by 2019. As the amount spent by employers for tax-favored health insurance decreased, the amount spent on taxable wages would increase. As a result, this option would increase federal revenues derived from income taxes and payroll taxes by about \$1.1 billion over the 2010–2019 period.

If the Medicare Part B payment system was modified to place the follow-on biologic in the same billing code as the original brand-name product, the estimated savings would be greater. With that modification, this option would save mandatory health programs about \$10.6 billion over the 2010–2019 period. Under the assumption that appropriations for discretionary health programs reflect the reduced costs to the programs, spending subject to appropriation would decrease by about \$1.1 billion over the 2010–2019 period, CBO estimates. Under this modification of the option, federal revenues from income taxes and payroll taxes would increase by an estimated \$1.4 billion over the 2010–2019 period.

Under alternative scenarios, savings from streamlining the regulatory process for follow-on biologics could be larger or smaller than indicated by those estimates, depending on the specific features of the scenario. For example, if the brand-name drug's period of exclusivity lasted more than 12 years, the estimated savings would be reduced. Conversely, if the period of exclusivity lasted fewer than 12 years, the savings would increase. Also, to the extent that the manufacturer could make certain modifications to the brand-name product and, as a result, qualify for another 12-year period of exclusivity, savings would be affected.

An advantage of this option is that it would reduce health care expenditures for both government programs and private payers. A potential disadvantage is that establishing a streamlined pathway for approving follow-on biologics could reduce the returns associated with developing a

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1. The Congressional Budget Office expects to receive new data on drug spending for certain federal programs, such as Medicare Part D, that will affect this estimate.
  2. The estimate does not include FDA's costs to administer the program.

new biologic and, therefore, could reduce investment in research and development of biologics. However, after an abbreviated regulatory pathway was approved for small-molecule drugs in 1984, investment in research and development of new drugs continued to grow at a healthy pace. Some stakeholders in the industry argue that an accelerated review process for biologics (which are much more complex than small-molecule drugs) could lead to the use of follow-on products with safety or efficacy

profiles that are not as good as the original product's, which could put some patient's health at risk. Other stakeholders counter that such claims are false because the FDA would have the ability to require clinical trials to establish that the follow-on product was safe and effective (although the clinical trials generally would not be as extensive as those required for the original product).

«CBO»

# Financing and Paying for Services in Medicaid and the State Children's Health Insurance Program

**M**edicaid and the State Children's Health Insurance Program (SCHIP) are federal health programs that serve lower-income individuals. Both programs are jointly financed by the federal government and the states, with the federal contribution set according to a statutory formula.

## Medicaid

Medicaid is a mandatory entitlement program that financed care for approximately 48 million low-income individuals, on average, during 2007. States operate Medicaid programs within broad federal statutory and regulatory guidelines. Although state programs must meet minimum federal standards, states have significant flexibility in determining eligibility thresholds, the amount of covered services, and payment rates for providers. States submit to the federal government a plan that specifies the manner in which they will operate their program within statutory guidelines; the plan also describes any optional services or eligibility categories a state may choose to cover. States may make changes to their programs at any time through plan amendments, as long as those changes conform to federal requirements and have the approval of the Centers for Medicare and Medicaid Services. In addition, the Social Security Act grants states the authority to waive certain requirements; states can provide care in alternative settings, expand the program to population groups not generally covered under Medicaid, or test program innovations.

The federal government pays a portion of the costs that states incur to provide services to Medicaid enrollees. The proportion of states' costs that the federal government pays is based on the "federal medical assistance percentage" (FMAP). The percentage for each state is determined through a formula that assigns a higher federal reimbursement rate to states that have lower income per

capita (and vice versa) relative to the national average. The average matching rate that the federal government pays is 57 percent nationwide; states contribute the remaining 43 percent. The federal matching rates have both a floor (50 percent) and a ceiling (83 percent).

Medicaid covers a comprehensive array of medical services. For example, the program pays for long-term care and supportive services that are not typically covered by private insurance or Medicare. Although three-fourths of Medicaid's enrollment constitutes nondisabled adults and children, about 70 percent of the program's spending is on behalf of the elderly and disabled. (About a third of Medicaid's spending is for long-term care services.) As with eligibility standards, states must meet the federal government's minimum requirements for covered benefits, but they have the option to provide certain additional services.

With respect to prescription drugs, two major financial transactions are involved in Medicaid: rebate payments from drug manufacturers to states and the federal government, and payments from states to pharmacies for the cost of providing drugs to beneficiaries. If a manufacturer chooses to participate in Medicaid, it is required to provide a statutory rebate for prescription drugs given to beneficiaries in fee-for-service settings. (Medicaid beneficiaries receive prescription drug coverage through managed care plans or on a fee-for-service basis. However, managed care plans are excluded from receiving the statutory rebate.) Rebates offset some of the state and federal Medicaid spending on prescription drugs.

Rebates are calculated on the basis of two prices: the "best price" (the lowest price offered to any purchaser excluding most rebates to pharmacy benefit managers and prices paid by certain federal and state programs) and the average manufacturer price (AMP) (the average price received

by the manufacturer for sales to retailers and mail-order pharmacies). The rebate for single-source drugs is based on the AMP and the best price; for generic drugs, the rebate is a fixed percentage of the AMP. An additional rebate is required if the prices of a manufacturer's brand-name drugs rise faster than inflation (as measured by the consumer price index for all urban consumers). Some states also negotiate supplementary rebates with certain manufacturers, which are also shared with the federal government.

Medicaid pays pharmacies for drugs on the basis of two prices: the average wholesale price (AWP) and, eventually, the AMP. The AWP represents the average price paid by retail pharmacies for a drug product purchased from drug wholesalers. Medicaid law limits the federal matching funds available for states' payments for generic drugs and brand-name drugs with generic substitutes by imposing a federal upper limit. Under the Deficit Reduction Act of 2005, that upper limit is set at 250 percent of the AMP of the least costly therapeutic equivalent. However, the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) delayed the implementation of that change until October 2009.

## 8

## The State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP), which was established in 1997, financed insurance coverage during 2007 for about 5 million low-

income children, on average. Like Medicaid, SCHIP is jointly administered and financed by the federal and state governments. States receive matching payments for expenditures from the federal government based on matching rates that are approximately one-third higher than those under Medicaid. Generally, states have more programmatic flexibility in SCHIP than in Medicaid. For example, states have the option of providing SCHIP coverage through a state program that offers benefits modeled on widely used private insurance "benchmark plans," or they can provide SCHIP coverage through the Medicaid program. SCHIP allows states to charge enrollees higher premiums and a higher rate of cost sharing than is permitted in Medicaid, although SCHIP cost sharing remains modest compared with that charged by private insurance.

Medicaid is classified as an entitlement—there is no limit on the federal funds that may be expended, given eligible expenditures—but SCHIP is a capped allotment, in which the annual amount of available federal funding is limited. SCHIP is authorized through March 31, 2009, at an annual funding amount of \$5 billion.

This chapter comprises options that would alter the financing and payment parameters in Medicaid and SCHIP, both with respect to the state and federal matching structure and payments for specific services. Changes in eligibility for Medicaid and SCHIP are discussed in Chapter 5.



**Option 69****Convert the Federal Share of Medicaid's Payments for Acute Care Services into an Allotment**

| (BILLIONS OF DOLLARS)   | 2010  | 2011  | 2012  | 2013  | 2014  | Total     |           |
|---|-------|-------|-------|-------|-------|-----------|-----------|
|   |       |       |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending  |       |       |       |       |       |           |           |
| <b>Index Allotment to Changes in the Consumer Price Index</b>                   |       |       |       |       |       |           |           |
| Budget authority  | -17.9 | -26.5 | -35.9 | -46.5 | -58.0 | -184.8    | -691.9    |
| Outlays   | -15.5 | -24.1 | -32.6 | -42.1 | -52.5 | -166.8    | -624.6    |
| <b>Index Allotment to Changes in the Consumer Price Index and in Population</b> |       |       |       |       |       |           |           |
| Budget authority  | -15.8 | -23.3 | -31.6 | -41.0 | -51.2 | -162.9    | -614.1    |
| Outlays   | -13.8 | -21.3 | -28.8 | -37.2 | -46.5 | -147.6    | -555.9    |
| <b>Index Allotment to Changes in National Health Expenditures</b>               |       |       |       |       |       |           |           |
| Budget authority  | -5.6  | -7.6  | -10.0 | -12.8 | -16.1 | -52.1     | -198.3    |
| Outlays   | -5.5  | -7.6  | -9.9  | -12.5 | -15.5 | -51.0     | -188.8    |

The Medicaid program funds coverage for two broadly different types of health care: acute care (including inpatient hospital stays, visits to physicians' offices, and prescription drugs); and long-term care (including nursing home care and home- and community-based assistance). The program is financed jointly by the states and the federal government, with the federal government's share equal to a percentage of the Medicaid program's overall spending. That percentage, referred to as the federal medical assistance percentage (FMAP), can range from 50 percent to 83 percent, depending on a state's per capita income. (The FMAP averages 57 percent nationwide.) Although the federal contribution to the program helps states provide health care coverage to disadvantaged populations, it may also encourage states to spend more than they otherwise would because it subsidizes part of each additional dollar of their spending for Medicaid. The Congressional Budget Office estimates the federal share of Medicaid's outlays for acute care in 2008 to be \$123 billion and \$61 billion for long-term care.

This option would convert the federal share of Medicaid's payments for acute care services into an allotment to each state, as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 did with funding for welfare programs. In exchange for the slower growth in the federal government's Medicaid payments that each of the alternatives in this option would produce, states would be

given more flexibility in how they could use those funds to meet the needs of their low-income and uninsured populations. A state's allotment would apply to acute care services for all of its Medicaid beneficiaries. However, long-term care would continue to be financed as it is under current law. This option includes three alternatives differentiated by the way each would adjust the allotment annually for inflation. All of the alternatives generate savings because under current law, the federal government's payments for Medicaid are projected to grow faster than inflation. Under the option, a state's allotment would equal its 2008 federal Medicaid payment for acute care, indexed to one of the following inflation factors:

- **Changes in the consumer price index.** Under the option, indexing each state's allotment to annual increases in the consumer price index would reduce federal outlays by about \$167 billion over the 2010–2014 period and by \$625 billion over the 2010–2019 period.
- **Changes in the consumer price index and in population.** If allotments were indexed to increases in the consumer price index as well as to changes in each state's overall population, federal savings under the option would be about \$148 billion over the 2010–2014 period and \$556 billion over the 2010–2019 period.

- **Changes in national health expenditures.** If allotments were indexed to projected increases in total national health expenditures, savings under the option would be approximately \$51 billion over the 2010–2014 period and \$189 billion over the 2010–2019 period.

A rationale for this option is that an allotment would eliminate the federal subsidy now provided for each additional dollar spent by states on acute care. In the past, legislative proposals to create allotments have typically coupled a change in financing with increased discretion for states to design and administer their Medicaid programs—for example, to modify their benefit packages and make corresponding adjustments in the number of people they covered. A further rationale for converting the federal contribution to an allotment is that it would lessen states’ ability to maximize federal assistance. For example, in the past, some states used their federal disproportionate share hospital (DSH) payments, which are provided to hospitals that serve a disproportionately large percentage of low-income patients, to effectively boost their FMAP under Medicaid. Because states had some discretion in the size of those payments and which hospitals received them, many states engaged in transferring funds from the DSH program to support Medicaid services and thus obtain increased federal Medicaid funding

without raising their net spending on DSH hospitals. To rein in that practice, policymakers in the 1990s established fixed ceilings on DSH payments to each state.

An argument against this option is that converting payments for acute care services into an allotment would reduce the total amount of federal funding for Medicaid, shifting more of the burden of the program’s growing costs to the states and possibly providing an incentive for states to scale back their spending for Medicaid. Unless states were willing to pay more of the costs themselves or were able to find ways to provide more cost-effective care, access to health services for low-income people might be diminished. Another argument against the option is that distinguishing between acute care and long-term care for the purposes of financing could be administratively difficult, especially in cases in which individuals are receiving both types of care. For example, many hospital patients who receive acute care services require additional services after they are released that are similar to long-term care. A final argument against the option is that greater discretion for the states in how they structure their Medicaid programs creates the potential for increased disparity from one state to another in eligibility requirements and benefit packages.

**Option 70****Remove or Reduce the Floor on Federal Matching Rates for Medicaid Services**

| (BILLIONS OF DOLLARS)   | 2010  | 2011  | 2012  | 2013  | 2014  | Total     |           |
|---|-------|-------|-------|-------|-------|-----------|-----------|
|   |       |       |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending  |       |       |       |       |       |           |           |
| Remove the floor on the federal medical assistance percentage               | -13.0 | -14.0 | -19.0 | -20.0 | -22.0 | -88.0     | -228.0    |
| Reduce the floor on the federal medical assistance percentage to 45 percent | -9.0  | -10.0 | -11.0 | -11.0 | -12.0 | -53.0     | -131.0    |

The federal government pays a share of the costs that states incur for providing health care services through the Medicaid program. For most medical services that Medicaid covers, the percentage of costs paid for by the federal government is determined by the federal medical assistance percentage (FMAP). The FMAP is based on a formula that assigns a higher federal reimbursement rate to states that have lower income per capita (and vice versa) relative to the national average. By law, a state's FMAP rate can be no less than 50 percent and no more than 83 percent. The average matching rate that the federal government pays is 57 percent nationwide; states contribute the remaining 43 percent of the cost of services.

Although the FMAP rates are set through a statutory formula, states generally determine the amount of Medicaid's spending because they first pay health care providers and then submit claims to the federal government for reimbursement at the appropriate FMAP rate. Medicaid spending is therefore driven by states' available revenues and the choices that states make regarding payment rates for providers, the coverage of optional benefits, and whether or not states use optional thresholds for eligibility for the program.

One alternative of this option would eliminate the 50 percent floor on federal matching rates for all Medicaid-covered services that are reimbursed at the FMAP rate. The removal of the FMAP floor would be phased in over the first three years that the option was in effect; thus, the floor would be 40 percent in 2010, 20 percent in 2011, and then zero in 2012. To maintain their Medicaid programs' current payment rates, benefit levels, and eligibility thresholds, affected states would have to replace the lost federal funding with state funds. If states did not

provide additional financing, they could maintain their current level of contributions by cutting overall spending for their programs. In preparing its estimates of the cost of the option, the Congressional Budget Office assumed that states would adopt a combination of those two approaches—that is, states would increase their contributions to make up for some of the reduced federal funding but not by enough to prevent overall spending for Medicaid from declining.

This alternative would save an estimated \$88 billion over the 2010–2014 period and about \$228 billion over the 2010–2019 period. Removing the 50 percent floor would reduce FMAP rates for 12 states; in 2012, the new rates would range from 15 percent to 49 percent. Federal matching rates would not change for the remaining 38 states.

Another version of this option that would produce a more moderate financial impact would be to lower the FMAP floor to 45 percent starting in 2010, which would save an estimated \$53 billion over the 2010–2014 period and \$131 billion over the 2010–2019 period. Lowering the floor to 45 percent would reduce FMAP rates for the same 12 states mentioned in the above alternative; the new rates would range from 45 percent to 49 percent. Federal matching rates would not change for the remaining 38 states.

A rationale for removing or lowering the floor on the federal matching rate is to lower federal spending for the Medicaid program by reducing payments to states that have the greatest financial resources available to fund their programs. The FMAP formula is designed to provide a larger federal contribution for states that have lower income per capita (per capita income serves as a

proxy for a state's financial resources) and a smaller federal contribution for states that have higher income per capita. However, the floor of 50 percent provides a number of states with FMAP rates well above the rates they would be assigned in the absence of such a floor. Removing or lowering the current floor would require states that had higher income per capita to pay a greater share of the cost of Medicaid services.

An argument against the option is that it would concentrate significant reductions in spending among a small

number of states. The 12 states affected by the option would generally have several mechanisms for reducing expenditures in their Medicaid programs: They could cut their payment rates to providers, reduce the kinds and amounts of medical benefits they provided, lower thresholds for eligibility, reduce outreach efforts, or increase administrative requirements for enrollment (thereby covering fewer people). States that face significant reductions in their FMAP rates could respond by using a combination of those cost-cutting approaches.

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**Option 71**

**Equalize Federal Matching Rates for Administrative Functions in Medicaid at 50 Percent**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -1.0 | -1.0 | -2.0 | -2.0 | -2.0 | -8.0      | -20.0     |

The federal government pays a portion of the costs that states incur to administer their Medicaid programs. For most administrative activities, the federal matching rate is 50 percent; in some cases, however, the assistance is higher. For example, the federal government pays 75 percent of the cost of employing skilled medical professionals under Medicaid; 75 percent of the cost of utilization review (the process of determining the appropriateness and medical necessity of various health care services); 90 percent of the cost of developing systems to manage claims and information; and 75 percent of the cost of operating such systems.

This option would set the federal matching rate for all of Medicaid’s administrative activities at 50 percent. The option would be phased in so that the highest administrative matching rate would be 70 percent in 2010, 60 percent in 2011, and then 50 percent in 2012. Those changes would save an estimated \$8 billion over the 2010–2014 period and \$20 billion over the 2010–2019 period.

Enhanced matching rates were originally designed to encourage states to develop and support particular

activities that the federal government considers important for managing the Medicaid program. Once those administrative systems are operational, however, there may be less reason to continue the higher subsidy. Moreover, because states pay, on average, about 43 percent of the cost of health care services for Medicaid beneficiaries, they have a substantial incentive to maintain efficient information systems and employ skilled professionals, even in the absence of higher matching rates for such activities.

A potential drawback of this option is that a reduced federal subsidy might cause states to cut back on the administrative activities that higher matching rates were designed to promote, with adverse consequences for program management. For instance, states might hire fewer nurses to conduct utilization reviews or oversee care in nursing homes, or they might make fewer improvements to their information management systems. In addition, some states may have committed to multiyear expenditures based on the current federal matching rates for those administrative activities.

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**Option 72****Restrict the Allocation to Medicaid of Common Administrative Costs**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -260 | -260 | -260 | -260 | -260 | -1,300    | -2,600    |

The federal government's three major public assistance programs—Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), and Medicaid—have certain administrative tasks in common. For instance, during the enrollment process, each program requires that potential recipients provide information about their family's income, assets, and demographic characteristics. Before enactment of the 1996 welfare reform law, the Personal Responsibility and Work Opportunity Act, which replaced Aid to Families with Dependent Children (AFDC) and some related programs with the TANF block grant program, all three programs reimbursed states for 50 percent of most administrative costs. As a matter of convenience, states usually charged the full amount of those common administrative costs to AFDC.

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TANF grants are calculated on the basis of past federal welfare spending, including what the states received as reimbursement for administrative costs. Because states had previously paid the common administrative costs of their AFDC, Medicaid, and Food Stamp programs from AFDC funds, those amounts are now included in their TANF grants. However, the Department of Health and Human Services now requires each state to charge Medicaid's share of common administrative costs to the federal Medicaid program, even if that amount is already

implicitly included in the state's TANF block grant. As a result, many states' TANF grants are artificially high because they include a portion of Medicaid's share of common administrative costs.

This option would limit the federal reimbursement for administrative costs for the Medicaid program to the amount not included in the state's TANF block grant, a restriction that would reduce federal payments by an estimated \$1.3 billion over the 2010–2014 period and by \$2.6 billion over the 2010–2019 period. Overall, the reduction in funding for Medicaid would equal about one-third of the common costs of administering Medicaid, AFDC, and SNAP that were charged to AFDC in 1996—the base period that is used to determine the amount of the TANF block grant. (A similar adjustment has already been made in the amount that the federal government pays the states to administer SNAP.)

A rationale for this option is that it would eliminate the current double payment to states and save federal funds. A potential drawback is that states could argue that reducing federal payments might cause states to offset the diminished federal funding by making cuts to other parts of their Medicaid programs.

«CBO»

**Option 73****Reduce the Taxes That States Are Allowed to Levy on Medicaid Providers**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -400 | -2,100 | -4,600 | -4,900 | -5,200 | -17,200   | -48,400   |

Medicaid, which is financed jointly by the states and the federal government, pays for health care services for certain low-income individuals. States administer the program, paying health care providers for services rendered to Medicaid beneficiaries and submitting evidence of payments for medical claims to the federal government. In turn, states receive financial assistance from the federal government in the form of matching payments. Those federal matching funds are paid at rates ranging from 50 percent to 83 percent of the state's payments for medical claims, depending on the state's per capita income.

Many states finance a portion of their share of Medicaid spending by imposing taxes on health care providers and then using the revenues to increase payment rates to those same providers. In the process, states collect federal matching funds to cover those higher payments. In a simple example, if a state with a federal matching rate of 50 percent paid a medical professional \$100 for services provided to Medicaid beneficiaries, it would receive a federal matching payment of 50 percent of that amount. In the absence of a tax on the health care provider, the state and federal governments would each pay \$50 for the services. But if the state assessed a tax on the provider of 5.5 percent—the maximum allowed in 2008—and then paid the provider \$106 (\$100 plus 5.5 percent rounded to the nearest dollar) for services rendered to Medicaid beneficiaries, the provider's net payment from the state would still be \$100 (\$106 minus \$6). However, the federal government would reimburse the state for 50 percent of the total payment—\$53 (\$106 times 50 percent), leaving the state paying only \$47 (\$53 minus \$6). The effective federal matching payment thus would increase from 50 percent to 53 percent in the above example.

In recent years, tax collections from providers have grown by more than 20 percent annually as states have increased their use of provider taxes. In the Tax Relief and Health Care Act of 2006, policymakers temporarily reduced the tax rate that states were allowed to assess on Medicaid providers from 6 percent of a health facility's gross revenue to 5.5 percent for the period beginning January 1, 2008, and ending September 30, 2011. After September 30, 2011, the rate will return to 6 percent. This option would gradually reduce the rate to 3.0 percent by 2012. As a result, federal spending would decrease by an estimated \$17 billion during the 2010–2014 period and by \$48 billion over the 2010–2019 period.

A rationale for implementing this option is that the states' ability to maximize federal payments by imposing taxes on providers would be reduced. Because some states may use provider taxes to effectively inflate their federal matching rates, lowering the ceiling on allowable provider taxes to 3 percent would limit states' ability to maximize federal assistance. Consequently, federal Medicaid payments to states would decrease.

An argument against this option is that lower federal payments could shift more of the burden of the Medicaid program's growing costs to the states and possibly provide an incentive for states to scale back their spending for Medicaid. Unless states were willing to pay more of the costs themselves or were able to find ways to provide more cost-effective care, access to health services for low-income people might be diminished. Reduced federal spending could also lead to decreased payment rates for providers.

RELATED CBO PUBLICATION: Statement of Donald B. Marron, Acting Director, Congressional Budget Office, before the Senate Special Committee on Aging, *Medicaid Spending Growth and Options for Controlling Costs*, July 13, 2006

**Option 74****Modify the Amount of the Brand-Name Drug Rebate in the Medicaid Program**

| (MILLIONS OF DOLLARS)   | 2010        | 2011        | 2012        | 2013        | 2014        | Total         |               |
|---|-------------|-------------|-------------|-------------|-------------|---------------|---------------|
|   |             |             |             |             |             | 2010-2014     | 2010-2019     |
| <b>Eliminate the Best-Price Provision and Increase the Flat Rebate to 23.1 Percent of AMP</b>         |             |             |             |             |             |               |               |
| Change in Mandatory Spending <sup>a</sup>   | -10         | -20         | -20         | -20         | -20         | -90           | -230          |
| Change in Revenues <sup>b</sup>   | <u>50</u>   | <u>80</u>   | <u>80</u>   | <u>90</u>   | <u>90</u>   | <u>390</u>    | <u>990</u>    |
| <b>Net Effect on the Deficit<sup>c</sup></b>  | <b>-60</b>  | <b>-100</b> | <b>-100</b> | <b>-110</b> | <b>-110</b> | <b>-480</b>   | <b>-1,220</b> |
| Change in Discretionary Spending  |             |             |             |             |             |               |               |
| Budget authority  | -10         | -10         | -10         | -10         | -10         | -50           | -120          |
| Outlays   | -10         | -10         | -10         | -10         | -10         | -50           | -120          |
| <b>Eliminate the Best-Price Provision and Increase the Flat Rebate to a Budget-Neutral Percentage</b> |             |             |             |             |             |               |               |
| Change in Mandatory Spending <sup>a</sup>   | 50          | 80          | 80          | 90          | 90          | 390           | 990           |
| Change in Revenues <sup>b</sup>   | <u>50</u>   | <u>80</u>   | <u>80</u>   | <u>90</u>   | <u>90</u>   | <u>390</u>    | <u>990</u>    |
| <b>Net Effect on the Deficit<sup>c</sup></b>  | <b>0</b>    | <b>0</b>    | <b>0</b>    | <b>0</b>    | <b>0</b>    | <b>0</b>      | <b>0</b>      |
| Change in Discretionary Spending  |             |             |             |             |             |               |               |
| Budget authority  | -10         | -10         | -10         | -10         | -10         | -50           | -120          |
| Outlays   | -10         | -10         | -10         | -10         | -10         | -50           | -120          |
| <b>Increase the Medicaid Flat Rebate from 15.1 Percent to 23.1 Percent of AMP</b>                     |             |             |             |             |             |               |               |
| Change in Mandatory Spending <sup>a</sup>   | -260        | -520        | -570        | -620        | -680        | -2,650        | -7,000        |
| Change in Revenues <sup>b</sup>   | <u>10</u>   | <u>20</u>   | <u>20</u>   | <u>20</u>   | <u>20</u>   | <u>90</u>     | <u>240</u>    |
| <b>Net Effect on the Deficit<sup>c</sup></b>  | <b>-270</b> | <b>-540</b> | <b>-590</b> | <b>-640</b> | <b>-700</b> | <b>-2,740</b> | <b>-7,240</b> |
| Change in Discretionary Spending  |             |             |             |             |             |               |               |
| Budget authority  | *           | *           | *           | *           | *           | -10           | -30           |
| Outlays   | *           | *           | *           | *           | *           | -10           | -30           |

Notes: AMP = average manufacturer price; \* = less than \$5 million.

- Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.
- Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.
- Estimates exclude the potential effect of changes in discretionary spending.

Spending for prescription drugs by the Medicaid program is subject to upward pressures that are similar to those affecting overall spending for prescription drugs. The federal component of Medicaid's prescription drug spending (Medicaid is a joint federal/state program) totaled approximately \$9 billion in 2007, net of rebates collected from manufacturers. That amount constitutes approximately 7 percent of the federal share of the program's fee-for-service spending in that year.

The amount that Medicaid pays for a particular drug depends on two prices: the average wholesale price (AWP), which is a list price published by a drug's manufacturer; and the average manufacturer price (AMP), which is the average price that a manufacturer actually receives for drugs that it distributes to retail pharmacies and mail-order establishments. For brand-name drugs, state Medicaid agencies typically pay pharmacies the AWP minus a percentage (usually ranging from 10 per-



cent to 15 percent, depending on the state) plus a dispensing fee. The federal and state governments recoup a portion of that spending through rebates that the drug manufacturers pay to Medicaid.

For brand-name drugs, the basic rebate is equal to the greater of a fixed, or flat, percentage of the AMP—15.1 percent currently—or the difference between the AMP and the “best price” at which the manufacturer sells the drug to any private purchaser. The Congressional Budget Office estimates that the average basic rebate at the end of 2007 was 23.1 percent of the AMP. Although many manufacturers offer large discounts to private purchasers, the best-price provision discourages manufacturers from offering discounts larger than the flat rebate because any such discount automatically triggers a larger rebate to Medicaid. An additional manufacturer’s rebate applies if the AMP grows faster than inflation. Makers of generic drugs must provide a rebate to Medicaid of 11 percent of the AMP. States’ payments for generic drugs are generally limited by a federal ceiling on prices. Some states, however, choose to set payments for generic drugs that are lower than the federal ceiling.

This option presents several ways to modify manufacturers’ rebates for brand-name drugs in the Medicaid program. Each approach generates a different budgetary outcome.

- The first alternative would eliminate the best-price provision and increase the flat rebate from 15.1 percent to 23.1 percent, which is currently the average Medicaid basic rebate amount after taking into account best price discounts. This alternative would reduce mandatory federal spending and increase revenues for a net reduction in the deficit of an estimated \$480 million over the 2010–2014 period and about \$1.2 billion over the 2010–2019 period.
- The second alternative would eliminate the best-price provision and increase the flat rebate to an amount that would be budget neutral from the perspective of direct spending and revenues. Eliminating the best-price requirement and leaving the flat rebate at 15.1 percent would impose a cost on the Medicaid program because the best-price provision would increase the average Medicaid rebate to 23.1 percent. As a result, CBO assumed in developing this alternative that policymakers would enact a new flat rebate amount to achieve budget neutrality.<sup>1</sup> Increasing the

flat rebate to a budget-neutral amount would offset the entire budgetary impact of this version of the option.

- The third alternative would leave the best-price provision intact and increase the flat rebate from 15.1 percent to 23.1 percent. That change would reduce mandatory federal spending and increase revenues for a net reduction in the deficit of an estimated \$2.7 billion over the five years from 2010 to 2014 and about \$7.2 billion over the 10 years from 2010 to 2019.

By completely eliminating the best-price provision, the first and second alternatives might allow private purchasers to buy certain drugs at much lower prices, because manufacturers would no longer be required to give those low prices to the Medicaid program as well. The third alternative would delay the point at which the best-price provision was triggered. In each case, federal revenues would increase slightly because a decrease in premiums would increase taxable wages for individuals with employment-based plans. Access to lower prices would lower premiums for private health insurance and the Federal Employees Health Benefits (FEHB) program. Additionally, discretionary spending by federal agencies on FEHB premiums for current employees would decrease, assuming appropriations for federal agencies reflect reduced FEHB costs.<sup>2</sup>

An argument in support of the three alternatives is that, to varying degrees, they would enable drug manufacturers to offer greater discounts to private purchasers. A potential drawback of each of the alternatives involves the Medicaid program’s treatment of manufacturers’ introductory prices for new drugs. Medicaid does not place constraints on those prices (unlike the restrictions it places on price increases by requiring an additional rebate when such increases exceed inflation). As a result, under each alternative, pharmaceutical firms might set higher

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1. This alternative would also decrease the price that some private purchasers would pay for prescription drugs. That, in turn, would lower private health insurance premiums and increase federal revenues. Therefore, the budget-neutral flat rebate would be somewhat less than 23.1 percent of the AMP.
  2. Prescription drug prices charged to certain purchasers, such as the Department of Veterans Affairs (VA), the Department of Defense (DoD), and Medicare Part D Prescription Drug Plans are excluded from best price. Therefore, CBO does not estimate any changes in VA, DoD, or Medicare spending under this option.

“launch” prices for new drugs to offset reduced revenues from Medicaid. Estimates for all alternatives reflect such costs. The prices of drugs covered by Medicaid would rise even more if the best-price provision was eliminated, although private health plans might be able to negotiate steeper discounts on new drugs to bring prices down to

what they might have been in the absence of any of the alternatives. However, the interaction of the higher basic rebate with the additional inflation-adjusted rebate makes the ultimate effect of this option on the prices paid by private purchasers difficult to project.

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**Option 75****Apply the Fee-for-Service Medicaid Drug Rebate to Drugs Purchased for Medicaid Managed Care Enrollees**

| (MILLIONS OF DOLLARS)  | 2010        | 2011        | 2012        | 2013        | 2014          | Total         |                |
|--|-------------|-------------|-------------|-------------|---------------|---------------|----------------|
|  |             |             |             |             |               | 2010-2014     | 2010-2019      |
| <b>Require Drug Manufacturers to Pay Medicaid MCOs the Medicaid Rebate</b>                               |             |             |             |             |               |               |                |
| Change in Mandatory Spending <sup>a</sup>  | -180        | -420        | -720        | -800        | -900          | -3,020        | -9,190         |
| Change in Revenues <sup>b</sup>  | *           | *           | -10         | -10         | -10           | -30           | -80            |
| <b>Net Effect on the Deficit<sup>c</sup></b>   | <b>-180</b> | <b>-420</b> | <b>-710</b> | <b>-790</b> | <b>-890</b>   | <b>-2,990</b> | <b>-9,110</b>  |
| Change in Discretionary Spending   |             |             |             |             |               |               |                |
| Budget authority   | *           | *           | *           | *           | *             | *             | 10             |
| Outlays  | *           | *           | *           | *           | *             | *             | 10             |
| <b>Require Drug Manufacturers to Pay States the Medicaid Rebate for Drugs Purchased by Medicaid MCOs</b> |             |             |             |             |               |               |                |
| Change in Mandatory Spending <sup>a</sup>  | -200        | -500        | -900        | -1,000      | -1,100        | -3,700        | -11,100        |
| Change in Revenues <sup>b</sup>  | *           | *           | -10         | -10         | -10           | -30           | -80            |
| <b>Net Effect on the Deficit<sup>c</sup></b>   | <b>-200</b> | <b>-500</b> | <b>-890</b> | <b>-990</b> | <b>-1,090</b> | <b>-3,670</b> | <b>-11,020</b> |
| Change in Discretionary Spending   |             |             |             |             |               |               |                |
| Budget authority   | *           | *           | *           | *           | *             | *             | 10             |
| Outlays  | *           | *           | *           | *           | *             | *             | 10             |

Notes: MCOs = managed care organizations; \* = less than \$5 million.

- Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.
- Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.
- Estimates exclude the potential effect of changes in discretionary spending.

Medicaid programs furnish health care coverage to beneficiaries through a combination of fee-for-service (FFS) and managed care arrangements. Under risk-based managed care arrangements, managed care organizations (MCOs) are responsible for the costs that enrollees incur for care above a fixed monthly payment that the MCOs receive from the states. According to the Centers for Medicare and Medicaid Services, 38 states contracted with risk-based MCOs in 2006, primarily to cover children and nondisabled adults.

Manufacturers of drugs covered under the FFS component of Medicaid pay rebates to the program on Medicaid's purchases of those drugs. The amount of the rebate is defined by law; however, the rebate does not apply to MCOs' purchases of drugs for Medicaid beneficiaries. Partly as a result, nearly a dozen states exclude the drug benefit when they contract with MCOs for services, an

arrangement known as "carving out" the drug benefit. In those states, enrollees in the managed care portion of Medicaid receive drug coverage through the FFS program.

This option would require prescription drug manufacturers to pay a rebate on drugs purchased for beneficiaries in the risk-based managed care component of Medicaid that is similar to the rebate required in the FFS component of the program in one of two ways. (This option does not prohibit MCOs from negotiating additional rebates above the amount defined by law.)

- The first alternative under this option would require manufacturers to pay the Medicaid FFS rebate to the Medicaid MCO. The combined effect of the estimated changes in revenues and spending by mandatory health programs under this alternative would

reduce deficits by about \$3.0 billion during the 2010–2014 period and by about \$9.1 billion during the 2010–2019 period.

- The second alternative would require manufacturers to pay the Medicaid FFS rebate directly to states. The combined effect of the estimated changes in revenues and spending by mandatory health programs under this alternative would reduce deficits by \$3.7 billion over the 2010–2014 period and by about \$11.0 billion over the 2010–2019 period.

Federal savings would be smaller under the first alternative than under the second because the Congressional Budget Office assumed that Medicaid MCOs would retain a portion of the higher rebate rather than pass on all savings to the Medicaid program. Under the second alternative, in contrast, all savings from the higher rebate would go directly to state Medicaid programs. Estimates for both alternatives reflect the effects on revenues and the higher federal spending for the Federal Employees Health Benefits (FEHB) program that would result from a slight rise in the drug prices charged to private purchasers. Those slightly higher drug prices would reduce federal revenues by a small amount because they would lead to higher health insurance premiums and, thus, a shift in compensation from taxable wages to nontaxable fringe benefits.

In addition to the reductions in state and federal outlays, an advantage of this option is that it would lessen the amount of influence that rebates exert in a state's decision

to carve out their pharmacy benefit. Indeed, the option might lead to an increase in the number of states that permit MCOs to manage the drug benefit, which would help the MCOs better coordinate and manage enrollees' care and their use of prescription drugs.

A drawback of this option is that manufacturers might try to offset reductions in their revenue under the new rebate by setting higher initial prices for new drugs. Additionally, this option might lead to slightly higher costs for prescription drugs for some private health plans, including those that participate in the FEHB program. The Medicaid drug rebate program—which now applies only to the fee-for-service portion of Medicaid—generally discourages manufacturers from offering large discounts to certain private purchasers; expanding the rebate program to include the managed care portion of Medicaid might further discourage such discounts.<sup>1</sup> Also, the estimated increase in private health plans' costs under this option would decrease federal revenues slightly because a rise in premiums would reduce taxable wages for people with employment-based plans. The calculations shown reflect the estimated budgetary effects of manufacturers' price offsets.

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1. Prescription drug prices charged to certain purchasers, such as the Department of Veterans Affairs (VA), the Department of Defense (DoD), and Medicare Part D Prescription Drug Plans are excluded from best price. Therefore, CBO does not estimate any changes in VA, DoD, or Medicare spending under this option.

**Option 76****Apply the Medicaid Additional Rebate to New Formulations of Existing Drugs**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -130 | -260 | -280 | -290 | -310 | -1,270    | -2,970    |

In the fee-for-service portion of the Medicaid program, drug manufacturers must enter into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) to have their products covered. For each prescription drug that is covered by Medicaid, participating manufacturers must report two market prices to CMS: the average manufacturer price (AMP), which is the average price that a drugmaker receives for sales to retail pharmacies and mail-order establishments, and the lowest transaction price, or “best price,” that the manufacturer receives from sales to certain private buyers of the drug. Those prices, which serve as reference points for determining manufacturers’ rebate obligations, must be reported for each formulation and dosage of each prescription drug purchased on behalf of Medicaid beneficiaries.

For brand-name prescription drugs, the manufacturer’s rebate obligation has two components: the basic rebate and an additional rebate. The basic rebate is the greater of either 15.1 percent of the AMP or the difference between the AMP and the best price. The second component, the additional rebate, may also apply depending on how quickly the manufacturer raises a drug’s price to private purchasers. Every form of every drug purchased on behalf of Medicaid beneficiaries has its own base-period AMP that is determined by the drug’s original market date. No additional rebate is owed if the drug’s current AMP does not exceed its inflation-adjusted base period level, as measured using the consumer price index for all urban consumers; if the AMP does exceed the allowed inflation-adjusted level, then an additional rebate is owed that is equal to the excess amount.

Currently, modifications to existing drugs—new dosages or formulations—are generally considered new products

for purposes of reporting AMPs to CMS. As a result, drugmakers can often avoid incurring an additional rebate obligation by making a slight alteration to an existing product.

This option would treat a certain type of new formulation—specifically, extended-release versions—of existing drugs more like the original product for purposes of calculating the additional rebate. Under the option, when a new, extended-release version of an existing drug was introduced, the additional rebate obligation for that new drug would be either the AMP percentage that is owed under current law or the AMP percentage owed for the original drug, whichever is greater. Implementing the option would increase rebate amounts and reduce federal outlays by an estimated \$1.3 billion over the 2010–2014 period and by \$3 billion over the 2010–2019 period.

An advantage of this option is that it would remove a loophole that enables drug manufacturers to circumvent their rebate obligations simply by altering an existing product. Under current law, even a minor change to an existing drug can lead to a “new” product designation that does not trigger the inflation-related rebate even if the initial price for that new product is substantially higher than the price for the original formulation.

A potential drawback to this option is that it could discourage some manufacturers from developing new formulations even when the new products might offer advantages over older versions of the same product. Also, the additional rebate, like the basic rebate, limits drugmakers’ pricing flexibility in private markets because changes in prices for private buyers can affect their rebate obligation.

RELATED CBO PUBLICATION: *The Rebate Medicaid Receives on Brand-Name Prescription Drugs*, Letter to the Honorable Charles E. Grassley, June 21, 2005

**Option 77****Base Medicaid's Pharmacy Payment Formulas for Brand-Name Drugs on the Average Manufacturer Price**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -270 | -260 | -250 | -240 | -220 | -1,240    | -2,750    |

In 2007, the federal government spent nearly \$9 billion, net of rebates, on prescription drugs covered by the Medicaid program. An important component of that spending is the amount Medicaid pays pharmacies to provide drugs to Medicaid beneficiaries. Each state Medicaid program determines its payment on the basis of two factors: the pharmacy's cost of acquiring the drug from the manufacturer (the ingredient cost) and the cost of dispensing the drug to the beneficiary (the dispensing fee).

For brand-name drugs with no available generic substitutes, states typically pay pharmacies using a formula based on the drugs' average wholesale price (AWP). Comparable to the automobile industry's "sticker price," the AWP is a list price that exceeds the actual acquisition cost of the drug. State payment formulas usually are set equal to 85 percent to 90 percent of the AWP plus a dispensing fee that typically ranges from \$3 to \$5 for each prescription filled.

This option would require states to change their Medicaid payment formulas for brand-name drugs that have no generic substitutes and to base those formulas on an actual transaction price—the average manufacturer price (AMP). The AMP, which does not include any wholesaler's markup, is the average price that manufacturers earn on sales to the retail class of trade. AMPs are currently confidential prices that are required to be reported to the Centers for Medicare and Medicaid Services (CMS) as the administrator of Medicaid's rebate program. In 2003, the AMP amounted to, on average, about 79 percent of the AWP for brand-name drugs with no generic substitutes. The Congressional Budget Office has estimated that the acquisition cost to retail pharmacies averages about 4 percent above the AMP for brand-name drugs that have no generic alternatives.

The federal government has already taken action to base Medicaid's payments for generic drugs and for brand-name drugs with generic substitutes on the AMP. The

payment rate for those drugs is subject to a federally imposed price ceiling called the federal upper limit (FUL). States do not receive federal Medicaid matching funds for amounts paid in excess of the FUL (plus a dispensing fee set by the state). In order to reduce the amount that Medicaid pays for these drugs, the Deficit Reduction Act of 2005 (DRA) required that FULs be calculated on the basis of the AMP rather than on published list prices. However, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Public Law 110-275) delayed the implementation of that change until October 2009. There are currently no laws in place that impose AMP-based payment calculations for brand-name drugs that do not have generic substitutes (and are not subject to the FUL).

States commonly base their payment methodologies on the average wholesale price partly because AWP's are widely available in drug-pricing compendiums. By contrast, the confidential nature of AMPs makes developing payment formulas based on those prices more difficult than developing them from published AWP's. After the passage of the DRA, which mandated that CMS share AMP data with states on a monthly basis and publish AMP data on the Internet on a quarterly basis, the National Association of Chain Drugstores obtained a preliminary injunction. The injunction stopped CMS from providing the AMPs to state Medicaid agencies and from publishing AMP data on the Internet. (Subsequently, MIPPA delayed the publication of the AMPs until October 2009.) The injunction also stopped the shift in Medicaid's pharmacy payment rates toward an AMP-based system for generic drugs and their brand-name counterparts. As of December 2008, a final decision in that case had not yet been reached.

This option would require states to pay pharmacies no more than 104 percent of the AMP, plus a dispensing fee set by the state, for brand-name drugs with no generic substitutes. States would not receive federal Medicaid

matching funds for payments to pharmacies that exceeded that amount. In estimating the savings associated with this option, CBO assumed that, by October 2009, states would have access to AMP data that they could then use to determine brand-name-drug payment rates.

According to CBO's estimates, this option would reduce mandatory federal spending by \$1.2 billion over the 2010–2014 period and by \$2.8 billion over the 2010–2019 period. Savings decrease in the near term because, over time, states would partially offset the limits placed on payments for ingredient costs under this option.

An advantage of this option is that it would link states' Medicaid payments for brand-name drugs more closely to the actual acquisition cost of the drug. A rationale for not making the change embodied in this option—one also used as a basis for the injunction—is that pharmacies would receive lower Medicaid payment rates that might prompt some of them to stop participating in the Medicaid program. If they are to sustain existing pharmacy networks, state Medicaid programs might have to modify payments to pharmacies, such as the dispensing fees, in order to offset the lower reimbursement rate for the ingredient cost.

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**Option 78****Encourage Therapeutic Substitution in Medicaid by Applying Federal Upper Payment Limits to Two Classes of Drugs**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -70  | -70  | -60  | -50  | -250      | -400      |

In 2007, Medicaid paid about \$1 billion, of which the federal share was about \$600 million, to pharmacies for prescriptions for proton pump inhibitors, a class of drugs for treating ulcers and other gastric acid conditions, and for nonbenzodiazepine hypnotic agents, for treating insomnia. More than 70 percent of that spending was for the top-selling brand-name drugs in those classes, all of which are available only from a single source; no bioequivalent generic alternative—that is, another drug with identical active ingredients that perform in the same manner as the brand-name drug—is available. However, generic alternatives that are not bioequivalent are available within each of those therapeutic classes at less cost. Substituting one of the lower-priced generic drugs for the single-source brand-name drug would reduce spending for the Medicaid program. (Substituting a generic drug for a brand-name drug in the same class when the generic version has a different active ingredient is called therapeutic substitution and requires the consent of the prescribing physician.)

Under the federal laws that govern Medicaid, states are allowed some discretion in how much they pay pharmacies for single-source drugs. However, states' payments for generic drugs and their brand-name counterparts (referred to as multiple-source drugs) are constrained overall by a cap, which is based on the federal upper limit (FUL). Currently, that limit is equal to 150 percent of the lowest published list price among the generic bioequivalent alternatives. Beginning in 2010, the FUL will be 250 percent of the lowest average manufacturer price among all generic alternatives.<sup>1</sup> For multiple-source drugs, states' limits on spending are based on the cost of those drugs valued at the FUL plus a dispensing fee set by each state. If a state's overall spending for multiple-source

drugs under Medicaid exceeds that limit, the federal government will not reimburse the state for the excess amount.

This option would create a payment system under Medicaid that would encourage therapeutic substitution of generic alternatives for certain single-source brand-name drugs. The option would extend the FUL concept to brand-name drugs with no generic alternatives in two specific therapeutic classes: proton pump inhibitors and nonbenzodiazepine hypnotic agents. An upper payment limit would be set equal to the average prescription cost (valued at its federal upper limit) of the most frequently used generic drug within the therapeutic class. Beginning in 2011, the federal government would not pay states for spending that exceeded that upper limit (plus a dispensing fee) for those single-source brand-name drugs.

Under such a payment system, states would have an incentive to create programs that shifted utilization toward generic drugs within the two therapeutic classes. States could, for example, place the single-source drugs within those classes on a prior authorization list to discourage their use. In that case, a Medicaid patient would be unable to obtain the single-source drug unless the prescribing physician first obtained permission from the state Medicaid program (by making a telephone call or completing the requisite paperwork). Many states require prior authorization for some drugs that are dispensed to Medicaid patients.

This option would save an estimated \$250 million over the 2010–2014 period and about \$400 million over the 2010–2019 period. Those estimates take into account anticipated competition over the 10-year period from bioequivalent generic alternatives for some of the brand-name drugs in the two therapeutic classes that are currently single-source drugs. That expected generic competition would cause savings to decline over time.

1. The average manufacturer price is the average price that manufacturers receive for drugs sold to retail and mail-order pharmacies. Manufacturers report those prices to the Centers for Medicare and Medicaid Services.



A rationale for this option is that, in the vast majority of cases, it could help reduce Medicaid's spending for prescription drugs without affecting health outcomes. The choice of proton pump inhibitors and non-benzodiazepine hypnotic agents for this option was based on the fact that those classes of drugs contain some of the top-selling drugs in the Medicaid program. Moreover, benefit managers for private-sector pharmacies commonly promote therapeutic substitution within those classes. Although under this option Medicaid would use a different mechanism, it would be adopting a similar

approach—therapeutic substitution—to achieve program savings.

A potential disadvantage of the option is that patients might not respond as well to the generic alternative as they did to the single-source brand-name drug they had previously been taking. Furthermore, some doctors believe that once a patient's condition has been stabilized with a prescription medication that appears to be working, a switch to a therapeutic alternative should not be made for cost reasons alone.

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**Option 79****Eliminate Allotment Caps for the State Children's Health Insurance Program and Permit States to Expand Coverage up to 400 Percent of the Federal Poverty Level**

| (MILLIONS OF DOLLARS)            | 2010         | 2011         | 2012         | 2013         | 2014         | Total         |               |
|----------------------------------|--------------|--------------|--------------|--------------|--------------|---------------|---------------|
|                                  |              |              |              |              |              | 2010-2014     | 2010-2019     |
| Change in Mandatory Spending     |              |              |              |              |              |               |               |
| SCHIP                            | 2,900        | 4,100        | 5,800        | 7,400        | 9,100        | 29,300        | 94,300        |
| Medicaid                         | -900         | -800         | -900         | -800         | -700         | -4,100        | -11,600       |
| Change in Revenues <sup>a</sup>  | *            | 100          | 100          | 200          | 300          | 700           | 2,400         |
| <b>Net Effect on the Deficit</b> | <b>2,000</b> | <b>3,200</b> | <b>4,800</b> | <b>6,400</b> | <b>8,100</b> | <b>24,500</b> | <b>80,300</b> |

Note: SCHIP = State Children's Health Insurance Program; \* = less than \$50 million.

a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

The State Children's Health Insurance Program (SCHIP) provides each state with a capped allotment of funds determined by an annually updated formula that is based on the number of low-income children in the state, the number of such children who are uninsured, and a factor to adjust for differences in states' health care costs. Federal funding for SCHIP has fluctuated over the years: Although the program was initially authorized at a funding level of approximately \$4 billion annually from 1998 to 2001, its annual funding dropped to about \$3 billion from 2001 to 2003, then returned to about \$4 billion from 2004 to 2006, and finally grew to \$5 billion in 2007—the final year of the initial authorization. SCHIP is now authorized through March 31, 2009, by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173) at an annual funding level of \$5 billion. As part of its baseline projections for SCHIP, the Congressional Budget Office assumes that the program's annual funding will continue at the 2007 level during the 2010–2019 period.

In recent years, health care costs have grown faster than the SCHIP allotments, and for some states, SCHIP's available funding is less than those states' projections of the amounts needed to maintain their programs at current levels of enrollment and benefits. As part of SCHIP's current reauthorization, the Congress appropriated additional funding of \$1.6 billion in 2008 and \$275 million for the first half of 2009 for states to maintain their programs at their present levels. For the remainder of 2009, an estimated 25 states would not have enough funding to maintain their current programs, by CBO's calculations; as a result, they would either use state-only funding to

maintain their programs or make cuts in payment rates to providers, reduce benefit levels, or lower thresholds for eligibility, to bring the program's costs within the federal allotments. Under the assumption that funding continues at \$5 billion annually over the next 10 years, many states would be forced to cut their SCHIP programs further as health care costs continued to grow.

