



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

Revised November 5, 1999

**S. 1788
Medicare, Medicaid, and SCHIP Adjustment Act of 1999**

As reported by the Senate Committee on Finance on October 26, 1999

SUMMARY

The Medicare, Medicaid, and SCHIP Adjustment Act would modify Medicare's payment rates for many services, including those furnished by skilled nursing facilities, home health agencies, hospitals, physicians, hospices, physical and speech therapists, occupational therapists, and managed care plans. The bill also would make changes to both Medicaid and the State Children's Health Insurance Program (SCHIP). Those changes would include revised allotments to states and territories of funds distributed through SCHIP and the Medicaid disproportionate share (DSH) program, and a new program of grants to states for services provided by federally qualified health centers and rural health clinics. In addition, the bill includes technical provisions that would have no effect on federal spending.

CBO estimates that the bill would increase federal direct spending by \$1.2 billion in fiscal year 2000, by \$12.2 billion over the 2000-2004 period, and by a total of \$16.4 billion over the 2000-2009 period. Although the bill would increase direct spending, section 607 of the bill specifies that any net deficit increase resulting from enactment shall not be counted for purposes of enforcing the pay-as-you-go procedures established by the Balanced Budget and Emergency Deficit Control Act.

The bill contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that provisions of the bill affecting Medicaid would result in additional federal and state spending for health programs. The bill contains several private-sector mandates on insurers that provide medigap coverage. CBO estimates that the cost of those mandates would not exceed the threshold specified in UMRA (\$100 million in 1996, annually adjusted for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of this bill is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, By Fiscal Year, in Billions of Dollars				
	2000	2001	2002	2003	2004
CHANGES IN DIRECT SPENDING					
Medicare					
Skilled Nursing Facility Provisions	0.3	1.3	0.5	b	0
Hospital Outpatient Department Provisions	0.1	0.3	0.3	0.3	0.2
Physician Update	0	0.3	0.1	-0.1	-0.3
Home Health Provisions	0.1	1.8	-0.4	0.1	0
Graduate Medical Education Provisions	0.2	0.5	0.6	0.6	0.1
Rural Provisions	b	0.1	0.1	0.1	0.1
Managed Care Provisions	0.1	0.3	0.4	0.6	0.7
Other Provisions	0.2	0.4	0.2	0.1	0.1
Interaction of Fee-for-Service Provisions and Medicare+Choice Payment Rates ^a	<u>0</u>	<u>0.7</u>	<u>0.6</u>	<u>0.3</u>	<u>0.1</u>
Subtotal, Gross Medicare Outlays	1.1	5.7	2.3	2.0	1.0
Part B Premium Receipts	<u>0</u>	<u>-0.3</u>	<u>-0.3</u>	<u>-0.1</u>	<u>b</u>
Subtotal, Net Medicare Outlays	1.1	5.4	2.0	1.9	1.0
Medicaid, SCHIP, and other mandatory health programs	<u>0.1</u>	<u>0.2</u>	<u>0.2</u>	<u>0.1</u>	<u>0.1</u>
Total Changes	1.2	5.7	2.2	2.0	1.1

Notes: SCHIP is the State Children's Health Insurance Program.
Components may not sum to totals because of rounding.

- a. The effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans.
b. Costs or savings of less than \$50 million.

BASIS OF ESTIMATE

Medicare

Compared with spending projected under current law, the bill would increase Medicare outlays by \$1.1 billion in fiscal year 2000 and by \$11.4 billion over the 2000-2004 period.

The following sections discuss changes in gross outlays directly attributable to provisions of the bill. In addition, the estimate includes two interactions: the effect of changes in per-enrollee spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans, and the effect of changes in Medicare Part B outlays on receipts from Part B premiums.

Payment rates for Medicare+Choice plans are based on spending in the fee-for-service sector, so provisions of the bill that increase fee-for-service spending would lead to higher payments to Medicare+Choice plans, beginning in 2001. No interaction with Medicare+Choice payments would occur in 2000 because the rates for 2000 have already been published and will not be adjusted unless services covered by the Medicare program change; the bill would not change covered services. CBO estimates the increase in spending attributable to the interaction between fee-for-service spending and Medicare+Choice payment rates would total \$1.6 billion during the 2000-2004 period.

