



CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

June 24, 2002

Medicare Modernization and Prescription Drug Act of 2002

As ordered reported by the House Committee on Energy and Commerce on June 21, 2002

SUMMARY

The bill would establish an outpatient prescription drug benefit in Medicare and would modify Medicare's payment rates or coverage rules for many services, including those furnished by hospitals, skilled nursing facilities, home health agencies, physicians, physical and speech therapists, occupational therapists, and managed care plans. CBO estimates those provisions would increase direct spending by \$4.3 billion in 2003 and by \$341 billion over the 2003-2012 period.

The bill would authorize the collection of civil penalties for the failure of interstate Internet pharmacies to comply with disclosure requirements. Those collections would be classified as revenues (i.e., governmental receipts). However, CBO assumes that there would be substantial compliance with the disclosure requirements and that the effect on revenues would be negligible. Because the bill would affect direct spending and revenues, pay-as-you-go procedures would apply.

The bill would also affect discretionary spending. It would require the Centers for Medicare and Medicaid Services to modify how Medicare regulations and policies are developed, communicated, and enforced. It also would establish a Medicare Benefits Administration to administer the outpatient drug benefit and the Medicare+Choice program. The bill also would establish an Office of Rare Diseases at the National Institutes of Health, require several studies, and authorize several grant programs. CBO has not completed an estimate of the costs of activities subject to appropriation of the necessary amounts.

The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about \$70 million in 2005 (the first year the mandate is effective) increasing to about \$100 million in 2009. Those losses would exceed the threshold established in UMRA (\$62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in the bill would impose minimal or no costs on state, local, or tribal governments.

The bill would modify several existing private-sector mandates on insurers that offer Medicare supplemental (medigap) coverage and would impose new requirements on Internet pharmacies and group health plans. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA (\$115 million in 2002, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is summarized in Table 1 and major components of those costs are outlined below. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

MAJOR PROVISIONS

The following discussion highlights changes in gross outlays directly attributable to provisions of the act. In addition, the estimate includes three interactions: the effect of changes in Medicare Part B outlays on receipts from Part B premiums, the effect of changes in Part B premiums and cost sharing on federal Medicaid spending, and the effect of changes in Medicare payment rates on federal Medicaid spending subject to the “upper payment limit” (UPL).

About 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total \$4.8 billion from 2003 through 2012. Such payments would be recorded as offsetting receipts (a credit against direct spending).

Medicaid pays some or all of premiums and cost sharing for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits. In addition to changing the Part B premium, the bill would change cost sharing for services furnished in hospital outpatient departments and would change payment rates for many services (which would affect cost sharing). CBO estimates that the changes in premiums and cost sharing would increase federal Medicaid costs by about \$0.3 billion over the 2003-2012 period.

Table 1. Estimated Impact on Direct Spending of the Medicare Modernization and Prescription Drug Act of 2002, as Ordered Reported by the Committee on Energy and Commerce on June 21, 2002

