

Health Options

The federal government provides budgetary resources for health care in three ways—through mandatory outlays for health care programs, subsidies for health care that are conveyed through reductions in federal taxes, and spending for health programs funded through annual discretionary appropriations. In fiscal year 2015, the most recent year of available data, the total for all three came to about \$1.4 trillion.

Net mandatory outlays for Medicare and Medicaid, the federal government’s two largest health care programs, totaled an estimated \$890 billion, roughly one-quarter of all federal spending in 2015. Other mandatory spending for health care programs included subsidies for health insurance purchased in the marketplaces established under the Affordable Care Act and related spending, the Children’s Health Insurance Program (CHIP), the Federal Employees Health Benefits program for civilian retirees, and the TRICARE for Life program for military retirees. All told, mandatory spending for health care totaled \$1.0 trillion in 2015.

In addition, the federal tax code gives preferential treatment to payments for health insurance and health care, primarily by excluding premiums for employment-based health insurance from income and payroll taxes. The staff of the Joint Committee on Taxation (JCT) estimates that the income tax expenditure for that exclusion was \$146 billion in 2015; the Congressional Budget Office estimates a similar payroll tax expenditure.¹ (Tax expenditures are exclusions, deductions, preferential rates, and credits in the tax system that resemble federal spending by providing financial assistance to specific activities, entities, or groups of people.) Together, the two subsidies

totaled about \$270 billion in 2015. Other tax preferences related to health care amounted to about \$26 billion.

The federal government also supports many health programs that are funded through annual discretionary appropriations: Taken together, discretionary spending for public health activities, health and health care research initiatives, health care programs for veterans, and certain other health-related activities totaled about \$120 billion in 2015. (The federal government also helps pay for health insurance premiums for its civilian workers, but that funding is part of agency budgets and is excluded from this discussion.) In addition, the Department of Defense spent an estimated \$40 billion in 2015 on health care for active-duty members, retirees, and their families.

CBO expects that under current law, federal budgetary costs related to health will rise as a share of gross domestic product (GDP). Policy changes could reduce federal deficits by reducing outlays for mandatory health care programs or by limiting tax preferences for health care, for example. Reductions in discretionary spending on health programs would lower total appropriations if the statutory caps set by the Budget Control Act of 2011 and subsequent legislation also were reduced or if appropriations were provided at amounts below those caps.

Trends in Health-Related Federal Spending and Revenues

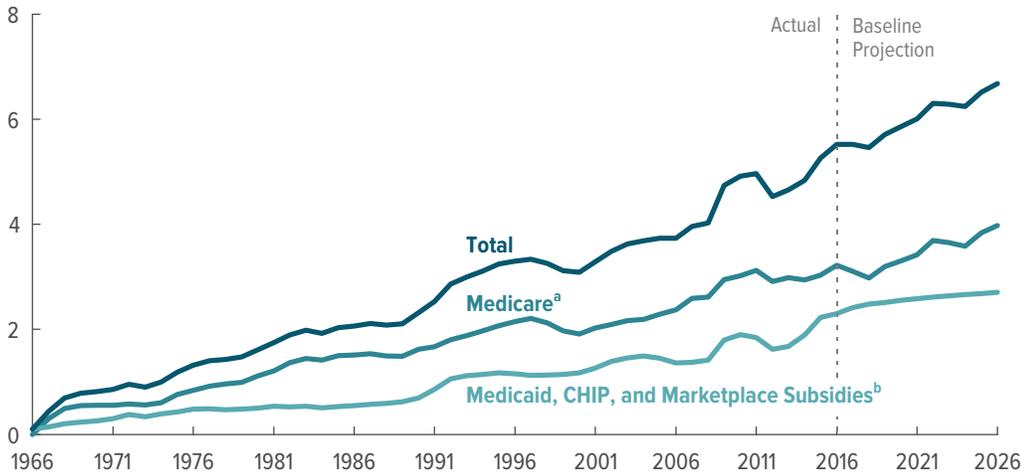
Spending for Medicare and Medicaid has grown sharply over recent decades, in part because of rising enrollment in those programs. Rising health care spending per beneficiary also has driven spending growth in those programs. Moreover, growth in such spending has outstripped GDP growth during the past few decades. In 1975, a decade after Medicare and Medicaid were created, federal spending, net of offsetting receipts for those

1. Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2015–2019*, JCX-141R-15 (December 2015), <http://go.usa.gov/xkSeb>.