This option would eliminate allotment caps for SCHIP. States could maintain their programs at their current levels of eligibility or expand coverage to children in families with income of as much as 400 percent of the federal poverty level. The option would not allow states to expand coverage to the parents of children covered under SCHIP or to childless adults beyond the current eligibility levels. SCHIP would remain a federal matching program using current-law enhanced matching rates.

Under this option, SCHIP outlays would increase by an estimated \$29.3 billion over the 2010–2014 period and by an estimated \$94.3 billion over the 2010–2019 period. CBO assumed that an interaction exists between SCHIP and Medicaid when SCHIP funding is less than states' projections of the amounts needed to maintain current program levels. This interaction causes an increase in Medicaid's outlays as states shift children from SCHIP to Medicaid. By contrast, when additional funding for SCHIP is provided, as would be the case under this option, Medicaid's projected spending would decrease. In addition, CBO assumed that the expansion of SCHIP would cause a number of low-income families to seek coverage, and some of those families would have children eligible for Medicaid rather than SCHIP, again

increasing Medicaid's outlays. On net, federal outlays for the Medicaid program would decrease by an estimated \$4.1 billion over the 2010–2014 period and by \$11.6 billion over the 2010–2019 period.

Implementation of this option would expand coverage for children in SCHIP and Medicaid by approximately 4.3 million individuals by 2014, once the option was fully phased in. In addition, because some families that had employment-based coverage would choose, under the option, to enroll their children in SCHIP and Medicaid, tax revenues would increase as compensation shifts from nontaxable fringe benefits to taxable wages. As a result, the option would increase tax revenues by an estimated \$700 million over the 2010–2014 period and by \$2.4 billion over the 2010–2019 period. The net effect of the proposal would be to increase deficits by an estimated \$24.5 billion over the 2010–2014 period and by \$80.3 billion over the 2010–2019 period.

An argument in support of this option is that providing states with enough federal funding to maintain their current level of SCHIP benefits and coverage beyond March 2009 would eliminate reductions in existing coverage. Furthermore, states would have more flexibility to provide coverage to additional children who were eligible under current criteria but were not enrolled in the program as well as to expand coverage to children at higher income levels who might otherwise be uninsured.

An argument against this option is that expanding coverage could lead to increased substitution of SCHIP for private coverage and increased costs as a result of states' efforts to maximize federal matching funds. Regarding substitution of coverage, CBO has concluded—on the basis of a review of the research literature—that for every 100 children enrolled in SCHIP, between 25 and 50 would otherwise have had private insurance. The potential for substitution would increase as the income levels of the families of eligible children rose (because larger proportions of children at higher income levels have private insurance coverage). Furthermore, CBO expects that converting the financing of SCHIP from a capped allotment to an entitlement would reduce states' incentives to be cost-efficient and would increase the incentive for states to manipulate their funding to maximize the amount of federal matching funds they could receive, as has occurred in the past under Medicaid. Such changes in incentives would lead to a rise in the costs of the program above and beyond the cost of new enrollment.

Although this option would cap eligibility for benefits at 400 percent of the federal poverty level, a proposal that did not include a limit on the program's upper eligibility threshold could have unforeseen interactions with the private insurance market, in the context of states' efforts to reform their health care systems, which could potentially increase the costs of this option beyond the estimates presented. However, for this option CBO has not estimated any additional costs as a result of significant changes in the private insurance market.

RELATED CBO PUBLICATIONS: *The State Children's Health Insurance Program*, May 2007; and Statements of Peter R. Orszag, Director, Congressional Budget Office, *Covering Uninsured Children in the State Children's Health Insurance Program*, before the House Subcommittee on Health, Committee on Energy and Commerce, May 15, 2008, and before the Senate Subcommittee on Health Care, Committee on Finance, April 9, 2008

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**Option 80****Adjust Funding for the State Children's Health Insurance Program to Reflect Increases in Health Care Spending and Population Growth**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013  | 2014  | Total     |           |
|------------------------------|------|------|------|-------|-------|-----------|-----------|
|                              |      |      |      |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending |      |      |      |       |       |           |           |
| SCHIP                        |      |      |      |       |       |           |           |
| Budget authority             | 300  | 600  | 900  | 1,300 | 1,700 | 4,800     | 20,300    |
| Outlays                      | 200  | 400  | 800  | 1,200 | 1,400 | 4,000     | 18,000    |
| Medicaid                     |      |      |      |       |       |           |           |
| Budget authority             | 0    | -100 | -300 | -400  | -500  | -1,300    | -6,800    |
| Outlays                      | 0    | -100 | -300 | -400  | -500  | -1,300    | -6,800    |
| Total                        |      |      |      |       |       |           |           |
| Budget authority             | 300  | 500  | 600  | 900   | 1,200 | 3,500     | 13,500    |
| Outlays                      | 200  | 300  | 500  | 800   | 900   | 2,700     | 11,200    |

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

8

Enacted as part of the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP) finances health care coverage for certain uninsured children from low-income families. States administer SCHIP through their Medicaid programs or as a separate program, or as a combination of those approaches. The program, which began operation in 1998, was originally authorized through 2007. It is currently operating under an extension provided under the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law 110-173) through March 31, 2009. For the purpose of its baseline budget projections and consistent with statutory guidelines, the Congressional Budget Office assumes that funding for the program beyond March 31, 2009, will continue at its level in 2007—\$5 billion annually.

Under the baseline's assumption of a steady level of \$5 billion in annual funding, SCHIP would gradually cover an increasingly smaller proportion of the eligible population because of the rising cost of medical care and the increasing size of the population of children nationwide. Thus, future funding for SCHIP as projected in CBO's baseline would not allow or enable a number of states to continue operating their current programs. (CBO estimates that 25 states will need \$1.7 billion in additional funding to maintain current program levels through the remainder of 2009.)

This option would index SCHIP's funding to the rate of growth of per capita health expenditures—using projections of national health expenditures (NHE) from the Centers for Medicare and Medicaid Services—and to the approximate rate of growth of the SCHIP-eligible population.<sup>1</sup> According to the most recent NHE projections, which were released in January 2008, per capita health expenditures will grow by nearly 6 percent annually after 2010, a pace more rapid than the rate of growth of the overall economy and general inflation. Under this option, funding for SCHIP would increase by about \$5 billion over the 2010–2014 period and by \$20 billion over the 2010–2019 period; SCHIP spending would increase by \$4 billion over the 2010–2014 period and by \$18 billion over the 2010–2019 period. However, savings to the Medicaid program resulting from the increase in SCHIP allotments would offset the total costs of this proposal by about \$1 billion over the 2010–2014 period and by \$7 billion over the 2010–2019 period. (Once their SCHIP spending exceeded their available funds, some states could continue to receive federal matching funds at the lower Medicaid matching rate. Therefore, additional funding for SCHIP would reduce the number of children shifted to Medicaid.)

1. Other growth indexes could be used—including general price inflation or nominal growth in the economy.

An argument for this option is that without the increase in funding, many states would be unable to maintain their current benefits and coverage beyond March 2009. (Even with the increase, some states may still not have the federal funding to meet fully the need of their current SCHIP program levels.) Therefore, to maintain their current programs, states would have to pay an increasing share of the costs, reduce the benefits they provide to recipients, restrict the number of children deemed eligible for aid, cut provider rates under Medicaid, or implement some combination of those four responses. Another argument for this option is that the number of children who are eligible for SCHIP will probably grow more quickly than the overall population of children as the share of people who have private health care coverage continues to decline gradually.

An argument against this option is that current levels of funding reflect policymakers' intention to establish

SCHIP as a program with limited federal funding. According to that argument, states should design programs with those limits in mind and pay for any additional spending entirely with their own funds. In general, states have flexibility in setting income eligibility levels and the benefit packages they provide through their programs, and they may alter those two components to reflect the availability of federal and state funds. Another argument against this option maintains that additional funding need not be provided because some states have used SCHIP funds—which were intended to insure children—to provide coverage for adults. However, that argument is undercut by the fact that SCHIP is serving fewer and fewer adults (because waivers of the program's rules that allowed that coverage to be provided are not being renewed). In addition, the Deficit Reduction Act of 2005 prohibits new SCHIP waivers for nonpregnant, childless adults.

RELATED CBO PUBLICATIONS: *The State Children's Health Insurance Program*, May 2007; and Statements of Peter R. Orszag, Director, Congressional Budget Office, *Covering Uninsured Children in the State Children's Health Insurance Program*, before the House Subcommittee on Health, Committee on Energy and Commerce, May 15, 2008, and before the Senate Subcommittee on Health Care, Committee on Finance, April 9, 2008

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## Premiums and Cost Sharing in Federal Health Programs

**E**ach federal health program operates under its own rules in regard to enrollees' financial obligations. Medicare beneficiaries generally do not pay a premium for services financed by Part A, such as hospital care, but they do face cost sharing for Part A services. Beneficiaries must also pay a premium for Part B services, and most Part B services require cost sharing at the point of service. The standard Part B premium will be \$96.40 per month in 2009; beneficiaries with high income must pay a greater amount. Many Medicare beneficiaries have supplemental coverage, either through an employment-based retirement policy or privately purchased commercial insurance (medigap plans), and some low-income beneficiaries are eligible for assistance from Medicaid for premiums and cost sharing.

Medicare beneficiaries who enroll in the program's drug benefit (Part D) generally pay a monthly premium and coinsurance for each prescription. However, Part D coverage is available through multiple private plans, which are allowed by law to offer either the standard benefit (with an annual deductible, coinsurance of 25 percent, a gap in coverage, and an out-of-pocket limit) or an alternative structure (for example, no deductible and variable cost sharing, in which generic and certain brand-name drugs are less expensive). Consequently, beneficiaries' obligations under Part D vary considerably. In addition, beneficiaries who meet certain income and eligibility requirements have little or no cost-sharing and receive assistance with their premiums through the Medicare Part D low-income subsidy program.

For individuals enrolled in the Federal Employees Health Benefits (FEHB) program, premiums and cost sharing depend on the choice of plan. The federal government covers 75 percent of each participating plan up to a limit set at 72 percent of the national average premium.

Retired federal employees may continue the insurance they had during their working life by continuing in the FEHB program. They may also enroll in Medicare, in which case the FEHB program and Medicare coordinate coverage and payments. (In that case, Medicare is the primary payer, and the FEHB plan usually pays for the cost sharing Medicare requires.)

Military personnel and retirees, and their dependents and survivors who are eligible to use TRICARE (the military's health plan) pay cost sharing and enrollment fees that depend on the type of coverage they use and whether they are also eligible for other coverage, such as Medicare. Veterans seeking health care from the Department of Veterans Affairs currently face no premiums or enrollment fees; however, eligibility and cost sharing in that system depend on disability status, income, and other factors.

The options in this chapter examine policies that would modify the cost-sharing obligations individuals face in those federal programs. Some options would provide greater uniformity among a program's cost-sharing obligations. Others would reduce overlapping coverage and duplication of benefits among programs.

**Option 81****Replace Medicare's Current Cost-Sharing Requirements with a Unified Deductible, a Uniform Coinsurance Rate, and a Catastrophic Limit**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|------|--------|--------|--------|-----------|-----------|
|                              |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -900 | -1,800 | -2,100 | -2,200 | -7,000    | -26,400   |

In Medicare's traditional fee-for-service program—consisting of services covered under Part A (hospital and other acute care) and Part B (which covers physicians' and other outpatient services)—enrollees' cost sharing varies significantly depending on the type of service provided. For example, enrollees who are hospitalized must pay a Part A deductible, which the Congressional Budget Office estimates will be \$1,148 in 2011, for each "spell" of illness for which they are hospitalized; in addition, they are subject to daily copayments for extended stays in the hospital and for skilled nursing care. Meanwhile, the annual deductible for outpatient services covered under Medicare's Part B is estimated to be \$142 in 2011. Beyond that deductible, enrollees generally pay 20 percent of allowable costs for most Part B services, but cost sharing can be significantly higher for outpatient hospital care. At the same time, certain services that are covered by Medicare, such as home health visits and laboratory tests, require no cost sharing. As a result of those variations, enrollees lack consistent incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing because the program does not cap those expenses.

This option would replace the current complicated mix of cost-sharing provisions with, first, a single combined annual deductible covering all services in Parts A and B of Medicare; second, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses); and, third, an annual cap on each enrollee's total cost-sharing liabilities. Specifically, under this option, the combined deductible would be \$525 in 2011, and the cap on total cost sharing would be \$5,250. In later years, those amounts would grow at the same rate as Medicare's costs per capita. According to CBO's estimates, if this option took effect on January 1, 2011, federal outlays would be reduced by about \$7 billion over the 2010–2014 period and by \$26 billion over the 2010–2019 period.

An argument in support of this option is that it would provide greater protection against catastrophic costs while reducing Medicare's coverage of more predictable

expenses. Capping enrollees' out-of-pocket expenses would especially help people who developed serious illnesses, required extended care, or underwent repeated hospitalizations but lacked supplemental (medigap) coverage for their cost sharing. The option would also increase incentives for enrollees to use medical services prudently. Deductibles and coinsurance rates expose enrollees to some of the financial consequences of their decisions about health care treatments and are aimed at ensuring that services are used only when an enrollee's benefits exceed those costs. Although this option's combined deductible would be lower than the Part A deductible, the vast majority of Medicare enrollees are not hospitalized in a given year; thus, most people without supplemental coverage would face the full cost for a larger share of the Part B services that they used. The uniform coinsurance rate across services would also encourage enrollees to compare the costs of different treatments in a more consistent way. In addition, the reductions in costs under this option for Medicare's Part B program would translate into lower premiums for all enrollees.

An argument against the option is that it would increase cost-sharing liabilities for most Medicare enrollees. Specifically, those liabilities would rise modestly in 2011 for more than three-fourths of enrollees (by about \$500, on average) and would stay the same for another 13 percent. (For the remaining 9 percent of enrollees, cost-sharing liabilities would fall by an average of about \$4,500.) Enrollees who were hospitalized only once in a year would generally face higher costs because of the coinsurance that would apply to that care; however, most enrollees have supplemental insurance and would be insulated from those direct effects. (Some enrollees might see the effects in the form of higher premiums for their supplemental policies.) In addition, the option would make enrollees responsible for paying coinsurance for certain services—such as home health care—that are not currently subject to cost sharing. That requirement would increase administrative costs for some types of health care providers and could discourage enrollees from seeking treatment in some cases.



**Option 82****Restrict Medigap Coverage of Medicare's Cost Sharing**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -2,000 | -3,900 | -4,100 | -4,400 | -14,400   | -41,400   |

Cost-sharing requirements in Medicare's fee-for-service sector can be substantial, so most enrollees obtain supplemental coverage from some source (including the Medicaid program or their former employer). About 25 percent of fee-for-service enrollees buy medigap policies—individual insurance policies that are designed to cover most or all of Medicare's cost-sharing requirements. Some studies have found that medigap policyholders use at least 25 percent more services than Medicare enrollees who have no supplemental coverage and at least 10 percent more services than enrollees who have supplemental coverage from a former employer (which tends to reduce, but not eliminate, their cost-sharing liabilities). Because enrollees are liable for only a portion of the costs of those additional services, it is taxpayers (through Medicare) and not medigap insurers or the policyholders themselves who bear most of the resulting costs. Federal costs for Medicare could be reduced if medigap plans were restructured so that policyholders faced some cost sharing for Medicare services but still had a limit on their out-of-pocket costs.

This option would bar medigap policies from paying any of the first \$525 of an enrollee's cost-sharing liabilities for calendar year 2011 and would limit coverage to 50 percent of the next \$4,725 in Medicare cost sharing. (All further cost sharing would be covered by the medigap policy, so enrollees could not pay more than about \$2,888 in cost sharing in that year.) If those dollar limits were indexed to growth in average Medicare costs for later years, savings would total about \$14 billion over the 2010–2014 period and \$41 billion over the 2010–2019 period. Those estimates—which assume that all current and future medigap policies will be required to meet the new standards—reflect a reduction in Medicare costs of about 5 percent for the population of medigap policyholders that would be affected. (The Medicare Modernization Act of 2003 authorized two similar—but optional—alternatives for medigap policies, but most enrollees choose plans that cover both the deductible and cost sharing.)

An argument in favor of this option is that if it was implemented, most Medicare enrollees who have medigap policies would be better off financially as a result. Because insurers that offer medigap plans must compete for business, they would most likely reduce premiums to reflect the lower costs of providing the new policies. Indeed, most medigap policyholders would have smaller annual expenses under this option because their medigap premiums would decline to a greater extent than their cost-sharing liabilities would increase. (Part of the reason is that premiums for medigap policies are generally somewhat higher than the average cost-sharing liabilities that the policies cover, because of the administrative and other costs that medigap insurers incur. But the primary reason is that most of those liabilities are generated by a minority of policyholders.) Greater exposure to Medicare's cost sharing might also lead some medigap policyholders to forgo treatments that would yield them few or no net health benefits. Indirectly, the decline in Medicare's costs would also cause the program's monthly premiums (which cover about 25 percent of costs for Medicare Part B) to fall, so other Medicare enrollees would also benefit.

An argument against this option is that medigap policyholders would face more uncertainty about their out-of-pocket costs. For that reason, some policyholders might object to being prevented from purchasing coverage for all of their cost sharing, even if they would be better off financially in most years under this option. (Most medigap policyholders buy optional coverage for the Part B deductible; high-deductible medigap policies have attracted only limited enrollment despite their lower premiums.) Finally, the decline in the use of services by medigap policyholders (which would generate the federal savings under this option) might lead beneficiaries to forgo needed health services and so might adversely affect their health.

**Option 83****Combine Changes to Medicare's Cost Sharing with Restrictions on Medigap Policies**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -3,200 | -6,200 | -6,800 | -7,200 | -23,400   | -73,000   |

The savings that would accrue from modifying Medicare's cost-sharing requirements could be increased if medigap coverage—individual insurance policies that are designed to supplement Medicare coverage and cover such costs as deductibles and coinsurance—was simultaneously restricted (see Options 81 and 82). That is, the savings that would result from instituting both changes at the same time would exceed the sum of the savings derived if each option was implemented separately. That synergy arises because medigap policyholders would not be insulated from the changes in Medicare's cost-sharing requirements if their medigap plans were also restructured.

Under this option, medigap plans would be prohibited from covering any of the new \$525 combined deductible—which would apply to both Part A and Part B of Medicare's fee-for-service program and which the Centers for Medicare and Medicaid Services would institute in 2011 (described in Option 81). In addition, medigap policies would be allowed to cover only 50 percent of the program's remaining cost-sharing requirements. Such a policy would correspond to the one described in Option 82, with coverage limited to 50 percent of a beneficiary's next \$4,725 in Medicare cost sharing (thus capping enrollees' out-of-pocket expenses at about \$2,888 in 2011). Under this combined option, the point at which the medigap policy's cap on out-of-pocket costs was reached would also be the point at which the Medicare program's new cap was reached. Between the deductible and the cap on out-of-pocket expenditures, policyholders would face a uniform coinsurance rate of

20 percent for all services. If those various dollar limits were indexed to growth in per capita costs for Medicare in later years, this option would save about \$23 billion over the 2010–2014 period and \$73 billion over the 2010–2019 period. Those estimates assume that participation in Medicare's new cost-sharing requirements will be mandatory and that all medigap policies will be required to follow the new standards.

An argument in favor of this option is that it would appreciably strengthen incentives for more prudent use of medical services—both by raising the initial threshold of health care costs that most Medicare beneficiaries faced and by ensuring that enrollees generally paid at least a portion of all subsequent costs (up to the out-of-pocket limit). As a result, the savings from this option over a five-year period would be about \$5 billion more than the sum of savings achieved by implementing Options 81 and 82 separately.

An argument against this option is that even with the new catastrophic cap—which would protect Medicare enrollees against substantial out-of-pocket expenses—some enrollees would object to any policy that denied them access to full supplemental coverage for their cost sharing. Furthermore, in any given year, a significant number of enrollees would see their combined payments for premiums and cost sharing rise as Medicare's average subsidies were reduced and medigap plans were restructured.

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**Option 84****Impose Cost Sharing for the First 20 Days of a Stay in a Skilled Nursing Facility Under Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -2,000 | -2,700 | -2,800 | -2,900 | -10,400   | -26,800   |

For enrollees who have been hospitalized and need continuing skilled nursing care or rehabilitation services on a daily basis, Medicare currently covers up to 100 days of care in a skilled nursing facility (SNF). There is no deductible for SNF care, and no copayment for the first 20 days of each stay. A daily copayment is required for days 21 through 100; it is projected to be about \$144 in 2011. A substantial share of Medicare SNF stays are shorter than 20 days and therefore do not require any copayment. The Congressional Budget Office projects that total Medicare spending for SNF services will rise from about \$25 billion in 2010 to \$41 billion in 2019.

This option would impose a copayment for each of the first 20 days of care in a skilled nursing facility equal to 5 percent of the inpatient deductible, which would be \$57.40 per day in 2011. The maximum additional liability for each SNF stay would thus equal the inpatient deductible (projected by CBO to be \$1,148 in 2011) and would rise at the same rate over time. Imposing that copayment would reduce federal outlays by about \$10 billion over the 2011–2014 period and by \$27 billion over the 2010–2019 period.

The effect of this option on the use of SNF services and on beneficiaries' out-of-pocket payments would depend on whether participants had supplemental coverage. Most individual medigap policies include full coverage of current SNF copayments, so beneficiaries with such policies would be insulated from the direct impact of the higher copayments—but they would most likely face higher medigap premiums. Employers' spending on

supplemental coverage for their retirees would also probably increase. This option would not directly affect Medicare beneficiaries who received full Medicaid benefits or those considered qualified Medicare beneficiaries, because Medicaid would be responsible for the additional copayments under this option. (The savings shown in this option are net of the additional federal Medicaid spending that would occur as a result.)

An argument in favor of this option is that it could discourage some unnecessary use of Medicare-covered SNF services. CBO estimates that relatively few Medicare beneficiaries would incur higher out-of-pocket costs under this option in any given year. For those beneficiaries, the absence of cost sharing under current law for the first 20 days of SNF care may encourage additional use of those services, some of which may not be clinically necessary.

One argument against this option is that the added copayment could lead some beneficiaries to forgo services that would help avoid further complications from surgery or improve their health in other ways. Some beneficiaries might choose instead to receive similar services, such as a home health care benefit, which currently has no cost sharing. (The resulting added payments for home health services are reflected in the estimate of net program savings for this option.) In addition, expenditures for states would rise as a result of the increase in copayments covered by Medicaid.

«CBO»

**Option 85****Require a Copayment for Home Health Episodes Covered by Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -2,500 | -3,700 | -4,100 | -4,500 | -14,800   | -46,800   |

Medicare's spending for home health care dropped during the late 1990s following the enactment of the Balanced Budget Act of 1997, which introduced a prospective payment system for home health services. Since 2000, however, spending for home health care has been rising. The Congressional Budget Office projects that the use of home health services, and the resulting costs to the Medicare program, will grow rapidly over the next 10 years as well. One reason for the projected rapid growth is that Medicare beneficiaries are not currently required to pay any of the costs of home health services covered by the program.

This option would charge Medicare beneficiaries a copayment amounting to 10 percent of the total cost of each home health episode—a 60-day period of services—starting on January 1, 2011. That change would yield net federal savings of about \$15 billion over the 2010–2014 period and \$47 billion over the 2010–2019 period.

9

An argument in favor of this option is that it would directly offset a portion of Medicare's home health outlays and encourage beneficiaries to use those services in a cost-conscious manner. The use of services would also decrease, most likely among the approximately 10 percent of beneficiaries with fee-for-service Medicare only (in other words, beneficiaries who do not have

supplemental insurance, such as medigap or “wrap-around” retiree coverage, and who are not enrolled in Medicaid or a health maintenance organization).

An argument against this option is that it would increase the risk of significant out-of-pocket costs for the 10 percent of Medicare enrollees who have fee-for-service coverage only—a population that tends to have lower income than do beneficiaries with private supplemental insurance. As a result, implementing the option could cause some of those individuals to forgo beneficial care. (Among the majority of enrollees who have supplemental insurance, little or no drop in use would be expected, because their supplemental policies would presumably be expanded to cover the home health copayment proposed in this option.) Also, the approximately 25 percent of enrollees with individually purchased medigap policies would probably face higher premiums, and the costs of employment-based supplemental policies could also rise (again under the assumption that supplemental policies would cover the proposed home health copayment). Finally, this option would result in increased spending by Medicaid for home health care for individuals who had both Medicare and Medicaid coverage. (The federal share of higher Medicaid outlays is included in the estimated change in outlays.)

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**Option 86****Impose a Deductible and Coinsurance for Clinical Laboratory Services Covered by Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011   | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|--------|--------|--------|--------|-----------|-----------|
|                              |      |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -1,400 | -2,100 | -2,300 | -2,400 | -8,200    | -23,800   |

Under current law, beneficiaries participating in Medicare Part B (which covers physicians' and other outpatient services and medical equipment) do not contribute to the costs of covered laboratory services. Medicare sets the payment for clinical lab services using a fee schedule, and providers must accept that amount as full payment for the service. For most other services covered under the Part B program, beneficiaries are subject to both a deductible (projected to be \$142 in 2011), which is updated annually by the increase in the average cost of Part B services for aged beneficiaries, and a coinsurance rate of 20 percent.