| | By Fiscal Year, Outlays in Billions of Dollars | | | | | | | | | | 2003-2012 |
|---|--|------------|------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | |
| Medicare Outlays | | | | | | | | | | | |
| Title I: Medicare Prescription Drug Benefit | 0 | 0 | 22.3 | 36.1 | 40.6 | 45.8 | 51.3 | 57.5 | 64.3 | 72.4 | 390.4 |
| Title II: Medicare-Choice | | | | | | | | | | | |
| 201 M+C payment improvements | 0.5 | 1.1 | 0.5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2.2 |
| 211 M+C competition program | 0 | 0 | 0.6 | 0.9 | 0.9 | 0.3 | -0.4 | -0.6 | -0.6 | -0.5 | 0.7 |
| Other provisions | * | * | * | * | * | * | * | * | * | * | <u>0.1</u> |
| Subtotal, title II | <u>0.5</u> | <u>1.2</u> | <u>1.2</u> | <u>0.9</u> | <u>0.9</u> | <u>0.3</u> | <u>-0.4</u> | <u>-0.6</u> | <u>-0.6</u> | <u>-0.5</u> | <u>2.9</u> |
| Title III: Rural Health Care Improvements | | | | | | | | | | | |
| 302 Disproportionate share adjustment | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 1.6 |
| 303 Standardized payment amount | 0.3 | 0.6 | 0.6 | 0.7 | 0.7 | 0.8 | 0.8 | 0.9 | 0.9 | 1.0 | 7.2 |
| 306 Home Health 10 percent rural add-on | 0.1 | 0.3 | 0.1 | * | 0 | 0 | 0 | 0 | 0 | 0 | 0.6 |
| Other provisions | * | * | * | * | * | * | * | * | * | * | <u>0.1</u> |
| Subtotal, title III | <u>0.4</u> | <u>1.0</u> | <u>0.9</u> | <u>0.9</u> | <u>0.9</u> | <u>1.0</u> | <u>1.0</u> | <u>1.1</u> | <u>1.2</u> | <u>1.2</u> | <u>9.5</u> |
| Title IV: Part A | | | | | | | | | | | |
| 401 Hospital update | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 0.4 | 0.4 | 0.5 | 3.6 |
| 402 Indirect medical education | 0.4 | 0.3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.7 |
| 404 Phase-in federal rate in Puerto Rico | * | * | * | * | * | * | * | * | * | * | 0.2 |
| 411 Skilled Nursing Facility payment rates | 0.4 | 0.5 | 0.6 | 0.1 | 0 | 0 | 0 | 0 | 0 | 0 | 1.6 |
| 421 Hospice Consultation Services | 0 | * | * | * | * | * | * | * | * | * | 0.2 |
| Other provisions | * | * | * | * | * | * | 0 | 0 | 0 | 0 | <u>0.1</u> |
| Subtotal, title IV | <u>1.1</u> | <u>1.2</u> | <u>0.9</u> | <u>0.5</u> | <u>0.4</u> | <u>0.4</u> | <u>0.4</u> | <u>0.5</u> | <u>0.5</u> | <u>0.5</u> | <u>6.4</u> |
| Title V: Part B | | | | | | | | | | | |
| 501 Updates for physicians' services | 1.6 | 4.4 | 6.6 | 5.7 | 2.9 | -0.4 | -2.5 | -3.0 | -2.5 | -1.4 | 11.5 |
| 511 Competitive acquisition | 0 | -0.2 | -0.4 | -0.7 | -0.8 | -0.9 | -1.0 | -1.1 | -1.2 | -1.3 | -7.7 |
| 512 Ambulance | 0.2 | 0.2 | 0.1 | 0.1 | * | 0 | 0 | 0 | 0 | 0 | 0.6 |
| 513 Therapy cap: 2 year extension of moratorium | 0.4 | 0.5 | 0.1 | * | * | * | * | * | * | * | 1.0 |
| 514 Hospital outpatient services | 0 | 0.2 | 0.5 | 0.7 | 0.8 | 0.8 | 0.8 | 1.0 | 1.8 | 3.1 | 9.7 |
| 515 Routine physical | 0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 1.3 |
| 516 Renal dialysis services | * | * | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.7 |
| Other provisions | * | <u>0.1</u> | <u>0.1</u> | * | * | * | * | * | * | * | <u>0.2</u> |
| Subtotal, title V | <u>2.2</u> | <u>5.4</u> | <u>7.2</u> | <u>6.0</u> | <u>3.0</u> | <u>-0.3</u> | <u>-2.5</u> | <u>-2.9</u> | <u>-1.6</u> | <u>0.7</u> | <u>17.3</u> |
| Title VI: Parts A and B | | | | | | | | | | | |
| Home Health Provisions | 0.4 | 0.2 | * | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | -0.1 | * |
| 611 Limit on high cost medical education programs | * | * | -0.1 | -0.2 | -0.2 | -0.3 | -0.3 | -0.4 | -0.5 | -0.5 | -2.6 |
| 612 Redistribute unused residency positions | * | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 1.0 |
| Other provisions | <u>0</u> | * | * | * | 0 | 0 | 0 | 0 | 0 | 0 | * |
| Subtotal, title VI | <u>0.3</u> | <u>0.3</u> | * | <u>-0.1</u> | <u>-0.2</u> | <u>-0.2</u> | <u>-0.3</u> | <u>-0.4</u> | <u>-0.4</u> | <u>-0.5</u> | <u>-1.6</u> |
| Title VII: Medicare Benefits Administration | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Title VIII: Regulatory Reform | * | * | * | * | * | * | * | * | * | * | 0.1 |

