

# 570

## Medicare

Budget function 570 comprises spending for Medicare, the federal health insurance program for elderly and eligible disabled people. Medicare consists of two parts, each tied to a trust fund. Hospital Insurance (Part A) reimburses providers for inpatient care that beneficiaries receive in hospitals, as well as care at skilled nursing facilities, home health care related to a hospital stay, and hospice services. Supplementary Medical Insurance (Part B) pays for physicians' services, outpatient services at hospitals, home health care, and other services. CBO estimates that Medicare outlays (net of premiums paid by beneficiaries) will total \$217.7 billion in 2001. That amount includes discretionary outlays of \$3.3 billion, which are for the administrative expenses of operating the Medicare program.

### Federal Spending, Fiscal Years 1990-2001 (In billions of dollars)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Estimate 2001
Budget Authority (Discretionary)	2.4	2.6	2.9	2.8	3.0	3.0	2.9	2.6	2.7	2.8	3.0	3.4
Outlays												
Discretionary	2.3	2.4	2.8	2.7	2.9	3.0	3.0	2.6	2.6	2.8	3.0	3.3
Mandatory	<u>95.8</u>	<u>102.0</u>	<u>116.2</u>	<u>127.9</u>	<u>141.8</u>	<u>156.9</u>	<u>171.3</u>	<u>187.4</u>	<u>190.2</u>	<u>187.7</u>	<u>194.1</u>	<u>214.4</u>
Total	98.1	104.5	119.0	130.6	144.7	159.9	174.2	190.0	192.8	190.4	197.1	217.7
<b>Memorandum:</b>												
Annual Percentage Change in Discretionary Outlays		6.3	16.4	-6.9	10.0	2.0	-0.6	-12.8	0.5	6.3	8.9	9.0

## 570-01 Reduce Medicare's Payments for the Indirect Costs of Patient Care That Are Related to Hospitals' Teaching Programs

	Outlay Savings (Millions of dollars)
2002	2,300
2003	1,800
2004	1,900
2005	2,100
2006	2,300
2002-2006	10,400
2002-2011	25,500

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-02, 570-03, and 570-04

### RELATED CBO PUBLICATION:

*Medicare and Graduate Medical Education* (Study), September 1995.

The Social Security Amendments of 1983 established the prospective payment system (PPS) under which Medicare pays hospitals for inpatient services provided to beneficiaries. Higher rates are paid to hospitals with teaching programs to cover their higher costs of caring for Medicare patients. Under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the additional percentage paid to teaching hospitals in 2001 will average approximately 6.5 percent for each increase of 0.1 in a hospital's ratio of full-time interns and residents to its number of beds. Beginning in 2003, hospitals will receive 5.5 percent more for every 0.1 increase in the resident-to-bed ratio. (Under the Balanced Budget Refinement Act of 1999, teaching hospitals would have received 6.25 percent more in 2001 and 5.5 percent more in 2002 and subsequent years for each 0.1 increase in the ratio.)

The Congress enacted the additional payments to teaching hospitals to compensate them for indirect teaching costs—such as the greater number of tests and procedures thought to be prescribed by interns and residents—and to cover higher costs from factors that are not otherwise accounted for in setting the PPS rates. Such factors might include more severely ill patients, a hospital's location in the inner city, and a more costly mix of staffing and facilities, all of which are associated with large teaching programs.

An alternative approach would combine Medicare's current additional payments to teaching hospitals into a single adjustment to PPS payments for patient care, to recognize that expenses for training represent patient care costs. The Medicare Payment Advisory Commission has considered various alternatives for combining those payments. The commission has estimated that a 3.2 percent adjustment to Medicare's payments would more closely match the increase in operating costs associated with teaching. If the teaching adjustment was lowered accordingly, outlays would fall by about \$10.4 billion from current-law spending over the 2002-2006 period and by about \$25.5 billion over the 2002-2011 period.

This option would better align payments with the actual costs incurred by teaching institutions. Furthermore, since the training that medical residents receive will result in a significant increase in their future income and since hospitals benefit from using residents' labor, it is reasonable for some or all of a hospital's indirect training costs to be borne by both residents and the hospital. Some of those costs are now passed on in the form of stipends that are lower than the value of the residents' services to the hospital. A lower teaching adjustment would probably lead to even lower stipends, however, as well as smaller residency programs. An additional consideration is that if the teaching hospitals now use some payments to fund activities such as charity care, people without health insurance could have less access to health services under this option.

## 570-02 Reduce Medicare's Direct Payments for Medical Education

	Outlay Savings (Millions of dollars)
2002	1,100
2003	1,200
2004	1,200
2005	1,300
2006	1,300
2002-2006	6,200
2002-2011	13,000

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-01, 570-03, and 570-04

### RELATED CBO PUBLICATION:

*Medicare and Graduate Medical Education* (Study), September 1995.

Medicare's prospective payment system does not include payments to hospitals for the direct costs they incur in providing graduate medical education (GME)—namely, residents' salaries and fringe benefits, teaching costs, and institutional overhead. Instead, Medicare makes those payments separately on the basis of its share of a hospital's 1984 cost per resident indexed for increases in the level of consumer prices. Medicare's direct GME payments, which are received by about one-fifth of all U.S. hospitals, totaled about \$2.3 billion for 2000.

Under this option, hospitals' direct GME payments would be based on 120 percent of the national average salary paid to residents in 1987, updated annually by the consumer price index for all urban consumers. In effect, this option would reduce teaching and overhead payments for residents but continue to pay their salaries and fringe benefits. The option would also continue the current-law practice of reducing payments for residents who have gone beyond their initial residency period. The savings from current-law spending would total about \$6.2 billion over the 2002-2006 period and about \$13 billion over the 2002-2011 period. Unlike the current system, under which GME payments vary considerably from hospital to hospital, this option would pay every hospital the same amount for the same type of resident. (Although the Congress took action in 1999 and in 2000 to lessen some of the variation among hospitals in payments per resident, considerable differences remain under current law.)