Figure 5-1.

Federal Spending on the Major Health Care Programs, by Category

Percentage of Gross Domestic Product



Over the next decade, federal spending on health care is projected to take up an increasing share of gross domestic product.

Source: Congressional Budget Office (as of August 2016).

CHIP = Children's Health Insurance Program.

- Net Medicare spending (includes offsetting receipts from premium payments by beneficiaries, recoveries of overpayments made to providers, and amounts paid by states from savings on Medicaid's prescription drug costs).
- Spending to subsidize health insurance purchased in the marketplaces established under the Affordable Care Act and provided through the Basic Health Program and spending to stabilize premiums for health insurance purchased by individual people and small employers.

programs, accounted for 1.2 percent of GDP.² By 1985, that share was 2.0 percent of GDP, and it more than doubled over the next three decades: In 2015, net federal spending for Medicare and Medicaid was 5.0 percent of GDP. Between 1985 and 2015—as a result of demographic and legislative changes alike—the share of the population enrolled in Medicare rose from 13 percent to 17 percent, and average annual enrollment in Medicaid rose from 8 percent to 23 percent of the population.

An important reason for the rise in spending for health care per beneficiary in recent decades has been the emergence, adoption, and widespread diffusion of new medical technologies and services. Other contributing factors include increases in personal income and the expanded scope of health insurance coverage. (Those factors also have led to increases in per capita health care spending in the private sector.) All together, over the past few decades, health care spending per beneficiary has expanded more rapidly than the economy has, although the rate of increase in health care spending per beneficiary has

abated recently. In CBO's judgment, such spending will continue to grow relatively slowly over the next decade.

Nevertheless, in CBO's latest baseline projections, mandatory outlays for health care programs over the next decade continue to exert pressure on the federal budget overall, primarily because of the burgeoning number of Medicare beneficiaries but also because of ongoing growth in health care spending per beneficiary in all of those programs. Under an assumption that current laws governing the programs generally remain unchanged, net federal spending for Medicare, Medicaid, CHIP, and subsidies for premiums and cost sharing in the health insurance marketplaces is projected by CBO to reach 6.7 percent of GDP in 2026, compared with 5.3 percent in 2015 (see Figure 5-1).³ (Outlays for Social Security, by

2. Net Medicare spending includes the federal government's receipts from premium payments by beneficiaries, recoveries of overpayments made to providers, and amounts paid by states from savings on Medicaid's prescription drug costs.

3. Subsidies for health insurance coverage purchased through the marketplaces take two forms: tax credits that cover a portion of the premiums and additional subsidies that reduce cost sharing. The premium subsidies are structured as refundable tax credits, and CBO and JCT estimate that the amounts of those credits generally exceed the amount of federal income tax that recipients would otherwise owe. The amounts that offset taxes are classified as revenue losses, and the amounts that exceed tax liabilities are classified as outlays. Cost-sharing subsidies also are categorized as outlays.

contrast, are projected to be 6.0 percent of GDP in 2026.) All told, spending for those major health care programs accounts for about one-third of the total increase in federal spending that CBO projects through 2026.⁴

The projected rise in the number of beneficiaries of the major federal health care programs has two main causes. First is the aging of the population, which, over the next 10 years, will result in an increase of about one-third in the number of people enrolled in Medicare as people in the baby-boom generation retire. Second, and less important, is the continued expansion of federal subsidies for health insurance expected under current law, which will increase the number of Medicaid recipients and the number of people purchasing health insurance through the marketplaces.

Most of the projected spending in the major federal health care programs is for people age 65 or older. Despite the significant expansion of federal support for health care for lower-income people in recent years, only about one-fifth of federal spending for the major health care programs in 2026 is projected to finance care for people without disabilities who are under the age of 65. CBO projects that roughly another one-fifth would fund care for people who are blind or have another disability, and about three-fifths would fund care for people who are 65 or older.