Continued

Table 1. Continued

| | By Fiscal Year, Outlays in Billions of Dollars | | | | | | | | | | |
|---|--|-------------------|-------------------|---------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2003-2012 |
| Title IX: Medicaid, Public Health, and other Provisions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Subtotal, Gross Medicare Outlays | 4.5 | 8.9 | 32.6 | 44.2 | 45.7 | 47.0 | 49.7 | 55.1 | 63.4 | 73.9 | 425.0 |
| Premium Collections | -0.7 | -1.6 | -2.0 | -1.6 | -0.9 | * | 0.7 | 0.8 | 0.5 | -0.1 | -4.8 |
| Subtotal, Net Medicare Outlays | 3.8 | 7.3 | 30.6 | 42.6 | 44.8 | 47.0 | 50.3 | 55.9 | 63.9 | 73.8 | 420.1 |
| Medicaid Outlays | | | | | | | | | | | |
| Title I: Medicare Prescription Drug Benefit | 0 | * | -3.8 | -8.2 | -8.7 | -9.5 | -10.6 | -11.8 | -13.3 | -14.8 | -81.0 |
| 902 Disproportionate Share Payments | 0.4 | 0.3 | 0.3 | 0.2 | 0.2 | 0.2 | 0.2 | 0.1 | 0.1 | * | 2.0 |
| Spending Subject to Upper Payment Limit | 0.1 | 0.1 | 0.1 | * | * | * | * | * | * | * | 0.2 |
| Medicaid Payments of Medicare Premiums | <u>0.1</u> | <u>0.2</u> | <u>0.2</u> | <u>0.2</u> | <u>0.1</u> | <u>*</u> | <u>-0.1</u> | <u>-0.1</u> | <u>-0.1</u> | <u>-0.1</u> | <u>0.3</u> |
| Subtotal, Medicaid | 0.5 | 0.6 | -3.3 | -7.8 | -8.4 | -9.4 | -10.5 | -11.8 | -13.3 | -14.9 | -78.3 |
| Other Direct Spending^a | | | | | | | | | | | |
| Title I: Medicare Prescription Drug Benefit | 0 | 0 | -0.1 | -0.2 | -0.2 | -0.2 | -0.2 | -0.3 | -0.3 | -0.3 | -1.7 |
| 702 Pharmacy Grant Program | <u>*</u> | <u>0.1</u> | <u>0.2</u> | <u>0.2</u> | <u>0.2</u> | <u>*</u> | <u>*</u> | <u>*</u> | <u>*</u> | <u>*</u> | <u>0.6</u> |
| Subtotal, other direct spending | * <u>*</u> | 0.1 <u>0.1</u> | 0.1 <u>0.1</u> | * <u>*</u> | -0.1 <u>-0.1</u> | -0.2 <u>-0.2</u> | -0.2 <u>-0.2</u> | -0.3 <u>-0.3</u> | -0.3 <u>-0.3</u> | -0.3 <u>-0.3</u> | -1.1 <u>-1.1</u> |
| Total Changes in Direct Spending | | | | | | | | | | | |
| Estimated Outlays | 4.3 | 8.0 | 27.4 | 34.8 | 36.3 | 37.5 | 39.6 | 43.9 | 50.3 | 58.7 | 340.7 |

NOTES: * = Between -\$50 million and \$50 million.

