CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 27, 2005

Reconciliation Recommendations of the Senate Committee on Finance

As approved by the Senate Committee on Finance on October 25, 2005

SUMMARY

This legislation would make a variety of changes to Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). CBO estimates that enacting this legislation would reduce direct spending by $819 million in 2006, by $10.0 billion over the 2006-2010 period, and by $54.8 billion over the 2006-2015 period. The Medicare program would account for 57 percent of the savings over the first five years, and 74 percent of the savings over 10 years. Enacting the legislation would not affect federal revenues.

The legislation would make numerous changes to the Medicare program. The largest savings would result from provisions that would lower spending by revising how the Centers for Medicare and Medicaid Services (CMS) accounts for the health status of individuals enrolled in Medicare Advantage (MA) when determining payment rates for MA plans, by eliminating payments from a regional stabilization fund for MA plans, and by reducing and delaying payments to health care providers to fund an initiative to promote value-based purchasing. The legislation also would increase payment rates for physician services in 2006, which would raise outlays over the 2006-2009 period and reduce them in later years. Finally, the legislation would shift $5.2 billion in outlays from 2006 to 2007 by temporarily halting payments to providers during the last six business days of September 2006. On net, CBO estimates that Medicare spending would be reduced by $5.7 billion over the 2006-2010 period and by $40.6 billion over the 2006-2015 period.

The provisions with the most significant effects on Medicaid spending would reduce spending by limiting payments for outpatient prescription drugs, increasing the rebates that Medicaid receives from drug manufacturers, and narrowing the range of covered case management services. Those savings would be partly offset by a temporary increase in the federal matching rates for Alabama, Louisiana, and Mississippi, and by allowing states to provide Medicaid coverage to certain disabled children. All together, the changes to Medicaid and SCHIP would reduce federal outlays by $4.3 billion over the 2006-2010 period and by $14.2 billion over the 2006-2015 period, CBO estimates.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that overall state spending on Medicaid and SCHIP would be reduced by about $7.2 billion over the 2006-2010 period as a result of provisions in the legislation, most notably from restrictions on pharmacy reimbursements and the increased federal matching rate for states affected by recent hurricanes.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the legislation is shown in Table 1. The effects of this legislation fall within budget functions 550 (health), 570 (Medicare), and 600 (income security).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF THE SENATE FINANCE COMMITTEE'S RECONCILIATION RECOMMENDATIONS

	Outlays in Millions of Dollars, By Fiscal Year											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-2010	2006-2015
CHANGES IN DIRECT SPENDING												
Medicaid and SCHIP												
Estimated Budget Authority	1,501	-1,302	-1,483	-1,482	-1,435	-1,591	-1,788	-1,682	-2,111	-2,546	-4,202	-13,920
Estimated Outlays	1,725	-844	-1,661	-1,815	-1,689	-1,618	-1,673	-1,872	-2,156	-2,581	-4,285	-14,184
Medicare												
Estimated Budget Authority	-2,530	5,511	-1,022	-2,696	-4,984	-7,559	-7,566	-7,916	-6,420	-5,428	-5,721	-40,609
Estimated Outlays	-2,544	5,517	-1,017	-2,694	-4,983	-7,558	-7,566	-7,916	-6,420	-5,428	-5,721	-40,609
Total Changes in Direct Spending												
Estimated Budget Authority	-1,029	4,208	-2,505	-4,178	-6,419	-9,149	-9,354	-9,598	-8,531	-7,975	-9,922	-54,529
Estimated Outlays	-819	4,673	-2,678	-4,510	-6,672	-9,176	-9,239	-9,787	-8,576	-8,009	-10,006	-54,794

NOTES: Components may not sum to totals because of rounding.
SCHIP = State Children's Health Insurance Program.

BASIS OF ESTIMATE

For this estimate, CBO assumes that the reconciliation bill will be enacted by the end of December 2005.

Subtitle A—Medicaid

The legislation would increase federal spending for Medicaid and SCHIP by an estimated $1.7 billion in 2006, mainly because of an increase in the federal match rates for states affected by Hurricane Katrina. CBO estimates that the legislation would reduce spending for those programs by a total of $4.3 billion over the 2006-2010 period and $14.2 billion over the 2006-2015 period, primarily by lowering payments for outpatient prescription drugs. (The figures in this estimate represent the federal share of Medicaid and SCHIP spending unless noted otherwise.) The estimated effects of Subtitle A are shown in Table 2.