This option would make laboratory services subject to the Part B standard deductible and to coinsurance requirements beginning on January 1, 2011. Because the administrative costs of billing enrollees for cost sharing would be large in comparison to the revenues that independent laboratories would obtain, this option would require that independent laboratories bill the provider who ordered the test instead of billing Medicare and the enrollee separately. Providers, who already bill and collect fees from patients, would also collect beneficiary copayments for laboratory services. The change would yield savings of about \$8 billion over the 2010–2014 period and \$24 billion over the 2010–2019 period. Because this option would reduce Medicare's spending for Part B services, it would also reduce receipts of Part B premiums. (Premiums are set to cover about 25 percent of Part B

spending.) The estimates of savings include an offset reflecting the lower Part B premiums that Medicare would collect. In addition, the estimates include the federal costs of covering out-of-pocket payments for Medicare beneficiaries who are also covered by Medicaid—because those beneficiaries are not responsible for cost sharing.

A rationale for this option is that, besides reducing Medicare's costs, such a change would make cost-sharing requirements under Part B more uniform and therefore easier for enrollees to understand. Moreover, although decisions about the appropriateness of tests are generally left to physicians, some enrollees might be less likely to request or undergo laboratory tests of little expected benefit if they had to pay part of the costs themselves.

An argument against this option is that only a small portion of the expected savings would stem from a more prudent use of laboratory services; the rest would reflect the transfer of costs now borne by Medicare to enrollees. Because of those costs, some Part B enrollees might forgo valuable or needed laboratory testing, potentially hindering timely and effective clinical decisionmaking. Another argument against this option is that physicians' billing costs might increase because providers would have to bill both Medicare and enrollees to collect payment for laboratory tests.

«CBO»

**Option 87****Increase the Basic Premium for Medicare Part B to 35 Percent of the Program's Costs**

| (BILLIONS OF DOLLARS)           | 2010   | 2011   | 2012   | 2013   | 2014   | Total     |           |
|---------------------------------|--------|--------|--------|--------|--------|-----------|-----------|
|                                 |        |        |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending    | -3.0   | -7.0   | -12.0  | -18.0  | -24.0  | -64.0     | -217.0    |
| <b>Memorandum:</b>              |        |        |        |        |        |           |           |
| Medicare Part B Premium         |        |        |        |        |        |           |           |
| Share of program cost (Percent) | 27     | 29     | 31     | 33     | 35     | n.a.      | n.a.      |
| Monthly amount (Dollars)        | 109.80 | 118.10 | 128.70 | 147.70 | 157.60 | n.a.      | n.a.      |

Note: n.a. = not applicable.

9 Medicare's Part B program allows beneficiaries to obtain coverage for physicians' and other outpatient services by paying a monthly premium (\$96.40 in 2009). When the program began in 1966, the premium was intended to finance 50 percent of the program's per-enrollee costs, with the remainder funded from general revenues. Legislation enacted in 1972, however, limited annual growth in the Part B premium to the cost-of-living adjustment (COLA) for Social Security. Because medical spending grew more quickly than inflation, though, the premium's share of costs subsequently fell below 25 percent. After setting the premium's share at 25 percent during much of the 1980s, policymakers enacted the Omnibus Budget Reconciliation Act of 1990, which specified a dollar amount for the premium for 1991 through 1995; yet when per capita health care spending grew more slowly than anticipated, the premium's share of per-enrollee costs rose to more than 31 percent. The Balanced Budget Act of 1997 permanently set the Part B premium at 25 percent of Part B spending per enrollee. General revenues fund the remainder of Part B spending. (Since January 2007, some higher-income enrollees have faced greater premiums for Part B, but the basic premium of 25 percent still applies to about 95 percent of enrollees. That "income-related" Part B premium is described in Option 91.)

This option would raise the basic Part B premium from 25 percent of the program's cost per enrollee to 35 percent over five years, beginning in 2010. The premium share would increase by 2 percentage points per year through 2014 and then remain at 35 percent, preserving the income-related premium shares specified in current

law. Also, the "hold-harmless" provision—which protects Part B enrollees (other than those paying the income-related premium) from a drop in their monthly net Social Security payment should the increase in the Part B premium exceed the Social Security COLA—would be reserved. (The hold-harmless provision would apply to more enrollees in 2010 because of the initial increase in premiums under this option.) This option would result in estimated savings of \$64 billion over five years and \$217 billion over 10 years.

The main rationale for this option is that it would ease the budgetary pressures posed by rising costs in the Part B program, which are expected to accelerate as members of the baby-boom generation age. Even under this option, the public subsidy for most Part B enrollees—65 percent when fully phased in—would still be greater than the 50 percent that was intended at the program's outset. Also, because Medicaid pays the premiums for certain low-income Part B enrollees with limited assets, about 18 percent of Medicare beneficiaries would be unaffected.

An argument against this option is that it would reduce disposable income for many Part B enrollees. Also, higher premiums might lead to a decline in Part B enrollment; if such an effect materialized, however, it would most likely be small. In addition, expenditures for states would rise by about \$18 billion over 10 years because they would pay higher premiums for people eligible for coverage through both Medicare and Medicaid. (The estimate above includes the federal share of increased Part B premium payments for individuals with dual eligibility.)

**Option 88****Permanently Extend the Provision That Provides Cost-Sharing Assistance for Qualifying Individuals Under Medicaid**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 300  | 500  | 600  | 700  | 800  | 2,900     | 8,700     |

The Medicare Savings Program (MSP) provides cost-sharing assistance for certain low-income Medicare beneficiaries who qualify for various levels of assistance on the basis of their income. To be considered a Qualifying Individual (QI)—one of the categories of MSPs—an individual must have income between 120 percent and 135 percent of the federal poverty level and meet certain requirements related to the assets he or she owns. Qualifying Individuals receive assistance only for premiums for Part B of Medicare (which pays for physicians' and other outpatient services). Other MSPs, such as the Qualified Medicare Beneficiary program and the Specified Low-Income Medicare Beneficiary program, apply to individuals whose income is below 120 percent of the federal poverty level. Those programs cover some or all of the costs of Medicare premiums, deductibles, and coinsurance. In fiscal year 2007, about 300,000 people were served under the QI provision, at a gross cost to the federal government of \$340 million (Part B premiums paid by Medicare beneficiaries offset about 25 percent of that amount).

Assistance for QIs was established by the Balanced Budget Act of 1997 and initially funded through the end of 2002; unlike the other MSPs, funding for QI assistance is not permanent. Policymakers have extended the funding for QIs several times; under the latest extension, enacted in the Medicare Improvement for Patients and Providers Act of 2008 (Public Law 110-275), the funding is set to expire on December 31, 2009. Although administered by the states through Medicaid, the QI provision is funded by the Medicare Supplementary Medical Insurance Trust Fund, and consequently the states are not required to provide matching funds. Another aspect of the QI provision is that it is subject to an annual funding cap of roughly \$500 million; once that cap is reached, no

additional enrollment is permitted. The cap, however, has traditionally been set at a level that allows states to cover all eligible individuals who are expected to enroll. A new funding cap has been set with each extension of the provision. This option would permanently fund the QI provision, which would increase spending for Medicare by \$3 billion over the 2010–2014 period and by \$9 billion during the 2010–2019 period.

An argument in support of this option is that the other MSPs that cover lower-income individuals are all funded through permanent legislation and do not face expiration dates or funding limits. The QI provision's numerous reauthorizations and increases in funding suggest substantial interest among policymakers in ensuring that the population that the program covers continues to receive assistance with their Medicare premiums. By providing permanent mandatory funding for Qualifying Individuals, the enrolled beneficiaries would be assured of receiving coverage for their Medicare Part B premiums. Another aspect for beneficiaries is that enrollment in an MSP triggers their automatic enrollment in the Low-Income Subsidy (LIS) of Medicare Part D (the prescription drug program.) That automatic enrollment would create continuity of coverage for such individuals, who would otherwise be required to reapply annually for the LIS (that budgetary effect is included in the Congressional Budget Office's estimates).

An argument against this option is that the existing limits on both the duration of the QI provision and the amount of its available funding force policymakers to periodically consider whether the funding for QIs is a better use of scarce resources than other potential new initiatives would be.

**Option 89****Eliminate the “Doughnut Hole” in Medicare’s Drug Benefit Design**

| (BILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 9.0  | 9.0  | 11.0 | 13.0 | 42.0      | 134.0     |

The standard benefit under Medicare’s prescription drug program, or Part D, has the following features: an annual deductible for which the beneficiary is responsible; an initial range of coverage in which the beneficiary pays coinsurance amounting to 25 percent of the cost of covered drugs; and a catastrophic threshold above which the beneficiary pays about 5 percent of covered drug costs. In the gap between the end of the initial coverage range and the catastrophic threshold—commonly called the “doughnut hole”—beneficiaries generally are liable for all of their drug costs. In 2011, the standard deductible is projected to be \$345, and initial coverage will be capped at \$3,190. Catastrophic coverage will begin when a threshold of \$7,234 is met. Therefore, the coverage gap is projected to be \$4,044 for enrollees with no supplemental drug coverage (supplemental coverage assists beneficiaries in paying for their drug costs).

Once enrollees reach the catastrophic threshold, Medicare will have covered a projected \$2,134 in drug costs for such enrollees (75 percent of the \$3,190 initial range of coverage minus the deductible of \$345); those enrollees, in turn, will have incurred \$5,100 in out-of-pocket drug costs (the deductible plus 25 percent coinsurance up to the initial coverage limit plus 100 percent of all costs within the gap). The standard benefit’s deductible, initial coverage limit, and catastrophic threshold will increase each year at the projected rate of growth in per capita drug expenditures for the Medicare population.

The gap is effectively larger for enrollees who have private supplemental drug coverage because of the drug benefit’s “true out-of-pocket” (TrOOP) provision, which specifies that costs covered by such supplemental policies generally do not count toward reaching the catastrophic threshold. (There are some specific exceptions to the TrOOP requirement.) Many enrollees with low income and few assets will receive additional federal subsidies to cover most of their drug costs in the doughnut hole, but about 24 percent of Part D participants, or about 4 million people, who are not enrolled in the program’s low-income

subsidy will have drug spending that exceeds the standard benefit’s initial coverage range in any given year.

This option would completely eliminate the doughnut hole in the standard benefit, starting in 2011, by extending the benefit’s initial 25 percent coinsurance rate up to the point at which the catastrophic threshold was reached. As a result, enrollees in 2011 would face 25 percent coinsurance for all drug costs incurred between the \$345 deductible and the new catastrophic threshold of \$19,365. At that point, beneficiaries would have incurred \$5,100 in out-of-pocket costs. (Because the TrOOP provision would continue to apply, beneficiaries with private supplemental drug coverage would still incur higher total drug costs before reaching the catastrophic threshold.)

Implementing this option would increase mandatory spending, the Congressional Budget Office estimates, by \$42 billion over the 2010–2014 period and by \$134 billion over the 2010–2019 period.<sup>1</sup> Those estimates assume that beneficiaries’ premiums will continue to cover 25.5 percent of the costs of providing the basic benefit. Because the cost of the basic benefit would increase under the option, beneficiaries’ average monthly premiums would rise to \$51 in 2011 and to \$98 in 2019. By contrast, under current law, beneficiaries’ monthly premiums would average \$33 in 2011 and \$63 in 2019. The estimate also reflects the fact that an increase in the cost of providing the basic drug benefit to all enrollees would be partially offset by reduced costs for providing the additional drug subsidies for low-income enrollees to cover the smaller cost-sharing liabilities that remained. (The estimates presented here reflect the assumption that subsidy payments from Medicare for employers’ drug plans—which are made on behalf of retirees who stay in those plans instead of enrolling in Part D—would be increased proportionally.)

1. That estimate is subject to change following analysis of the 2007 Medicare Part D Prescription Drug Event data, which are not yet available.



A rationale for this option is that it would reduce cost-sharing burdens for the large number of beneficiaries who are projected to exceed the current benefit's initial coverage limit, which would ensure that beneficiaries had continuous drug coverage and might improve their health outcomes.

An argument against this option is that a substantial portion of the additional federal costs it would impose would displace spending that probably would have been covered by third parties. Also, beneficiaries might object to the fact that the increased premiums would delay their break-

even point—that is, the point at which the benefits they received equaled their premium payments. (Although that delay could result in a reduction in the number of beneficiaries participating in Part D, a reduction in enrollment was not taken into account when developing this estimate.) Alternatively, the insurance design of the standard Part D benefit could be modified at a lower federal cost by first increasing the deductible and then raising the coinsurance rate before extending that coverage across the doughnut hole.

«CBO»

**Option 90****Institute a Premium for Higher-Income Enrollees Under Medicare's Drug Benefit Similar to That Used in Part B**

| (MILLIONS OF DOLLARS)   | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|---|------|------|------|------|------|-----------|-----------|
|   |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending  |      |      |      |      |      |           |           |
| Increase Part D premiums for higher-income enrollees, adjusting for inflation         | 0    | -100 | -300 | -550 | -670 | -1,620    | -7,840    |
| Increase Part D premiums for higher-income enrollees, without adjusting for inflation | 0    | -120 | -320 | -650 | -820 | -1,910    | -10,060   |

Medicare's Part D benefit subsidizes prescription drug coverage for participating beneficiaries. Some low-income Part D enrollees whose assets are limited receive fully subsidized coverage, but most enrollees pay a standard premium that is intended to cover about 25 percent of the program's average costs per capita. By comparison, Medicare's Part B benefit, which provides coverage for physicians' services and other outpatient care for participating beneficiaries, has a somewhat different premium structure. As is the case with Part D, some low-income Part B enrollees receive fully subsidized coverage—Medicaid pays the Part B premium for enrollees who meet certain income criteria—but most enrollees pay a standard premium of 25 percent of the program's projected average costs per enrollee. Unlike Part D, however, Part B charges progressively higher premiums for beneficiaries whose income exceeds certain levels. For example, in 2009, people who participate in Part B and have income of more than \$85,000 but less than \$107,000 face a premium that represents 35 percent of Part B's projected costs per capita; enrollees with income of more than \$107,000 but less than \$160,000 pay 50 percent; those whose income is greater than \$160,000 but less than \$213,000 pay 65 percent; and those with more than \$213,000 in income pay 80 percent. (The corresponding income thresholds for married couples are double the amounts for individuals.) Under current law, those income thresholds rise annually with changes in the consumer price index for urban consumers.

This option would raise the Part D premium for higher-income beneficiaries in one of two ways.

- The first alternative would implement the same premium formula currently used by Part B for higher-income beneficiaries, using the same income cutoffs and scheduled adjustments for inflation. (For example, single beneficiaries who had income of more than \$213,000 would face a Part D premium equal to 80 percent of Part D's projected costs per capita.) Subsidies for low-income beneficiaries would not be altered. If the alternative was implemented in 2011 and phased in over three years, federal savings would be an estimated \$7.8 billion over the 2010–2019 period. When the option was fully implemented, in 2013, enrollees affected by this proposal (that is, enrollees with income of more than \$85,000 in 2009 dollars) would face additional premium costs of about \$20 to \$90 per month on top of the projected basic Part D premium of about \$38 per month.
- The second alternative would use the same approach as the first but would eliminate the scheduled inflation adjustments to the income thresholds after 2010. Effectively, this alternative would apply the income-related premium to a greater number of enrollees over time than would the first alternative. If this version of the option was implemented in 2011, federal savings would be an estimated \$10.1 billion over the 2010–2019 period.

Both alternatives would leave employment-based plans for retirees unaffected.

One rationale for this option is that it would offer budgetary savings but leave an overwhelming majority of Part D enrollees unaffected. Fewer than 6 percent of

Part D enrollees would face a higher premium in a given year under either alternative, and all of those individuals would still be receiving subsidized coverage. Furthermore, for enrollees who were affected by this option, the additional payment would represent only a small share of their income.

An argument against the option is that some higher-income enrollees might react by opting out of the Part D program. (The Congressional Budget Office estimates that about 1 percent of Part D enrollees would ultimately decline to enroll in the program or would delay enrollment

as a result of the higher premiums.) If those who opted out of the coverage had relatively low drug costs, which seems likely, then the average costs for the enrollees who remained—and therefore, their premiums—would be higher than they otherwise would have been. Another concern about the option has been the administrative costs and burdens of tying enrollees' Medicare premiums to their income. However, the steps needed to implement this option—for example, a process for verifying people's income—are already in place for determining income-related premiums for Part B.

«CBO»

**Option 91****Increase the Fraction of Beneficiaries Who Pay an Income-Related Premium for Part B of Medicare**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013   | 2014   | Total     |           |
|------------------------------|------|------|------|--------|--------|-----------|-----------|
|                              |      |      |      |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | -600 | -900 | -1,300 | -1,700 | -4,500    | -20,500   |

Medicare Part B finances coverage for physicians' and other outpatient services, in part through premiums paid by beneficiaries who enroll in the voluntary program. Before January 2007, the Part B premium was set at 25 percent of the program's costs per aged enrollee (enrollees who were age 65 or older) and was applied universally to all enrollees. Since then, under a provision of the Medicare Modernization Act, approximately 1.7 million higher-income beneficiaries have faced progressively greater shares of those costs—35 percent, 50 percent, 65 percent, or 80 percent, depending on income. The income categories that those shares apply to are based on enrollees' modified adjusted gross income. In 2009, the income thresholds for those premium shares are \$85,000, \$107,000, \$160,000, and \$213,000, respectively. (For married couples, the corresponding income thresholds are twice those values.) The income thresholds rise each year with changes in the consumer price index for all urban consumers.

This option would apply higher Part B premiums to more enrollees by eliminating the scheduled adjustments to the income thresholds for inflation after 2010. As under current law, enrollees who paid the basic premium of 25 percent would be covered by the "hold-harmless" provision; that provision ensures that the amount of an enrollee's Social Security check does not decline if the Social Security cost-of-living adjustment is insufficient to cover a rise in the Part B premium that reflects growth in the costs of the Part B program. This option would not

reduce outlays in 2010 but would decrease them by an estimated \$21 billion from 2011 to 2019.

A rationale for this option is that it would provide savings to help relieve the growing budgetary pressures posed by Medicare's spending, yet leave most Part B enrollees—particularly those with low income—unaffected. In 2019, an estimated 95 percent of enrollees would pay no more than the basic premium, and fewer than 1 percent would face the highest premium. Furthermore, for enrollees who did face a higher premium, the additional cost would be small compared with their income. All Part B enrollees, including those who paid an income-related premium, would still receive a substantial subsidy from taxpayers.

An argument against the option is that enrollees who faced the higher premiums would effectively see a reduction in their disposable income, and some of them might drop out of the Part B program as a result. However, the number dropping out is expected to be small because, despite the voluntary nature of the Part B program, the percentage of beneficiaries who enroll in it has always been quite large. Also, when the income-related premium was established, some observers objected because Medicare rules traditionally applied universally to elderly persons regardless of income (Medicaid pays the Part B premium for certain low-income Medicare beneficiaries).

«CBO»

**Option 92****Base Federal Retirees' Health Benefits on Length of Service**

| (MILLIONS OF DOLLARS)                     | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|---|------|------|------|------|------|-----------|-----------|
|   |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending <sup>a</sup> | 10   | -20  | -50  | -70  | -90  | -220      | -1,100    |

a. Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.

Upon retirement, federal employees are allowed to continue receiving benefits from the Federal Employees Health Benefits (FEHB) program if they have participated in the program during their last five years of service and are eligible to receive a pension immediately. More than 80 percent of new retirees elect to continue receiving federally funded health benefits. For those retirees over age 65, FEHB benefits are coordinated with Medicare benefits; under that policy, FEHB plans typically pay amounts not covered by Medicare (but no more than they would have paid for a given service or treatment in the absence of Medicare).

The government and participants in FEHB share the cost of premiums. That cost-sharing provision sets the government's contribution for all enrollees at 72 percent of the average (weighted by enrollment) of all premiums charged for the various plans participating in the federal system—up to a cap of 75 percent of the premium charged for any individual plan. The Congressional Budget Office estimates that in 2009, the government will pay almost \$12 billion in premiums for roughly 2 million federal retirees plus their dependents and survivors (including retirees of the U.S. Postal Service).

This option would reduce premium subsidies for retirees who had relatively short federal careers, although it would preserve their right to participate in the FEHB program. In recent years, about 14 percent of the more than 80,000 employees who retire from federal service annually and opt to continue in the FEHB program have fewer than 20 years of service. Under this option, the government's share of premium costs for new retirees only—those retiring on January 1, 2010, or later—would be cut by 2 percentage points for every year of service less than 20 years. In the case of a retiree with 15 years of service, for example, the government's contribution would decline from 72 percent of the weighted average premium to 62 percent.

Because some individuals would retire sooner than planned to avoid the greater contribution toward premiums required under the new rule, the option would have a small effect on mandatory spending in 2010. After higher outlays for federal pensions were taken into account, the option would reduce net spending for government contributions to the FEHB program by an estimated \$1.1 billion over the 2010–2019 period. Savings would be lower if the option exempted those retiring on a disability pension and survivors of workers who died while still actively employed. In addition, the option would probably cause some Medicare-eligible retirees to drop their FEHB coverage and elect to join Medicare Part B (which covers physicians' and other outpatient services), Part C (Medicare Advantage), and Part D (the prescription drug benefit). As a result, spending for Medicare would increase, on net, by about \$20 million over the 2010–2019 period. In total, by CBO's estimates, implementing this option would reduce mandatory spending by about \$1.1 billion over the 2010–2019 period.

The option would also increase the incentive for retirees affected by the change in benefits to choose lower-cost health care plans under the FEHB program and thus could increase the incentive for insurers to offer such low-cost plans. Those plans would then be available to other federal workers and retirees.

A potential advantage of this option is that it would strengthen the link between length of service and the amount of deferred compensation a retiree could expect. It would also help bring federal retirement benefits more in line with those provided by other employers. Federal retirees' health care benefits are significantly better than those offered by most large private firms. According to a survey conducted in 2007 by the Kaiser Family Foundation and the Health Research and Educational Trust, only about one-third of firms with 200 or more workers offer health care benefits for current retirees. In 1988, two-thirds of those employers offered coverage. (Large firms

are significantly more likely than small and midsize firms to offer retiree health care benefits; just 5 percent of small and midsize firms offer such coverage.) Moreover, firms have been aggressively paring or eliminating retirement health care benefits for newly hired workers in recent years. Other surveys indicate that, among firms still offering medical coverage, eligibility rules for new workers have been tightened, typically requiring them to have 10 or more years of service to qualify. Benefits for recent retirees have also been reduced. For example, employees recently retired from large firms pay, on average, about 40 percent of the total premium.

A possible disadvantage of this option is that it would mean a substantial cut in benefits that were implicitly promised to people already in federal careers, particularly for those with shorter federal careers (roughly 3 percent of retirees have 10 years of service or less). Such a cut in

benefits could lead some people to drop out of the program. The individuals who would face the greatest increases in payments for premiums would include those retiring on disability pensions. In 2005, people with disabilities represented nearly 60 percent of new retirees with 10 years of service or less. The option could also have unintentional and perhaps adverse effects on the composition of the federal workforce by encouraging some employees to retire sooner than planned to avoid the new policy; at the same time, it could induce others to delay retirement to extend their length of service. Equity issues for current federal workers and the avoidance of a surge of anticipatory retirements could be addressed by postponing or phasing in the option, or by making exceptions for those retiring because of disability. Doing so, however, would delay or reduce the option's potential budgetary savings.

RELATED CBO PUBLICATIONS: *The President's Proposal to Accrue Retirement Costs for Federal Employees*, June 2002; and *Comparing Federal Employee Benefits with Those in the Private Sector*, August 1998

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**Option 93****Adopt a Voucher Plan for the Federal Employees Health Benefits Program**

| (MILLIONS OF DOLLARS)                     | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|---|------|------|--------|--------|--------|-----------|-----------|
|   |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending <sup>a</sup> | 0    | -500 | -1,200 | -2,000 | -2,900 | -6,600    | -36,500   |
| Change in Discretionary Spending          |      |      |        |        |        |           |           |
| Budget Authority                          | 0    | -500 | -1,200 | -1,900 | -2,700 | -6,300    | -33,100   |
| Outlays                                   | 0    | -500 | -1,200 | -1,900 | -2,700 | -6,300    | -33,100   |

Note: Savings measured from the 2010 funding level are adjusted for increases in premiums and changes in employment.

a. Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage to 4 million federal workers and annuitants, as well as to 4 million of their dependents and survivors. In 2009, those benefits are expected to cost the government almost \$27 billion (including amounts paid by the U.S. Postal Service). Policyholders are required to pay at least 25 percent of the premium, a figure that, depending on the cost of the plan that is selected, can increase. That cost-sharing structure provides some incentive for federal employees to switch from higher-cost to lower-cost plans, although the incentive is less than it would be if they realized the full savings from choosing a less expensive plan. (As in the private sector, premium payments are deducted from an employee's, but not an annuitant's, pretax income.) Cost sharing also imposes some competitive pressure on all participating plans to hold down premiums.

Retired enrollees pay the same premiums that active employees pay, and the federal government typically shares in the cost of the premiums to the same extent for both groups.<sup>1</sup> For retirees of the U.S. Postal Service, the share of premium payments paid by the federal government is split between the Treasury and the Postal Service. The government contributes as much as 75 percent toward the enrollee's premium for the insurance plan the individual selects, up to a maximum dollar amount that is equal to 72 percent of the weighted (by enrollment) average premium of all participating plans. Thus, the government's contribution is less than 75 percent for the most expensive plans.