Numbers may not add up to totals because of rounding.

a. Federal savings in the Federal Employees Health Benefits program, Department of Defense spending on health benefits for Medicare-eligible retirees, and spending from the Combined Benefits Funds for the United Mine Workers Association.

State Medicaid programs use Medicare payment rates to calculate the maximum amount, known as the upper payment limit, that they can pay for services furnished by hospitals and nursing homes. In recent years, many states have increased their Medicaid payments up to the UPL in order to draw down additional federal funds. The bill would raise Medicare payment rates for services furnished by hospitals and skilled nursing facilities, thus boosting the UPL and allowing states to receive additional federal Medicaid funds. CBO estimates that the bill would increase federal Medicaid spending subject to the UPL by \$0.2 billion over the 2003-2012 period.

Title I—Medicare Outpatient Prescription Drug Benefit

Title I would create a voluntary outpatient prescription drug benefit, beginning in 2005, under a new Part D of the Medicare program. The prescription drug benefit would be offered by competing private drug plans that would be at financial risk for covering the cost of the benefit. Premiums would be charged to participating beneficiaries and subsidized, in part, by the Medicare program. The bill would establish a program to subsidize premiums and cost sharing for certain low-income beneficiaries, and would reduce federal Medicaid payments to states through 2012 by a proportion of the spending for subsidized premiums and cost sharing attributed to Medicare enrollees who are entitled to prescription drug coverage under Medicaid.

CBO estimates that the Part D provisions would increase direct spending by about \$308 billion over the 2003-2012 period (see Table 2). Of that 10-year total, \$301 billion represents outlays for federal payments to plans offering qualified prescription drug coverage and \$92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by \$96 billion in federal savings associated with the new drug program, because Part D would replace or supplement drug coverage that some Medicare enrollees obtain through Medicaid, the Federal Employees Health Benefits program, the Department of Defense, or the Combined Benefits Funds of the United Mine Workers Association. Other effects of the program—largely the result of increased enrollment of Medicare enrollees in Medicaid, offset, in part, by the reduction through 2012 in federal Medicaid payments to states—would increase federal spending by \$11 billion through 2012, CBO estimates.

Table 2. Effect on Direct Spending of Establishing a Prescription Drug Benefit in Medicare:
Title I of the Medicare Modernization and Prescription Drug Act of 2002

| | By Fiscal Year, Outlays in Billions of Dollars | | | | | | | | | | |
|---|--|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2003-2012 |
| Changes in Direct Spending | | | | | | | | | | | |
| Medicare Spending on Prescription Drugs | 0 | 0 | 19 | 29 | 32 | 35 | 39 | 44 | 49 | 54 | 301 |
| Spending by Medicaid and Other Programs on Drugs for Medicare Enrollees | 0 | 0 | -4 | -9 | -10 | -12 | -13 | -14 | -16 | -18 | -96 |
| Low-income Subsidy | 0 | 0 | 4 | 8 | 10 | 11 | 13 | 14 | 16 | 17 | 92 |
| Other Direct Spending ^a | <u>0</u> | <u>*</u> | <u>*</u> | <u>*</u> | <u>*</u> | <u>1</u> | <u>2</u> | <u>2</u> | <u>3</u> | <u>3</u> | <u>11</u> |
| Total Federal Spending | 0 | * | 18 | 28 | 32 | 36 | 41 | 45 | 51 | 57 | 308 |
| <hr/> | | | | | | | | | | | |
| Memorandum: | | | | | | | | | | | |
| Monthly Premium | n.a. | n.a. | \$34 | \$36 | \$39 | \$42 | \$46 | \$51 | \$55 | \$60 | |
| Deductible | n.a. | n.a. | \$250 | \$276 | \$303 | \$333 | \$364 | \$398 | \$435 | \$475 | |

NOTES: * = Costs or savings of less than \$500 million.

n.a. = not applicable because the benefit would not take effect until 2005.