Chapter 1: Prescription Drugs. The provisions of this chapter would limit payments for outpatient prescription drugs and increase the rebates that Medicaid receives from drug manufacturers. CBO estimates that those provisions would represent the bulk of Medicaid savings under the legislation and would reduce Medicaid spending by $325 million in 2006, $6.3 billion over the 2006-2010 period, and $20.1 billion over the 2006-2015 period.

Limits on Pharmacy Reimbursement. The legislation would replace Medicaid's current payment system for outpatient prescription drugs, which is largely based on average wholesale price, with a new system based on average manufacturer price (AMP). The AMP is the average price that manufacturers receive for sales to retail pharmacies. The legislation would limit federal Medicaid payments for prescription drugs to 105 percent of AMP for a single-source drug and 115 percent of the volume-weighted AMP for a multiple-source drug. (The volume-weighted average would be calculated across all therapeutically equivalent and bio-equivalent forms of a drug.) Those limits would apply only to a drug's ingredient costs and would not include dispensing fees, which would continue to be determined by the states.

The new AMP-based limits would take effect on January 1, 2007. In the interim, the legislation would reduce the payment limits that CMS currently applies to certain multiple-source drugs.

Based on administrative data on AMPs and prescription drug spending by Medicaid, as well as other data on national drug sales, CBO estimates that this provision would reduce Medicaid spending by $4.6 billion over the 2006-2010 period and $15.4 billion over the 2006-2015 period. Those savings reflect CBO's expectation that states would raise dispensing fees to mitigate the effect of the new payment limits on pharmacies and preserve the widespread participation of pharmacies in Medicaid. The estimate also accounts for lower rebates from drug manufacturers resulting from increased use of cheaper generic drugs.

TABLE 2. ESTIMATED BUDGETARY EFFECTS OF SUBTITLE A—MEDICAID

	Outlays in Millions of Dollars, By Fiscal Year											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-2010	2006-2015
CHANGES IN DIRECT SPENDING												
Chapter 1: Prescription Drugs												
Limits on Pharmacy Reimbursement	-70	-750	-1,025	-1,250	-1,500	-1,700	-1,925	-2,150	-2,400	-2,675	-4,595	-15,445
Increased Rebates	-230	-255	-265	-305	-345	-375	-415	-455	-505	-550	-1,400	-3,700
Include Authorized Generics in Best Price	-15	-30	-40	-45	-50	-60	-70	-80	-90	-105	-180	-585
Rebates on Physician-Administered Drugs	-10	-35	-35	-35	-35	-35	-35	-35	-40	-40	-150	-335
Chapter 2: Long-Term Care												
Revisions to Asset Transfer Rules	-36	-59	-70	-85	-85	-85	-110	-110	-120	-130	-335	-890
Long-Term Care Partnership Programs	0	0	0	5	5	5	5	5	5	5	10	35
Chapter 3: Fraud, Waste, and Abuse												
Third-Party Recovery	-20	-70	-110	-140	-140	-150	-160	-170	-170	-190	-480	-1,320
State False Claims Acts	0	1	-1	-7	-18	-32	-44	-60	-77	-96	-25	-333
False Claims Act Education Programs	0	0	-1	-2	-4	-7	-9	-12	-16	-19	-7	-70
Double Billing of Drug Claims	*	*	*	*	*	*	*	*	*	*	*	*
Limits on Contingency Fees	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid Integrity Program	59	75	75	94	100	79	75	75	75	75	403	781
Chapter 4: State Financing												
Temporary FMAP Increases for Katrina Areas	1,810	0	0	0	0	0	0	0	0	0	1,810	1,810
Targeted Case Management Services	-30	-100	-180	-230	-220	-230	-250	-260	-280	-290	-760	-2,070
Temporary FMAP Increase for Alaska	65	65	0	0	0	0	0	0	0	0	130	130
Restrictions on Provider Taxes	-5	-15	-15	-20	-20	-20	-25	-25	-25	-30	-75	-200
Coverage of Podiatry Services	10	10	10	10	15	15	15	15	15	20	55	135
DSH Payments for the Dist. of Columbia	20	20	20	20	20	21	21	22	22	23	100	209
IMD Demonstration Project	10	20	0	0	0	0	0	0	0	0	30	30
Chapter 5: Medicaid/SCHIP Improvements												
Coverage of Certain Disabled Children	0	0	10	160	550	780	930	1,000	1,080	1,170	720	5,680
Money-Follows-the-Person Demonstration	0	0	0	20	85	210	350	460	400	285	105	1,810
SCHIP Provisions and Interactions	165	245	-90	-70	-110	-110	-90	-155	-95	-95	140	-405
Demonstration Programs	0	2	8	11	15	31	14	13	10	6	36	110
Change Start Date of Medicaid Eligibility	0	20	25	30	30	35	40	40	45	50	105	315
Funding for Outreach Activities	0	10	20	20	15	10	10	10	10	5	65	110
Health Information Centers	0	2	3	4	2	*	*	0	0	0	11	11
Chapter 6: Delayed Application Date	2	0	0	0	0	0	0	0	0	0	2	2
Total Changes in Subtitle A	1,725	-844	-1,661	-1,815	-1,689	-1,618	-1,673	-1,872	-2,156	-2,581	-4,285	-14,184