1. The federal share is different for the U.S. Postal Service under that agency's collective bargaining agreement with current employees.

This option would offer a voucher for the FEHB program that would cover the first \$4,300 of an individual employee's or retiree's total premiums or the first \$9,900 of a family's premiums beginning on January 1, 2011. Those amounts, which are based on the Congressional Budget Office's estimate of the government's average expected contribution in 2010, would increase annually at the rate of inflation as measured by the consumer price index for all urban consumers, rather than at the average weighted rate of change for FEHB premiums. According to CBO's estimates, indexing vouchers to inflation rather than to the growth of premiums would produce budgetary savings because FEHB premiums are predicted to grow three times faster than inflation.

This option would reduce discretionary spending by federal agencies (because of lower payments for FEHB premiums for current employees and their dependents) by an estimated \$6.3 billion over the 2010–2014 period and by \$33.1 billion over the 2010–2019 period, under the assumption that appropriations reflect the reduced costs. The option would also reduce mandatory spending because of lower payments from the Treasury for FEHB premiums for retirees and payments by the U.S. Postal Service relating to FEHB premiums for retirees. Estimated savings from those reductions would be \$6.7 billion over the 2010–2014 period and \$37.0 billion over the 2010–2019 period.

In addition, CBO anticipated that the option would affect FEHB annuitants' participation in Medicare Part B (physicians' and other outpatient services), Part C (Medicare Advantage), and Part D (the prescription drug benefit). As a result, Medicare spending would increase by an estimated \$0.1 billion over the 2010–2014 period and by

\$0.5 billion over the 2010–2019 period. In total, the option would reduce mandatory spending, on net, by an estimated \$6.6 billion over the 2010–2014 period and by \$36.5 billion over the 2010–2019 period.

For many employees, this option, if implemented, would increase the incentive to choose lower-cost plans and could strengthen price competition among health care plans participating in the FEHB program. Employees who selected plans that cost more than the voucher amount would pay the full additional cost of the plan. Moreover, because enrollees would pay nothing for plans that cost the face value of the voucher, insurers would have a greater incentive to offer lower-cost plans that approached or matched the value of the voucher.

This option could have several drawbacks. First, because the federal contribution would grow more slowly than premiums over time, the average participant would even-

tually pay more for his or her health insurance coverage. As a result, some participants might drop out of the FEHB program.<sup>2</sup> For the most part, large private-sector companies currently provide health care benefits for their employees that are comparable to benefits that the government provides; however, under this option, government benefits could be less attractive than private-sector benefits, making it harder for the government to attract highly qualified workers. Finally, in the case of current federal retirees and longtime workers, this option would cut benefits that had already been earned.

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2. The option does not reflect any potential effect on federal revenues from individuals who might drop out of FEHB and obtain health coverage through other nonfederal employment-based insurance plans (for example, through a spouse's health plan). If such a shift in coverage occurred, the mix of taxable compensation and benefits would change, and federal revenues could be reduced.

RELATED CBO PUBLICATIONS: *The President's Proposal to Accrue Retirement Costs for Federal Employees*, June 2002; and *Comparing Federal Employee Benefits with Those in the Private Sector*, August 1998

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**Option 94****Require Federal Employees Health Benefits Plans to Subsidize Premiums for Medicare Part B and Reduce Coverage of Medicare Cost Sharing by an Equivalent Amount**

| (MILLIONS OF DOLLARS)                     | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|---|------|------|--------|--------|--------|-----------|-----------|
|   |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending <sup>a</sup> | 0    | -900 | -1,000 | -1,000 | -1,100 | -4,000    | -11,000   |
| Change in Discretionary Spending          |      |      |        |        |        |           |           |
| Budget authority                          | 0    | -10  | -10    | -20    | -20    | -60       | -160      |
| Outlays                                   | 0    | -10  | -10    | -20    | -20    | -60       | -160      |

a. Estimates include potential savings realized by the U.S. Postal Service, whose spending is classified as off-budget.

Upon retirement, many federal employees are eligible to maintain health insurance coverage under the Federal Employees Health Benefits (FEHB) program. Most are also eligible for Medicare Part A (hospital insurance) once they reach age 65. In addition, retirees may choose to enroll in Medicare Part B (physicians' and other outpatient services.) If federal retirees enroll in Medicare, they may opt to continue their enrollment in the FEHB program. In that case, FEHB benefits are coordinated with Medicare. For retirees who are enrolled in both Medicare Part A and Part B, many FEHB plans cover the cost sharing (in the form of deductibles and copayments) that Medicare requires. For retirees who are enrolled only in Medicare Part A, FEHB plans cover the cost sharing that is required under Part A as well as the benefits that would have been provided under Part B.

Retired enrollees pay the same premiums that active employees pay, and the federal government typically shares in the cost of the premiums to the same extent for both groups.<sup>1</sup> The government contributes as much as 75 percent toward the enrollee's premium for the insurance plan the individual selects, up to a maximum dollar amount that is equal to 72 percent of the weighted (by enrollment) average premium of all participating plans. Thus, the government's contribution is less than 75 percent for the most expensive plans. About 75 percent of

federal retirees who are age 65 or older and enrolled in the FEHB program are also enrolled in Medicare Part B. Those retirees must pay the Part B premium—\$96.40 per month in 2009—in addition to the FEHB premium. Under current law, retirees' FEHB premiums do not change if they enroll in Medicare Part B.

Starting January 1, 2011, this option, if implemented, would require FEHB health plans to modify the benefit packages they offered to enrollees who also had Medicare coverage in such a way that their Part B premiums would be subsidized. In return, FEHB health plans would reduce their coverage of Medicare cost sharing by an equivalent amount. If necessary, other adjustments to the benefit package would be allowed. The Office of Personnel Management would be responsible for reviewing the design of FEHB health plans to verify that the expected average reduction in payments for Medicare cost sharing would be equal to the Part B premium subsidy. Enrollment in Part B would remain optional for FEHB enrollees who were eligible for Medicare.

If implemented, this option would reduce Medicare spending by an estimated \$3.9 billion over the 2010–2014 period and reduce mandatory outlays (primarily for government payments for retirees who participate in the FEHB program) over that period by \$100 million. Spending by the FEHB program and Medicare would decline because FEHB enrollees with Medicare coverage would reduce their use of services when faced with higher cost sharing. Because of that resulting expected drop in FEHB plan costs, average premiums charged under the FEHB program to all enrollees would be lower. Thus, the

1. The federal share is different for the U.S. Postal Service under that agency's collective bargaining agreement with current employees. For retirees of the Postal Service, the share of premium payments paid by the federal government is split between the Treasury and the Postal Service.

option would also reduce the contributions that federal agencies make toward FEHB premiums for their current employees. Discretionary spending by federal agencies would be reduced by an estimated \$60 million over the 2010–2014 period, under the assumption that appropriations reflect the reduced costs. The estimates include the effects of an expected increase in the number of FEHB retirees who would enroll in Part B because of the premium subsidy. In addition, the Congressional Budget Office anticipates, some individuals would purchase medigap health insurance plans in the private market in order to avoid the increased cost sharing required under the option. Individuals purchasing medigap plans would not be exposed to higher cost sharing; as a result, such coverage would lower the federal savings expected under the option.

A rationale for this option is that exposing FEHB enrollees with Medicare coverage to cost sharing would lead them to forgo some services that have little or no expected benefit. Currently, FEHB participants who are enrolled in both Parts A and B of Medicare face little or no cost sharing and therefore have little incentive to weigh the financial costs of treatment against the expected benefits.

A potential disadvantage of this option is that FEHB enrollees with Medicare coverage would face greater uncertainty about their out-of-pocket costs. Moreover, in any given year, some individuals would be worse off under this option than under current law, because the increase in their cost sharing would exceed the reduction in their Part B premiums.

RELATED CBO PUBLICATIONS: *The President's Proposal to Accrue Retirement Costs for Federal Employees*, June 2002; and *Comparing Federal Employee Benefits with Those in the Private Sector*, August 1998

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**Option 95****Increase Health Care Cost Sharing for Family Members of Active-Duty Military Personnel**

| (MILLIONS OF DOLLARS)                        | 2010      | 2011      | 2012       | 2013       | 2014       | Total      |              |
|--|-----------|-----------|------------|------------|------------|------------|--------------|
|  |           |           |            |            |            | 2010-2014  | 2010-2019    |
| Change in Mandatory Spending                 | 10        | 40        | 50         | 60         | 60         | 220        | 580          |
| Change in Revenues <sup>a</sup>              | -10       | -40       | -70        | -70        | -80        | -270       | -750         |
| <b>Net Effect on the Deficit<sup>b</sup></b> | <b>20</b> | <b>80</b> | <b>120</b> | <b>130</b> | <b>140</b> | <b>490</b> | <b>1,330</b> |
| Change in Discretionary Spending             |           |           |            |            |            |            |              |
| Budget authority                             | -60       | -530      | -740       | -780       | -830       | -2,940     | -7,870       |
| Outlays                                      | -30       | -370      | -650       | -750       | -800       | -2,600     | -7,380       |

- a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.
- b. Estimates exclude the potential effect of changes in discretionary spending.

The Department of Defense (DoD) provides health care benefits to family members of active-duty personnel through a collection of health plans known as TRICARE. There are currently three TRICARE plans from which such beneficiaries may choose—Prime, Standard, or Extra—and those beneficiaries pay no premiums or enrollment fees for their coverage. TRICARE Prime is operated much like a civilian health maintenance organization (HMO), with a military or civilian primary care manager providing referrals to network providers. Family members of active-duty personnel enrolled in TRICARE Prime generally face no copayments at the point of service, whether they receive care from a military or civilian provider.<sup>1</sup> In part because of the low out-of-pocket costs, those beneficiaries have rates of utilization of services that are substantially higher than those of a comparison group in a civilian HMO.<sup>2</sup> Family members who choose not to enroll in Prime are covered by TRICARE Standard (the program's fee-for-service plan) or Extra (the program's preferred provider plan). Beneficiaries in those two plans have a greater choice of providers but face deductibles and coinsurance rates that vary depending on the

type of service and whether the provider participates in a TRICARE network.

Under this option, DoD would provide active-duty personnel who have dependents with a special \$500 cash allowance for health expenses while at the same time increasing out-of-pocket costs for care received through TRICARE Prime. The allowance would be nontaxable (like the current housing allowance) and could be used in one of two ways. Under the first alternative, family members could use the allowance to help offset the out-of-pocket costs of any of the current TRICARE plans (Prime, Standard, or Extra). However, cost sharing under TRICARE Prime would be altered to incorporate copayments that would cover, on average, about 10 percent of the cost of health care services obtained either at military facilities or from civilian providers. Each TRICARE plan would include an annual cap on out-of-pocket expenditures to control the financial consequences of catastrophic illness. Under the second alternative, military family members could show proof of insurance and apply the \$500 allowance toward their share of the premiums,

1. One exception is for pharmaceuticals. Beneficiaries who have prescriptions filled at retail pharmacies or through mail order face copayments of \$3, \$9, and \$22, respectively, for generic, brand-name formulary, and brand-name nonformulary medications. Prescriptions filled at out-of-network retail pharmacies are reimbursed at 50 percent of the cost. Prescriptions filled at military treatment facilities are free.

2. DoD estimates that among TRICARE Prime enrollees, inpatient utilization is 58 percent higher and outpatient utilization is 39 percent higher than a civilian HMO comparison group. These results were adjusted to reflect differences in age and sex among the populations being compared. See Department of Defense, *Evaluation of the TRICARE Program: FY2008 Report to Congress* (February 29, 2008).

copayments, and deductibles of another health insurance plan.

Currently, military treatment facilities (MTFs) do not charge eligible individuals copayments for medical services or pharmaceuticals. In order to reduce beneficiaries' incentive to switch to MTFs and avoid the minimum out-of-pocket requirements, DoD would need to establish procedures for collecting payments from TRICARE beneficiaries seeking care from MTFs.

If implemented, this option would save about \$3 billion in discretionary outlays over the next five years and roughly \$7 billion from 2010 to 2019. That estimate incorporates the cost of the cash allowances and accounts for the decreased demand for medical care among enrollees that would result under the new plan. (The higher out-of-pocket expenses would be expected to encourage restraint in health care purchases.) The estimate also accounts for the increased cost of the benefit for a small number of eligible family members of active-duty personnel who do not use TRICARE but instead rely on an employment-based health plan. Those beneficiaries currently cost the system nothing but would still receive the cash allowance.

This option would also result in a small increase in mandatory outlays resulting from some military dependents' increased use of Medicaid services. In addition, federal tax revenues would decrease somewhat as more dependents of active-duty service members enrolled in private insurance plans, which would yield a shift in compensation from taxable wages to nontaxable fringe benefits. The degree of those two effects would depend on the specifics of any enacting legislation.

This option would offer several advantages. First, enrollees in TRICARE Prime would have a stronger incentive to use medical services prudently because they would be responsible for a share of the cost. Second, the ability to use the allowance to pay the premiums of another health insurance plan would induce some spouses to enroll in their employer's plan rather than in TRICARE. That feature of the option would mean that some health care costs would be shifted to the civilian employers of military spouses, thus reducing DoD's spending. Finally, because family members would commit annually to enrolling in a health insurance plan, total utilization of services would be easier to predict than it is under the current system, which allows users to join or leave at any time. Thus, this option would improve resource planning within the military health care system and allow DoD to negotiate firmer contracts for pharmaceuticals and civilian medical services. That advantage would exist even if most beneficiaries chose to remain in one of the three traditional TRICARE plans.

This option would also have potential disadvantages. Enrollees in TRICARE Prime would assume additional risks and might face financial difficulties, despite the plan's cap on families' annual out-of-pocket expenditures. Moreover, families that obtained health insurance through a spouse's employer might have their coverage disrupted if the active-duty service member relocated to a new post. DoD would have to develop methods to prorate cash allowances and deductibles for beneficiaries who were forced to change from a private health care plan to TRICARE coverage (or vice versa) midyear.

RELATED CBO PUBLICATIONS: *Evaluating Military Compensation*, June 2007; *Consumer-Directed Health Plans: Potential Effects on Health Care Spending and Outcomes*, December 2006; *Military Compensation: Balancing Cash and Noncash Benefits*, Issue Brief, January 16, 2004; and *Growth in Medical Spending by the Department of Defense*, September 2003

**Option 96****Introduce Minimum Out-of-Pocket Requirements Under TRICARE For Life**

| (MILLIONS OF DOLLARS)            | 2010     | 2011          | 2012          | 2013          | 2014          | Total          |                |
|----------------------------------|----------|---------------|---------------|---------------|---------------|----------------|----------------|
|                                  |          |               |               |               |               | 2010-2014      | 2010-2019      |
| Change in Mandatory Spending     |          |               |               |               |               |                |                |
| Department of Defense            | 0        | -2,000        | -3,000        | -3,300        | -3,500        | -11,800        | -32,600        |
| Medicare                         | 0        | -300          | -700          | -700          | -800          | -2,500         | -7,100         |
| <b>Net Effect on the Deficit</b> | <b>0</b> | <b>-2,300</b> | <b>-3,700</b> | <b>-4,000</b> | <b>-4,300</b> | <b>-14,300</b> | <b>-39,700</b> |

TRICARE For Life (TFL) was introduced in 2002 as a supplement to Medicare for military retirees and their family members who are eligible for Medicare. The program pays nearly all medical costs not covered by Medicare and requires few out-of-pocket fees. Because the Department of Defense (DoD) is a passive payer in the program—it neither manages care nor provides incentives for the cost-conscious use of services—it has virtually no means of controlling the program's costs. In 2008, DoD spent about \$8 billion on TFL-eligible beneficiaries in addition to amounts spent for those individuals by Medicare.

This option would help reduce the costs of TFL, as well as costs for Medicare, by introducing minimum out-of-pocket requirements for beneficiaries. Under this option, TFL would not cover any of the first \$525 of an enrollee's cost-sharing liabilities for calendar year 2011 and would limit coverage to 50 percent of the next \$4,725 in Medicare cost sharing that the beneficiary incurred. (Because all further cost sharing would be covered by TFL, enrollees could not pay more than \$2,888 in cost sharing in that year. Those dollar limits would be indexed to growth in average Medicare costs for later years.) The true out-of-pocket provisions in Medicare's prescription drug program, or Part D, are an example of how this option could work in practice. Under that program, any amounts paid by Medicare or by any other insurer are not included when calculating whether a beneficiary has reached the level of eligibility for catastrophic coverage.

Currently, military treatment facilities (MTFs) do not charge eligible individuals copayments for medical services or pharmaceuticals. In order to reduce beneficiaries' incentive to switch to MTFs and avoid the minimum out-of-pocket requirements that are central to this option, DoD would need to establish procedures for collecting payments from TFL beneficiaries seeking care from MTFs.

If the savings that would accrue from reduced spending for Medicare were included, the introduction of cost sharing under this option would reduce the federal spending devoted to TFL beneficiaries by about \$14 billion through 2014 and by about \$40 billion through 2019. Approximately 22 percent of those savings would come from a reduced demand for medical services rather than from a transfer of spending from the government to military retirees and their families.

An advantage of this option is that greater cost sharing would increase TFL beneficiaries' awareness of the cost of health care and promote a corresponding restraint in their use of medical services. Research has generally shown that introducing modest cost sharing can substantially reduce medical expenditures without causing measurable increases in adverse health outcomes.

Among its disadvantages, this option could discourage some patients (particularly low-income patients) from seeking preventive medical care or from managing their chronic conditions under close medical supervision, which might negatively affect their health.

RELATED CBO PUBLICATIONS: *Evaluating Military Compensation*, June 2007; *Military Compensation: Balancing Cash and Noncash Benefits*, Issue Brief, January 16, 2004; and *Growth in Medical Spending by the Department of Defense*, September 2003

**Option 97****Increase Medical Cost Sharing for Military Retirees Who Are Not Yet Eligible for Medicare**

| (MILLIONS OF DOLLARS)                        | 2010      | 2011       | 2012       | 2013       | 2014       | Total        |              |
|--|-----------|------------|------------|------------|------------|--------------|--------------|
|  |           |            |            |            |            | 2010-2014    | 2010-2019    |
| Change in Mandatory Spending                 | 10        | 30         | 50         | 70         | 80         | 240          | 1,040        |
| Change in Revenues <sup>a</sup>              | -40       | -130       | -260       | -300       | -350       | -1,080       | -4,000       |
| <b>Net Effect on the Deficit<sup>b</sup></b> | <b>50</b> | <b>160</b> | <b>310</b> | <b>370</b> | <b>430</b> | <b>1,320</b> | <b>5,040</b> |
| Change in Discretionary Spending             |           |            |            |            |            |              |              |
| Budget authority                             | -200      | -1,400     | -2,000     | -2,200     | -2,500     | -8,300       | -26,000      |
| Outlays                                      | -200      | -1,200     | -1,800     | -2,100     | -2,400     | -7,700       | -24,800      |

- a. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.  
b. Estimates exclude the potential effect of changes in discretionary spending.

In the mid-1990s, the Department of Defense (DoD) instituted a plan called TRICARE to provide health care for members of the military and their dependents, as well as for eligible military retirees and their families. TRICARE comprises three different options: an option similar to a health maintenance organization (HMO), called TRICARE Prime; an option with a preferred-provider network, called TRICARE Extra; and a traditional fee-for-service plan, called TRICARE Standard. When most military personnel enter the armed forces, they are between 18 and 22 years of age, and they are able to retire after serving 20 years. Military retirees who are not yet eligible for Medicare (generally those ages 38 to 65) may enroll in TRICARE Prime by paying an annual enrollment fee of \$230 (for single coverage) or \$460 (for family coverage). In addition, those Prime enrollees make a \$12 copayment for each outpatient visit to a civilian physician or other civilian health care provider (visits to military providers are free). Those who do not enroll in TRICARE Prime may receive benefits under TRICARE Extra or Standard. Beneficiaries who use either one of those two plans must pay an annual deductible of \$150 (single coverage) or \$300 (family coverage) before typical cost-sharing rates apply. The TRICARE enrollment fees, copayments, and deductibles have remained unchanged since 1995.

Military retirees enrolled in TRICARE Prime bear smaller costs than would be owed under typical civilian plans. DoD has estimated that a typical military retiree and his family who enrolled in the Prime plan faced

about \$780 in annual out-of-pocket costs (that is, TRICARE copayments and the enrollment fee) in 2007, whereas a comparable family enrolled in an HMO through a civilian employment-based plan paid \$3,950 (as the employee's share of the premium plus copayments). TRICARE Prime beneficiaries also use the system more than comparable civilian beneficiaries do: DoD estimates that the rate of utilization of inpatient services is 58 percent higher and the outpatient utilization rate 39 percent higher for Prime enrollees than for civilian HMO enrollees.<sup>1</sup>

This option would raise the enrollment fees, copayments, and deductibles for younger military retirees who wished to use TRICARE. Single beneficiaries could enroll in TRICARE Prime by paying a \$550 annual fee, and families could enroll for \$1,100 annually. The family enrollment fee of \$1,100 per year is approximately equivalent to the \$460 fee first instituted in 1995, after an adjustment for the nationwide growth in health care spending per capita. Under this option, each medical visit to a civilian Prime provider would entail a copayment of \$28, which, again, is approximately equivalent to the amount that was established in 1995. Copayments for mental health visits and inpatient care would also be adjusted accordingly. Single retirees (or their surviving spouses) who used TRICARE Standard or Extra would face an annual deductible of \$350; the deductible for families

1. Department of Defense, *Evaluation of the TRICARE Program: FY2008 Report to Congress* (February 29, 2008).

would be \$700. Those increases would also be consistent with the nationwide growth in per capita health care spending. In addition, and for the first time, users of TRICARE Standard or Extra would be required to enroll and pay a \$50 annual fee for single coverage and a \$100 annual fee for family coverage. For people currently serving in the military and for their families, enrollment fees, copayments, and deductibles in the three plans would remain at their current levels.

The option would reduce DoD's outlays in three ways. First, the increased fees would be used to directly offset the costs of treating military retirees. Second, the higher out-of-pocket costs would induce some retirees who would otherwise have used TRICARE to enroll in a civilian health plan instead. Third, the higher copayments and deductibles would reduce the use of health care services by military retirees who remained in TRICARE. DoD's precise cost savings under the option are difficult to predict because they would depend on how strongly people responded to the new fee structure. The net effect on the federal budget is also difficult to predict because increased fees may cause eligible retirees to switch to other federal programs, such as Medicaid (if an individual has low income), the Federal Employees Health Benefit (FEHB) program (if a person is employed as a civilian by the federal government), or the Veterans Health Administration. An estimate of the effects of increasing TRICARE fees, copayments, and deductibles is that

discretionary outlays would be reduced, on net, by about \$25 billion over the 2010–2019 period, under the assumption that appropriations were reduced accordingly. This option would increase mandatory spending for Medicaid and for FEHB annuitants by \$1 billion over the same period, and it would reduce revenues by \$4 billion. The drop in revenues would occur because some of the retirees who left TRICARE would switch to employment-based health benefits, leading to a shift in compensation from taxable wages to nontaxable fringe benefits.

The increased fees for retirees would not affect service members currently on active duty or in the reserves. In fact, only about 15 percent of enlisted service members and approximately 50 percent of officers remain for an entire career and qualify for retiree health benefits.

Much of the estimated savings under this option stems from increasing the enrollment fees charged for TRICARE Prime, with the expectation that some current users would leave the system and some potential users would seek care elsewhere. Although researchers have found that increasing cost sharing can reduce medical expenditures without adversely affecting the health of the average person, an argument against implementing the higher fees set out in this option is that they could discourage some people from seeking health care or treating their illnesses in a timely manner.

RELATED CBO PUBLICATIONS: *Evaluating Military Compensation*, June 2007; *Military Compensation: Balancing Cash and Noncash Benefits*, Issue Brief, January 16, 2004; and *Growth in Medical Spending by the Department of Defense*, September 2003

**Option 98****Require Copayments for Medical Care Provided by the Department of Veterans Affairs to Enrollees Without a Service-Connected Disability**

| (MILLIONS OF DOLLARS)            | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|----------------------------------|------|------|------|------|------|-----------|-----------|
|                                  |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending     | 40   | 40   | 40   | 40   | 40   | 200       | 420       |
| Change in Discretionary Spending |      |      |      |      |      |           |           |
| Budget authority                 | -580 | -630 | -650 | -670 | -700 | -3,230    | -7,060    |
| Outlays                          | -540 | -620 | -640 | -670 | -690 | -3,160    | -6,970    |

Note: Discretionary savings accrue to the Department of Veterans Affairs; increases in mandatory outlays are projected for the Medicare and Medicaid programs.

In 2008, just over 5 million veterans received medical care from the Department of Veterans Affairs (VA). All VA patients are enrolled in one of eight priority care groups, determined on the basis of income, disability status, and other factors. Currently, veterans in Priority Groups 6 to 8, the lower-priority groups, are charged copayments (and the health plans of any who have private insurance may be billed) for treatment of non-service-connected conditions.