Numbers may not add up to totals because of rounding.

a. Other direct spending includes changes in Medicare and Medicaid spending associated with increases in the number of Medicare beneficiaries enrolled in Medicaid and reductions in federal Medicaid payments to states.

Under the prescription drug benefit, plan sponsors would offer either “standard coverage” or actuarially equivalent coverage, if approved by the Medicare Benefits Administration. For 2005, standard coverage would have a \$250 deductible; 20 percent cost sharing for costs between \$250 and \$1,000; and 50 percent cost sharing for costs between \$1,000 and \$2,000. Beneficiaries would be responsible for 100 percent of costs above \$2,000 until the beneficiary reaches the catastrophic limit at \$3,700 in out-of-pocket spending. In subsequent years, those amounts would be increased by the percentage change in per-capita spending for outpatient prescription drugs among the Medicare population.

The beneficiary would stop paying for covered prescription drugs after reaching the catastrophic limit (out-of-pocket spending of \$3,700 in 2005). However, only payments made by the beneficiary, the low-income subsidy, or by Medicaid would count toward that catastrophic limit; payments or reimbursements made by other insurance or third-party payers would not count toward that limit.

Each plan would establish its own premium. CBO estimates that premiums would average about \$34 in 2005, increasing to \$60 in 2012.

The Medicare program would subsidize the drug benefit through two payments to plans: reimbursement of 36 percent of the plan's spending for the standard benefit and "individual reinsurance" payments for high-cost beneficiaries that, in aggregate, equal 30 percent of total spending for standard benefits.

Individuals with incomes below 150 percent of the federal poverty level would be eligible for a full subsidy of the lowest premium in the market and the cost sharing for drug spending below \$2,000. For individuals with incomes between 150 percent and 175 percent of the federal poverty level, there would be a full subsidy of cost sharing for costs below \$2,000 and there would be a sliding-scale subsidy of the lowest premium in the market. (In 2002, the federal poverty level is \$8,860 for an individual and \$11,940 for a couple.)

Title II—Medicare+Choice Revitalization and Competition

Title II would increase rates paid to Medicare+Choice plans in calendar years 2003 and 2004, and would establish a new Medicare+Choice payment system based on competitive bidding, beginning in 2005. The bill also would extend several expiring programs and demonstration programs involving group plans. CBO estimates the provisions in title II would increase direct spending by \$0.5 billion in 2003 and by \$2.9 billion over the 2003-2012 period.

CBO estimates that a requirement in current law will hold increases in rates paid to nearly all Medicare+Choice plans to 2 percent in both 2003 and 2004. The bill would eliminate that requirement and modify the payment formula to pay the largest of four amounts: a minimum payment amount, a blend of local and national amounts based on inflated historical per-capita costs in the fee-for-service sector, estimated current per-capita costs in the fee-for-service sector, and a minimum increase of 3 percent. (The minimum payment amounts would be \$425 in most counties and \$525 in counties in a metropolitan area with a population greater than 250,000, updated from 2001 by the increase in per-capita spending in the Medicare program.) That provision would affect spending during fiscal years 2003 through 2005, increasing outlays by \$0.5 billion in 2003 and by a cumulative total of \$2.2 billion.