NOTES: Components may not sum to totals because of rounding.

Changes in budget authority would be identical to changes in estimated outlays for all provisions except those affecting the Medicaid Integrity Program, the Medicaid demonstrations, family-to-family health information centers, and SCHIP.

DSH = disproportionate share hospital; FMAP =Federal Medical Assistance Percentage; IMD = Institution for Mental Diseases; SCHIP = State Children's Health Insurance Program.

* = between -$500,000 and $500,000.

Increased Rebates on Prescription Drugs. The legislation contains several provisions that would increase the rebates that Medicaid collects from drug manufacturers. The legislation would raise the minimum rebate for brand-name drugs from 15.1 percent of AMP to 17 percent and raise the flat rebate for generic drugs from 11 percent of AMP to 17 percent. Other provisions would expand the definition of the "best price"—which the Secretary uses in calculating the rebate that manufacturers of brand-name drugs must pay to Medicaid—to include the prices of authorized generics and require states to collect rebates on drugs administered by physicians. CBO estimates that the additional rebate payments would reduce Medicaid spending by $1.7 billion over the 2006-2010 period and $4.6 billion over the 2006-2015 period.

Chapter 2: Long-Term Care. The provisions of this chapter would tighten Medicaid's penalties for individuals who transfer assets for less than fair market value in order to receive Medicaid benefits for nursing home care and would encourage the purchase of certain kinds of long-term care insurance by allowing individuals who purchase such insurance to protect more of their assets if they eventually need nursing home care under Medicaid. Those provisions would reduce Medicaid outlays by an estimated $325 million over the 2006-2010 period and $855 million over the 2006-2015 period.

Revisions to Asset-Transfer Rules. Medicaid law requires that states impose a period of ineligibility for certain Medicaid long-term care benefits—the so-called penalty period—on individuals who transfer assets for less than fair market value. This section would lengthen the penalty period for individuals who make certain asset transfers prior to nursing home admission and would expand the set of penalized transfers. Under current law, states may round the penalty period down to a whole month. The legislation would require states to impose partial months of ineligibility rather than rounding down.

Additionally, the legislation would restrict the kinds of annuities and other financial instruments that may be held by a Medicaid beneficiary or his or her spouse. It would require Medicaid applicants to name the state as remainder beneficiary to the extent of Medicaid's expenditures for that individual. Those provisions would reduce Medicaid expenditures by $335 million over the 2006-2010 period and by $890 million over the 2006-2015 period.

Long-Term Care Partnership Programs. The legislation would repeal a moratorium on the number of states that may operate Long-Term Care Partnership Programs, which allow individuals who purchase certain kinds of long-term care insurance to protect more of their assets if they later need nursing home care under Medicaid. Four states currently operate those programs, and CBO anticipates that about a third of the remaining states would do so under the legislation, increasing Medicaid spending by $5 million annually after 2008.