Part B premiums for 2000 have already been announced, and would not be changed by this bill. In subsequent years, however, about 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total \$0.6 billion from 2000 through 2004.

Skilled Nursing Facilities. The bill would amend three policies enacted in the Balanced Budget Act of 1997 (BBA) regarding payment to skilled nursing facilities (SNFs). First, it would increase the federal rates paid for cases assigned to the extensive and special care categories by 25 percent and the federal rates paid for cases assigned to certain rehabilitation categories by a specified dollar amount. Those new rates would apply to services provided from April 1, 2000, through September 30, 2001. Second, it would enable SNFs that participated in the Nursing Home Case Mix and Quality Demonstration to receive an additional payment for Part B services in the facility-specific component of their payment rates. That policy would apply retroactively to services furnished since the enactment of BBA. Third, for cost-reporting periods beginning after enactment, it would allow SNFs to elect to be paid exclusively under the federal rate, rather than a blend of federal and facility-specific rates. CBO estimates that those three provisions would increase Medicare expenditures by \$0.3 billion in 2000 and by \$2.1 billion over the 2000-2004 period.

Hospital Outpatient Department Services. The BBA established a prospective payment system (PPS) to replace cost-based reimbursement for most outpatient hospital services. The Secretary of Health and Human Services plans to implement the PPS in July 2000. Some hospitals will experience gains under the PPS—Medicare payments will exceed the cost of providing outpatient services—while other hospitals will experience losses. The bill would

limit each hospital's loss during the first three years of the PPS, authorize the reclassification of certain urban hospitals as rural, exempt cancer hospitals and certain rural hospitals from the PPS, and establish outlier adjustment payments for high-cost cases and transitional payments for certain drugs, biologicals, and medical devices under the PPS. CBO estimates that those provisions would increase Medicare expenditures by \$0.1 billion in 2000 and by \$1.2 billion over the 2000-2004 period.

Physician Update. The BBA established payment formulas that tie the growth of per-enrollee expenditures for physician services to the growth of gross domestic product. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

The bill would modify those payment formulas to reduce the oscillations around the smooth trend. CBO estimates the bill would not change spending in 2000 and would not change cumulative spending during the 2000-2004 period. Compared to current law, however, payments to physicians would be higher in 2001 and 2002 and lower in 2003 and 2004.

Home Health. The bill would amend several policies enacted in BBA regarding payment to home health agencies. It would eliminate the contingency reduction and gradually implement the 15-percent cut mandated in BBA by phasing in the reduction for implementing the PPS for home health services at a rate of 5 percent in the first year, 10 percent in the second year, and the full 15 percent in the third year. It would temporarily increase the per-visit limit to 112 percent of the median cost per visit for services furnished after October 1, 1999, and it would temporarily increase the per-beneficiary limits by 1 percent for services provided in cost-reporting periods beginning in 2000. Those increases in the per-visit and per-beneficiary limits would not be reflected in the payment rates set when the PPS is implemented. The bill would also postpone the elimination of periodic interim payments until the year after the PPS is implemented. Those policies would increase Medicare expenditures by \$0.1 billion in 2000 and by \$1.5 billion over the 2000-2004 period.

Graduate Medical Education. Medicare's PPS for hospital inpatient services adjusts payments for the higher patient care costs associated with medical education. The bill would freeze through 2003 the 1999 adjustment of 6.5 percent for every 0.1 change in the ratio of residents to beds. The adjustment would then revert to the current-law adjustment of 5.5 percent. CBO estimates that this provision would increase outlays by \$0.2 billion in 2000 and by \$1.8 billion over the 2000-2004 period.