An overall reduction in the level of subsidies to medical education might be warranted since market incentives appear to be sufficient to encourage a continuing flow of new physicians. Moreover, since hospitals use resident physicians to care for patients and since residency training helps young physicians earn higher incomes in the future, both hospitals and residents might reasonably contribute more to those training costs than under current practices. Residents would contribute more to those costs if hospitals responded to the changes in reimbursements by cutting residents' salaries or fringe benefits.

If hospitals lowered residents' salaries or benefits, the costs of longer residencies—in terms of forgone practice income—could exert greater influence on the young physicians' decisions about pursuing a specialty. More residents might choose to begin primary care practice rather than specialize further. That outcome could be negative for the individual resident; by contrast, the Council on Graduate Medical Education and other groups believe that a relative increase in the number of primary care practitioners would be desirable. Finally, decreasing GME reimbursement could force some hospitals to reduce the resources they commit to training, possibly jeopardizing the quality of their medical education programs.

### 570-03 Eliminate Additional Capital-Related Payments for Hospitals with Residency Programs

	Outlay Savings (Millions of dollars)
2002	300
2003	300
2004	300
2005	300
2006	300
2002-2006	1,400
2002-2011	3,000

**SPENDING CATEGORY:**

Mandatory

**RELATED OPTIONS:**

570-01, 570-02, and 570-04

Under the prospective payment system for inpatient hospital services, Medicare pays hospitals an amount for each discharge that is intended to compensate the hospital for capital-related costs. Currently, teaching hospitals receive additional capital-related payments that are based on teaching intensity, measured as the ratio of a hospital's residents to its average daily number of inpatients. Specifically, an increase of 0.1 in that ratio raises the hospital's capital-related payment by 2.8 percent.

Eliminating those extra payments would save the Medicare program about \$300 million in 2002. Five-year savings would equal roughly \$1.4 billion, and savings over the 2002-2011 period would be \$3 billion.

In contrast to higher operating costs, which analyses indicate are indeed associated with teaching intensity, a hospital's capital costs per case appear to be unrelated to that intensity. Furthermore, paying teaching hospitals more than nonteaching hospitals for otherwise similar patients may discourage efficient decisionmaking by hospitals. In addition, Medicare's payment adjustments for teaching intensity may distort the market for residency training by artificially increasing the value (or decreasing the cost) of residents to hospitals. If residents' training raises the costs of patient care for a hospital, arguably the hospital should bear those costs in order to encourage an efficient amount of training. Hospitals are likely to shift such costs to residents in the form of lower stipends or greater workloads. Residents will engage in such training if they perceive that their future productivity, as reflected in their future income, will be great enough to outweigh those costs.

Eliminating the special capital-related payments would, however, reduce revenues to teaching hospitals at a time when those hospitals already face pressure to reduce costs to remain competitive. Teaching hospitals would probably have to reduce some services in response to the decline in their revenues. Those reductions in services could include less provision of public goods, such as medical research, or fewer medical services for indigent people.

## 570-04 Convert Medicare Payments for Graduate Medical Education to a Block Grant and Slow Their Rate of Growth

	Outlay Savings (Millions of dollars)
2002	300
2003	0
2004	100
2005	300
2006	500
2002-2006	1,200
2002-2011	6,100

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-01, 570-02, and 570-03

### RELATED CBO PUBLICATION:

*Medicare and Graduate Medical Education* (Study), September 1995.

Three types of Medicare graduate medical education (GME) payments are tied to the size or intensity of a teaching hospital's residency program: direct graduate medical education payments, the indirect medical education adjustment for inpatient operating costs, and the indirect medical education adjustment for inpatient capital-related costs. Under provisions in the Balanced Budget Act of 1997, teaching hospitals have begun to receive GME payments for participants in Medicare+Choice health plans in addition to the payments that they have traditionally received for fee-for-service Medicare patients. Several variables determine the total amount of GME payments that a hospital receives, including the number and diagnoses of Medicare discharges and numerical factors used for annually updating payments for inpatient operating costs and capital-related costs. Because of changes in those variables over time, the Congressional Budget Office expects GME payments under current law to grow at an average annual rate of 5 percent between 2002 and 2011.

This option would replace the current system with a consolidated block grant to fund the special activities of teaching hospitals. Under the current system, a hospital receives GME payments based on formulas set forth in regulations, and total Medicare GME spending is the resulting sum of what Medicare owes each hospital. The option considered here assumes that a switch to the block-grant program would occur in 2002 and that the amount of the grant would be based on spending in 2001, increased for overall inflation. Compared with projected spending under current law, federal outlays would be reduced by \$1.2 billion over the first five years and \$6.1 billion over the 2002-2011 period.

Establishing a block grant for the three types of GME payments would allow the Congress to better monitor and adjust that funding. Another feature of the option is that Medicare would no longer pay different rates to hospitals for inpatient services merely because of differences in the size or presence of residency programs.

However, because this option would reduce total payments to teaching hospitals below the amounts expected under current law, such hospitals would, on average, receive less revenue than they would otherwise. In response, teaching hospitals might reduce the amount or quality of some of their services or their provision of some public goods, such as medical research or care for indigent people.

## 570-05 Eliminate Medicare's Additional Payments to Sole Community Hospitals

	Outlay Savings (Millions of dollars)
2002	100
2003	200
2004	200
2005	200
2006	200
2002-2006	900
2002-2011	2,200

### SPENDING CATEGORY:

Mandatory

Under Medicare's prospective payment system (PPS) for inpatient hospital services, special rules apply to providers designated as sole community hospitals (SCHs). There are more than 700 SCHs, constituting about one-third of all rural hospitals. Under the current rules, a hospital may be designated as an SCH if it meets specific criteria that define a sole provider of inpatient, acute care hospital services in a geographic area. In addition, some SCHs have been permitted to retain that status regardless of whether they continue to meet the current sole-provider criteria.

Payments to SCHs generally equal the highest of four amounts: the regular federal PPS payment that would otherwise apply; or an amount based on the hospital's costs in 1982, 1987, or 1996, updated to the current year. Hospitals that choose to receive the regular PPS payment—about half of all SCHs—are eligible to receive higher payment adjustments for disproportionate share status than are other rural hospitals. Hospitals that receive payments based on their updated costs are ineligible for those higher adjustments.