Chapter 3: Fraud, Waste, and Abuse. This chapter includes several provisions intended to improve payment integrity in the Medicaid program. CBO estimates that those provisions would lower Medicaid outlays by $20 million in 2006, $512 million over the five-year window, and $1.7 billion over 10 years, largely by making it easier for states to avoid overpayments for Medicaid recipients who also have private health insurance. In addition, the chapter would add spending of $403 million over five years and $781 million over 10 years for activities to promote program integrity.

Third-Party Recovery. The legislation would strengthen Medicaid's status as payer of last resort relative to private health insurance by specifying that pharmacy benefit managers and self-insured plans are liable third parties, requiring insurers to submit eligibility and claims data for Medicaid recipients to states on a regular basis, and requiring insurers to pay claims for Medicaid recipients that are submitted within three years of the date of service. Those provisions would take effect on January 1, 2006. CBO estimates that the legislation would improve states' abilities to identify liable third parties and would increase the amounts that Medicaid recovers from insurers for recipients who also have private health insurance, thereby reducing Medicaid spending by $480 million over the 2006-2010 period and $1.3 billion over the 2006-2015 period.

Other Savings. The legislation also would require states to comply with restrictions on the use of contingency fees in contracts, encourage states to enact false claims acts, mandate that certain employers conduct education campaigns for employees about false claims acts, and prohibit states from billing Medicaid twice for prescription drugs. CBO estimates that those provisions would reduce Medicaid spending by a combined $32 million over the 2006-2010 period and $403 million over the 2006-2015 period.

Medicaid Integrity Program. The legislation would appropriate $50 million per year in 2006 through 2008 and $75 million annually after that for the Secretary of Health and Human Services to improve payment integrity in the Medicaid program. The legislation also would appropriate $25 million annually between 2006 and 2010 for Medicaid-related activities by the department's Office of the Inspector General (OIG). Based on historical spending patterns for the OIG and for program integrity activities in Medicare, CBO estimates that those appropriations would increase direct spending by $403 million over the 2006-2010 period and by $781 million over the 2006-2015 period.

Chapter 4: State Financing. The provisions of this chapter would boost Medicaid spending by $1.9 billion in 2006, primarily by increasing federal match rates for parts of Alabama, Louisiana, and Mississippi affected by Hurricane Katrina. The legislation would reduce outlays in later years, mostly by restricting coverage of targeted case management services. Overall, we estimate that the provisions of this chapter would increase direct spending by $1.3 billion over five years and $44 million over 10 years.

Temporary FMAP Increases for Katrina Areas. The legislation would increase the federal government's share of Medicaid spending—known as the federal medical assistance percentage (FMAP)—to 100 percent for program spending for individuals who lived in specified areas of Alabama, Louisiana, and Mississippi during the week prior to August 28, 2005. Under current law, the federal government pays about 70 percent of Medicaid costs in Alabama and Louisiana and 76 percent of costs in Mississippi. The full federal funding would continue through May 15, 2006.

The parishes and counties named in the bill were home to about 60 percent of Medicaid recipients in Louisiana and Mississippi and 25 percent of recipients in Alabama. CBO estimates that this provision would increase Medicaid spending by $1.8 billion in 2006.

Targeted Case Management Services. Medicaid allows states to cover case management services that help recipients obtain access to medical, social, and other services and permits states to target those services to specific populations, such as disabled adults. However, current law provides little guidance on the specific types of services that Medicaid will cover, and some states have billed the program for services that are core elements of other programs, such as juvenile justice and foster care. The legislation would clarify that case management services must help recipients gain access to needed medical, social, educational, and other services and would specify that Medicaid will not cover services that are normally provided under other programs (including certain activities provided by foster care programs). This provision would take effect on January 1, 2006.

CBO estimates that this provision would reduce Medicaid spending on case management services by about 10 percent, yielding savings of $1.1 billion over the 2006-2010 period and $3.0 billion over the 2006-2015 period. Based on information provided by CMS, we anticipate that some of the case management services previously covered by Medicaid would be billed instead to the federal foster care program, raising spending by $350 million over the 2006-2010 period and $940 million over the 2006-2015 period. Together, those reductions in spending for Medicaid and increases in spending for foster care would reduce federal spending by $760 million over the 2006-2010 period and $2.1 billion over the 2006-2015 period, CBO estimates.