The bill would establish a competitive bidding program for Medicare+Choice plans, beginning in 2005. Under the program, plans would submit bids for the cost of providing standard benefits under Parts A and B of Medicare and the standard drug benefit under Part D. Those bids for standard Part A and Part B benefits would be compared to a benchmark amount, which in 2005 through 2007 would be the larger of the minimum payment amount and estimated current per-capita costs in the fee-for-service sector. Beginning in 2008, the benchmark amount would be the larger of the minimum payment amount and 95 percent of per-capita costs in the fee-for-service sector. If a plan were to bid below the benchmark amount, Medicare would pay the plan the bid plus an amount that would approximate 75 percent of the difference between the bid and the benchmark amount (after adjusting for differences in risk attributable to the health status of the plan's enrollees). The plans could rebate that additional payment to Medicare enrollees, or could use it to pay for additional benefits. CBO estimates that the competition program would increase spending during the 2005-2008 period and reduce spending beginning in 2009, with spending through 2012 increasing by a total of \$0.7 billion.

Title III—Rural Health Care Improvements

Title III would increase payment rates for inpatient services furnished by hospitals in rural areas or metropolitan areas with a population under one million, and for services furnished by home health agencies located in rural areas. CBO estimates those provisions would increase spending by \$0.4 billion in 2003 and by about \$9.5 billion through 2012. Two provisions—increasing the standardized payment amount and increasing payments to hospitals that qualify for a payment adjustment as a disproportionate share hospital—account for \$8.8 billion of that 10-year total.

Title IV—Provisions Relating to Medicare Part A

Title IV would increase payment rates for inpatient services furnished by hospitals, skilled nursing facilities, and hospices. CBO estimates the provisions in title IV would increase spending by \$1.1 billion in 2003 and by \$6.4 billion over the 2003-2012 period.

The bill would increase the 2003 update to payment rates for hospital inpatient services paid under the prospective payment system from 0.55 percentage points below the “market basket index” measure of changes in hospital input prices to 0.25 percentage points below that index. Hospitals designated as sole community hospitals would receive an update in 2003 equal to the market basket index. CBO estimates that provision would increase spending by \$0.3 billion in 2003 and \$3.6 billion over the 2003-2012 period.

Temporary increases in payments to teaching hospitals and skilled nursing facilities account for most of the remaining costs of title IV. Teaching hospitals would receive higher payments for two years, at an estimated cumulative cost of \$0.7 billion, and skilled nursing facilities would receive higher payment rates for three years, at a cumulative cost of \$1.6 billion.

Title V—Provisions Relating to Medicare Part B

CBO estimates that the provisions of title V would increase Medicare spending by \$2.2 billion in 2003 and \$17.3 billion over the 2003-2012 period. The provisions with the largest budgetary effects include changes in payments for physicians' services, assumption of some cost sharing for services furnished by hospital outpatient departments, establishment of a competitive acquisition program for durable medical equipment and certain orthotics, coverage of some routine physical examinations, and a two-year delay in the implementation of caps on payments for certain therapy services.

Compared to current law, CBO estimates that the bill would increase payments for services paid under the physician fee schedule during 2003 through 2007, with outlays increasing by \$1.6 billion in 2003 and by \$21.3 billion through 2007. However, the bill would reduce payments for those services in 2008 and subsequent years, with a net increase in spending during the 2003-2012 period of \$11.5 billion.

Before the Balanced Budget Act of 1997 (BBA), beneficiaries paid cost sharing of 20 percent of charges for hospital outpatient services and the program paid 80 percent of allowed charges. Allowed charges generally were a much lower amount than charges. As a result, beneficiaries, on average, were paying about half of payments to hospitals for outpatient services. The BBA and subsequent legislation are phasing in increases in payments for outpatient services while limiting cost sharing, with the objective of reducing the share paid by beneficiaries to 20 percent. The bill would accelerate the Medicare program's assumption of cost sharing in excess of 20 percent, beginning in 2004. CBO estimates that provision would increase spending by \$9.7 billion over the 2003-2012 period.

The bill would expand and make permanent a demonstration project in which certain durable medical equipment and orthotics are acquired through competitive bidding instead of paying on the basis of a fee schedule. CBO estimates that provision would reduce spending by \$7.7 billion through 2012.