If all sole community hospitals received the regular PPS payment rather than their updated costs, total PPS payments would be about \$100 million less in 2002 and \$2.2 billion less for the 2002-2011 period. Those savings assume that SCHs would continue to be eligible for higher disproportionate share adjustments.

A primary objective of the SCH rules is to assist hospitals in locations where closings would threaten access to hospital care, but the federal support is not particularly well aimed at such essential providers. Moreover, whether an SCH actually receives higher payments under the special rules that permit payments to be based on a hospital-specific amount depends not on its current financial condition but on whether its costs in any of the specified base years (1982, 1987, or 1996) were relatively high.

If the special payment rules were eliminated, however, revenues of many sole community hospitals would be lower than under the special rules, which might cause financial distress for some hospitals. And because many SCHs are the sole providers of hospital services in their geographic areas, access to health care or the quality of care might be reduced in some rural locations.

## 570-06 Expand Global Payments for Hospitals' and Physicians' Services Provided During an Inpatient Stay

	Outlay Savings (Millions of dollars)
2002	100
2003	100
2004	100
2005	100
2006	100
2002-2006	600
2002-2011	1,300

### SPENDING CATEGORY:

Mandatory

Hospitals receive payments under Medicare's prospective payment system (PPS) for the operating costs of providing inpatient services to the program's beneficiaries. The payments are determined on a per-case basis; payment rates vary with the patient's diagnosis, which Medicare classifies within a system of diagnosis-related groups (DRGs), and the characteristics of the hospital. Those rates take into account reasonable variations in the treatment of patients within a given DRG and offer an incentive to the hospital to reduce the cost of treatment. PPS payments do not cover all services rendered to patients during their hospital stay. In particular, Medicare pays separately for physicians' services provided on an inpatient basis.

The Health Care Financing Administration (HCFA) has explored the feasibility of making a single global payment for high-cost, high-volume inpatient procedures. That payment would be lower than the separate payments that are now made for hospitals' operating costs and physicians' services. Expanding the use of global payments would yield savings of \$100 million in 2002 and \$1.3 billion for the 2002-2011 period.

In a recent demonstration project involving heart bypass surgery, discounted payment rates were established through negotiations with participating hospitals in conjunction with teams of physicians. With a global payment, hospitals and physicians alike have an incentive to reduce operating costs while maintaining a satisfactory standard of care. Institutions can offset the discounts in their Medicare payments by two means: improving efficiency (with resultant cost savings) and increasing (using new marketing efforts) their volume of heart bypass patients. Medicare outlays to the seven hospitals participating in a recent five-year demonstration project averaged about 10 percent less than would have been spent otherwise.

HCFA has investigated ways to extend the global payment concept. Other high-cost, high-volume inpatient procedures that might also yield savings include cataract surgery, coronary angioplasty, heart valve replacement, and joint replacement surgery. Receiving such global payments might be attractive to hospitals, which could market themselves as "centers of excellence." However, such terminology could be controversial because it might be construed as suggesting that other hospitals did not offer high-quality care. In addition, only a modest number of institutions and high-cost procedures might become eligible for global payments.

**570-07 Increase and Extend the Reductions in the Medicare PPS Market Basket**

	Outlay Savings (Millions of dollars)
2002	500
2003	1,100
2004	2,400
2005	3,800
2006	5,200
2002-2006	13,000
2002-2011	54,800

**SPENDING CATEGORY:**

Mandatory

**RELATED OPTION:**

570-08

Under Medicare's prospective payment system (PPS), payments for hospitals' operating costs for inpatient services provided to beneficiaries are determined on a per-case basis, according to preset rates that vary with the patient's diagnosis and the characteristics of the hospital. Payment rates are adjusted each year using an update factor that is determined, in part, by the projected increase in the hospital market-basket index (MBI), which reflects increases in hospital costs. Because Medicare's payments to hospitals are factored into calculations of payments for Medicare+Choice plans, changes in the MBI also affect those payments.

Under current law, the hospital update factor is MBI minus 1.1 percentage points for discharges occurring from October 1, 2000, to April 1, 2001; MBI plus 1.1 percentage points for discharges occurring from April 1, 2001, to October 1, 2001; and MBI minus 0.55 percentage points for fiscal years 2002 and 2003. After 2003, the update factor reverts to the full value of the MBI. If the factor was reduced to MBI minus 1.1 percentage points in 2002 and stayed at that level throughout the 2002-2011 period, total savings during that time would be \$54.8 billion (including savings due to reduced payments to Medicare+Choice plans).

In 1997, hospitals' average profit margins on Medicare inpatient services were about 17 percent. Moreover, the Medicare Payment Advisory Commission reports that despite the payment freeze imposed by the Balanced Budget Act of 1997, the inpatient margin was 14.4 percent in 1998. Even with the reductions in the update factor from 1999 to 2002, the average PPS inpatient margin is expected to be 12.6 percent in 1999, falling to 11.2 percent by 2002. Thus, further reductions in update factors could be justified. The American Hospital Association, however, maintains that high inpatient margins reflect major efforts by hospitals to cut costs, which cannot continue indefinitely. Moreover, almost one-quarter of all hospitals have negative profit margins on Medicare inpatient services, so further reductions in payment update factors could cause considerable hardship for those facilities, especially as some hospitals are only now beginning to feel the effects of past payment reductions.

## 570-08 Reduce Medicare's Payments for Hospitals' Inpatient Capital-Related Costs

	Outlay Savings (Millions of dollars)
2002	400
2003	400
2004	400
2005	500
2006	500
2002-2006	2,300
2002-2011	5,100

### SPENDING CATEGORY:

Mandatory

### RELATED OPTION:

570-07

In 1992, Medicare revised its method of paying hospitals for their inpatient capital-related costs by replacing cost-based reimbursement with a prospective payment method. Under the prospective system, hospitals receive a predetermined amount for each Medicare patient to pay for capital-related costs, which include depreciation, interest, taxes, insurance, and similar expenses for buildings and fixed and movable equipment. The prospective system applies to about 5,000 hospitals paid under Medicare's prospective payment system for operating costs. A hospital's prospective rate is adjusted for its mix of patients and certain other characteristics.