This option would increase out-of-pocket costs for veterans in Priority Group 5—those who do not have service-connected disabilities and whose income is below a VA-defined threshold. The option is targeted toward the largest priority group (31 percent of VA enrollees) that consumes the greatest share (33 percent) of VA's medical resources each year. Currently, those patients pay no fees for inpatient or outpatient medical care, although veterans in this group who earn more than the VA pension level (\$11,000 or more per year, depending on whether the veteran has a spouse or dependents) pay \$8 per prescription, up to an annual cap of \$960. This option would maintain that prescription copayment for higher-income enrollees but also institute copayments of \$1 for prescriptions that the lowest-income enrollees fill at VA facilities and copayments of between \$1 and \$2 for each health care encounter that veterans in Priority Group 5 have with the VA medical system. Such increased cost sharing for Priority Group 5 veterans would reduce discretionary spending for VA medical services by about \$3 billion over the five-year period from 2010 through

2014. Although VA-provided medical care would remain less expensive than alternative care for many veterans, some of those for whom VA facilities were less convenient might switch to civilian providers and services funded under Medicare or Medicaid, and mandatory spending for those programs would increase by \$200 million for that same period. From 2010 through 2019, this option would reduce discretionary outlays by \$7 billion but would increase mandatory outlays by \$420 million.

A rationale for this option is that increased cost sharing for veterans in Priority Group 5 could reduce VA's spending by making those veterans more cost-conscious in their demand for health care services. An argument against the option is that it focuses on one of the poorest groups of veterans and leaves unchanged the out-of-pocket expense of those in lower-priority groups. Veterans in Priority Groups 6 to 8—a population that is expected to equal 33 percent of VA enrollees and consume 15 percent of VA's medical resources in 2009—make copayments, and their insurance plans (if any) are billed; however, the resulting revenue covers about a fifth of the cost of their care. (Net of copayments, those veterans are expected to consume 13 percent of VA's medical resources.) Veterans in Groups 6 to 8 have more income than veterans in Group 5, lending support to the argument that VA should concentrate first on recovering additional costs from those lower-priority groups through higher copayments and improved billing practices. However, such changes are unlikely to substantially reduce the growth in VA's medical spending.

RELATED CBO PUBLICATIONS: Statement of Allison Percy, Principal Analyst, Congressional Budget Office, *Future Medical Spending by the Department of Veterans Affairs*, before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, February 15, 2007; *Potential Growth Paths for Medical Spending by the Department of Veterans Affairs*, Letter to the Honorable Larry E. Craig, July 14, 2006; and *The Potential Cost of Meeting Demand for Veterans' Health Care*, March 2005



## Long-Term Care

**L**ong-term care services provided to elderly and disabled individuals include institutional care, such as care received in a nursing facility, and services received in the community, such as home health care, adult day care, or personal care.

In 2005, approximately 69 percent of all long-term care was funded by government programs: Medicaid (48 percent), Medicare (18 percent), and other public spending (3 percent).<sup>1</sup> Out-of-pocket spending (20 percent), private insurance (9 percent), and other private spending (2 percent) made up the remainder of long-term care spending.<sup>2</sup> Public spending for long-term care has been increasing. The Congressional Budget Office projects that in 2009, federal Medicaid spending for long-term care services will be about \$66 billion, or roughly one-third of the program's federal spending on benefits. (Much long-term care is provided personally by the family and friends of elderly and disabled individuals.)

Under current law, long-term care provided in institutional settings (such as nursing homes) is a mandatory benefit under Medicaid. As a result, there is no statutory limit on the number of people who may receive such care through Medicaid, as long as they meet specific institutional level-of-care requirements and other requirements related to income and assets. By contrast, home- and community-based services (HCBS), which include assis-

tance with activities of daily living (such as bathing and dressing), are not a mandatory benefit under Medicaid. States may provide HCBS to Medicaid-eligible individuals through optional state plan amendments or through waivers approved by the Centers for Medicare and Medicaid Services (CMS). Currently, all states cover HCBS for some beneficiaries under such waivers.

Some people may exhaust their income and assets in paying for long-term care and in doing so reach a point at which they become eligible for Medicaid. When they meet Medicaid's eligibility requirements, the program then covers their costs. Other individuals, however, may, in advance of needing long-term care, dispose of assets they own whose value exceeds Medicaid's threshold for eligibility to qualify for long-term care coverage. Under current law, Medicaid programs are authorized to conduct reviews of any asset transfers that occur within five years of an individual's application for Medicaid coverage. States may delay long-term care coverage through Medicaid for individuals who otherwise would have been ineligible for Medicaid had they not transferred their assets.

Individuals may purchase long-term care insurance to assist in paying for care needed later in life. Research indicates, however, that the rates of such purchases are low.

The options in this chapter present a range of approaches to address the provision and financing of long-term care services. Several options would enhance the provision of long-term care services in the home or community and expand coverage for home- and community-based services for individuals who are not eligible under current law. Other options present opportunities to reduce federal spending and encourage people to purchase long-term care insurance.

1. Medicare does not cover long-term custodial or residential care for individuals. Medicare does pay for short-term skilled nursing facility services, part-time home health care, and post-acute services furnished after a hospital stay.
2. Government Accountability Office, *Long-Term Care Financing Growing Demand and Cost of Services Are Straining Federal and State Budgets*. Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 2005.

**Option 99****Increase States' Flexibility to Offer Home- and Community-Based Services Through Medicaid State Plan Amendments**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 200  | 400  | 500  | 700  | 900  | 2,700     | 8,100     |

In the Medicaid program, states have the option of covering the costs of a range of medical and supportive services—such as home health care, personal care, and case-management services—for beneficiaries in the community who need extensive long-term care. States are permitted to offer those benefits under waiver authority in accordance with section 1915(c) of the Social Security Act. The waivers allow states to cover home- and community-based services (HCBS) for individuals who would otherwise qualify for institutional care and whose income is below 300 percent of the eligibility threshold for federal Supplemental Security Income (SSI) benefits. (That income level is roughly equivalent to 225 percent of the federal poverty level.) States are allowed to cap the number of people they serve under the waivers and to maintain waiting lists; they may cover the list of allowed services as described in the law (such as home health and personal care) as well as other services (such as transportation and home modification) that have been approved by the Secretary of Health and Human Services.

Currently, all states cover HCBS for some beneficiaries. The Centers for Medicare and Medicaid Services (CMS) approves waivers to provide such services initially for up to three years; states must then reapply and may be granted a waiver for an additional five years at a time. However, each time states reapply, they must show that implementation of the waiver will be cost-neutral.

The Deficit Reduction Act of 2005 (DRA) introduced a new mechanism that allows states to cover home- and community-based services through a state plan amendment in addition to covering them under the existing waiver mechanism. The authority that the law provides to include home- and community-based services in a state plan amendment established requirements for eligibility and restrictions on benefits that differ from those associated with waivers. For example, the authority limits receipt of home- and community-based services under a state plan amendment to individuals who already are eligible for Medicaid and who have an income below 150 percent of the federal poverty level. By contrast, a waiver could cover individuals with higher income who

would not otherwise be eligible for Medicaid. The authority for state plan amendments also restricts the services that a state may cover and prevents the Secretary from approving the coverage of additional services. (Under waivers, states may seek approval to cover a broader array of services.) Moreover, a state plan amendment may extend home- and community-based services to individuals who do not meet the requirement of needing an institutional level of care that applies under a waiver. However, state plan amendments are similar to waivers in certain respects: For example, under an amendment, as under a waiver, states may limit the number of people who receive HCBS and the geographic availability of such services.

In general, states may prefer to use the state plan amendment mechanism rather than obtain a waiver. The administrative requirements for a waiver—such as the need to demonstrate cost-neutrality—tend to be more difficult to satisfy; also, waivers expire, and states must reapply for them. However, few states have made use of the new authority for state plan amendments—as of early 2008, only four had submitted amendments to CMS to cover beneficiaries under the mechanism. Analysts have suggested that the limited participation can be traced in part to the state plan amendments' lower income cutoff and the restriction they place on the services that may be covered.

This option would alter the current authority to cover HCBS through a state plan amendment in two ways: It would raise the ceiling on the income limit to 300 percent of the SSI eligibility threshold, and it would permit the Secretary of Health and Human Services to approve coverage of additional services. The lower level of medical need established by the DRA would be retained, as would states' ability to maintain waiting lists and to restrict access to the benefits provided under an amendment to certain parts of a state. The option would increase Medicaid's spending by an estimated \$2.7 billion over the 2010–2014 period and by \$8.1 billion over the 2010–2019 period.

An argument in support of this option is that it would make the state plan amendment mechanism established by the DRA more attractive to states that are interested in offering home- and community-based services to individuals who do not require institutional-level care. Moreover, providing basic services to people while they are still able to live independently may reduce or eliminate their eventual need for institutional services. In addition, under the option, beneficiaries can enjoy greater choice regarding where they receive services. Another argument in favor of state plan amendments is that they are less

burdensome for states to administer because, unlike waivers, they do not have a time limit and are not required to demonstrate cost-effectiveness.

An argument against the option is that the increase in the number of individuals served by each state as a result of expanding the level of medical need required to obtain services would put additional strain on states' budgets and resources.

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**Option 100****Make Home- and Community-Based Services a Mandatory Benefit Under Medicaid**

| (MILLIONS OF DOLLARS)         | 2010 | 2011  | 2012  | 2013  | 2014  | Total     |           |
|-------------------------------|------|-------|-------|-------|-------|-----------|-----------|
|                               |      |       |       |       |       | 2010-2014 | 2010-2019 |
| Changes in Mandatory Spending | 0    | 1,700 | 3,700 | 6,000 | 8,700 | 20,100    | 89,800    |

Home- and community-based services (HCBS) are medical and support services that allow the elderly and individuals with disabilities and other health needs to remain in their home and community instead of having to receive care in institutional settings, such as nursing homes. In Medicaid, states can furnish HCBS through waiver authority or as an optional benefit provided through the Medicaid state plan (see Option 99) for additional detail). Regardless of which authority a state chooses for providing HCBS, neither alternative offers Medicaid beneficiaries a guarantee that they will receive such services in their home or through community organizations. (Currently, many states maintain waiting lists as a way to manage demand for HCBS.) Long-term care obtained at the institutional level, however, is a mandatory benefit under Medicaid and is therefore guaranteed. In other words, there is no limit on the number of people who can receive institutional care, provided that the beneficiary meets the level-of-care requirement.

Under this option, states would be required to provide HCBS to all Medicaid beneficiaries who met the requirement for receiving institutional care, should the individual choose the home- or community-based treatment setting. This option would therefore eliminate all waiting lists for services provided under the HCBS waiver authority. (This option also includes the effects of making personal care services—currently an optional state plan benefit not offered by all states—a mandatory benefit under Medicaid for eligible beneficiaries.) This option would increase Medicaid spending by approximately \$20 billion over the 2010–2014 period and by about \$90 billion over the 2010–2019 period. That estimate incorporates a reduction in nursing home spending as a result of a modest decline—compared with current law—in the number of Medicaid beneficiaries who receive care in nursing homes and a subsequent increase in the number of individuals receiving HCBS. However, that reduction in

spending would be offset by the number of new individuals receiving services under this option, leading to a net cost to the federal government. Given the need to ensure that adequate HCBS capacity exists to accommodate new demand for those services under this option, the Congressional Budget Office assumed a one-year implementation delay in the 2010–2019 period to allow the federal government and states time for preparation.

A rationale for this option is that it would require states to offer HCBS to a larger group of Medicaid beneficiaries. Some beneficiaries and their family members who preferred those treatment settings would be able to avoid nursing homes or similar institutional care settings and receive services in their home or community. Also, such a guarantee would eliminate waiting lists and serve individuals who might not be on the waiting list but who could benefit from home and community-based services.

An argument against this option is that states and communities may not have the infrastructure and resources needed to meet the demand for home- and community-based services. States would most likely need to make an up-front investment in the HCBS delivery system to ensure an adequate supply of providers and staff. Furthermore, the current number of beneficiaries receiving HCBS through waivers or optional state plan benefits might not reflect the true number of people who would demand such services if they became a guaranteed benefit. Thus, the greater availability of HCBS could result in increased enrollment in Medicaid, which would put an additional strain on state budgets. Moreover, providing HCBS as a mandatory benefit could result in additional costs to the federal government because of the displacement of informal care currently provided by family members or other caregivers.

**Option 101****Increase the Federal Matching Rate for Home- and Community-Based Services and Decrease the Federal Matching Rate for Nursing Home Services**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012  | 2013  | 2014  | Total     |           |
|------------------------------|------|------|-------|-------|-------|-----------|-----------|
|                              |      |      |       |       |       | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 3,200 | 2,700 | 2,300 | 8,200     | 13,400    |

States have several mechanisms for providing home- and community-based services (HCBS) to Medicaid beneficiaries instead of requiring that they seek care in institutional settings, such as nursing homes or skilled nursing facilities. Under current law, long-term care provided in institutional settings is a guaranteed benefit under Medicaid, whereas HCBS is an optional benefit (see Option 99 and Option 100 for additional detail). Typically, HCBS is less expensive on a per-person basis than institutional care and is often the preferred service setting of consumers and their families.

Regardless of the setting in which a beneficiary obtains care, states generally receive the same federal medical assistance percentage (FMAP) rate from the federal government for all medical services. However, in order to encourage certain behavior by the states, the federal government has established different reimbursement rates for Medicaid administrative services. Treating the FMAP for medical services in a similar manner could encourage states to change how they fund the delivery of services.

This option would increase the FMAP for home- and community-based services by 5 percentage points to encourage states to increase the number of eligible individuals served in community settings. At the same time, to reduce the incentive for states to rely on nursing homes as a default service provider for individuals who could be served in their community, the FMAP rate would decrease by 5 percentage points for services provided in nursing homes. The increased matching rate would be applied to all home- and community-based services furnished on or after January 1, 2012. However, the reduced matching rate for nursing home services would apply only to patients admitted to a nursing home on or after that date. (The Congressional Budget Office assumed an

implementation delay, given the time needed to ensure adequate HCBS capacity and for states to prepare for reduced reimbursement for institutional settings.) This option would increase Medicaid spending by about \$8 billion over the 2010–2014 period and by about \$13 billion over the 2010–2019 period.

A rationale for implementing this option is that it would help ensure that individuals who could be served efficiently and effectively in HCBS settings would have an increased opportunity to be placed there. In addition, Medicaid beneficiaries would have more choices about where they received long-term care services. The increased FMAP rates for home- and community-based services would provide states with additional resources to serve more Medicaid beneficiaries in those settings, to build up a more comprehensive infrastructure and array of community-based services, or both. As a result, nursing homes and other institutional settings might not have to be considered a default care setting.

An argument against this option is that changes in the FMAP rate could entice states to transfer or divert individuals to HCBS settings—people who might not benefit clinically from that level of care—just for the sake of reducing spending or getting enhanced HCBS matching funds. States could take advantage of this option without reinvesting the additional matching funds in the HCBS system or serving additional people—instead allocating the additional funds to other areas of government spending. Furthermore, this option represents a large increase over existing HCBS spending because it applies the new matching rate to everyone who receives HCBS on or after January 1, 2012, as opposed to new beneficiaries only.

«CBO»

**Option 102****Clarify Medicaid's Definition of Permissible Asset Transfers**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 440  | 490  | 530  | 550  | 580  | 2,590     | 5,900     |

Medicaid is the largest third-party payer for long-term care (LTC) services, accounting for approximately half of total LTC spending in the United States in 2005. Medicaid's coverage of LTC services is contingent on certain requirements being met—specifically, those related to beneficiaries' health status, income, and assets. Currently, individuals who have more than \$2,000 in countable assets such as cash, funds in bank accounts, or stocks are ineligible for LTC services under Medicaid. (Certain assets—one automobile, an individual's primary residence, life insurance policies worth \$1,500 or less, and household goods—are not counted toward Medicaid's asset eligibility criteria.)<sup>1</sup> The high out-of-pocket costs for long-term care prompt some individuals to transfer countable assets in excess of \$2,000 to family members, or other third parties, in order to qualify for Medicaid LTC coverage.

Under current law, individuals may transfer a certain amount of their assets without risking their eligibility for LTC services through Medicaid. Some examples of permissible transfers are the sale of assets at fair market value, transfers to a spouse, and some transfers to children with disabilities and certain other individuals. The law also permits any transfer made exclusively for a purpose other than qualifying for Medicaid. It does not, however, explicitly define which transfers fall into that category.

Upon receipt of a Medicaid application, states look back 60 months to determine whether the applicant made an impermissible transfer. If such a transfer did occur, the state is permitted to penalize the beneficiary by delaying Medicaid coverage for LTC services. The length of the delay in coverage depends on the amount transferred and the state's average private nursing home payment rate. To curb the number of individuals transferring assets explicitly to gain Medicaid eligibility for LTC services, the Deficit Reduction Act of 2005 made a variety of changes to

Medicaid's LTC asset-transfer rules and Medicaid's treatment of specific assets such as annuities and trusts.

This option would explicitly define which types of transfers are permissible. Because the rules are ambiguous, states tend to interpret them narrowly. This option would clarify that the following types of transfers are permissible:

- Providing financial assistance to a family member for educational expenses;
- Assisting a family member with medical expenses;
- Assisting a family member facing a financial crisis, including a failing business or family farm;
- Assisting an individual who is a caregiver for a family member or person with whom he or she lives; or
- Donating funds to a church, religious organization, or charity.

Implementing this change would increase mandatory federal spending by about \$2.6 billion over the 2010–2014 period and by \$6 billion over the 2010–2019 period. This option would increase federal costs because it would expand the category of transfers that are not subject to Medicaid penalties.

One argument for implementing this option is that it would enable additional individuals to have more timely access to Medicaid coverage for LTC services. An argument against this change is that it might prompt an increase in the number of Medicaid beneficiaries who engaged in the transfer of exempted assets for the sole purpose of receiving Medicaid coverage for LTC services. Some observers maintain that the Medicaid program was never intended to cover the additional individuals who might transfer assets and then seek the LTC coverage afforded by this policy.

1. Assets that are not counted toward Medicaid's asset eligibility criteria are subject to recoupment by the state upon the beneficiary's death.

**Option 103****Increase the “Look-Back” Period for Transfers of Assets in Medicaid**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 0    | 0    | 0    | 0         | -220      |

Medicaid is the largest third-party payer for long-term care (LTC) in the United States, accounting for approximately half of total LTC spending in 2005. Medicaid covers LTC services (including medical and custodial care for chronically ill individuals in both institutional and home-based settings) for people who meet certain requirements related to income, assets, and health status. Under current law, individuals who have more than \$2,000 in “countable” assets (for example, funds in a savings account) are ineligible for the program. (Under the law, a person’s car is a “noncountable” asset.) The high cost of long-term care prompts some people to transfer assets in excess of \$2,000 in order to qualify for Medicaid’s LTC coverage.

When a state receives an application for the Medicaid program, the law requires it to look back 60 months to determine whether the applicant impermissibly transferred assets during that period. If a transfer did occur, the state is permitted to penalize the beneficiary by delaying coverage under Medicaid. The length of the delay depends on the value of the assets that were impermissibly transferred and the state’s average rate for nursing home care paid by individuals who are not enrolled in Medicaid and who pay privately for LTC services. To curb the number of individuals who explicitly transfer assets to become eligible for Medicaid’s coverage of LTC services, the Deficit Reduction Act of 2005 made a variety of changes to the program’s asset transfer rules, one of

which extended the look-back period from 36 months to 60 months.

This option would further extend that period from 60 months to 84 months for transfers made on or after October 1, 2009. Transfers made prior to that date would be subject to the 60-month look-back period. The look-back period would increase to 84 months over time, with the option generating its first budgetary effects in year six of the 10-year period from 2010 to 2019—that is, after 60 months had passed. Therefore, this change would have no effect on federal spending until 2015; over the period from 2015 through 2019, it would reduce spending by approximately \$220 million.

One rationale for this option is that it would further discourage individuals from transferring excess assets for the sole purpose of becoming eligible for Medicaid-covered LTC services. An argument against the option is that it would probably penalize some individuals who had never intended to use Medicaid’s coverage and had transferred assets in good faith. Moreover, the longer the look-back period, the more administratively burdensome the look-back process would become for states, especially given that beneficiaries’ recordkeeping might not be complete enough for states to determine whether penalties should apply.

«CBO»

**Option 104****Implement Policies That Encourage the Use of Advance Directives**

| (MILLIONS OF DOLLARS)            | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|----------------------------------|------|------|------|------|------|-----------|-----------|
|                                  |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending     | 0    | 0    | -10  | -10  | -10  | -30       | -100      |
| Change in Discretionary Spending |      |      |      |      |      |           |           |
| Budget authority                 | 35   | 9    | 9    | 9    | 9    | 71        | 116       |
| Outlays                          | 14   | 19   | 12   | 9    | 9    | 63        | 108       |

Payments for health care provided at the end of an individual's life make up a significant portion of the federal government's outlays for health care. Both Medicaid and Medicare provide a variety of end-of-life services, such as those provided by hospice facilities and nursing homes. One component of end-of-life care is advance directives—legal documents that individuals sign to give health care providers directions about treatment choices under certain circumstances. In short, advance directives allow people to clarify ahead of time their desires regarding end-of-life care.

Two common forms of advance directives are living wills and durable powers of attorney. Living wills are documents that specify what actions should or should not be taken for an individual who experiences a medical emergency or a terminal illness. A durable power of attorney, also called a health care proxy, allows people to appoint someone else to make medical decisions for them should they become unable to do so for themselves. Those two forms of advance directive may be used independently or in combination; individuals execute them or another form of advance directive voluntarily—that is, people initiate the process on their own. The legal requirements surrounding advance directives differ among the states and they are not portable from one state to another. Therefore, an individual's wishes may not be followed if he or she receives medical care in a state other than the one in which the advance directive was registered.

The Patient Self-Determination Act of 1990, enacted as part of the Omnibus Budget Reconciliation Act of 1990, requires many providers of services in Medicaid and Medicare to give adult patients information about their specific rights under state laws regarding advance directives. That information includes patients' rights—to participate in and direct decisions regarding health care, to

refuse treatment, and to develop an advance directive—and policies regarding those rights that apply to providers. (The Patient Self-Determination Act of 1990 does not address the portability of advance directives.)

Under this option, advance directives that were completed by health care consumers would be portable—that is, states would be required to acknowledge the terms and conditions of directives that were completed and authorized in other states. To ensure that the portability of advance directives was fully implemented, this option would require the development and ongoing operation of a central database for all advance directives executed by health care consumers. The database would serve as a resource for providers who needed to confirm whether or not a patient had an advance directive, to fully understand a patient's end-of-life preferences, and to determine a course of treatment consistent with those preferences. The database would be compliant with all federal rules and regulations regarding privacy and confidentiality of medical records and would require no standard form for submitting information. All materials transmitted from the database to requesting providers would be in an electronic document format.

Other components of this option would require the Department of Health and Human Services to conduct the following activities:

- Establish a national advance-directive-assistance service by employing the existing infrastructure of State Health Insurance Assistance Programs for Medicare beneficiaries. (Those programs are funded by grants from the Centers for Medicare and Medicaid Services to provide assistance and counseling through public presentations, media activities, telephone support, and face-to-face interactions.)



- Convene an advisory board for a period of three years—composed of advocates, researchers, government officials, providers, and other experts in the field—that would be dedicated solely to issues surrounding end-of-life care.
- Develop a nationwide campaign to educate people about advance directives.

Provided that appropriated funds were available, implementing those activities would increase federal discretionary spending by about \$60 million over the 2010–2014 period and by \$110 million over the 2010–2019 period. There would be a savings to Medicare of about \$30 million over the 2010–2014 period and \$100 million over the 2010–2019 period resulting from the portability of advance directives. (It is uncertain whether such estimated Medicare savings would be counted for Congressional scorekeeping purposes if legislation requiring development of an advance directives database was considered. In that event, CBO would consult with the House and Senate Budget Committees before determining the scoring impact of such legislation.)

An argument in support of this option is that it would give states and health care providers access to advance

directives that had been completed in other states, thus making providers aware of and fully able to carry out the preferences of patients regarding their end-of-life care. In addition, the option would establish an infrastructure for information about the available options for such care, organizing resources and expertise to educate and communicate with the public on a broad scale.

An argument against the option is that providers and patients might perceive it as forcing individuals to discuss and make decisions about end-of-life care. In addition, states might contend that their legal and medical positions regarding such care were complex and suited specifically to the needs of their residents and medical institutions, which would make accepting the end-of-life preferences of other states and their residents too complicated. Furthermore, given the ethical, political, and religious undertones of this issue, individuals and organizations might consider federal funding for activities related to advance directives to be evidence of the government's involving itself in matters that should be personal and private. Other questions might be raised about whether funding for such activities could be better spent in other sectors of health care or in the economy as a whole.

«CBO»

**Option 105****Require Deposits to Individual Accounts for Purchasing Long-Term Care Insurance**

| (BILLIONS OF DOLLARS)                       | 2009     | 2010     | 2011        | 2012         | 2013         | Total        |               |
|---|----------|----------|-------------|--------------|--------------|--------------|---------------|
|   |          |          |             |              |              | 2009-2013    | 2009-2018     |
| Change in Mandatory Spending                | 0        | 0        | 0           | 14.0         | 55.0         | 69.0         | 422.0         |
| Change in Revenues <sup>a</sup>             |          |          |             |              |              |              |               |
| Long-term care fund receipts                | 0        | 0        | 0           | 14.0         | 55.0         | 69.0         | 422.0         |
| Payroll and income tax effects <sup>b</sup> | <u>0</u> | <u>0</u> | <u>9.0</u>  | <u>11.0</u>  | <u>-54.0</u> | <u>-34.0</u> | <u>-214.0</u> |
| Subtotal                                    | 0        | 0        | 9.0         | 25.0         | 1.0          | 35.0         | 208.0         |
| <b>Net Effect on the Deficit</b>            | <b>0</b> | <b>0</b> | <b>-9.0</b> | <b>-11.0</b> | <b>54.0</b>  | <b>34.0</b>  | <b>214.0</b>  |

a. Estimates of revenues were provided by the Joint Committee on Taxation.

b. Some of those estimated revenues would come from Social Security payroll taxes and so would be classified as off-budget.