Beginning in 2004, the bill would require Medicare to pay for a routine physical examination, and associated services, when furnished within six months of when a beneficiary first enrolls

in Medicare. Beneficiaries already enrolled in Medicare would not be eligible for this benefit. CBO estimates this provision would cost \$1.3 billion over the 2003-2012 period.

Title VI—Provisions Relating to Medicare Parts A and B

Title VI would modify payment rates for home health services, limit subsidies to hospitals with graduate medical education (GME) programs and permit redistribution of subsidized GME slots, and establish several demonstration programs. CBO estimates that the provisions of title VI would increase Medicare spending by \$0.3 billion in 2003 and would reduce spending by \$1.6 billion over the 2003-2012 period.

Under current law, there will be a so-called “15 percent” reduction in 2003 in rates paid for services to furnished by home health agencies (the actual reduction would be about 7 percent). The bill would eliminate the reduction, but would provide for smaller annual updates to payment rates in subsequent years. CBO estimates that provision would increase federal spending by \$0.4 billion in 2003 and reduce spending by less than \$50 million over the 2003-2012 period.

Under current law, a limit on subsidies for GME programs—at 140 percent of the adjusted national average per-resident amount—will expire at the end of 2002. The bill would extend that limit through 2012, reducing federal spending by about \$2.6 billion over the 2003-2012 period. Current law caps the number of residency slots at each teaching hospital that are eligible for GME subsidies. The bill would permit unused residency slots to be redistributed to hospitals that have reached their caps. CBO estimates that provision would increase spending by \$1 billion over the 2003-2012 period.

Title VII—Medicare Benefits Administration

The bill would establish a Medicare Benefits Administration within the Department of Health and Human Services to administer the Medicare+Choice competition program and the prescription drug benefit. The bill also would provide \$150 million a year during 2004 through 2007 for a program for grants to pharmacies. CBO estimates that title VII would increase direct spending by \$0.6 billion over the 2003-2012 period.

Title VIII—Regulatory Reduction and Contracting Reform

Title VIII would establish a procedure for obtaining a determination before a service is furnished whether Medicare will pay for that service. CBO estimates that provision would increase direct spending by about \$0.1 billion over the 2003-2012 period.

Title IX—Medicaid, Public Health, and Other Health Provisions

CBO estimates that the provisions of title IX would have no effect on direct spending.

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 and governmental receipts that are 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 through 2006 are counted.

| | By Fiscal Year, in Millions of Dollars | | | | | | | | | | |
|---------------------|--|-------|-------|--------|--------|--------|--------|--------|--------|--------|--------|
| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
| Changes in outlays | 0 | 4,100 | 7,700 | 26,600 | 34,000 | 35,700 | 37,200 | 39,500 | 43,700 | 50,200 | 58,500 |
| Changes in receipts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act. CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about \$70 million in 2005 (the first year the mandate is effective) increasing to about \$100 million in 2009. Those losses would exceed the threshold established in UMRA (\$62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in the bill would impose minimal or no costs on state, local, or tribal governments. Provisions of the bill affecting Medicaid would result in net savings to state and local governments of about \$48 billion over the 2003-2012 period, and additional spending for disproportionate share hospitals would total \$1.5 billion over the same period.

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs), and this prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs would result in a shift away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues. CBO estimates that approximately 10 million people would change their insurance coverage for prescription drugs from taxable plans to PDPs. As a result, states would be unable to collect premium taxes (ranging from 0.2 percent to 3.0 percent of premiums) on those plans. CBO estimates that state losses of premium tax revenue as a result of this preemption would range from about \$70 million in 2005 to \$100 million in 2009.

The bill also would allow the Secretary of Health and Human Services to waive state licensure requirements for PDPs in cases where a state fails to act on a license application within 90 days or where a state denial is based on discriminatory treatment or solvency requirements that differ from those in the bill. In cases where the Secretary waives licensure requirements, states would lose fees associated with those licenses. CBO cannot estimate the magnitude of such losses because we have no basis for predicting the number of cases where a waiver would be possible or would be granted.