Analyses conducted by the Health Care Financing Administration (HCFA) suggest that the initial federal and hospital-specific rates were too high. The 1992 rates were based on actual 1989 and 1990 data (for the federal rate and hospital-specific rates, respectively) projected to 1992, but more recent data indicate that the rate of growth of capital costs between 1989 and 1992 was slower than expected. Moreover, the initial level of capital costs per case in 1989 was probably higher than would be optimal in an efficient market because of incentives provided by the Medicare payments. Factors such as changes in capital prices, the mix of patients treated by hospitals, and the "intensity" of hospital services contributed to the overestimate. Analyses by the Medicare Payment Advisory Commission and HCFA found that the overestimate ranged from 15 percent or 20 percent to 28 percent, with an average of about 22 percent.

The Balanced Budget Act of 1997 reduced the federal rate by 17.8 percent for capital payments made to hospitals for patient discharges occurring in 1998 through 2002. (A small part of that reduction, 2.1 percentage points, will be restored beginning in 2003.) A further reduction of 5 percentage points (bringing the total reduction in capital payments to about 22 percent) would yield savings of \$400 million in 2002 and \$5.1 billion for the 2002-2011 period.

Most hospitals would probably be able to adjust to the reductions by lowering their capital costs or partially covering them with other sources of revenue, because Medicare's payments for capital costs are a small share of hospitals' revenues—less than 5 percent of their total revenues from all sources. Hospitals that are in poor financial condition, however, might have difficulty absorbing the reductions. As a result, the quality of the care they offer might decline, and they might provide fewer services to people without insurance.

## 570-09 Increase the Number of Postacute Care Discharges Treated as Hospital Transfers Under Medicare

	Outlay Savings (Millions of dollars)
2002	200
2003	300
2004	300
2005	300
2006	300
2002-2006	1,400
2002-2011	3,400

### SPENDING CATEGORY:

Mandatory

Medicare's prospective payment system (PPS) for inpatient hospital stays provides hospitals with payments that encompass a patient's entire stay and are based on the patient's diagnosis. The PPS amounts were developed using data on costs for an average length of stay in a hospital for each diagnostic grouping. Over time, the average length of stay has decreased, particularly for patients in certain diagnosis-related groups (DRGs) with high rates of discharge to postacute care settings, such as home health agencies and skilled nursing facilities. In turn, Medicare's payments to postacute care providers, which are based on their costs, have increased.

Medicare reduces its payment to an admitting hospital if a patient is transferred from that acute care hospital to another for related care. Full payment is made to the final discharging hospital, whereas the admitting hospital receives a per diem payment not to exceed the full amount. Beginning in October 1998, the Balanced Budget Act of 1997 applied a similar transfer policy to hospitals that discharge certain patients to postacute care settings. Specifically, hospitals receive reduced payments for patients in 10 DRGs who are transferred to a postacute care setting and whose stay in the admitting hospital is shorter than the average length of stay for that DRG.

Researchers evaluating the impact of the new policy found that average length of stay in a hospital increased slightly for the 10 DRGs subject to the new policy, while the length of stay for other DRGs continued to decline. They also found that the policy resulted in a reduction of \$239 million in Medicare payments for the first half of fiscal year 1999.

This option would increase the number of DRGs to which the postacute transfer policy applies. Applying the transfer policy to the 13 additional DRGs with the next highest rates of discharge to postacute care facilities would reduce Medicare outlays by \$200 million in 2002 and \$3.4 billion over the 2002-2011 period. In addition to providing savings to Medicare, this option would expand the incentive to hospitals to ensure that patients are fully ready to be discharged before transferring them to a postacute care setting.

Hospitals have objected to the transfer policy even in its limited form, however, because it undermines one of the original incentives in the prospective payment system—to reduce hospital costs by discharging patients as soon as is practicable. Moreover, the policy creates an administrative burden related to verifying discharge destinations and provides incentives for hospitals to delay postacute care placements following hospital discharges, which may diminish the quality of care for some patients.

## 570-10 Reduce Medicare Payments for Currently Covered Prescription Drugs

	Outlay Savings (Millions of dollars)
2002	240
2003	490
2004	590
2005	700
2006	780
2002-2006	2,810
2002-2011	8,500

### SPENDING CATEGORY:

Mandatory

Medicare Supplementary Medical Insurance (Part B) paid providers about \$5 billion in 2000 for certain outpatient drugs. Prescription drugs are covered under Part B when they must be administered under a physician's supervision, as is the case with many drugs requiring injection or infusion. Medicare also pays for drugs that must be delivered by durable medical equipment covered under the program. In addition, some oral chemotherapy and antinausea drugs for cancer patients as well as immunosuppressive drugs for organ transplant recipients are covered, as are certain vaccines and drugs related to end-stage renal disease.

Medicare payments for covered prescription drugs delivered at home and in physicians' offices have varied over time. Since 1997, the amount Medicare has allowed as a reasonable charge has been set at 95 percent of the average wholesale price, or AWP, which is a published list price established by the manufacturer. But as a list price, the AWP is not the actual price providers pay for drugs; pegging Medicare's payment to the AWP in this way has meant that providers and suppliers could profit from administering or dispensing Medicare-covered drugs. The Inspector General of the Department of Health and Human Services has reported that actual wholesale drug prices available to physicians were about 30 percent less than the AWP in 1997.

The Health Care Financing Administration announced in September 2000 that it would permit Medicare intermediaries to use a new price schedule for 32 drugs that is based on physicians' and pharmacies' estimated costs of acquiring the drugs. However, under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, implementation of the price schedule may not proceed until the General Accounting Office recommends a method for establishing prices and the Secretary of Health and Human Services reviews the report. The Congressional Budget Office assumes that the new price schedule would take effect on January 1, 2002. All other drugs covered by Medicare would continue under the current payment formula.

