Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2020 Budget

Medicare is the federal health insurance program for people who are 65 or older, for younger people with certain disabilities, and for people of any age with end-stage renal disease. The program has three principal components: Part A (Hospital Insurance), Part B (Medical Insurance, which covers doctors' services, outpatient care, home health services, and other medical services), and Part D (which covers outpatient prescription drugs). Nearly all Medicare beneficiaries enroll in the program soon after they become eligible, typically either at age 65 or two years after they qualify for Social Security Disability Insurance benefits. Part A benefits are paid from the Hospital Insurance Trust Fund (funded largely through payroll taxes); Part B and Part D benefits are paid from the Supplementary Medical Insurance Trust Fund (about 25 percent funded by premiums paid by enrollees and about 75 percent funded from general revenues).

Proposals for Medicare - CBO's Estimate of the President's Fiscal Year 2020 Budget

	By Fiscal Year, Millions of Dollars										2020-2024	2020-2029
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029		
Increases or Decreases (-) in Direct Spending Outlays (a)												
1. Eliminate cost-sharing on generic drugs and biosimilars for low-income beneficiaries	0	1,730	2,680	2,500	2,280	2,640	2,700	2,770	3,200	2,500	9,190	23,000
2. Exclude manufacturer discounts from the calculation of beneficiary out-of-pocket costs in the Medicare Part D coverage gap	0	-4,350	-6,880	-6,920	-6,820	-8,150	-8,760	-9,470	-11,170	-10,690	-24,970	-73,210
3. Establish a beneficiary out-of-pocket maximum in the Medicare Part D catastrophic phase	0	-120	-180	-180	-170	-200	-210	-220	-260	-230	-650	-1,770
4. Give the Secretary authority to contract with pharmaceutical manufacturers entering into new coverage gap discount program agreements on a quarterly basis	0	0	0	0	0	0	0	0	0	0	0	0
5. Permanently authorize a pilot on retroactive Medicare Part D coverage for low-income beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
6. Authorize the HHS Secretary to leverage Medicare Part D plans' negotiating power for certain drugs covered under Part B		Not enough detail										
7. Establish an inflation limit on reimbursement for Medicare Part B drugs		Not enough detail										
8. Improve manufacturers' reporting of average sales prices to set accurate payment rates	0	0	0	0	0	0	0	0	0	0	0	0
9. Modify payment for drugs hospitals purchased through the 340B discount program and require a minimum level of charity care for hospitals to receive a payment adjustment related to uncompensated care	0	0	0	0	0	0	0	0	0	0	0	0
10. Eliminate pass-through payments for drugs, biologicals, and biosimilars	0	-60	-90	-90	-100	-110	-120	-130	-140	-140	-340	-980
11. Reduce Wholesale Acquisition Cost-based payments		Not enough detail										
12. Reduce average sales price-based payments when the primary patent expires		Not enough detail										
13. Improve the Medicare appeals system (b)	3	7	8	8	8	9	9	9	10	9	34	80
14. Improve and tailor the way Medicare educates beneficiaries about the program (b)	0	90	90	90	90	90	90	90	90	90	360	810
15. Eliminate arbitrary thresholds and other burdens to encourage participation in advanced Alternative Payment Models	-95	-195	-165	45	170	70	5	10	15	15	-240	-125
16. Simplify reporting for clinicians participating in the Merit-based Incentive Payment System	0	0	0	0	0	0	0	0	0	0	0	0
17. Alter the frequency of skilled nursing facility surveys	0	0	0	0	0	0	0	0	0	0	0	0
18. Remove timeframe for initial surveys for end-stage renal disease facilities under the Bipartisan Budget Act of 2018	0	0	0	0	0	0	0	0	0	0	0	0
19. Allow CMS flexibility to determine the frequency of Programs of All-Inclusive Care for the Elderly audits	0	0	0	0	0	0	0	0	0	0	0	0
20. Eliminate the requirement of a face-to-face provider visit for durable medical equipment	0	0	0	0	0	0	0	0	0	0	0	0