The bill also would allow exemptions from per-hospital caps on residency positions enacted by the BBA. One exemption would allow a hospital to increase its cap to absorb residents in a training program that had lost accreditation. Other provisions would allow certain hospitals to add three residency positions, as well as making other minor adjustments to the limits. Those provisions would increase spending by less than \$50 million a year, with a cumulative increase in spending of \$0.1 billion during the 2000-2004 period.

Rural Provisions. Payment rates in the prospective payment system for inpatient services furnished by acute care hospitals are updated annually by a market basket index (MBI) intended to reflect the prices of hospitals' input factors. The BBA mandated reductions from the MBI for payment updates in fiscal years 1998 through 2002. The bill would give hospitals classified as sole community hospitals and as Medicare-dependent small rural hospitals the full market basket increase in their prospective payment rates in fiscal years 2000 through 2002. CBO estimates that granting those hospitals the full MBI update would increase spending by \$0.3 billion during the 2000-2004 period.

The BBA created a new classification of limited-service hospitals, called Critical Access Hospitals (CAHs), which are exempted from the PPS. Those hospitals are limited to providing inpatient hospital stays no longer than 96 hours (with case-by-case exceptions). The bill would allow longer inpatient stays in CAHs, provided that stays average 96 hours. CBO assumes that provision would make it more attractive for hospitals that meet the size and geographic eligibility requirements to obtain certification as a CAH, and would increase Medicare outlays by exempting more inpatient stays from the PPS. CBO estimates that this provision would increase Medicare outlays by less than \$50 million in 2000 and by \$0.1 billion over the 2000-2004 period.

The bill would extend for two years the Medicare-dependent small rural hospital program (which will expire at the end of 2000), and require the Secretary to create a waiver process to permit certain hospitals located in urban areas to be reclassified to obtain higher payment rates available to rural hospitals. We estimate that those provisions would increase spending by \$0.1 billion during 2000 through 2004.

Managed Care. The bill would slow the implementation of adjustment of Medicare+Choice payment rates to more accurately reflect differences in cost per enrollee that are associated with health status. CBO estimates that this provision would not change spending in 2000, but would increase Medicare spending by \$1.6 billion over the 2000-2004 period.

Under current law, the Secretary may collect from Medicare+Choice plans \$100 million in user fees annually to pay for programs to educate beneficiaries about their Medicare+Choice

and supplemental insurance options. The bill would require such plans and the Hospital Insurance Trust Fund to contribute up to \$100 million a year to pay for those programs; the allocation of that amount between plans and the trust fund would be based on the share of Medicare enrollment in plans and in the fee-for-service program. CBO estimates that this provision would increase spending by \$0.1 billion in 2000 and by \$0.4 billion during 2000 through 2004.

Other provisions would allow beneficiaries more time to enroll in Medicare+Choice or Medigap plans when plans withdraw from markets, allow cost contracts with health maintenance organizations to be renewed until December 31, 2004, make the administration of the Medicare+Choice program more flexible, and ease certain requirements that limit how potential providers design and market managed care products to offer to Medicare beneficiaries. In addition, the bill would modify and extend a number of demonstration projects. We estimate that those provisions would increase Medicare spending by \$0.1 billion during 2000 through 2004.

Other Medicare Provisions. The bill includes numerous other modifications of Medicare law that are either technical in nature—that is, they have no effect on federal spending—or would result in relatively small changes in Medicare spending. The additional provisions that would affect Medicare spending are discussed below. In total, CBO estimates that these other provisions would increase Medicare outlays by about \$1 billion over the 2000-2004 period.

Hospice Update. Effective for services furnished on or after October 1, 1999, the bill would increase the annual increase in payment rates for hospice services from MBI minus 1 percentage point to MBI minus one-half of a percentage point in 2000 through 2002. CBO estimates that would increase Medicare expenditures by less than \$50 million in 2000 and by \$0.2 billion over the 2000-2004 period.

Payments for Hospital Inpatient Services. The bill contains several provisions that would affect payments to hospitals for inpatient care, but would increase spending by less than \$50 million during the 2000-2004 period. One provision would limit the reduction in disproportionate share payment rates to 3 percent in 2001, instead of the 4 percent reduction enacted in the BBA. Other provisions would codify the Administration's announced implementation of the PPS for inpatient care provided by rehabilitation hospitals, mandate that certain hospitals be reclassified as rural or urban for payment purposes, and require the Secretary to recalculate the area wage index for a Metropolitan Statistical Area using more recent data.