This option would limit Medicare's reimbursements for all prescription drugs that are not on the new price schedule by reducing the allowed charge from 95 percent to 85 percent of the AWP and by limiting increases in the allowed charge for covered drugs to changes in the rate of inflation. (Changes in the allowed charge would track the consumer price index for all urban consumers, excluding food and energy.) As a result, Medicare Part B outlays would decrease by \$8.5 billion between 2002 and 2011.

One disadvantage of the option is that it would encourage manufacturers to introduce new drugs at AWP's that were higher than they would otherwise be in order to restore the profit margins available to physicians and other suppliers. Physicians would prescribe newly introduced drugs more quickly as a result. Therefore, the option's effectiveness in limiting Part B spending growth would gradually erode as new drugs replaced older ones in the mix of covered drugs. Critics of the option also claim that the profit margins physicians now obtain when they administer drugs to Medicare patients subsidize the cost of drug administration. Savings would be reduced and patient care might suffer if patients were diverted from physicians' offices to hospital outpatient settings, where Medicare payment rates are higher. CBO's estimate accounts for that possibility.

## 570-11 Index Medicare's Deductible for SMI Services

	Outlay Savings (Millions of dollars)
2002	90
2003	290
2004	490
2005	700
2006	920
2002-2006	2,490
2002-2011	11,120

**SPENDING CATEGORY:**

Mandatory

**RELATED OPTIONS:**

570-12-A, 570-12-B, 570-14,  
and 570-15

Medicare offers insurance coverage for physicians' and hospital outpatient services through the Supplementary Medical Insurance (SMI, or Part B) program. The program has a number of cost-sharing requirements. One way to achieve federal savings in SMI is to increase the deductible—that is, the amount that enrollees must pay for services each year before the government shares responsibility. The deductible is now \$100 a year and has been increased only three times since Medicare began in 1966, when it was set at \$50. In relation to average annual per capita charges under the SMI program, the deductible has fallen from 45 percent in 1967 to about 3 percent in 2000.

Increasing the SMI deductible for 2002 and later years according to the growth in total spending per enrollee for Part B services would save \$90 million in 2002, \$2.5 billion over the five-year period, and \$11.1 billion over the 10-year period.

An increase in the amount of the deductible would enhance the economic incentives for prudent consumption of medical care while spreading the impact of an increase in cost sharing among most enrollees. In 2002, the deductible would be \$106, so no enrollee's out-of-pocket costs would rise by more than \$6 in that year.

However, over time the additional out-of-pocket costs under this option might discourage some low-income enrollees who are not eligible for Medicaid from seeking needed care. In addition, costs to states would increase because their Medicaid programs pay the deductibles for Medicare enrollees who also receive benefits under Medicaid.

## 570-12-A Simplify and Limit Medicare's Cost-Sharing Requirements

	Outlay Savings (Millions of dollars)
2002	220
2003	570
2004	730
2005	950
2006	1,170
2002-2006	3,640
2002-2011	13,360

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-11, 570-12-B, and 570-15

### RELATED CBO PUBLICATION:

*Restructuring Health Insurance for Medicare Enrollees* (Study), August 1991.

Medicare's cost-sharing requirements in its fee-for-service sector are varied and difficult for beneficiaries to understand. Further, they do not accurately reflect the relative costs of alternative services. In contrast with most private insurance plans, Medicare places no limit on the cost-sharing expenses for which enrollees may be liable. As a result, most fee-for-service enrollees seek supplementary coverage (either through their employers or by purchasing individual medigap plans) to protect them from the potentially catastrophic expenses they might be left with under Medicare. Those enrollees with the nearly first-dollar coverage that medigap plans provide no longer have financial incentives to use medical services prudently. Consequently, Medicare's costs are higher than they would be if there were no medigap supplements.

Medicare could simplify and limit cost-sharing requirements in the fee-for-service sector while also reducing federal costs. For example, the current complicated mix of cost-sharing requirements could be replaced with a single deductible, a uniform coinsurance rate of 20 percent for amounts above the deductible, and a cap on each beneficiary's total cost-sharing expenses—whether they arose from Part A or Part B of the Medicare program. If those provisions were in place beginning in January 2002 with a deductible of \$1,000 and a cap on total cost sharing of \$2,000, federal savings would be \$220 million for 2002, \$3.6 billion over five years, and \$13.4 billion over 10 years. Those estimates assume that both the deductible and the cap would be indexed to growth in per capita benefits paid by Medicare.

For three reasons, such changes in Medicare's cost-sharing requirements would increase the incentives for enrollees to use medical services prudently. First, because of the higher deductible, enrollees with no supplement or with a medigap plan that did not cover the deductible would face the full cost for a larger proportion of the services they used. Second, over time, fewer enrollees would purchase medigap plans because their cost-sharing expenses would be capped under Medicare. Third, the uniform coinsurance rate on all services would encourage enrollees without supplementary coverage to consider relative costs appropriately when choosing among alternative treatments.

Although this option would generally reduce out-of-pocket costs for enrollees who had serious illnesses or were hospitalized during the year, it would increase out-of-pocket costs for most enrollees. On average, enrollees' cost-sharing expenses under Medicare would increase by about \$70 a year in 2002. Expenses would fall for about 10 percent of enrollees, rise for about 70 percent, and be unchanged for all others. The option would also introduce cost-sharing requirements for services—such as home health care—that are not now subject to them, increasing administrative costs for the affected providers.

## 570-12-B Restrict Medigap Coverage

	Outlay Savings (Millions of dollars)
2002	1,230
2003	2,190
2004	2,480
2005	2,830
2006	3,190
2002-2006	11,920
2002-2011	34,180

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-11, 570-12-A, 570-13,  
and 570-15

### RELATED CBO PUBLICATION:

*Restructuring Health Insurance  
for Medicare Enrollees (Study),  
August 1991.*

Savings from option 570-12-A could be substantially increased by restricting or prohibiting medigap coverage in addition to changing Medicare's cost-sharing provisions. Alternatively, some or all of the additional savings from restricting medigap coverage could be used to improve Medicare's coverage by reducing the deductible or cap.