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	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029		
Increases or Decreases (-) in Direct Spending Outlays (a)												
21. Remove the requirement that physicians certify that all critical access hospital patients are expected to be discharged within 96 hours of admission	0	10	30	40	60	80	80	90	100	100	140	590
22. Create a consolidated hospital quality payment program	0	0	0	0	0	0	0	0	0	0	0	0
23. Authorize the Secretary to implement new measures for the End-Stage Renal Disease Quality Incentive Program	0	0	0	0	0	0	0	0	0	0	0	0
24. Increase end-stage renal disease networks funding to match consumer price index		Not enough detail										
25. Consolidate and block grant GME payments (c)	0	-14,260	-15,100	-15,960	-16,810	-17,700	-18,610	-19,520	-20,810	-21,850	-62,130	-160,620
26. Modify payments to hospitals for uncompensated care (c)	0	-14,830	-16,380	-17,070	-17,620	-19,360	-20,540	-21,700	-24,130	-23,730	-65,900	-175,360
27. Reduce Medicare coverage of bad debts	0	-480	-1,520	-3,130	-4,050	-4,600	-4,950	-5,320	-5,980	-5,930	-9,180	-35,960
28. Address excessive payment for post-acute care providers by implementing post-acute care reductions	0	-1,070	-2,650	-4,250	-6,320	-9,230	-10,370	-11,120	-12,550	-12,480	-14,290	-70,040
29. Authorize long-term care hospital site-neutral exceptions criteria	0	-420	-460	-470	-480	-520	-550	-570	-620	-600	-1,830	-4,690
30. Pay all hospital-owned physician offices located off-campus at the physician office rate	-450	-900	-1,080	-1,170	-1,240	-1,460	-1,620	-1,810	-2,140	-2,140	-4,840	-14,010
31. Pay on-campus hospital outpatient departments at the physician office rate for certain services	-1,990	-5,230	-6,050	-6,340	-6,570	-7,500	-8,160	-8,910	-10,260	-10,080	-26,180	-71,090
32. Redesign Outpatient Prospective Payment System and Ambulatory Surgical Center payment systems to make risk-adjusted payments	0	0	0	0	0	0	0	0	0	0	0	0
33. Implement value-based purchasing program for outpatient hospitals and ambulatory surgical centers	0	0	0	0	0	0	0	0	0	0	0	0
34. Expand basis for beneficiary assignment for Accountable Care Organizations	0	0	5	5	5	5	5	5	5	5	15	40
35. Reform physician self-referral law to better support and align with alternative payment models and to address overutilization												
36. Reprioritize primary and preventive care in Medicare	0	0	0	0	0	0	0	0	0	0	0	0
37. Require prior authorization when physicians order certain services excessively relative to their peers		Not enough detail										
38. Reform and expand durable medical equipment competitive bidding	0	0	0	0	0	0	0	0	0	0	0	0
39. Support coverage for innovative alternatives to durable medical equipment for treatment and management of diabetes	0	0	0	0	0	0	0	0	0	0	0	0
40. Allow for federal/state coordinated review of dual eligible Special Needs Plan marketing materials	0	0	0	0	0	0	0	0	0	0	0	0
41. Improve appeals notifications for dually eligible individuals in Integrated Health Plans	0	0	0	0	0	0	0	0	0	0	0	0
42. Clarify the Part D special enrollment period for dually eligible beneficiaries	0	-20	-30	-30	-30	-30	-30	-40	-40	-40	-110	-290
43. Allow Medicare beneficiaries with high-deductible health plans to make tax-deductible contributions to Health Savings Accounts or Medical Savings Accounts (b)	0	0	10	20	20	20	30	40	40	60	50	240