Outpatient Therapy Services. The BBA established annual limits on per-beneficiary payments for outpatient therapy services provided by independent therapists, comprehensive outpatient rehabilitation facilities (CORFs), SNFs and other nonhospital providers. The limits are a \$1,500 combined annual cap on physical therapy and speech language pathology services, and a \$1,500 annual cap on occupational therapy services. The bill would impose a two-year moratorium on the caps beginning in January 2000. We estimate that this provision would increase Medicare expenditures by \$0.2 billion in 2000 and by \$0.6 billion over the 2000-2004 period.

Renal Dialysis. The bill would increase Medicare's composite rate for renal dialysis by 2 percent beginning in October 2000. That provision would have no budgetary effect in 2000 and would increase Medicare expenditures by \$0.3 billion over the 2000-2004 period.

Pap Smears. The bill would increase Medicare's payment rate for the clinical laboratory component of pap smear tests from January 2000 through December 2001. That provision would increase Medicare expenditures by less than \$50 million over the 2000-2004 period.

Inherent Reasonableness Authority. The BBA granted the Secretary the authority to adjust Medicare Part B payment rates when they are not "inherently reasonable." The bill would suspend the Secretary's authority to use the inherent reasonableness provision until three months after the release of a report by the Comptroller General on the impact of the inherent reasonableness provision. That provision would increase Medicare expenditures by less than \$50 million over the 2000-2004 period.

Medicaid and SCHIP

The bill would increase federal Medicaid spending by \$91 million in 2000 and \$441 million over the 2000-2004 period. Federal SCHIP spending would increase by \$49 million in 2000 and \$248 million over the 2000-2004 period. In addition, the bill would create a new mandatory program that would provide grants to states to give to federally qualified health centers (FQHCs) and rural health clinics (RHCs). CBO estimates that this new program would cost \$75 million over the 2000-2004 period.

The bill contains numerous revisions to Medicaid and SCHIP law that would result in no estimated impact on federal spending. The provisions that would affect federal spending are discussed below.

Welfare-related transitional assistance for administrative costs. Under current law, states can receive an enhanced match rate for certain administrative expenses related to enrollment of low-income families receiving assistance under the Temporary Assistance for Needy Families (TANF) program who are no longer automatically eligible for Medicaid because of welfare reform. Under current law, total federal spending under the enhanced match rate is limited to \$500 million nationally and ends at the end of fiscal year 2000. In addition, the enhanced match rate applies only to spending in the first 12 quarters after each state began its TANF program. The bill would allow the enhanced match rate to continue after fiscal year 2000 and would eliminate the 12-quarters restriction.

CBO estimates that spending under the enhanced match will be \$263 million through fiscal year 2000 under current law. Eliminating the restrictions on the availability of the enhanced match rate would increase federal spending by \$60 million in 2000 and \$220 million over the 2000-2004 period.

Increased DSH allotment for certain states and the District of Columbia. The federal share of Medicaid DSH payments for each state is capped at specified levels in current law through 2002. Individual state allotments are increased by inflation starting in fiscal year 2003. The bill would increase allotments for several states and the District of Columbia in fiscal years 2000, 2001, and 2002. The District of Columbia's allotment would increase from \$23 million to \$32 million, Minnesota's allotment would increase from \$16 million to \$33 million, New Mexico's allotment would increase from \$5 million to \$9 million, and Wyoming's allotment would increase from 0 to \$0.1 million.

CBO assumes that those states would be able to spend the full amount of their allotment increases, and therefore estimates that federal spending would increase by \$30 million a year through 2002. Because allotments after 2002 are increased by inflation using 2002 as a base year, federal spending would increase in 2003 and thereafter. We estimate that this provision would cost \$152 million over the 2000-2004 period.