If, for example, medigap plans were prohibited from covering any part of Medicare's new deductible (described in option 570-12-A), savings would be \$11.9 billion over five years and \$34.2 billion over 10 years. By raising Medicare's deductible and prohibiting medigap plans from covering it, the incentives for more prudent use of health care services would be appreciably strengthened for enrollees who now have medigap plans. Those incentives would be still greater if medigap coverage was prohibited altogether. However, despite Medicare's new copayment cap, which would protect enrollees against very large cost-sharing expenses, some enrollees would object to any policy that denied them access to first-dollar coverage.

## 570-13 Prohibit First-Dollar Coverage Under Medigap Policies

Outlay  
Savings  
(Millions  
of dollars)

2002	2,250
2003	3,620
2004	3,890
2005	4,200
2006	4,530
2002-2006	18,490
2002-2011	46,880

**SPENDING CATEGORY:**

Mandatory

**RELATED OPTION:**

570-12-B

**RELATED CBO PUBLICATION:**

*Restructuring Health Insurance for Medicare Enrollees (Study)*, August 1991.

About 35 percent of Medicare's fee-for-service enrollees purchase individual supplementary private insurance (medigap coverage) that covers all or most of the cost sharing that the Medicare program requires. On average, medigap policyholders use at least 25 percent more services than they would if they did not have first-dollar coverage. However, taxpayers, through Medicare, pay most of the cost of those additional services, not medigap insurers.

Federal costs for Medicare could be reduced if medigap plans were prohibited from offering first-dollar coverage for Medicare's cost-sharing requirements. If, for example, medigap plans were barred from paying any portion of the first \$1,500 of an enrollee's cost-sharing liabilities for calendar year 2002, use of medical services by medigap policyholders would fall, and federal savings in 2002 would total \$2.2 billion. Assuming that the medigap limit was linked to growth in the average value of Medicare's costs for later years, savings over the 2002-2006 period would total \$18.5 billion. Over 10 years, savings would total \$46.9 billion.

Only enrollees who have medigap policies would be directly affected by this option, and most of them would be financially better off under it. Because their medigap premiums would decrease more than their out-of-pocket liabilities would increase, most medigap enrollees would have lower yearly expenses under this option. Indirectly, all enrollees might be better off because Medicare's premiums would be lower than under current law.

Medigap policyholders, however, would have to assume a higher level of financial risk for Medicare-covered services than they do now. Because they might feel more uncertain about their expenses, some policyholders might object to eliminating their option to purchase first-dollar coverage, even if in most years they would be financially better off. Moreover, in any given year, about a quarter of the people with medigap policies would actually incur higher expenses under this option, and those with expensive chronic conditions might be worse off year after year. Finally, the decrease in use of services by medigap policyholders that would generate federal savings under this option might not be limited to unnecessary care, so the health of some policyholders might be adversely affected.

## 570-14 Collect Deductible and Coinsurance Amounts on Clinical Laboratory Services Under Medicare

Outlay  
Savings  
(Millions  
of dollars)

2002	680
2003	1,130
2004	1,230
2005	1,340
2006	1,460
2002-2006	5,840
2002-2011	15,640

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-11 and 570-15

Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to enrollees. Medicare's payment is set by a fee schedule, and providers must accept that fee as full payment for the service. For most other services provided under Medicare's Supplementary Medical Insurance (SMI) program, beneficiaries are subject to both a deductible and a coinsurance rate of 20 percent.

Imposing the SMI program's usual deductible and coinsurance requirements on laboratory services would yield appreciable savings. If this policy was in place beginning on January 1, 2002, federal savings would be \$680 million in 2002, \$5.8 billion over five years, and \$15.6 billion over 10 years.

In addition to reducing Medicare's costs, this option would make cost-sharing requirements under the SMI program more uniform and therefore easier to understand. Moreover, enrollees might be somewhat less likely to undergo laboratory tests with little expected benefit if they paid part of those costs.

However, enrollees' use of laboratory services would probably not be substantially affected because decisions about what tests are appropriate are generally left to physicians, whose judgments do not appear to depend on enrollees' cost-sharing liabilities. Hence, a small part of the expected savings under this option would stem from more prudent use of laboratory services, but the greater part would reflect the transfer to enrollees of costs now borne by Medicare. Billing costs for some providers, such as independent laboratories, would be higher under the option because they would have to bill both Medicare and enrollees to collect their full fees. (Currently, they have no need to bill enrollees directly for clinical laboratory services.) In addition, states' Medicaid costs would increase for enrollees who also received Medicaid benefits.

## 570-15 **Impose a Copayment Requirement on Home Health Visits Under Medicare**

	Outlay Savings (Millions of dollars)	
	With \$5 Copoly- ment	With \$10 Copoly- ment
2002	790	1,430
2003	1,300	2,360
2004	1,470	2,640
2005	1,650	2,970
2006	1,850	3,310
2002-2006	7,060	12,710
2002-2011	19,880	35,480

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-11, 570-12-A, 570-12-B,  
and 570-14

Despite the recent drop in spending for home health care under Medicare, the use of services and the resulting costs are expected to resume growing rapidly. One reason for unrestrained growth of such costs is that the services are free to enrollees—currently, enrollees are not required to pay any portion of the cost of home health services under Medicare.

If a copayment of \$5 was required for each home health visit covered by Medicare beginning in January 2002, net federal savings would be nearly \$800 million in 2002, \$7.1 billion over five years, and \$19.9 billion over 10 years. If the copayment was \$10, five-year savings would be \$12.7 billion and 10-year savings would be \$35.5 billion. Those estimates assume that the copayment would be indexed to the consumer price index after 2002.

This option would reduce Medicare's costs for home health care not only by shifting a small part of the cost per visit to users but also by reducing enrollees' use of the service—at least among the 10 percent of fee-for-service enrollees with no supplementary coverage for their cost-sharing expenses. However, little or no drop in use would be expected among the 90 percent of enrollees who have Medicaid, medigap, or employment-sponsored supplementary coverage. Further, the option would increase private insurance premiums for the 35 percent of enrollees with medigap supplements, and it would increase Medicaid program costs on behalf of the 15 percent of enrollees who also receive Medicaid benefits. Moreover, it would increase the risk of very large out-of-pocket costs for those with no supplementary coverage.