The tax expenditure stemming from the exclusion from taxable income of employers' contributions for health care and workers' premiums for health insurance—described in this volume as the exclusion for employment-based health insurance—depends on the number of people enrolled in employment-based health insurance (in 2015, about 57 percent of the population under age 65 was in that category, CBO and JCT estimate) and on health care spending per person. That tax expenditure equaled 1.5 percent of GDP in 2015; it is projected to remain close to that percentage for the coming decade. Although per capita health care costs are expected to continue to grow faster than the economy—a development that will tend to increase the tax expenditure relative to GDP—the smaller share of the population under age 65 with employment-based coverage and the excise tax on high-cost employment-based insurance plans (set to begin in

2020) will tend to decrease the tax expenditure relative to GDP.

Analytic Method Underlying the Estimates Related to Health

CBO and JCT estimated the budgetary effects of the options in this chapter relative to CBO's March 2016 baseline projections.⁵ CBO's 10-year baseline projections for mandatory spending and revenues incorporate the assumption that current laws generally remain unchanged. They also incorporate estimates of future economic conditions, demographic trends, and other developments that reflect the experience of the past several decades and the effects of broad changes to the nation's health care and health insurance systems that are occurring under current law.

As directed by section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, CBO's baseline projections for individual discretionary programs reflect the assumption that current appropriations will continue in future years, with adjustments to keep pace with inflation. (Although CBO follows that law in constructing baseline projections for individual components of discretionary spending, its baseline projections of overall discretionary spending incorporate the caps and automatic spending reductions put in place by the Budget Control Act.)

Options in This Chapter

Most of the 18 options in this chapter would either decrease mandatory spending on health programs or increase revenues (or, equivalently, reduce tax expenditures) as a result of changes in tax provisions related to health care. Several others involve discretionary spending. Some options would result in a reallocation of health care spending—from the federal government to businesses, households, or state governments, for example—and most would give parties other than the federal government stronger incentives to control costs while exposing them to more financial risk.

Fifteen options are similar in scope to others in this report. For each, the text provides background information, describes the possible policy change or changes,

4. Because funding for CHIP is set to expire at the end of September 2017, under the rules governing baseline projections, funding and enrollment for that program are assumed to decline after that year.

5. Congressional Budget Office, *Updated Budget Projections: 2016 to 2026* (March 2016), www.cbo.gov/publication/51384.

presents the estimated effects on spending or revenues, and summarizes arguments for and against the changes.

The other three address broader approaches to changing federal health care policy, all of which would offer lawmakers a variety of ways to alter current law. For each one, the amount of federal savings and the consequences for stakeholders—beneficiaries, employers, health care providers, insurers, and states—would depend crucially on its details. Those three broad options are as follows:

- Impose caps on federal spending for Medicaid (Option 2),
- Change the cost-sharing rules for Medicare and restrict medigap insurance (Option 7), and
- Reduce tax preferences for employment-based health insurance (Option 18).

Another way to reduce federal spending on health care would be to convert Medicare to a premium support system. Under such a program, beneficiaries would purchase health insurance from a list of competing plans, and the federal government would pay part of the cost of the coverage. Past proposals for such a conversion have differed in many respects, including the way that the federal contribution would be set and the way that contribution might change over time. In 2013, CBO analyzed the

effects of two illustrative options on federal spending and beneficiaries' choices and payments.⁶ The agency currently is refining its modeling approach and updating its analysis to account for new data; it expects to release updated estimates in 2017.

All 18 options in this chapter would have consequences beyond their effects on the federal budget. Some would influence people's behavior as they participated in the health care system. Others would focus on the actions of health care providers or health care plans. Still others would change the ways the government paid providers or alter the federal or state role in paying for health care services. One option would promote better health in the population—and increase federal revenues—by collecting a higher excise tax on cigarettes. Some options could shift the sources or types of health insurance coverage or cause different types of health care to be sought and delivered. Whether that care was delivered more efficiently or was more appropriate or of higher quality than it would be otherwise would hinge on the responses of those affected.

6. See Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581. CBO last updated those estimates in 2014; see Congressional Budget Office, *Options for Reducing the Deficit: 2015 to 2024* (November 2014), www.cbo.gov/publication/49638.