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	By Fiscal Year, Millions of Dollars										2020-2024	2020-2029
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029		
Increases or Decreases (-) in Direct Spending Outlays (a)												
44. Expand prior authorization to additional Medicare fee-for-service items at high risk of fraud, waste, and abuse	0	0	0	0	0	0	0	0	0	0	0	0
45. Prevent fraud by applying penalties on providers and suppliers who fail to update enrollment records (b)	2	3	4	4	4	5	6	6	6	6	17	46
46. Require reporting on clearinghouses and billing agents when Medicare providers and suppliers enroll in the program	0	0	0	0	0	0	0	0	0	0	0	0
47. Ensure providers that violate Medicare's safety requirements and have harmed patients cannot quickly re-enter the program	0	0	0	0	0	0	0	0	0	0	0	0
48. Assess a penalty on physicians and practitioners who order services or supplies without proper documentation (b)	1	1	1	1	1	2	2	2	2	2	5	15
49. Improve safety and quality of care by publicly reporting Medicare survey and certification reports conducted by accreditation organizations	0	0	0	0	0	0	0	0	0	0	0	0
50. Require providers and suppliers to produce Part B records to support Part D investigations or audits	0	0	0	0	0	0	0	0	0	0	0	0
51. Pass Treasury collection fees for CMS overpayment collections on to debtors (b)	15	25	25	25	25	25	25	25	30	25	115	245
52. Improve efficiency and strengthen program integrity efforts in Medicare Parts C and D	0	0	0	0	0	0	0	0	0	0	0	0
53. Implement targeted risk-adjustment prepayment review in MA	0	0	0	0	0	0	0	0	0	0	0	0
54. Clarify authority for the Healthcare Fraud Prevention Partnership	0	0	0	0	0	0	0	0	0	0	0	0
55. Extend flexibility in annual Open Payments reporting deadline	0	0	0	0	0	0	0	0	0	0	0	0
56. Require physician-owned distributors to report in Open Payments	0	0	0	0	0	0	0	0	0	0	0	0
57. Create authority to revoke or deny Medicare billing privileges based on medical board or independent review organizations	0	0	0	0	0	0	0	0	0	0	0	0
58. Extend mandatory sequestration	0	0	0	0	0	0	0	6,900	-15,800	-20,600	0	-29,500
59. Reform exclusivity for first generics to spur greater competition and access (b, c)	0	-10	-25	-30	-30	-35	-35	-40	-45	-40	-95	-290
60. Medicare interactions	0	390	620	620	610	730	780	840	1,000	940	2,240	6,530
Total Changes												
Estimated On-Budget Direct Spending	**-2,514**	**-39,689**	**-47,137**	**-52,282**	**-56,967**	**-65,219**	**-70,223**	**-68,063**	**-99,447**	**-104,798**	**-198,589**	**-606,339**
Estimated Unified-Budget Direct Spending	**-2,514**	**-39,689**	**-47,137**	**-52,282**	**-56,967**	**-65,219**	**-70,223**	**-68,063**	**-99,447**	**-104,798**	**-198,589**	**-606,339**

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	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029		
Increases or Decreases (-) in Revenues												
13. Improve the Medicare appeals system (b)	5	5	5	6	6	6	6	6	6	6	27	57
14. Improve and tailor the way Medicare educates beneficiaries about the program (b)	0	90	90	90	90	90	90	90	90	90	360	810
43. Allow Medicare beneficiaries with high-deductible health plans to make tax-deductible contributions to Health Savings Accounts or Medical Savings Accounts (b)												
On-budget	0	-204	-538	-863	-1,005	-1,076	-1,127	-1,177	-1,254	-875	-2,609	-8,117
Off-budget	0	-97	-254	-404	-467	-501	-525	-547	-531	-348	-1,223	-3,675
45. Prevent fraud by applying penalties on providers and suppliers who fail to update enrollment records (b)	2	2	3	3	3	3	4	4	4	4	13	32
48. Assess a penalty on physicians and practitioners who order services or supplies without proper documentation (b)	1	1	1	1	1	1	1	1	1	1	5	10
51. Pass Treasury collection fees for CMS overpayment collections on to debtors (b)	20	20	20	20	20	20	20	20	20	20	100	200
59. Reform exclusivity for first generics to spur greater competition and access (b, c)												
On-budget	0	2	4	5	5	6	6	7	7	8	16	50
Off-budget	0	1	2	2	2	2	2	2	2	3	7	18
Total Changes												
Estimated On-Budget Revenues	**28**	**-84**	**-415**	**-738**	**-880**	**-950**	**-1,000**	**-1,049**	**-1,126**	**-746**	**-2,088**	**-6,958**
Estimated Unified-Budget Revenues	**28**	**-180**	**-667**	**-1,140**	**-1,345**	**-1,449**	**-1,523**	**-1,594**	**-1,655**	**-1,091**	**-3,304**	**-10,616**
Net Increase or Decrease (-) in the Deficit from Direct Spending and Revenues												
Changes in On-Budget Deficits	**-2,542**	**-39,605**	**-46,722**	**-51,544**	**-56,087**	**-64,269**	**-69,223**	**-67,014**	**-98,321**	**-104,052**	**-196,501**	**-599,381**
Total Changes in Unified-Budget Deficits	**-2,542**	**-39,510**	**-46,470**	**-51,142**	**-55,622**	**-63,770**	**-68,700**	**-66,469**	**-97,792**	**-103,707**	**-195,286**	**-595,724**