## 570-16 Permit Competitive Bidding for High-Volume Items of Durable Medical Equipment

	Outlay Savings (Millions of dollars)
2002	0
2003	30
2004	80
2005	150
2006	200
2002-2006	460
2002-2011	1,410

### SPENDING CATEGORY:

Mandatory

Medicare paid about \$6 billion for durable medical equipment (DME) supplies and orthotics/prosthetics in 1998. Suppliers of DME and orthotics/prosthetics are paid under a fee schedule specified in the Medicare statute. Both the General Accounting Office and the Inspector General of the Department of Health and Human Services have found that Medicare payments for many items are far higher than the prices paid by other insurers or the prices in retail stores. For example, the Inspector General found that fees paid by Medicare for albuterol sulfate, a commonly prescribed drug, were more than three times the suppliers' acquisition costs. In addition, Medicare paid 14 percent more than other payers for semi-electric hospital beds.

The Balanced Budget Act of 1997 authorized the Health Care Financing Administration (HCFA) to conduct a competitive bidding demonstration for DME and orthotics/prosthetics. HCFA initiated competitive bidding in Polk County, Florida, in October 1999. Bidders competed on price and quality for five categories of medical supplies: oxygen supplies, hospital beds, enteral nutrition equipment and supplies, surgical dressings, and urological supplies. All interested suppliers were required to bid. Only a limited number were selected as Medicare suppliers for each product, and no other suppliers were permitted to provide those products in Polk County.

Savings from the Florida competition averaged 17 percent across all five product categories and were as high as 30 percent for hospital beds. The program saved 16 percent on oxygen supplies, which account for 28 percent of total Medicare DME charges. The competition resulted in slightly higher prices for some items, primarily surgical dressings. The Florida demonstration shows that Medicare can use market forces to reduce total costs while maintaining quality and a choice of suppliers.

A second demonstration was held in three Texas counties, with 79 suppliers bidding to provide oxygen supplies, hospital beds, manual wheelchairs, noncustomized orthotic devices, and certain drugs. HCFA established payment rates that were 20 percent lower, on average, than Medicare's current fee schedule for the five categories of medical equipment and supplies. Medicare began paying the competitively bid rates in those three counties in January 2001.

Under this option, Medicare would use competitive bidding to purchase high-volume DME supplies in areas with large numbers of suppliers. By using that approach to purchase just two high-volume DME items—oxygen supplies and hospital beds—Medicare would reduce outlays by \$30 million in 2003 and \$1.4 billion over the 2002-2011 period.

One disadvantage of this option is that fewer oxygen and hospital bed suppliers would be participating in Medicare, although beneficiary access to suppliers would be a major consideration in selecting the number of winning bidders. In addition, competitive bidding could create financial hardship for oxygen and hospital bed suppliers that were not selected in the bidding process because Medicare is a major source of their revenue.

## 570-17 Increase the Premium for SMI Services Under Medicare to 30 Percent of Program Costs

	Outlay Savings (Millions of dollars)
2002	3,210
2003	4,940
2004	5,630
2005	6,280
2006	6,800
2002-2006	26,860
2002-2011	71,510

### SPENDING CATEGORY:

Mandatory

### RELATED OPTION:

570-18

Benefits under Medicare's Supplementary Medical Insurance (SMI) program are partially funded by monthly premiums paid by enrollees, with the remainder funded by general revenues. Although the SMI premium was initially intended to cover 50 percent of the cost of benefits, premium receipts between 1975 and 1983 covered a declining share of SMI costs—falling from 50 percent to less than 25 percent. That drop occurred because premium increases were limited by the cost-of-living adjustment (COLA) for Social Security benefits (which is based on the consumer price index) but the per capita cost of the SMI program rose faster. Since 1984, premiums generally have been set to cover about 25 percent of average benefits for an aged enrollee, a provision that was made permanent in the Balanced Budget Act of 1997.

If the SMI premium was set to cover 30 percent of costs for 2002 and all years thereafter, outlay savings would be \$3.2 billion in 2002, \$26.9 billion over five years, and \$71.5 billion over 10 years. The premium for 2002 would be \$68.80 a month instead of \$57.30. Those estimates assume a continuation of the current hold-harmless provisions, which ensure that no enrollee's monthly Social Security benefit will fall as a result of the Social Security COLA (which is based on the whole benefit) being smaller than the SMI premium increase.

Most SMI enrollees would pay a little more under this option, in contrast to proposals—such as increasing cost-sharing requirements—that could substantially raise the out-of-pocket costs of those who become seriously ill. This option need not affect enrollees with income below 120 percent of the federal poverty threshold because all of them are eligible to have Medicaid pay their Medicare premiums. (Some people who are eligible for Medicaid do not apply for benefits, however.)

Low-income enrollees who are not eligible for Medicaid could find the increased premium burdensome. A few might drop SMI coverage and either do without care or turn to sources of free or reduced-cost care, which could increase demands on local governments. In addition, states' expenditures would rise because states would pay part of the higher premium costs for those Medicare enrollees who also receive Medicaid benefits.

## 570-18 Tie the Premium for SMI Services Under Medicare to Enrollees' Income

	Outlay Savings (Millions of dollars)
2002	540
2003	1,890
2004	2,190
2005	2,530
2006	2,910
2002-2006	10,060
2002-2011	32,350

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-17 and REV-19

### RELATED CBO PUBLICATIONS:

*The Medicare Catastrophic Coverage Act of 1988* (Staff Working Paper), October 1988.

*Subsidies Under Medicare and the Potential for Disenrollment Under a Voluntary Catastrophic Program* (Study), September 1989.