Additional Provisions. The chapter also contains provisions that would: increase the federal match rate for Alaska in 2006 and 2007; restrict states' ability to use revenues from taxes on Medicaid managed care plans as the state share of program spending; require states to cover podiatry services; allow the District of Columbia to make additional payments to disproportionate share hospitals; and authorize institutions for mental diseases to receive Medicaid funds under a demonstration project. CBO estimates that those provisions would increase Medicaid spending by a total of $240 million over the 2006-2010 period and $304 million over the 2006-2015 period.

Chapter 5: Medicaid and SCHIP Improvements. This chapter contains a number of provisions that would increase direct spending, most notably by allowing states to provide Medicaid coverage to certain kinds of disabled children and funding state efforts to shift recipients from nursing homes into less expensive settings in the community. In aggregate, we estimate that the provisions of this chapter would increase Medicaid and SCHIP spending by $165 million in 2006, $1.2 billion over 5 years, and $7.6 billion over the next 10 years.

Allow States to Cover Certain Disabled Children. The legislation would allow state Medicaid programs to cover children who meet the disability standard used in the Supplemental Security Income (SSI) program but are ineligible for SSI because they do not meet that program's income or asset requirements. Eligibility would be limited to children whose family incomes do not exceed 300 percent of the federal poverty level. This provision would take effect on January 1, 2008, and would be phased in over a three-year period.

CBO anticipates that about two-thirds of states would ultimately provide Medicaid coverage under this provision. Based on information from the Survey of Income and Program Participation and Medicaid administrative data, we estimate that this provision would increase Medicaid outlays by $720 million over the 2006-2010 period and $5.7 billion over the 2006-2015 period.

Money-Follows-the-Person Demonstration. The legislation would authorize a demonstration project under which the federal government would pay 90 percent of the costs of the first 12 months of home- and community-based long-term care services for Medicaid recipients who used to be in nursing homes. The legislation would provide a total of $1.8 billion in funding for the project, which would take effect on January 1, 2009. After accounting for reduced spending on nursing home care and the additional cost of home- and community-based services beyond the initial 12 months, CBO estimates that this provision would increase Medicaid spending by $105 million over the 2009-2010 period and by $1.8 billion over the 2009-2015 period.

SCHIP Provisions and Interactions. The legislation contains several provisions affecting the State Children's Health Insurance Program (SCHIP). Most of the budget impact would stem from provisions that would provide additional funds to states that have spent their existing allotments and prohibit additional states from using SCHIP funds to cover childless adults. We estimate that SCHIP spending would increase by $300 million over five years and decline by $165 million over 10 years as a result of this legislation. Those estimates reflect the effects on SCHIP spending of provisions elsewhere in the legislation, such as the FMAP increases and the state option to cover certain disabled children. The SCHIP changes would also reduce Medicaid spending by $160 million over the 2006-2010 period and by $240 million over the 2006-2015 period by reducing states' use of Medicaid funds to offset funding shortages in SCHIP.

Other Provisions. This chapter also would authorize a demonstration project to provide home- and community-based services to disabled children who otherwise would require psychiatric residential treatment, change the date that Medicaid eligibility starts for certain SSI recipients, fund efforts to enroll more children in Medicaid and SCHIP, and appropriate funds to develop health information centers. None of these provisions would take effect until 2007. Taken together, CBO estimates that they would raise Medicaid spending by $217 million over the 2006-2010 period and by $546 million over the 2006-2015 period.

Subtitle B—Medicare

The legislation would lower federal outlays for Medicare by an estimated $2.5 billion in 2006, $5.7 billion over the 2006-2010 period, and $40.6 billion over 2006-2015 period. Those savings include the effect of changes in Medicare spending in the fee-for-service sector on payment rates for enrollees in Medicare Advantage plans and the effect of changes in spending for services covered by Part B of Medicare on receipts from Part B premiums.

The estimated effects of Subtitle B on direct spending are shown in Table 3.

Payments to Medicare Advantage Plans. Two provisions of the legislation would reduce payments to plans in the Medicare Advantage program beginning in 2007. CBO estimates those provisions would reduce Medicare payments by $11.9 billion over the 2006-2010 period and by about $36 billion over the 2006-2015 period.