Health—Option 1

Function 550

Adopt a Voucher Plan and Slow the Growth of Federal Contributions for the Federal Employees Health Benefits Program

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays ^a	0	0	-0.5	-1.3	-2.1	-3.1	-4.1	-5.2	-6.5	-7.8	-4.0	-30.6
Change in Discretionary Spending												
Budget authority	0	0	-0.6	-1.2	-2.0	-2.8	-3.7	-4.6	-5.7	-7.0	-3.8	-27.5
Outlays	0	0	-0.6	-1.2	-2.0	-2.8	-3.7	-4.6	-5.7	-7.0	-3.8	-27.5

This option would take effect in January 2019.

a. Includes estimated savings by the Postal Service, whose spending is classified as off-budget.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage to 4 million federal workers and annuitants, as well as to approximately 4 million of their dependents and survivors. In 2016, those benefits are expected to cost the government (including the Postal Service) about \$35 billion. Policyholders, whether they are active employees or annuitants, generally pay 25 percent of the premium for lower-cost plans and a larger share for higher-cost plans; the federal government pays the rest of the premium. That premium-sharing structure provides some incentive for federal employees to choose plans with lower premiums, although the incentive is smaller than it would be if they realized the full savings from choosing such plans. The premium-sharing structure also imposes some competitive pressure on insurers to hold down premiums—but again, less pressure than would exist if employees paid the full cost of choosing more expensive plans.

This option would replace the current premium-sharing structure with a voucher, starting in January 2019. The voucher, which would be excluded from income and payroll taxes, would cover roughly the first \$6,100 of a self-only premium, the first \$13,200 of a self-plus-one premium, or the first \$14,000 of a family premium. The Congressional Budget Office calculated those amounts by taking its estimates of the government’s average expected contributions to FEHB premiums in 2018 and then increasing them by the projected rate of inflation between 2018 and 2019 (as measured by the consumer price index for all urban consumers). Each year, the voucher would

continue to grow at the rate of inflation, rather than at the average rate of growth for FEHB premiums. That would produce budgetary savings because FEHB premiums grow significantly faster than inflation in CBO’s projections. (The expected rate of growth for FEHB premiums is similar to the expected rate for private insurance premiums.)

By reducing federal agencies’ payments for FEHB premiums for current employees and their dependents, this option would reduce discretionary spending by an estimated \$27 billion from 2019 through 2026, provided that appropriations were reduced to reflect those lower costs. The option also would reduce mandatory spending for FEHB by \$32 billion because the Treasury and the Postal Service would make lower payments for FEHB premiums for annuitants and postal workers. (That number includes estimated savings by the Postal Service, whose spending is classified as off-budget.) In addition, the option would have some effects that increased mandatory spending. CBO anticipates that starting in 2019, the option would cause some FEHB participants to leave the program. Some of those participants would enroll in coverage through the health insurance marketplaces established under the Affordable Care Act (ACA), some would enroll in Medicare, some would enroll in employment-based coverage (through a spouse, for example), and some would become uninsured. As a result, marketplace subsidy costs would increase by \$170 million, and Medicare spending would increase by an estimated

\$1 billion.¹ Overall, the option would reduce mandatory spending by an estimated \$31 billion from 2019 through 2026.

Revenues also would be affected by the option, but CBO expects that the net change would be negligible. Some of the people who became uninsured would pay penalties to the government, as the ACA specifies. That increase in revenues would be roughly offset because of changes that would take place in the number of people with employment-based insurance and changes in the costs of that insurance. Those changes would affect the share of total compensation that takes the form of taxable wages and salaries and the share that takes the form of nontaxable health benefits; taxable compensation would increase for some people and decrease for others.

An advantage of this option is that it would increase enrollees' incentive to choose lower-premium plans: If they selected plans that cost more than the voucher

amount, they would pay the full additional cost. For the same reason, the option would strengthen price competition among health care plans participating in the FEHB program. Because enrollees would pay no premium for plans that cost no more than the value of the voucher, insurers would have a particular incentive to offer such plans.

The option also could have several drawbacks. First, because the voucher would grow more slowly over time than premiums would, participants would eventually pay more for their health insurance coverage. In 2026, on average, participants would contribute more than \$700 more for a self-only premium, \$1,500 more for a self-plus-one premium, and \$1,600 more for a family premium than they would under current law, CBO estimates. Some employees and annuitants who would be covered under current law might therefore decide to forgo coverage altogether. Second, many large private-sector companies currently provide health care benefits for their employees that are comparable to what the government provides. Under this option, the government benefits could become less attractive than private-sector benefits, making it harder for the government to attract highly qualified workers. Finally, the option would cut benefits that many federal employees and annuitants may believe they have already earned.