Health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, would be required to disclose whether the coverage they offer provides benefits at least equivalent to the benefits under the PDP. That disclosure requirement would be an intergovernmental mandate as defined by UMRA; however CBO estimates that the costs of the mandate would be minimal.

The bill would preempt state solvency standards for PDP sponsors and would supercede all state laws governing Medicare+Choice plans, with the exception of licensing or solvency requirements. While these preemptions would limit the application of state laws, they would impose no duties on states that would result in additional spending.

Other Impacts

The net effect of the bill on state Medicaid spending is expected to be savings totaling about \$48 billion over the 2003-2012 period. On the one hand, state Medicaid programs would benefit as coverage responsibility for individuals that are dually eligible for Medicaid and Medicare shift from Medicaid to Medicare. However, some of these savings would be offset by new prescription drug spending for new enrollees who are dually eligible for both

Medicare and Medicaid. CBO estimates that savings to states from these provisions would total about \$60 billion over the 2003-2012 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state savings over the same period by about \$12 billion.

States would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare. The costs associated with this additional requirement would decrease over time because the matching rate from the federal government would increase annually until 2014 when it would equal 100 percent. In addition, increased allotments for disproportionate share hospitals in states would increase state Medicaid spending by about \$1.5 billion. Because states may alter their programmatic and financial responsibilities to offset these costs, they would not be intergovernmental mandates as defined in UMRA.

State and local governments that provide health insurance to their employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in their health plans for retirees. Because CBO cannot predict how states might restructure the prescription drug component of their health plans, we cannot estimate the size of any federal reinsurance payments that would accrue to those governments.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill would modify or create a number of mandates on private-sector entities. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA (\$115 million in 2002, adjusted annually for inflation).

Section 104 of the bill would modify several existing private-sector mandates on insurers that offer Medicare supplemental (medigap) coverage. One change would bar insurers from offering policies that include prescription drug coverage (policy categories H, I, and J) except to beneficiaries currently enrolled in the plans. However, insurers would be allowed to offer to beneficiaries who enroll in the Part D program two new medigap policies whose coverage would complement the Part D coverage. In addition, insurers who sell medigap policies without prescription drug coverage (policy categories A–G) would have to make those policies available, on a similar basis as they do to beneficiaries newly eligible to purchase medigap coverage, to any beneficiary who enrolls in the new Medicare Part D program and who, at the time of enrollment in Part D, held an H, I, or J policy.

CBO estimates that most Medicare beneficiaries who would purchase medigap plans with prescription drug coverage under current law would join the new Part D program under the bill and would also purchase one of the two new medigap drug plans. As a result, nearly all of the profits lost by insurers due to restrictions on current medigap plans would be offset by profits earned on the new drug plans.

The bill would also impose three new private-sector mandates. Section 1860A would require health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, to certify that the coverage they offer provides benefits at least equivalent to the benefits under Part D. Such a certification would be needed by enrollees who wanted to enter the Medicare drug benefit late because they had previously obtained coverage from the certifying plan. Section 850 would bar group health plans from requiring dental providers to obtain a claims determination from Medicare for dental benefits specifically excluded from Medicare coverage as a condition for obtaining a claims determination for such benefits under the group health plan. Section 912 would require pharmacies operating on the Internet to disclose their existence to state licencing boards and to post certain information on their web sites. CBO estimates that the direct cost of these mandates would be small.

ESTIMATE PREPARED BY:

Federal Costs:

Medicare outpatient prescription drug benefit—Julia Christensen, Jeanne De Sa, and Eric Rollins, Rachel Schmidt, and Sarah Thomas

Medicare+Choice Competition—Niall Brennan

Other provisions—Alexis Ahlstrom, Charles Betley, Niall Brennan, Julia Christensen, Jeanne De Sa, Eric Rollins, and Christopher Topoleski

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