Risk Adjustment for Payment to MA Plans. Section 6111 would require the phased elimination of certain payments to Medicare Advantage health plans. Currently, Medicare makes a "budget neutrality" adjustment to payment rates that returns to MA plans all of the savings that would result from the application of risk adjustment based on health status. The legislation would require the Secretary to phase out that budget-neutrality adjustment and to ensure that the risk-adjustment system adequately reflects differences between health plans and fee-for service providers in the reporting of data on health status. This section would not affect outlays in 2006. CBO estimates that it would reduce spending by $6.5 billion over the 2006-2010 period and by $26 billion over the 2006-2015 period.

TABLE 3. ESTIMATED BUDGETARY EFFECTS OF SUBTITLE B—MEDICARE

	Outlays in Millions of Dollars, By Fiscal Year											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2006-2010	2006-2015
CHANGES IN DIRECT SPENDING												
Risk Adjustment of Payments to MA Plans	0	0	-1,440	-2,090	-2,930	-3,610	-3,320	-3,880	-4,270	-4,490	-6,460	-26,030
Regional Stabilization Fund for MA Plans	0	-1,100	-1,450	-1,450	-1,440	-1,530	-1,390	-1,420	-390	0	-5,440	-10,170
Value-Based Purchasing	0	-1,220	-860	-1,450	-980	-1,020	-680	-600	-220	-190	-4,510	-7,220
Payments for Physician Services	2,000	3,200	3,200	2,500	-100	-2,300	-3,100	-2,900	-2,100	-1,100	10,800	-700
Payment for Dialysis Services	60	100	110	120	130	140	150	150	160	170	520	1,290
Hospital Hold-Harmless Provision	130	40	0	0	0	0	0	0	0	0	170	170
Medicare-Dependent Hospitals	0	3	3	4	4	4	0	0	0	0	14	18
Extend Moratorium on Therapy Caps	530	180	0	0	0	0	0	0	0	0	710	710
Inpatient Rehabilitation Facilities	30	70	5	0	0	0	0	0	0	0	105	105
Cover Additional FQHC Services	5	5	10	10	10	15	15	15	20	20	40	125
Rural PACE Grants	5	9	9	7	7	7	7	8	8	9	37	76
Waiver of Late Enrollment Penalty	0	4	5	5	6	6	7	7	8	9	20	57
Purchase of Durable Medical Equipment	-140	-190	-190	-190	-200	-210	-230	-250	-270	-290	-910	-2,160
Bad Debt Payments to SNFs	*	-10	-50	-90	-100	-110	-120	-130	-140	-150	-250	-900
Limits on Physician Self-Referrals	-4	-4	-4	-5	-5	-5	-5	-6	-6	-6	-22	-50
Medicare Advantage Interactions	0	80	200	170	50	-110	-200	-230	-220	-160	500	-420
Premium Interactions	0	-810	-565	-235	565	1,165	1,300	1,320	1,000	750	-1,045	4,490
Delay Payments to Providers	-5,160	5,160	0	0	0	0	0	0	0	0	0	0
Total Changes in Subtitle B	-2,544	5,517	-1,017	-2,694	-4,983	-7,558	-7,566	-7,916	-6,420	-5,428	-5,721	-40,609

NOTES: FQHC = federally-qualified health center; MA = Medicare Advantage; PACE = Program for All-Inclusive Care for the Elderly; SNF = skilled nursing facility.

Changes in budget authority would be identical to changes in estimated outlays for all provisions except the rural PACE grants.

* = between -$500,000 and $500,000.

Regional Stabilization Fund for MA Plans. Section 6112 would eliminate the stabilization fund for regional preferred provider organizations (PPOs) in the Medicare Advantage Program. Under current law, $10 billion will be available over the 2006-2013 period to encourage the development and retention of preferred provider plans in the 26 PPO regions. In addition to the initial $10 billion, the fund will receive and spend half of the amount that Medicare will save when plans submit bids that are below the "benchmark" for regional payment rates. Eliminating the fund would have no effect on Medicare spending in 2006, and would reduce Medicare spending by an estimated $5.4 billion over the 2006-2010 period and $10.2 billion over the 2006-2015 period.