1. In general, people whose employers offer insurance coverage are not eligible for marketplace subsidies. However, an exemption exists for people whose contribution for health insurance would exceed a specified percentage of their income. By increasing enrollees' premium contributions, this option would boost the number of federal employees eligible for marketplace subsidies through that exemption.

RELATED CBO PUBLICATIONS: *Comparing the Compensation of Federal and Private-Sector Employees* (January 2012), www.cbo.gov/publication/42921; *Characteristics and Pay of Federal Civilian Employees* (March 2007), www.cbo.gov/publication/18433; *The President's Proposal to Accrue Retirement Costs for Federal Employees* (June 2002), www.cbo.gov/publication/13806; *Comparing Federal Employee Benefits With Those in the Private Sector* (August 1998), www.cbo.gov/publication/11100

Health—Option 2

Function 550

Impose Caps on Federal Spending for Medicaid

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Caps on Overall Spending, With Growth of Caps Based on the CPI-U^a												
Change in Mandatory Outlays	0	0	-35.1	-50.3	-63.6	-77.5	-92.4	-108.2	-123.4	-139.1	-149.0	-689.6
Change in Revenues ^b	0	0	-0.4	-0.6	-0.8	-1.0	-1.3	-1.5	-1.8	-2.1	-1.8	-9.6
Decrease in the Deficit	0	0	-34.7	-49.7	-62.8	-76.5	-91.1	-106.7	-121.6	-137.0	-147.2	-680.0
Caps on Overall Spending, With Growth of Caps Based on the CPI-U Plus 1 Percentage Point^a												
Change in Mandatory Outlays	0	0	-25.1	-36.5	-45.8	-55.5	-66.1	-77.4	-87.8	-98.5	-107.4	-492.7
Change in Revenues ^b	0	0	-0.3	-0.4	-0.5	-0.7	-0.8	-1.0	-1.2	-1.4	-1.3	-6.4
Decrease in the Deficit	0	0	-24.8	-36.1	-45.3	-54.8	-62.5	-76.4	-86.6	-97.1	-106.2	-486.3
Caps on Spending per Enrollee, With Growth of Caps Based on the CPI-U^c												
Change in Mandatory Outlays	0	0	0	-47.0	-59.7	-71.4	-83.0	-95.6	-107.2	-119.7	-106.6	-583.5
Change in Revenues ^b	0	0	0	-0.5	-0.6	-0.8	-1.0	-1.2	-1.4	-1.6	-1.2	-7.0
Decrease in the Deficit	0	0	0	-46.4	-59.1	-70.6	-82.1	-94.4	-105.8	-118.1	-105.5	-576.5
Caps on Spending per Enrollee, With Growth of Caps Based on CPI-U Plus 1 Percentage Point^c												
Change in Mandatory Outlays	0	0	0	-32.3	-40.2	-47.0	-53.8	-60.6	-67.4	-73.2	-72.5	-374.4
Change in Revenues ^b	0	0	0	-0.4	-0.4	-0.5	-0.6	-0.7	-0.8	-0.9	-0.8	-4.2
Decrease in the Deficit	0	0	0	-31.9	-39.8	-46.5	-53.2	-59.5	-66.6	-72.3	-71.7	-370.2

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

CPI-U = consumer price index for all urban consumers.

- a. This alternative would take effect in October 2019.
- b. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.
- c. This alternative would take effect in October 2020.

Overview of the Issue

Medicaid is a joint federal-and-state program that covers acute and long-term health care for groups of low-income people, chiefly families with dependent children, elderly people (people over the age of 65), nonelderly people with disabilities, and—at the discretion of individual states—other nonelderly adults whose family income is up to 138 percent of the federal poverty guidelines. Under current law, the federal and state governments share in the financing and administration of Medicaid. The federal government provides the majority of Medicaid’s funding; establishes the statutory, regulatory, and administrative structure of the program; and monitors state compliance with the program’s rules. As part of its

responsibilities, the federal government determines which groups of people and medical services states must cover if they participate in the program and which can be covered at states’ discretion. For their part, the states administer the program’s daily operations, reimburse health care providers and health plans, and determine which eligibility and service options to adopt. The result is wide variation among states in enrollment, services covered, providers’ and health plans’ payment rates, and spending per capita, among other elements.