Optional deferment of the effective date for outpatient drug agreements. Under current law, when new manufacturers of outpatient prescription drugs enter into agreements under the Medicaid drug rebate program the agreement is not effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into. Under the bill, states would have the option to consider the agreement effective on any date between the time the agreement is entered into and the date it would become effective under current law.

CBO estimates that this provision would have a negligible cost—less than \$500,000 over the 2000-2004 period. Very few new manufacturers enter into rebate agreements with the Medicaid program each year. In most cases the agreements are entered into well before a drug manufactured by a new manufacturer is available for distribution on the market. In addition, states often require time after becoming aware of a new drug to update their systems to cover the drug and to notify pharmacies of the change. Nonetheless, it is possible that this change in law could result in very small additional costs to the federal government.

Medicaid interactions with Medicare Part B premium. Because Medicaid covers the cost of the Medicare Part B premium for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits, a change in the Medicare Part B premium affects federal Medicaid spending. CBO estimates that by increasing the amount of the Part B premium, the bill would increase federal Medicaid costs by about \$50 million over the 2000-2004 period.

Increased allotments for Puerto Rico and the territories. Under current SCHIP law, the territories are allotted 0.25 percent of the total amount made available to all states and territories each year. In the 1999 appropriations act (Public Law 105-277), the Congress provided an extra \$32 million to the territories. The bill would provide the territories with an additional \$34.2 million in 2000 and 2001, \$25.2 million each year for 2002 through 2004, \$32.4 million in each of 2005 and 2006, and \$40 million for 2007. CBO assumes that the full amount of the allotment would be spent in each year under the bill, resulting in increased federal spending of about \$150 million in the 2000-2004 period.

Improved data collection and evaluations of the SCHIP program. The bill would appropriate funds for three different research activities related to the SCHIP program. First, \$10 million a year would be available for the Bureau of the Census to make adjustments to the Current Population Survey to produce more reliable state-level data on the number of low-income children who do not have health insurance coverage. Second, \$9 million a year would be available for the National Center for Health Statistics to collect data on children's health insurance through the State and Local Area Integrated Telephone Survey. Third, \$10 million would be available beginning in 2000 for federal evaluation of SCHIP programs in 10 states. CBO estimates that these provisions would cost \$15 million in 2000 and \$104 million over the 2000-2004 period.

In addition, the bill would instruct the Inspector General of the Department of Health and Human Services (HHS) to audit a sample of states every three years to determine the number of SCHIP enrollees who are eligible for Medicaid and assess state progress in reducing the number of low-income children without health insurance coverage. The bill also would

instruct the Secretary of HHS to establish a clearinghouse for the consolidation and coordination of all federal databases and reports regarding children's health. These two provisions would increase the authorizations of appropriations for HHS, but CBO has not yet estimated those amounts.

Grants to states for items and services provided by FQHCs and RHCs. The bill would create a mandatory grant program under which certain states would receive a share of \$25 million a year for fiscal years 2001, 2002, and 2003 for distribution to FQHCs and RHCs. The FQHCs and RHCs could only use grant funds for providing Medicaid services to individuals not eligible for Medicaid. A state is not eligible to receive grant funds if it has reduced Medicaid reimbursement to FQHCs and RHCs under a state option established in the Balanced Budget Act of 1997. Under that option, states may phase-out cost-based reimbursement, a policy under which states pay facilities 100 percent of costs, beginning in fiscal year 2000. States that have already begun to implement the option may be eligible for the grant funds if they revert to paying facilities 100 percent of costs in fiscal year 2001.