Long-term care (LTC) is financed from a variety of sources, both public and private. Although private long-term care insurance covers a substantial amount of care for those who have such policies, very few people actually hold long-term care insurance policies (about 10 percent of individuals age 65 or above). Medicare finances long-term care for a small portion of services that its beneficiaries receive; however, Medicaid is the largest public source of payment for long-term care. In 2006, approximately 48 percent—or \$52.9 billion—of Medicaid’s spending went toward long-term care services. Medicaid pays for long-term care services provided in the home or community as well as for institutional care for low-income elderly and disabled individuals who exhibit a physical need. To be eligible for long-term care benefits under Medicaid, individuals are required to deplete most of their assets, including savings, as well as meet specific income requirements. Many analysts believe that Medicaid’s requirements for financial eligibility may discourage people from setting aside savings or purchasing long-term care insurance in preparation for the possibility of functional impairment when they are older.

Given that many individuals do not purchase long-term care insurance policies and do not hold such policies as long-term care needs arise, there is an increased reliance on public payers—especially Medicaid—to fund long-term care services. Increasing the ability of individuals to purchase private long-term care insurance could help reduce the strain on federal and state budgets. This option is designed to create a stable source of funding for

long-term care. It would require workers to contribute a percentage of their pretax wages to an individual account reserved specifically to pay for long-term care insurance. In the Congressional Budget Office’s estimation, a contribution of 1.2 percent of income subject to the Social Security payroll tax would meet the option’s funding requirements.<sup>1</sup> (Non-wage earners, such as stay-at-home spouses, would not be covered under this option.)

The option has the following parameters:

- The accounts themselves would be administered by a federal entity, which would invest them in Treasury securities.
- The money in the account would be the property of the individual and would be part of the individual’s estate if he or she died before turning 65.
- At age 65, the balance of the account would be required to be used to purchase the most generous long-term care insurance policy available given that balance.
- In the case of accounts with money left over after the purchase of the most generous policy, the account holder would have free use of the remaining funds after paying income tax.

1. In 2009, the cap on wage income subject to the Social Security tax will be \$106,800.

- Regardless of an individual's earnings, the same requirements would apply once the individual came to need long-term care services. Low-wage workers would have relatively small balances with which to purchase coverage and might need Medicaid coverage once their policy was exhausted. In contrast, high-wage workers would presumably have large balances, would purchase policies that provided inexhaustible benefits, and could have money remaining in their account.
- Individuals younger than 50 but older than 30 years of age on January 1, 2012, would have the value of their countable assets (the Medicaid asset test) reduced by the total dollar value of their insurance benefits. For individuals who were younger than 30—given the number of years before they would reach 65—policy-makers could wait until more information was available before deciding how to apply Medicaid's financial eligibility rules.

Typically, people purchasing long-term care insurance at age 65 find that their choices are limited and costly because insurers expect adverse selection—that is, most people who purchase policies at that age do so because they expect they will have to use the coverage. CBO assumed that under this option, the LTC insurance market would change as a result of the option's size and scope. For example, the risk of adverse selection at age 65 would be small because all workers would be purchasing coverage. In addition, the array of LTC insurance products is expected to increase. Insurance carriers would be required to community-rate their offerings (charge all policyholders the same amount for the same package of benefits) and to provide standard benefit packages to all individuals participating in the program. In addition, carriers would be subject, as they are now, to federal and state laws regarding such insurance. Private LTC insurance policies can be purchased at a very young age, but given the changing nature of this type of insurance, waiting to purchase a policy at age 65 increases the probability that the coverage has an appropriate benefit design and lessens the concern that a purchaser might have that the policy issuer could go out of business at some point before the purchaser needed to draw on the benefits.

CBO assumed that deductions under this option would begin in 2012 and, given the sizable balances that would have to accumulate to be able to buy insurance, would only apply to workers who were less than 50 years of age

on January 1 of that year. The Joint Committee on Taxation estimated that contributions to the accounts would total \$69 billion over the 2009–2013 period and \$422 billion over the 2009–2018 period. Because those contributions would be directed and managed by federal law, the program would be included in the federal budget. Contributions to the individual accounts would be considered to be revenues and outlays in equal amounts. As a result, CBO would not estimate a net impact on the federal budget as a result of establishing the individual accounts themselves. However, the deductions from wages for the accounts would be tax-exempt, which would cause revenues from income and payroll taxes to decline by about \$34 billion over the 2009–2013 period and by \$214 billion over the 2009–2018 period. In total, the option would increase the deficit by the amount of the change in revenues from income and payroll taxes.

Administrative mechanisms would also need to be in place to make this option effective. CBO presumed that a federal agency would be responsible for collecting, managing, and distributing contributions to the individual accounts. In addition, the federal government would be responsible for any enforcement mechanisms as well as the execution of any penalties related to individuals' failure to participate in the program.

In the future, as policymakers observed the program, they might wish to consider further changes for individuals who were younger than age 30 in 2012. Alternatives to this option's approach could be considered that still would achieve its ultimate goals of reducing reliance on public financing for long-term care needs. One formulation would be to make no changes to current law. After people exhausted their private insurance benefits, they would have to deplete their personal finances before qualifying for Medicaid. Another possible formulation would be to retain the Medicaid financial eligibility requirements but allow the dollar value of the private LTC insurance benefits to be applied against the insured individual's assets in determining eligibility. That is, if a person used the account to purchase a policy with benefits equaling \$150,000 (1,000 days of coverage at \$150 per day) and had assets worth \$175,000, the assets for purposes of assessing Medicaid eligibility would be \$25,000. A third alternative would be to eliminate Medicaid asset tests entirely. However, that modification would redefine current Medicaid eligibility rules, possibly resulting in more individuals' receiving Medicaid-funded long-term care services. Any changes to Medicaid eligibility rules could

have substantial implications for long-term Medicaid costs. CBO has not analyzed those options in detail and so has not estimated their implications for the federal budget.

An advantage of this option is that it would create a stable source of financing for long-term care by requiring that individuals set aside money for the eventual purchase of a long-term care insurance policy. The United States' aging population is likely to put further pressure on caregivers as well as federal and state budgets. This option would compel people to save for their long-term care needs and possibly relieve pressure on "safety-net" systems. In addition, this option could result in savings for Medicaid. If it was successfully designed and implemented, savings in the form of reduced Medicaid expenditures could offset the lost tax revenues. Because all working individuals—including low-income workers—would be required to purchase LTC insurance under this option, Medicaid might not remain the primary payer of LTC services. Under this option, low-income individuals who would

otherwise have been Medicaid beneficiaries would receive at least a portion of their LTC services through privately purchased insurance. As a result, their eligibility for Medicaid could be delayed, leading to federal and state savings.

The main disadvantage of this option is that it would be costly in the short run because the federal government would forgo some tax revenues without the possibility of realizing any Medicaid savings. Given that, under the option, so many people would have a ready means for financing their long-term care needs, the use of such services and the corresponding spending for them would probably increase. In addition, some portion of long-term care that is currently donated by family and friends could be displaced by paid care. Finally, this option would not cover people, such as stay-at-home spouses, who might not participate in the labor force for extended periods of their working life.

«CBO»

## Health Behavior and Health Promotion

**H**ealth insurance—and the access to care it can promote—is only one determinant of an individual’s overall health status. Health status largely depends on an individual’s decisions and behavior regarding, in particular, diet, exercise, smoking, and the use of preventive services. Federal policy can encourage or discourage behavior that affects health through several channels. For example, Medicare coverage of and payment for a given service can encourage wider use, both within the Medicare program and more generally. In the same way, if Medicare decides not to cover a particular intervention or limits coverage to certain populations, that decision can

have an impact beyond the Medicare program. Excise taxes can increase the cost of certain behaviors that are detrimental to health.

This chapter includes options that would affect the health of individuals through several mechanisms. In some instances, spending for health care could be affected by some of the options. However, the Congressional Budget Office has not estimated the amounts represented by those potential changes in health care spending, and such changes are not included in the estimated budgetary effects of the options in this chapter.

**Option 106****Impose an Excise Tax on Sugar-Sweetened Beverages**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | 4.5  | 4.7  | 4.8  | 4.9  | 5.0  | 23.9      | 50.4      |

Source: Joint Committee on Taxation.

In 2006, 19 states imposed taxes on soft drinks that were higher than the taxes on most other types of food products. In some cases, those levies took the form of special excise taxes or sales taxes that applied not only to soft drinks but also to snack foods, candy, or, more broadly, any products sold in vending machines. A few states apply a sales tax to soft drinks and snack products while exempting other food products. It has been estimated that the taxation of soft drinks and other snack foods generates about \$1 billion in yearly revenue for the states; some of the revenue derived from those taxes is earmarked for particular uses ranging from the control of litter to subsidies for medical and dental schools.

This option would impose a federal excise tax of 3 cents per 12 ounces of “sugar-sweetened” beverage. Sugar-sweetened beverages under this option would include a variety of carbonated and uncarbonated beverages, such as nondiet soft drinks, fruit cocktails, fruit drinks, flavored iced teas, and flavored milk and dairy drinks. The tax would apply to beverages sweetened with sugar, high-fructose corn syrup, or other similar sweeteners. The tax would not apply to artificially sweetened soft drinks—for example, those sweetened with aspartame or saccharine. Sugar-sweetened fountain-drink syrup would be taxed at a higher rate per ounce, such that the rate per ounce of fountain drink would be roughly equivalent to the tax rate on ready-to-drink soft drinks. (“Fountain-drink syrup” refers to concentrated, flavored syrup that is sold in bulk to establishments such as restaurants and that is mixed with water at the point of purchase.) If implemented, the tax described in this option would generate an estimated \$24 billion in revenues over the 2009–2013 period, and about \$50 billion over the 2009–2018 period. Because such an excise tax would reduce the consumption and production of soft drinks, it would reduce the tax base of income and payroll taxes and would therefore lead to reductions in revenues derived from those sources. The estimates shown here reflect those reductions, some of which would be off-budget, as well as

projected declines in soft-drink purchases resulting from higher after-tax prices.

Medical research has found a link between the consumption of sweetened drinks and weight gain, and other studies have found that soft-drink consumption may also be directly associated with diabetes. Research on the effects of existing state excise taxes on soft drinks seems to indicate that a federal tax of the size incorporated in this option would have a small but quantifiable effect on average body mass index (BMI), a standard measure of obesity. By helping reduce BMI and health problems related to obesity—such as heart disease, diabetes, stroke, and cancer—this option might reduce federal outlays for health care, although the magnitude of those effects is not known.

Opponents of the tax argue that other goods associated with obesity, such as those that are high in fat, pose very similar health risks but would remain exempt from increased taxation. The difference in tax treatment could simply encourage consumption of those other products and produce little improvement in health outcomes. Other opponents point out that, given current patterns of consumption, the tax would be regressive. (In other words, it would affect lower-income consumers more than it would those at higher income levels.)

Opponents of the tax have also noted that the manufacturing and pricing of soft drinks are heavily influenced by subsidies provided to farmers and other agricultural producers. They argue that government subsidies have encouraged the production of high-fructose corn syrup, which is used as an inexpensive sweetener in the drinks, and that limiting the subsidy for corn would be a more effective approach than imposing a tax to discourage the consumption of soft drinks and other snack products and to improve health.

**Option 107****Increase the Excise Tax on Cigarettes by One Dollar Per Pack**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | 8.5  | 10.1 | 9.8  | 9.7  | 9.6  | 47.7      | 94.9      |

Source: Joint Committee on Taxation.

Both the federal and state governments tax tobacco products. Currently, the federal excise tax on cigarettes is 39 cents per pack; similar levies apply to other tobacco products. In 2007, federal tobacco taxes raised a total of \$8.4 billion, or about 0.3 percent of all federal revenues. At the state level, excise taxes on cigarettes have almost tripled in the past nine years, from an average of 42 cents per pack to \$1.18. In addition, settlements reached with states' attorneys general require major tobacco manufacturers to pay fees that are equal to an excise tax of about 40 cents per pack. Together, those federal and state taxes and fees boost the price of a pack of cigarettes by \$1.97.

This option would raise the federal excise tax on cigarettes by one dollar per pack, generating \$10.1 billion in additional revenues in 2010 and a total of \$47.8 billion through 2013. Because excise taxes reduce the income base to which income and payroll taxes are applied, a boost in excise taxes would lead to reductions in income and payroll tax revenues. The estimates shown here reflect those reductions, as well as projected declines in purchases of cigarettes because of higher after-tax prices. Researchers estimate that each 10 percent increase in the price of cigarettes is likely to cause their consumption to fall by 4 percent to 6 percent (probably more in the case of teenagers).

One rationale for imposing an excise tax on cigarettes is that tobacco consumers may underestimate the addictive power of nicotine and the harm they do to themselves by smoking. Teenagers in particular may not have the perspective necessary to evaluate the long-term effects of beginning to smoke. Raising taxes on cigarettes would reduce the number of smokers and the number of cigarettes consumed by those who do smoke, thereby reducing the damage people do to their long-term health. That damage is substantial: Medical evidence identifies smoking as a cause of many varieties of cancer and of cardiovascular and respiratory diseases. In 2004, the Surgeon General called cigarette smoking the "single greatest cause

of avoidable morbidity and mortality in the United States."

Another rationale for levying an excise tax on cigarettes is that smokers impose costs on nonsmokers that are not reflected in the pretax cost of cigarettes. Known as external costs, they include higher expenditures for health insurance (to cover the medical expenses linked to smoking) and the damaging effects that cigarette smoke has on the health of nonsmokers. Most research indicates that the external costs of smoking are covered by current tax rates, although what to include in calculating those costs remains a point of contention for some experts—for example, whether to consider tobacco's effects on the health of smokers' families or the savings in spending for health care and pensions that result from smokers' shorter lives. From the perspective of the federal budget, discouraging smoking reduces spending—including spending by Medicare and Medicaid—for smoking-related diseases, but the lower mortality rates that result from less smoking at any given age could increase federal spending for Social Security and Medicare. Whether the net result of those changes would be an increase in spending is unclear, however, and the Congressional Budget Office does not have a sufficient basis for estimating the net budgetary impact of those effects.

An argument against raising taxes on cigarettes is the regressive nature of such levies, which take up a larger percentage of the earnings of low-income families than of middle- and upper-income families, for two reasons. First, lower-income people are more likely to smoke than are people from other income groups. Second, the amount that smokers spend on cigarettes does not rise appreciably with income.

Some opponents of higher cigarette taxes note that the market has mechanisms that already make individual smokers, rather than society, bear many of the costs of smoking—for example, higher insurance premiums for smokers than for nonsmokers and isolation of smokers in

restaurants and other public places. In that view, such mechanisms and the penalty they exact for smoking eliminate the need to raise taxes to reduce the costs that cigarette smoking inflicts on society.

Other opponents object to a tax that is intended to protect consumers from a supposed lack of foresight about

the harmful effects of smoking. They argue that consumer protection is a specious justification for focusing on cigarette taxes when many other choices that people make—for example, to use alcohol, consume some types of food, or engage in risky sports—may also cause unforeseen health or social problems.

«CBO»



**Option 108****Increase All Taxes on Alcoholic Beverages to \$16 Per Proof Gallon**

| (BILLIONS OF DOLLARS) | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|-----------------------|------|------|------|------|------|-----------|-----------|
|                       |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues    | 4.8  | 5.7  | 5.8  | 5.9  | 6.0  | 28.2      | 59.9      |

Source: Joint Committee on Taxation.

In 2007, the federal government collected \$9.3 billion in revenue from excise taxes on distilled spirits, beer, and wine. Under current law, the way in which those taxes are levied treats different alcoholic beverages in different ways: Specifically, taxes are much lower on the alcohol content of beer and wine than on the alcohol content of distilled spirits because the taxes are determined on the basis of different liquid measures. Distilled spirits are measured in proof gallons (a standard unit for measuring the alcohol content of a liquid). The current excise tax rate on those spirits, \$13.50 per proof gallon, translates to about 21 cents per ounce of alcohol. Beer, by contrast, is measured by the barrel, and the current tax rate of \$18 per barrel translates to about 10 cents per ounce of alcohol (under the assumption that the average alcohol content of beer is 4.5 percent). The current levy on wine is \$1.07 per gallon, or about 8 cents per ounce of alcohol (assuming an average alcohol content of 11 percent).

This option would standardize the base on which the federal excise tax is levied by using the proof gallon as the measure for all alcoholic beverages. The tax rate would be raised to \$16 per proof gallon, thus increasing revenues by about \$28 billion over the 2009–2013 period and by \$60 billion over the 2009–2018 period. (Because excise taxes reduce producers' and consumers' income, higher excise taxes would lead to reductions in income and payroll tax revenues. The estimates shown here reflect those reductions.)

A tax of \$16 per proof gallon would equal about 25 cents per ounce of alcohol. Under this option, the federal excise tax on a 750-milliliter bottle (commonly referred to as a fifth) of distilled spirits would rise from about \$2.14 to \$2.54. The tax on a six-pack of beer would jump from about 33 cents to 81 cents, and the tax on a 750-milliliter bottle of table wine would increase by a similar amount, from about 21 cents to 70 cents.

The consumption of alcohol creates costs for society that are not reflected in the pretax price of alcoholic beverages.

Examples of those “external costs” include spending on health care that is related to alcohol consumption and covered by the public, losses in productivity because of alcohol consumption that are borne by others besides the consumer, and the loss of lives and property in alcohol-related accidents and crimes. Calculating such costs is difficult. However, a study conducted for the National Institute on Alcohol Abuse and Alcoholism estimated that the external economic costs of alcohol abuse exceeded \$100 billion in 1998—an amount far greater than the revenues currently derived from taxes on alcoholic beverages. When adjusted for inflation, excise tax rates on alcohol are far lower than historic levels. In the 1950s, excise taxes accounted for nearly half of the pretax price of alcohol, whereas rates now account for between 10 percent and 20 percent of the pretax price.

One argument in favor of raising excise taxes on alcoholic beverages is that they would reduce alcohol use—and thus the external costs of that use—and make consumers of alcoholic beverages pay a larger share of such costs. Research has consistently shown that higher prices lead to less alcohol consumption, even among heavy drinkers.

Moreover, raising excise taxes to reduce consumption might be desirable, regardless of the effect on external costs, if lawmakers believed that consumers underestimated the extent of the harm they do to themselves by drinking. Heavy drinking is known to cause organ damage and cognitive impairment; and the links between highway accidents and drinking are well documented and are especially strong among the young. There is also substantial evidence that early use of alcohol can lead to heavy consumption later in life. When deciding how much to drink, individuals may not adequately consider these longer-term risks to their health. Those longer-term costs may be particularly difficult for teenagers and young adults to weigh adequately.

In addition to any benefits from raising the tax rate, this option would also equalize the taxation of alcohol in

different kinds of beverages. Some analysts believe that such an evenhanded treatment would be beneficial because it would avoid distorting consumers' choices among those various beverages.

An increase in taxes on alcoholic beverages would have disadvantages as well. It would make a tax that is already regressive—that takes up a greater percentage of income for low-income families than for middle- and upper-income families—even more so. In addition, it would affect not only problem drinkers but also drinkers who imposed no costs on society and who thus would be

unduly penalized. Furthermore, higher taxes would reduce consumption by some light drinkers whose intake of alcohol has health benefits. Moderate alcohol consumption, particularly of wine, has been linked to lower incidence of heart disease, obesity, and stroke, and increases in life expectancy in middle age. Finally, with regard to the argument that drinkers underestimate the personal costs of alcohol consumption, some opponents of raising taxes on alcohol argue that the government should not try to modify consumers' private behavior for reasons other than major external costs to society.

«CBO»

**Option 109****Reduce Medicare Payment Rates for Primary Care Physicians Who Do Not Meet Benchmarks for Influenza Vaccination**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -170 | -200 | -160 | -530      | -620      |

The Centers for Disease Control and Prevention (CDC) has estimated that seasonal outbreaks of influenza result in an average of 226,000 hospitalizations and 36,000 deaths per year. That burden of morbidity and mortality falls most heavily on the elderly, who account for 90 percent of influenza-related deaths. CDC's Advisory Committee on Immunization Practices has identified vaccination against influenza as "the most effective method for preventing influenza virus infection and its potentially severe complications" and has recommended that all individuals above the age of 50 receive an annual vaccination. Despite that recommendation, roughly half of Medicare beneficiaries currently do not receive a Medicare-covered annual vaccination against influenza.

This option would reduce Medicare's payment rates for services rendered by primary care physicians (PCPs) who do not meet a benchmark rate of influenza vaccination among their Medicare patients. Vaccination rates would be calculated on the basis of panels of patients; each PCP's panel would consist of all Medicare beneficiaries ages 50 and older whom the physician had treated at any point during the previous flu season (September through March). The vaccination rate would equal the share of those beneficiaries who had received an influenza vaccination at some point during that flu season. Patients would be counted as having received a vaccination if a claim was submitted to Medicare for that service—whether provided by the PCP or another provider—or if a code was submitted to Medicare indicating either that the vaccination was contraindicated or that the patient had been offered a vaccination and had declined it. Under this option, PCPs who did not meet a threshold vaccination rate of 60 percent in the previous flu season would see a reduction of 1.5 percent in all fees that Medicare paid them for the covered services they provided. The option would reduce spending for Medicare by

\$0.5 billion over the 2010–2014 period and by \$0.6 billion over the 2010–2019 period. CBO expects that by 2019 the great majority of PCPs would meet the threshold vaccination rate and avoid the fee reductions.

CBO expects that this option would initially reduce Medicare spending but increase it over the long run, reflecting several offsetting effects. This option would reduce Medicare physician spending through the 1.5 percent fee reductions, and, by increasing vaccination rates, it would reduce influenza-related hospitalizations and mortality. CBO expects, however, that vaccination rates, and Medicare spending on vaccinations, would increase over the 2010–2019 period, and that the share of PCPs facing the fee reductions would decline substantially. Over the long run, CBO expects that the savings from fee reductions and avoided hospitalizations would be more than offset by the combination of the direct costs of additional vaccinations and the increase in the number of Medicare beneficiaries surviving to older ages.

An argument in favor of this option is that among older adults, influenza accounts for a large burden of disease, and vaccination is a highly cost-effective approach to preventing it. Furthermore, the option might encourage physicians to adopt and use health information technology systems to track the vaccination status of their patients.

An argument against the option is that physicians could perceive themselves as being unfairly held accountable for patients with whom they may have had little contact and over whose behavior they may have little control. Physicians would also suffer financially under this option in the case of vaccine shortages, such as the one that occurred in the United States in 2004.

«CBO»

**Option 110****Base Medicare's Coverage of Preventive Services on Evidence of Effectiveness**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | -30  | -80  | -80  | -80  | -90  | -360      | -850      |

The United States Preventive Services Task Force (USPSTF), which is sponsored by the Department of Health and Human Services' Agency for Healthcare Research and Quality, conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services. The task force reviews the available research, estimates the magnitude of the benefits and harm associated with each service, reaches a consensus about the service's net benefit, and issues recommendations on an ongoing basis. It grades the strength of the evidence of a service's effectiveness as follows: A—the task force strongly recommends the service; B—the task force recommends the service; C—the task force has no recommendation for or against the service (that is, there is at least fair evidence that the service can improve outcomes for patients, but the balance of benefits and harm is too even to justify a general recommendation); D—the task force recommends against using the service (that is, at least fair evidence was found that the service is ineffective or that its harm outweighs its benefits); and I—the evidence is insufficient for a recommendation for or against (that is, evidence is lacking that the service is effective, of poor quality, or conflicting, and the balance of benefits and harm cannot be determined).

The USPSTF's recommendations are considered the "gold standard" for clinical preventive services by health care experts and are updated periodically to reflect new evidence. For several services that Medicare is currently required by law to pay for, the task force has assigned grades indicating that the evidence of the service's benefits is insufficient, that the service is ineffective, or that the potential harm from the service outweighs its benefits.

The Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) gives the Secretary of the Department of Health and Human Services the authority to cover additional preventive services that the Secretary determines meet the following criteria: The

services are reasonable and necessary for the prevention or early detection of an illness or disability; the services are recommended with a grade of A or B by the USPSTF; and the services are appropriate for Medicare beneficiaries. The Secretary may not eliminate existing coverage for preventive services that do not meet the USPSTF's standards for an A or B grade. The USPSTF has given grades of A or B to only 7 of the 18 preventive services that Medicare covers.<sup>1</sup>

This option would allow the Secretary of Health and Human Services to modify Medicare's coverage of preventive services to which the USPSTF has assigned a grade other than A or B. The Secretary could maintain coverage despite the USPSTF's recommendations, restrict coverage to certain subgroups that had risk factors that made the preventive service more likely to be beneficial, or eliminate Medicare's coverage of the service. In estimating the change in outlays that this option might generate, the Congressional Budget Office assumed that coverage for all services assigned a grade of D would be eliminated and that most services assigned a grade of C or I would be retained. Specifically, coverage for the following services, CBO expects, would be eliminated: electrocardiograms provided during the "Welcome to Medicare" visit that the program routinely provides for low-risk beneficiaries; cervical cancer screening for women over the age of 65 whose recent PAP smears have been normal; and the use of prostate-specific antigen tests to screen for prostate cancer in men over age 75. This option would reduce outlays by about \$360 million over the 2010–2014 period and by about \$850 million over the 2010–2019 period.