In 2015, the states received \$350 billion in federal funding for Medicaid and spent \$205 billion of their own funds for the program. Under current law, almost all

federal funding is open-ended: If a state spends more because enrollment increases or costs per enrollee rise, larger federal payments are automatically generated. On average, the federal government pays about 63 percent of program costs, with a range among the states of 51 percent to the current high of 80 percent, reflecting the variation in state per capita income and in the share of enrollees (if any) in each state that became eligible for Medicaid as a result of the optional expansion of that program under the Affordable Care Act (ACA). Through 2016, the federal government paid all costs for enrollees who became eligible as a result of the ACA. The federal government will cover a slightly declining share of costs for that group from 2017 to 2019, and it will cover 90 percent of costs in 2020 and beyond.

Medicaid spending has consumed a rising share of the federal budget over the past several decades, representing a growing percentage of gross domestic product (GDP)—a trend that the Congressional Budget Office projects will continue in the future. Over the past 20 years, federal Medicaid spending has risen at an average rate of slightly more than 7 percent annually as a result of general growth in health care costs, mandatory and optional expansions of program eligibility and covered services, and the amount of state spending that receives federal matching payments.

CBO expects that although federal Medicaid spending will grow more slowly in the next decade, it will continue to increase faster than GDP growth and general inflation, in part because of continued growth in health care costs and in part because more states are expected to expand Medicaid coverage under the ACA. (To date, 31 states and the District of Columbia have done so.) Medicaid spending is projected to rise at an average rate of 5 percent a year, whereas GDP is projected to increase by about 4 percent a year on a nominal basis, and general inflation is expected to average about 2 percent a year. Under current law, CBO estimates, Medicaid's share of federal noninterest spending will rise from 10 percent in 2015 to 11 percent in 2026.

Lawmakers could make structural changes to Medicaid to decrease federal spending on the program. Among the possibilities are reducing the scope of covered services, eliminating eligibility categories, repealing the ACA expansion, reducing the federal government's share of total Medicaid spending, or capping the amount that states receive from the federal government to operate the program. This option focuses on the last approach,

although the others could have similar implications for federal and state spending or for individual enrollees, depending on the way states were permitted to, or decided to, respond to such policy changes.

From the federal government's perspective, capping Medicaid funding to states could confer several advantages relative to current law. For example, the caps could generate budgetary savings in greater or lesser amounts depending on their level, and setting spending limits would make federal costs for Medicaid more predictable. Federal spending caps also would curtail states' current ability to increase federal Medicaid funds—an ability created by the open-ended nature of federal financing for the program—and could reduce the relatively high proportion of program costs now covered by the federal government. Because the federal government matches states' Medicaid spending, an additional state dollar spent on Medicaid is worth more to a state than an additional state dollar spent outside the program. Therefore, states have considerable incentive to devote more of their budgets to Medicaid than they would otherwise and to shift other unmatched program expenditures into Medicaid. For example, states have sometimes chosen to reconfigure health programs—previously financed entirely with state funds—in order to qualify for federal Medicaid reimbursement. And most states finance at least a portion of their Medicaid spending through taxes collected from health care providers with the intention of returning the collected taxes to those providers in the form of higher Medicaid payments, thereby boosting federal Medicaid spending without a concomitant increase in state spending. Those incentives would be reduced under a capped program.

Caps on federal Medicaid spending also could present several disadvantages relative to current law. Capped federal spending would create uncertainty for states as they plan future budgets because it could be difficult to predict whether Medicaid spending would exceed the caps and thus require additional state spending. If the limits on federal payments were set low enough, additional costs—perhaps substantial costs—would be shifted to states. States then would need to decide whether to commit more of their own revenues to Medicaid or reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extent feasible) arriving at more efficient methods for delivering services. Moreover, depending on the caps' structure, Medicaid might no longer serve as a countercyclical source of

federal funds for states during economic downturns. That is, the states might not automatically receive more federal funds if a downturn caused an increase in Medicaid enrollment. In addition, because Medicaid programs differ widely from state to state—and because spending varies widely (and grows at varying rates) for different enrollee categories within a state—federal policymakers could find it difficult to set caps at levels that accurately reflected states' costs. Finally, it might be difficult to set caps that balanced the competing goals of creating incentives for efficiency and generating federal savings, providing funding to states that was sufficient to generally maintain the scope of their programs, and designing caps that did not disadvantage states that already have established efficient programs while benefiting states that have not.