Instead of increasing the basic premium to 30 percent of costs for all enrollees in the Supplementary Medical Insurance (SMI) program (see option 570-17), this option would collect relatively more from higher-income people. For example, people with modified adjusted gross income of less than \$50,000 and couples with income below \$75,000 would pay only the basic premium, set at 25 percent of SMI costs per aged enrollee. Premiums would rise progressively for higher-income enrollees, however. The maximum total premium would be set to cover 50 percent of costs for people with income exceeding \$100,000 and for couples with income exceeding \$150,000. The income-related premiums would have to be collected through the income tax system so that rates could be aligned with income. Current premiums are deducted automatically from Social Security checks for most enrollees.

If this option was in place in calendar year 2002, savings would total \$540 million in fiscal year 2002, \$10.1 billion over five years, and \$32.4 billion over 10 years. Those estimates assume that the current hold-harmless provisions would continue only for people subject to the basic 25 percent premium. (The hold-harmless provisions ensure that no enrollee's Social Security check will decrease because an increase in the SMI premium exceeds the cost-of-living adjustment.)

Most SMI enrollees would be unaffected by tying a portion of the program's premium to income. Roughly 86 percent of enrollees would face the basic 25 percent premium, about 3 percent would pay the maximum premium, and 11 percent would pay a premium somewhere in between.

Enrollees subject to the income-related premium would pay substantially more, however. The maximum monthly premium for 2002 would be \$114.60 instead of the \$57.30 premium projected under current law. That increase might lead some enrollees to drop out, although it is estimated that fewer than 0.5 percent would do so. Enrollees with retirement health plans that do not require Medicare enrollment (mainly, retired government employees) would be most likely to drop out. Some healthy enrollees who have no other source of health insurance might do so as well, if they were not averse to the risk that they might incur large health care costs.

## 570-19-A Increase Medicare's Age of Eligibility to Match Social Security's Normal Retirement Age

Outlay  
Savings  
(Millions  
of dollars)

2002	0
2003	390
2004	1,060
2005	1,790
2006	2,650
2002-2006	5,900
2002-2011	36,310

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-19-B and REV-19

### RELATED CBO PUBLICATIONS:

*The Long-Term Budget Outlook*  
(Report), October 2000.

*Long-Term Budgetary Pressures  
and Policy Options* (Report),  
May 1998, Chapter 4.

Under current law, the normal retirement age (NRA) for Social Security will gradually increase from 65 to 67 in the first quarter of this century. However, eligibility for Medicare based on age will remain at 65. Because the two programs affect the same population and because eligibility is based on the same work history, some people have argued that the age requirements should be the same.

If the age at which a person became eligible for Medicare was raised in step with increases in the NRA for Social Security, the first cohort to be affected would be people who turned 65 in 2003—for that group, eligibility for Medicare would be delayed by two months. The age of eligibility would be increased by an additional two months each year through 2008 and then remain at 66 for 12 years. Beginning in 2020, the age of eligibility would again increase by two months a year until it reached 67 in 2025. Under that option, federal budget savings would total \$390 million in 2003, \$5.9 billion through 2006, and \$36.3 billion through 2011. Reduced spending for Medicare would be partially offset by increased spending under Medicaid, the Federal Employees Health Benefits program, and the military's Tricare programs (reflected in the savings estimates). In addition, outlays for Social Security would fall by \$8.9 billion from 2002 to 2011 because some people who were affected would delay retirement. (That drop in costs is not reflected in the estimates.)

The same reasons that have been used to justify increasing the NRA for Social Security apply to this option as well. Life expectancy has increased substantially since Social Security and Medicare began, and a majority of workers now live well beyond the age of eligibility. When Social Security was established in 1935, average life expectancy at birth was less than 65 years; now average life expectancy is greater than 75 years. Unless changes are made in those programs, longer expected lifetimes, together with the population bulge of the baby-boom generation, will increase costs enormously under Social Security and Medicare after 2010. One way to limit that cost growth would be to reduce the number of people eligible for benefits.

However, about 70 percent of Social Security beneficiaries retire before the normal retirement age—generally at Social Security's early retirement age of 62, which entitles them to benefits at a reduced level. Increasing Medicare's age of eligibility would also raise the number of years during which early retirees would be at risk of having no health insurance—just when their need for health care would be expected to increase significantly and their access to private individual insurance would be limited.

## 570-19-B Permit Early Buy-In to Medicare and Increase the Normal Age of Eligibility

	Outlay Savings (Millions of dollars)
2002	-30
2003	0
2004	630
2005	1,320
2006	2,120
2002-2006	4,040
2002-2011	31,080

### SPENDING CATEGORY:

Mandatory

### RELATED OPTIONS:

570-19-A and REV-19

### RELATED CBO PUBLICATIONS:

*The Long-Term Budget Outlook* (Report), October 2000.

*An Analysis of the President's Budgetary Proposals for Fiscal Year 1999* (Report), March 1998, Appendix B.

*Long-Term Budgetary Pressures and Policy Options* (Report), May 1998, Chapter 4.

One way to alleviate the problem that early retirees may have in continuing health insurance coverage until they are eligible for Medicare would be to introduce an early age of eligibility (62) for nondisabled retirees. (Disabled people already become eligible for Medicare after a two-year waiting period, regardless of their age.) That change would make the conditions for age-based eligibility under Medicare wholly consistent with those for Social Security.

Allowing people to buy in to Medicare at age 62 beginning in January 2002, together with the gradual move to a later normal age of eligibility (67) described in option 570-19-A, would reduce federal costs by \$4 billion over the 2002-2006 period and by \$31.1 billion through 2011. (Social Security costs—which are not reflected in the estimates—would increase in the early years when only the buy-in was in place. However, savings would occur after 2005 as delays in retirement due to the increase in the eligibility age for Medicare more than offset earlier retirement among those taking advantage of the buy-in option.) Those estimates assume that people who used the early buy-in option would pay an actuarially fair premium for their age group during the buy-in years. The estimates also assume that once buy-in participants reached the normal age of eligibility, they would pay a premium surcharge to compensate for any excess costs incurred during their buy-in years. (Buy-in participants are likely to be more costly to Medicare than the average person in their age group.)