A rationale for this option is that it would give the Secretary of Health and Human Services the flexibility to adjust Medicare's coverage of preventive services that have been judged ineffective or harmful by an expert,

1. See [www.ahrq.gov/clinic/uspstfix.htm#Recommendations](http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations) for the USPSTF recommendations.

independent body. The option would also permit the Secretary to modify coverage if the evidence about a particular service changed. In addition, the option would represent an incremental step toward evidence-based medicine, an approach supported by many advocates of changing the way health care services are delivered. Furthermore, if Medicare based its coverage of preventive services on the USPSTF's recommendations, that shift in policy would help disseminate the task force's considered judgments to physicians, which should improve the quality of care that Medicare beneficiaries receive.

An argument against this option is that if it was implemented, some Medicare beneficiaries would no longer have coverage for services that could benefit them. That concern could be addressed by limiting the Secretary's flexibility to adjust coverage, restricting that authority to services that are given a grade of D (rather than grades of C, D, or I) by the task force. Another concern is that because the USPSTF's recommendations under this option would have a more direct effect on Medicare's coverage policy than they do now, the task force's members might feel increased pressure to give a service the benefit of the doubt. The Secretary could face similar pressure in revising Medicare's coverage of some services.

«CBO»



## Closing the Gap Between Medicare's Spending and Receipts

**T**he Medicare program is financed in several ways. A payroll tax, which is shared between employers and employees (self-employed individuals pay the entire tax), funds the Hospital Insurance (HI) Trust Fund, which pays part of the costs for benefits covered under Part A of Medicare (that is, inpatient hospital care and other services furnished by institutional providers).<sup>1</sup> The Supplementary Medical Insurance (SMI) Trust Fund, which funds Part B (physicians' and other outpatient services) and Part D (outpatient drugs) is financed through general revenues and beneficiaries' premiums. Medicare Advantage, or Part C of Medicare, is financed by both the HI and SMI trust funds.

Federal spending for Medicare has been growing faster than the economy for decades and is projected to continue doing so. Between 1975 and 2008, spending for Medicare grew from 1.0 percent of gross domestic product (GDP) to 2.8 percent. The Congressional Budget Office projects that, under current law, federal spending for Medicare will rise to nearly 9 percent of GDP in 2050. The program's future spending growth will be driven primarily by the growth in per capita medical costs, with the aging of the population playing a secondary role.

Income from payroll taxes and premiums, however, is not keeping pace with the rising cost of the program. The Medicare Modernization Act of 2003 included a provision that requires the Medicare trustees to issue a warning

when general revenues are projected to account for 45 percent or more of Medicare's total expenditures for any one year within a seven-year projection period.<sup>2</sup> (The law defines those periods as the current fiscal year and the subsequent six fiscal years.) If two consecutive funding warnings are issued, the Medicare Modernization Act directs the President to propose to the Congress legislation intended to prevent general revenue funding from actually exceeding 45 percent of the program's expenditures. The Medicare trustees issued such a warning in their 2006, 2007, and 2008 reports; in March 2008, the Administration proposed legislation in response to the funding warning, but the Congress has not acted on it.

Because Medicare is a mandatory program, its funding does not require an annual appropriation, and changes to its operations require authorizing legislation. In contrast, most funding for program management—that is, the money that the Centers for Medicare and Medicaid Services uses to administer the program—is subject to appropriation, but there is some mandatory administrative funding, including resources dedicated to minimizing waste, fraud, and abuse within the program.

This chapter includes broad options for addressing, in part, some of the short- and long-term challenges of financing the Medicare program. In addition, one option considers increased funding to address waste, fraud, and abuse.

1. A small number of Medicare beneficiaries also pay a premium to receive HI-funded services because they have not paid into the HI trust fund for at least 10 years.

2. The Medicare trustees comprise the Secretaries of the Treasury, Health and Human Services, and Labor, as well as the Commissioner of Social Security and two public trustees. They report annually on the financial status of the Medicare trust funds.

**Option 111****Increase the Payroll Tax Rate for Medicare Hospital Insurance by 1 Percentage Point**

| (BILLIONS OF DOLLARS)                                | 2009 | 2010 | 2011 | 2012 | 2013 | Total     |           |
|--|------|------|------|------|------|-----------|-----------|
|  |      |      |      |      |      | 2009-2013 | 2009-2018 |
| Change in Revenues                                   |      |      |      |      |      |           |           |
| Increase the rate on all earnings                    | 6.2  | 27.7 | 43.6 | 64.5 | 67.5 | 209.5     | 592.2     |
| Increase the rate on earnings in excess of \$150,000 | 2.2  | 6.3  | 1.3  | 8.2  | 8.7  | 26.6      | 77.2      |

Source: Joint Committee on Taxation.

The primary source of financing for the Hospital Insurance (HI) Trust Fund, which pays for benefits covered under Part A of Medicare, is a payroll tax.<sup>1</sup> Employers and employees each pay 1.45 percent of wages, and self-employed workers pay 2.9 percent of their net income. Unlike the payroll tax for Social Security, which applies to earnings up to an annual maximum (\$106,800 in 2009), the HI tax is levied on total earnings.

According to the Congressional Budget Office's estimates, expenditures from the Hospital Insurance Trust Fund will grow at an average annual rate of 6.6 percent through 2017, and revenues to the HI Trust Fund will grow at an average annual rate of 4.6 percent. In 2011 and thereafter, expenditures for hospital insurance are projected to exceed the program's total income, causing a drawing down of reserves in the HI Trust Fund. CBO projects that the balances will fall sharply in the last few years of the 2009–2018 period and will be exhausted in 2019.<sup>2</sup>

This option comprises two alternatives for increasing revenues from the HI payroll tax. The first alternative would raise the HI tax rate on all earnings by a total of 1 per-

centage point. The payroll tax rate paid by employers and employees would each increase to 1.95 percent, and the rate paid by self-employed people would rise to 3.9 percent. That alternative would increase revenues by \$209.5 billion over the 2009–2013 period and by \$592.2 billion over the 2009–2018 period. By 2050, the option would have increased receipts to the HI Trust Fund by 34 percent—or, measured relative to the size of the economy, from 1.2 percent of gross domestic product to 1.6 percent.

Increasing the HI payroll tax rate would boost the revenues that flowed to the HI Trust Fund to a substantial degree and extend the solvency of the fund, but the option would also have some drawbacks. Higher tax rates on earnings reduce people's incentive to work and encourage taxpayers to shift income from taxable to non-taxable forms, which causes economic resources to be allocated less efficiently than they otherwise might be. (Conversely, because a higher tax rate would also reduce total after-tax income, workers under this option might choose to work more so as to maintain the same level of disposable income that they had before the increase in rates.)

Another drawback to this alternative is that an increase in the HI payroll tax rate would be relatively more burdensome for low- and middle-income workers than for higher-income earners. Taxable wages make up a smaller proportion of income for higher-income earners than for low- and middle-income workers. Although HI payroll taxes constitute the same percentage of taxable earnings for all workers, higher-income households end up paying a smaller percentage relative to their total income because they derive a greater share of that income from sources

1. In 2007, payroll tax revenues accounted for approximately 85 percent of the income credited to the HI Trust Fund (which is the budgetary accounting mechanism that keeps track of receipts and outlays for benefits covered by Part A of Medicare as well as associated administrative costs). Other sources of revenue credited to the trust fund include a portion of the federal income tax that people pay on their Social Security benefits and interest on the trust fund's reserves.
2. The estimated exhaustion date for the HI Trust Fund does not reflect the recent deterioration in economic conditions, which could result in earlier exhaustion of the trust fund.



other than wages, such as capital income and rental income, which are not subject to the HI payroll tax.

An alternative approach under this option would be to raise the HI payroll tax rate by 1 percentage point on earnings above \$150,000 in 2010 and index the earnings threshold for inflation thereafter. That approach would avoid a tax increase for low- and middle-income workers but still extend the period of solvency of the HI Trust Fund. The alternative would increase revenues by

\$26.6 billion over the 2009–2013 period and by \$77.2 billion over the 2009–2018 period; it would provide about 13 percent of the revenues that would be collected under the first alternative (which would raise the tax rate on all earnings). By 2050, this alternative would have increased HI revenues by 4 percent—or, measured relative to the size of the economy, from 1.2 percent of gross domestic product to 1.3 percent.

«CBO»

**Option 112****Limit Growth in Medicare Per Capita Spending to Growth in Per Capita Gross Domestic Product Plus 1 Percentage Point**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 0    | 0    | 0    | 0         | -2,500    |

The Congressional Budget Office projects that, under current law, federal spending for Medicare and Medicaid as a percentage of gross domestic product (GDP) will rise from 4 percent in 2008 to 12 percent in 2050. The bulk of that projected increase in health care spending reflects higher per-beneficiary costs rather than an increase in the number of beneficiaries associated with an aging population.

In recent years, many proposals for improving the efficiency of the health care system have emerged. Because spending for Medicare accounts for a large share of total federal health care costs and is thought to influence health care delivery in the broader health care system, some policymakers have proposed giving the executive branch broader authority to make changes to Medicare that would reduce the program's costs while balancing the need to maintain or improve the quality of the care being delivered. Currently, the Secretary of Health and Human Services has some discretion in managing the Medicare program but cannot, for example, change beneficiaries' copayments; alter the hospital market-basket update (which increases payments to hospitals to reflect increases in their cost of doing business); or modify benchmark levels for Medicare Advantage (the program that allows enrollees to obtain Medicare benefits through private plans). If policymakers were to give the Secretary more authority to make program changes than the scope permitted under current law, they would probably want to set clear performance goals to accompany that increased authority.

Lawmakers could choose to set an explicit limit on the growth of expenditures in the Medicare program and provide the Secretary with authority to make changes in levels of coverage, payments to Medicare providers, and beneficiaries' cost sharing to keep the growth in the program's spending below the limits specified by law. To be effective, such a policy would need an enforcement mechanism, such as an across-the-board reduction in providers'

payments that would take effect if the Secretary failed to make sufficient changes to the program to bring the growth of spending within the prescribed limit.

This option would create a target that would limit annual growth in Medicare's per-enrollee spending between 2009 and 2019 to yearly per capita growth in GDP plus 1 percentage point. The Secretary would have new authority to make program changes to reduce spending to targeted levels. Those levels would be enforced by requiring actuaries employed by the Centers for Medicare and Medicaid Services (CMS) to include in the annual Medicare trustees' report an analysis of how actual per-enrollee expenditures during a given fiscal year had increased in comparison with the growth in per-enrollee expenditures allowed under the limit. If growth exceeded the limit, CMS's actuaries would estimate the percentage decrease in payments required to reduce expenditures below the limit for the following year. The reduction in payments would be applied equally to all claims for services furnished in the fee-for-service sector of Medicare (the part of the program that pays hospitals, physicians, and other providers directly for services). The reduction would not apply to services for which payment rates are set through a competitive bidding process. For Medicare Advantage plans (Part C), the reduction in payments would be reflected in benchmarks for the next calendar year.

In estimating the budgetary effects of this option, CBO used its current baseline estimates of Medicare's per capita outlays and its estimates of per capita growth in GDP. Under those assumptions, the limit on expenditures would not be lower than Medicare's current level of spending until 2014, and the savings from carrying out the across-the-board reduction would not occur until 2015. Overall, the expenditure limit would reduce federal outlays by \$2.5 billion between 2010 and 2019. (CBO's estimate of this option's budgetary effects is based on the reduction in outlays that would occur if the across-the-board enforcement mechanism was implemented. The

Secretary's changes could result in more savings or in a different pattern of savings.)

The target used for this option is roughly consistent with CBO's current-law baseline projections of Medicare's per-enrollee spending for 2009 through 2013, which reflect a 21 percent reduction in physician payment rates for 2010 and further reductions for most of the following years. (Some people view current-law baseline projections as an unrealistic estimate of Medicare's spending because lawmakers have enacted legislation to prevent large reductions in physicians' fees for several years in a row.) The savings target could be met by implementing combinations of a number of options found elsewhere in this volume.

An advantage of this option is that it would allow lawmakers to set goals for reducing health care spending while delegating the authority to make the program changes necessary to achieve the savings. That delegation of authority potentially would give the Secretary of

Health and Human Services the flexibility to experiment with the Medicare program's parameters and to adjust those parameters on the basis of lessons learned during the implementation of a particular approach. Under this option, performance relative to the target would be assessed retrospectively, on the basis of actual program experience rather than on projected program costs. As a result, the option would be more likely to control spending growth than would an option featuring a target that was assessed prospectively.

An argument against this option is that it would greatly expand the authority of the Secretary and would do so with little accountability. Another disadvantage of the option is that it does not include a cap on the maximum allowable reduction and so could result in large—and potentially disruptive—cuts in payments if spending in a given year was very high relative to the target. As a result, significant pressure might arise for legislation to avert such cuts, and the savings might not be attained.

«CBO»

**Option 113****Design an Enforcement Mechanism for the Medicare Funding Warning**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|------------------------------|------|------|------|------|------|-----------|-----------|
|                              |      |      |      |      |      | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | 0    | 0    | 0    | 0         | -73,500   |

The Medicare program is funded primarily through payroll taxes, premiums paid by beneficiaries, and general revenues (that is, funds from the Treasury not already designated for another purpose). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included a provision to prompt lawmakers to look at the financial health of Medicare on a regular basis. Under that provision, the Medicare trustees are required to determine the percentage of Medicare costs that are funded from general revenues in the prior fiscal year and estimate the percentage for the current year and the six ensuing years—a total of seven fiscal years. When they project that general revenue funding will exceed 45 percent during that seven-year period, the trustees must issue a “Medicare funding warning.” Moreover, if a warning is issued for two successive fiscal years, the President is required to submit legislation to the Congress that is intended to bring financing from general revenues below 45 percent for the seven-year period. Procedures are in place to expedite the consideration of such legislation. However, the Congress is not required to act on the President’s proposal, thus limiting the effectiveness of the trigger as a tool for constraining Medicare spending.

This option would leave in place the existing requirements and expedited procedures, and establish a fail-safe mechanism that would be activated once the trustees determined that the percentage of funding from general revenues exceeded 45 percent in the prior fiscal year. On July 1 or two months after the Medicare trustees’ report is released, whichever comes last, the mechanism would apply an automatic 1.0 percent reduction in payments for services furnished in Medicare’s fee-for-service sector. The reduction would not apply to services for which payment rates are set through a competitive bidding process. For Medicare Advantage plans (which allow beneficiaries to receive their Medicare benefits through private insurers), the 1.0 percent reduction would apply to benchmark rates for the next calendar year. The reductions would be increased by 1.0 percentage point each time the trustees

determined that the percentage of funding from general revenues exceeded 45 percent in the prior fiscal year, thereby creating a cumulative effect—that is, the reduction would be 2.0 percent in the second year and 3.0 percent in the third year. The Congressional Budget Office currently projects that the threshold will be breached in fiscal year 2014; therefore, the mechanism would apply to the fee-for-service sector beginning in July 2015 and to Medicare Advantage plans starting on January 1, 2016.<sup>1</sup> Because of delayed implementation, this option would not reduce federal outlays over the 2010–2014 period. However, it would reduce federal outlays by \$73.5 billion over the 2010–2019 period.<sup>2</sup> Funding from general revenues would not be reduced to 45 percent of Medicare’s spending until several years after 2019. To ensure that financing from general revenues dropped below the 45 percent threshold by 2019, the mechanism would need to apply at least a 4.5 percent reduction in payments for Medicare services.

An argument in favor of this option is that the fail-safe mechanism would allow policymakers to put in place an automatic constraint on Medicare’s spending. An argument against this option is that Medicare beneficiaries could see their access to health care become more limited as payments to providers and institutions were cut. Such action could result in decreased participation in the Medicare program. Another potential disadvantage of this option is that Medicare spending reductions would result whenever the threshold was exceeded, even when lawmakers opted to take no action or had other priorities for the Medicare program.

1. The year in which funding from general revenues is projected to exceed 45 percent of Medicare’s spending is sensitive to changes in both projected spending and projected payroll tax receipts.
2. Those reductions would be in addition to decreases in physician payments under the sustainable growth rate mechanism.

**Option 114****Set a Savings Target to Reduce Spending for Medicare by 1 Percent**

| (MILLIONS OF DOLLARS)        | 2010 | 2011 | 2012   | 2013   | 2014   | Total     |           |
|------------------------------|------|------|--------|--------|--------|-----------|-----------|
|                              |      |      |        |        |        | 2010-2014 | 2010-2019 |
| Change in Mandatory Spending | 0    | 0    | -1,000 | -6,900 | -7,200 | -15,100   | -55,500   |

Rising health care costs are one of the central fiscal challenges facing the United States today. Medicare's spending accounts for a large share of total federal health care costs and is thought to influence the broader health care delivery system. Some people have proposed giving the executive branch broader authority to make changes in the Medicare program that would improve its performance while balancing the need to maintain or improve the quality of the care it delivers. Currently, the Secretary of Health and Human Services (HHS) has some discretion in managing the Medicare program but cannot, for example, change beneficiaries' copayments, the hospital payment update, or the benchmark levels for payments in the Medicare Advantage program. If policymakers were to give the Secretary of HHS more authority to make changes than is available under current law, lawmakers might want to set clear goals to be achieved with that increased authority.

One way for policymakers to set such goals would be to assign the Medicare program a specific target for savings that the Secretary of HHS would be required to achieve through administrative action. To be effective, such a policy would have to specify the amount of savings to be garnered each year and the metric against which savings would be assessed (for example, the projections by the Centers for Medicare and Medicaid Services, or CMS, of spending for the program under current law). Once approaches were developed to achieve the targeted savings, the projected effects of those approaches would have to be independently verified. In addition, such a policy would need to include an enforcement mechanism, such as an across-the-board reduction in payments to providers if the Secretary failed to make the changes necessary to achieve the specified target for savings. There are a variety of ways in which such a policy could be structured; the option presented here illustrates one approach.

This option would set annual targets for Medicare, for 2012 through 2019, of a 1 percent reduction in outlays and would give the Secretary of HHS broad but tempo-

rary authority to make changes in the program to achieve that specified amount. Once the target was enacted, the Secretary would have two years to develop a set of changes to achieve it, after which his or her authority to make program changes under the savings target provision would expire—once final regulations implementing the changes were published. The CMS actuaries would estimate the reduction in outlays that the changes would produce relative to what projected spending would otherwise have been and publish their results in the March 2012 report of the Medicare trustees. If the actuaries did not project that the changes would reduce outlays by an amount sufficient to meet the targeted level of savings for the 2012–2019 period, then an across-the-board reduction in providers' payments would be instituted to achieve that level.

The legislation that established the target policy would have to carefully identify the method for assessing whether or not the target had been met. To enhance the CMS actuaries' independence in certifying the estimated savings in Medicare's costs, the legislation could require the Government Accountability Office to audit the procedures used in the estimating process and report its findings to the Congress. In addition, the Secretary of HHS could be required to have the actuaries' estimates certified by separate, independent actuaries.

This option would yield estimated savings of \$15.1 billion between 2010 and 2014 and of about \$55.5 billion over the 10 years from 2010 to 2019. The Congressional Budget Office's estimate of the budgetary effects of this option are based on the reduction in outlays that would occur if the enforcement mechanism was implemented—that is, if an across-the-board cut was instituted that would reduce payments for services furnished in Medicare's fee-for-service sector. That cut would not apply to services for which payment rates are set through a competitive bidding process. For Medicare Advantage plans, the reduction in payments would apply to benchmarks for the next calendar year.

An advantage of this option is that it would allow policy-makers to set goals for reducing health care spending while delegating authority to the Secretary of HHS to make the required changes in Medicare to achieve those savings. That delegation of authority would potentially give the Secretary the flexibility to implement changes

that would allow for building on program experience and recent research.

An argument against the option is that it would greatly expand the Secretary's authority but institute little accountability.

«CBO»

**Option 115****Increase Funding for the Health Care Fraud and Abuse Control Program in Medicare and Medicaid**

| (MILLIONS OF DOLLARS)                                     | 2010 | 2011 | 2012 | 2013 | 2014 | Total     |           |
|---|------|------|------|------|------|-----------|-----------|
|   |      |      |      |      |      | 2010-2014 | 2010-2019 |
| <b>Spend \$100 Million in 2010</b>                        |      |      |      |      |      |           |           |
| Change in HCFAC Outlays                                   | 100  | 0    | 0    | 0    | 0    | 100       | 100       |
| <b>Memorandum:</b>  |      |      |      |      |      |           |           |
| Estimated Savings Attributable to Increased HCFAC Funding | -45  | -45  | -45  | -45  | 0    | -180      | -160      |
| <b>Spend \$100 Million per Year</b>                       |      |      |      |      |      |           |           |
| Change in HCFAC Outlays                                   | 100  | 100  | 100  | 100  | 100  | 500       | 1,000     |
| <b>Memorandum:</b>  |      |      |      |      |      |           |           |
| Estimated Savings Attributable to Increased HCFAC Funding | -40  | -90  | -130 | -180 | -180 | -620      | -1,520    |

Notes: HCFAC = Health Care Fraud and Abuse Control.

Savings attributable to funding for administration or program management are not counted for Congressional scorekeeping purposes.

The Health Care Fraud and Abuse Control (HCFAC) program focuses on reducing waste, fraud, and abuse within the Medicare and Medicaid programs. Funding for HCFAC is provided through a permanent authorization of funds from Medicare's Hospital Insurance (HI) Trust Fund and general revenues; that funding is not subject to annual appropriation. Under current law, the Congressional Budget Office projects, spending for HCFAC will total about \$1.1 billion annually over the coming decade.

Money from the HCFAC program supports activities within the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services' Office of the Inspector General, the Department of Justice, and the Federal Bureau of Investigation. More specifically, funding from the HCFAC program enables CMS to perform background checks on Medicare providers, to staff dedicated antifraud offices, and to audit providers' claims for payment to determine their accuracy and appropriateness. Money from HCFAC that is allocated to the Office of the Inspector General is used to evaluate the Medicare and Medicaid programs, to discover improprieties, and to recommend corrective action.

The President's budget request for 2009 proposed \$198 million in new appropriated discretionary funding for HCFAC, which the Administration estimated would generate about \$350 million in savings in one year for Medicare and Medicaid. Those amounts represent a return on investment of about 1.75 to 1.0—that is, for every \$1.00 that the government spent for HCFAC, there would be a return of \$1.75, which, according to the Administration, would reflect the recoupment of improper payments to providers. Previously, the Administration estimated a return of 13 to 1 for the Medicare Integrity Program, which funds a variety of activities, including prevention of waste, fraud, and abuse in the Medicare drug benefit (Part D) program, and an overall return on investment of 4 to 1 for HCFAC funding. (Estimating the return on investment for the HCFAC program can be challenging, however, because resources that the program spends in one year may yield savings in a subsequent year. Moreover, each additional dollar of HCFAC funding may not yield the same return on investment. Instead, there may be diminishing returns to an increase in funding.)

In its analysis of the President's budgetary proposals for 2009, CBO estimated that the new discretionary HCFAC funding would result in savings of about \$350

million—the same amount that the Administration estimated. Unlike the Administration, however, CBO did not estimate that all savings would accrue in the first year but rather that those savings would accrue over several years.

This option would provide an additional \$100 million in appropriated funding for HCFAC—either on a one-time basis or in each year over the next 10 years.

In CBO’s estimation, such spending would result in savings to Medicare and Medicaid of about \$180 million and about \$1.5 billion, respectively, over the next 10 years. In either case, the savings would exceed the initial expenditures.

The Congressional budget process follows a set of rules established by the Congress for use in estimating the cost of proposed legislation.<sup>1</sup> Those “scorekeeping guidelines” ensure consistent treatment of spending and revenue legislation across programs and over time. Scorekeeping rule 14 states: “No increase in receipts or decrease in direct (i.e., mandatory) spending will be scored as a result of provisions of a law that provides direct spending for administration or program management activities.” Similarly, scorekeeping rule 3 prohibits scoring changes in

mandatory spending as a result of changes in the amount appropriated for administrative or program management activities.

Those scorekeeping rules mean that, for Congressional budget enforcement purposes, the budgetary impact recorded for a boost in funding for the HCFAC program—whether that increase was funded with an appropriation or mandatory spending—would reflect the change in the cost of HCFAC’s activities but not a reduction in mandatory spending for Medicare or Medicaid benefits. When such a reduction occurred, however, those savings would be recorded in the budget and thus would ultimately reduce the overall deficit.

The view that such opportunities for savings might exist is supported by the Government Accountability Office, which has long had both Medicare and Medicaid on its high-risk list (meaning that the programs are vulnerable to inappropriate spending, fraud, and abuse).<sup>2</sup> Yet boosting funding for program integrity under HCFAC probably offers diminishing returns, and increased investment in combating waste, fraud, and abuse is unlikely to significantly slow overall growth in spending for Medicare and Medicaid.

1. In general, federal budget law is set out in the Congressional Budget and Impoundment Act of 1974, as amended, and the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

2. Government Accountability Office, *High-Risk Series: An Update*, GAO-07-310 (January 2007).



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