Value-Based Purchasing. Section 6110 would establish a program to encourage providers to report data that could be used to improve the quality of care and to provide additional payments to providers that are determined to provide care that is high quality or has

improved in quality. The program would reduce payment rates by 2 percent for certain services if the provider does not report certain quality-related data (those services are hospital inpatient services, and services furnished by physicians, home health agencies, and skilled nursing facilities). The program also would reduce payment rates for all such providers, and for dialysis facilities and Medicare Advantage plans, to establish a pool of funds that would be distributed the following year to those that have provided high-quality care or have improved the quality of their care. (The creation of this pool of funds would delay some spending for a year, but would not change total spending over time.) Those provisions would apply to hospitals and physicians in 2007 (as would the 2 percent reduction in payment to nonreporting home health agencies), and would be phased in for other providers. The payment reduction to establish the funding pool would be 1 percent initially and would grow to 2 percent over a period of five years. CBO estimates that those provisions would have no effect on Medicare spending in 2006, and would reduce Medicare spending by $4.5 billion over the 2006-2010 period and by $7.2 billion over the 2006-2015 period. By shifting some spending from 2010 to 2011, establishing the pool for redistribution accounts for almost two-thirds of the savings ($2.8 billion) over the 2006-2010 period.

Payments for Physician Services. Section 6105 would set the update to payment rates under the physician fee schedule at no less than 1.0 percent in 2006. Preliminary estimates indicate that under the current sustainable growth rate (SGR) payment formula, physicians are scheduled to receive a 4.3 percent reduction in fees in 2006. CBO estimates enacting the 1.0 percent update would increase gross Medicare spending by $2.0 billion in 2006 and by $10.8 billion over the 2006-2010 period. Under the current SGR formula, future updates to the physician fee schedule would have to be reduced as a way of offsetting the cost of the 1.0 percent update in 2006. Consequently, payment rates for physicians' services would be below current-law levels from 2010 through 2015. Assuming that occurs, CBO estimates that Medicare spending would be reduced by about $700 million over the 2006-2015 period.

Other Provisions and Interactions. Several provisions of the legislation would increase spending, including provisions to increase payment rates for dialysis services, hospital outpatient services, and certain small hospitals; to expand coverage for therapy services; and to delay the phase-in of rules that reduce the number of hospitals that qualify for special payment rates as rehabilitation hospitals. Other provisions of the legislation would reduce spending, including provisions to require that certain durable medical equipment be purchased after it is rented for 13 months and to reduce payments to skilled nursing facilities for bad debt (from uncollected cost-sharing owed by Medicare patients). In aggregate, those provisions would increase spending in 2006 and 2007, and would reduce spending in 2008 and subsequent years. CBO estimates that, in total, those provisions would increase spending by $0.6 billion in 2006 and $0.4 billion over the 2006-2010 period, and would reduce spending by $0.6 billion over the 2006-2015 period.

Changes in the rate of increase in Medicare spending affect the "benchmarks" that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. CBO estimates that the changes in Medicare spending discussed above would have no effect on MA payments in 2006, would increase those payments by $0.5 billion over the 2006-2010 period, and would reduce them by $0.4 billion over the 2006-2015 period.

Beneficiaries enrolled in Part B of Medicare pay premiums for Part B that offset about 25 percent of the cost of those benefits. Therefore, about one-quarter of the changes in Part B spending would be offset by changes in those premium receipts. The Part B premium for 2006 has already been announced and will not be changed. Therefore, the legislation would have no effect on Part B premium receipts in 2006. CBO estimates that the legislation would increase receipts of Part B premiums by $1 billion over the 2006-2010 period, and would reduce receipts by about $4.5 billion over the 2006-2015 period.

Delay in Payment of Claims. Section 6112, which would eliminate the regional stabilization fund for MA plans, also would postpone payments for Medicare Part A and B benefits for six business days at the end of the fiscal year 2006. The provision would postpone—until October 2, 2006—payments that would otherwise be made by Medicare carriers and fiscal intermediaries during the period from September 22 through September 30, 2006. This provision would shift spending from 2006 to 2007 but would not affect total spending over the 2006-2010 or 2006-2015 periods.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

The legislation contains no intergovernmental or private-sector mandates as defined in UMRA. CBO estimates that overall state spending on Medicaid and SCHIP would be reduced by about $7.2 billion over the 2006-2010 period as a result of provisions in the legislation, most notably from restrictions on pharmacy reimbursements and the increased federal matching rate for states affected by recent hurricanes.

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