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	By Fiscal Year, Millions of Dollars										2020-2024	2020-2029
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029		
Memorandum: Cross-Cutting Policies												
25. Consolidate and block grant GME payments (c)												
Medicaid	0	-3,140	-3,364	-3,599	-3,834	-4,084	-4,349	-4,622	-4,907	-5,211	-13,937	-37,110
Medicare	0	-14,260	-15,100	-15,960	-16,810	-17,700	-18,610	-19,520	-20,810	-21,850	-62,130	-160,620
New combined GME pool	0	15,290	15,524	15,752	15,972	16,187	16,403	16,623	16,846	17,074	62,537	145,669
Total Outlays	0	-2,110	-2,940	-3,807	-4,672	-5,598	-6,556	-7,519	-8,872	-9,987	-13,529	-52,061
26. Modify payments to hospitals for uncompensated care (c)												
Medicare	0	-14,830	-16,380	-17,070	-17,620	-19,360	-20,540	-21,700	-24,130	-23,730	-65,900	-175,360
New uncompensated care pool	0	7,790	7,987	8,184	8,380	8,577	8,777	8,983	9,193	9,409	32,341	77,281
Total Outlays	0	-7,040	-8,393	-8,886	-9,240	-10,783	-11,763	-12,717	-14,937	-14,321	-33,559	-98,079
59. Reform exclusivity for first generics to spur greater competition and access (b, c)												
Medicare (function 570, on-budget)	0	-10	-25	-30	-30	-35	-35	-40	-45	-40	-95	-290
Other health programs (function 550, on-budget)	0	-3	-6	-7	-8	-8	-8	-9	-9	-10	-24	-68
Postal Service (function 370, off-budget)	0	*	*	*	*	*	*	*	*	*	-1	-2
Total Outlays	0	-13	-31	-37	-38	-43	-43	-49	-54	-50	-120	-360
Revenues												
On-budget	0	2	4	5	5	6	6	7	7	8	16	50
Off-budget	0	1	2	2	2	2	2	2	2	3	7	18
Total Revenues	0	3	6	7	7	8	8	9	9	11	23	68
Changes in On-Budget Deficits	0	-15	-35	-42	-43	-49	-49	-56	-61	-58	-135	-408
Changes in Unified-Budget Deficits	0	-16	-37	-44	-45	-51	-51	-58	-63	-61	-143	-428
61. Reform medical liability - effect on health programs (d)												
Outlays												
Medicare	0	0	0	0	0	0	0	0	0	0	0	0
Other health programs (function 550) (e)	-55	-329	-894	-210	-222	-234	-246	-259	-270	-284	-1,711	-3,004
Total Outlays (on- and off-budget)	-55	-329	-894	-210	-222	-234	-246	-259	-270	-284	-1,711	-3,004
Revenues (on- and off-budget)	25	179	521	911	1,074	1,145	1,214	1,282	1,354	1,439	2,710	9,144
Changes in Unified-Budget Deficits	-80	-508	-1,415	-1,122	-1,296	-1,379	-1,460	-1,541	-1,625	-1,722	-4,421	-12,148

Components may not sum to totals because of rounding. * = between -$500,000 and $500,000.

(a) Medicare provisions include interactions with MA payments, the effect on Medicare Part A and B premiums, and TRICARE.

(b) Proposal would affect both direct spending and revenues, which are shown separately.

(c) Medicare effects are shown in the table; effects on other health programs and revenues are shown in the memorandum.

(d) Shown for reference; no Medicare effect.

(e) Other function 550 health programs includes mandatory outlays for Medicaid, CHIP, FEHB, PSRHBF, DoD health plans, and marketplaces established under the Affordable Care Act. Details for those programs can be found in "Proposals Affecting Health Programs in Budget Function 550 - CBO's Estimate of the President's Fiscal Year 2020 Budget" at https://www.cbo.gov/publications/55208.

CMS = Centers for Medicare & Medicaid Services; CHIP = Children's Health Insurance Program; DoD = Department of Defense; FEHB = Federal Employees Health Benefits program; GME = graduate medical education; HHS = Department of Health and Human Services; MA = Medicare Advantage; PSRHBF = Postal Service Retiree Health Benefits Fund; TRICARE = the health care program operated by the Department of Defense.