CBO expects that states would spend the total amount of the grant funds by 2004, resulting in \$75 million in increased direct spending over the 2000-2004 period. Most of the funds would be spent by states that would not otherwise have reduced reimbursement to FQHCs and RHCs under the Medicaid option. However, some states that would otherwise have reduced payments to FQHCs and RHCs would not reduce reimbursement under the bill in order to access grant funds during the period in which those funds are available. After the funds cease to be available, some of those states would opt to reduce reimbursement. As a result of the provision, CBO estimates that Medicaid outlays would be \$1 million higher in fiscal year 2000 and \$19 million higher over the 2000-2004 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that would be subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the budget year and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Changes in outlays	1,200	5,700	2,200	2,000	1,100	1,000	800	800	800	800
Changes in receipts										Not applicable

Section 607 of the bill specifies that any net deficit increase resulting from enactment shall not be counted for purposes of enforcing the pay-as-you-go procedures.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill contains no intergovernmental mandates as defined in the UMRA. CBO estimates that provisions of the bill affecting Medicaid would result in additional federal and state spending for health programs.

By eliminating restrictions on the enhanced match for administrative costs under the TANF program, the bill would increase funds to states by \$220 million over the 2000-2004 period. These funds would be available to states without any changes to their projected spending over that time.

Medicaid spending for DSH in each state is capped under current law through 2002, and any spending over those caps is paid for with state funds alone. Increasing these federal allotments for the District of Columbia, Minnesota, New Mexico, and Wyoming would result in additional funds to those states totaling \$152 million over the 2000-2004 period. In order to receive the additional federal funds, CBO estimates that states would spend \$75 million of their own Medicaid funds over that period. Similarly, increased allotments for Puerto Rico and the territories under the SCHIP program would make an additional \$150 million available to states in the form of federal matching funds over the 2000-2004 period. In order to receive the additional federal funds, Puerto Rico and the territories would spend about \$80 million in their own funds over that period.

Just as federal expenditures for Medicaid would increase from changes to the Medicare Part B premium, state expenditures for Medicaid would also increase. CBO estimates that those state costs would total about \$40 million over the 2000-2004 period.

Finally, states would receive \$75 million in additional grants for items and services provided by federally qualified health centers and rural health clinics. States that have reduced

reimbursement rates to FQHCs and RHCs would not be eligible for the grants. Consequently, the implementation of this program would be an incentive to maintain full reimbursement rates, which would result in additional Medicaid costs. CBO estimates that the state portion of those costs would total about \$15 million over the 2000-2004 period.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would impose several new mandates on insurers who provide medigap coverage. Under current law, Medicare beneficiaries who lose supplemental coverage because of the termination or discontinuation of the employer-sponsored supplemental plan or the Medicare+Choice plan in which they are enrolled are entitled to purchase medigap coverage on favorable terms, if they apply within 63 days of the termination of enrollment. Under those circumstances, medigap insurers may not refuse to sell them a supplemental policy; charge them higher premiums based on their health status, claims experience, receipt of health care, or medical condition; or impose exclusions based on preexisting conditions.

The bill would allow beneficiaries to obtain medigap coverage under the same favorable terms if they applied within 63 days of being notified of the pending termination or discontinuation of their plan, effectively giving them two windows of opportunity to apply. It would also give protections to Medicare+Choice enrollees whose plan terminated and who subsequently chose to enroll in another Medicare+Choice plan. They would be able to obtain medigap coverage under the same terms if they disenrolled from the second plan within 12 months. Finally, the bill would grant enrollees in the Program of All-Inclusive Care for the Elderly the same medigap protections as Medicare+Choice enrollees.

Those provisions would enable more Medicare beneficiaries to obtain medigap coverage on a community-rated basis. Because of the restrictions on the premiums that they could charge, medigap insurers might incur costs that they could not immediately recover from premiums. However, the additional number of beneficiaries that the provisions would affect is likely to be small, so the costs imposed on insurers would be below the threshold specified in UMRA (\$100 million in 1996, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

This estimate supercedes a previous cost estimate that was transmitted on October 26, 1999. The previous estimate did not include the cost of \$0.1 billion in 2000 and \$0.4 billion over the 2000-2004 period for the provision that would reduce user fees collected from

Medicare+Choice plans and increase spending from the Hospital Insurance Trust Fund to pay for programs to educate beneficiaries about their Medicare+Choice and supplemental insurance options. This revised estimate corrects the error in the previous estimate. This estimate also reflects a change in the name of the bill, as reported by the Senate Committee on Finance.

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