Key Design Choices That Would Affect Savings

A variety of designs for caps could be considered that would significantly affect federal Medicaid savings, and they could interact in complicated ways. The key areas to consider include the following:

- Whether to set overall or per-enrollee caps;
- What categories of Medicaid spending and eligibility categories to include in the spending limits;
- Which year's spending to use to set the base year and what growth factor, or percentage rate, to use to increase the caps over time;
- How much flexibility to grant to states to make changes to the program; and
- Whether optional expansion of coverage under the ACA also would be subject to the caps (thus creating special complexities for states that have not yet expanded coverage but that might do so in the future).

Overall or Per-Enrollee Caps. Among the first questions are those that involve whether to pursue a cap on federal Medicaid spending across the board or to provide each state with a fixed amount of funding for each enrollee. In general, overall caps would consist of a maximum amount of funding that the federal government would give a state to operate Medicaid. Once established, and depending on the way they were scheduled to increase, the federal caps generally would not fluctuate in response

to rising or falling enrollment or as a result of changes in the cost of providing services.

Overall caps could be structured in one of two main ways. First, the federal government could provide block grants at amounts that would not change, regardless of fluctuations in costs or enrollment. Alternatively, the federal government could maintain the current financing structure—paying for a specific share of a state's Medicaid spending—but capping the total amount provided to states. In that case, states would bear all additional costs above the federal caps, but the state and the federal government would share the savings if spending fell below the caps. In CBO's view, however, if caps were set below current projections of federal Medicaid spending, such savings would be unlikely. Given the incentive to maximize federal funding, CBO expects that states would generally structure their programs to qualify for all available federal funds up to the amount of the caps.

Caps on per-enrollee spending would set an upper limit on the amount a state could spend on care for Medicaid enrollees, on average. Under such a plan, the federal government would provide funds for each person enrolled in the program, but only up to a specified amount per enrollee. As a result, each state's total federal funding would be calculated as the product of the number of enrollees and the per-enrollee spending cap. (Individual enrollees whose care proved more expensive than the average could still generate additional federal payments, as long as the total per capita average did not exceed the cap.) Unlike an overall spending cap, such an approach would allow for additional funding if enrollment rose (when a state chose to expand eligibility under the ACA, for example, or as a result of an enrollment increase during an economic downturn). Funding would decline if Medicaid enrollment fell (for example, when a state chose to restrict enrollment or when enrollment fell as result of an improving economy).

Several structures are possible for per-enrollee caps. Fixed, monthly, per-enrollee federal payments could be set in the same way that public or private payers set payments to managed care companies. Caps could be set on the basis of average federal spending per enrollee for all Medicaid beneficiaries or for people by eligibility category. In those circumstances, the federal government would count the enrollees overall or the number in each category and multiply that sum by the spending limit per enrollee. For caps based on eligibility category, the overall limit on

Medicaid spending for each state would be the sum of the groups' limits. A similar but more flexible approach would be to set a total limit consisting of the sum of the limits for the groups as above, but to allow states to cross-subsidize groups (that is, to spend more than the cap for some groups and less for others) as long as the state's total spending limit was maintained.

Spending Categories. Policy options to cap federal Medicaid spending could target all Medicaid spending or spending for specific categories of services. Most federal Medicaid spending covers acute care (\$244 billion in 2015) or long-term care (\$75 billion in 2015); both types of spending could be divided among various sub-categories. Other spending categories include payments (known as DSH payments) to hospitals that serve a disproportionate share of Medicaid enrollees and uninsured patients, spending under the Vaccines for Children (VFC) program, and administrative spending. (The total in 2015 for those three categories was \$31 billion.) In general, the more spending categories included, the greater the potential for federal budgetary savings.

Eligibility Categories. In addition to setting the types of spending to cap, policymakers would face choices about which groups of Medicaid enrollees to include. As with service categories, the more eligibility categories covered, the greater the potential for federal savings. For example, caps could limit federal spending (either overall or per enrollee) only for children and certain adults but leave spending unchanged for elderly and disabled enrollees. Because the latter two groups of enrollees currently account for about 48 percent of Medicaid spending—and are projected to account for about 45 percent in 2026—caps that did not apply to them would produce far smaller savings than caps that covered all groups (assuming that the other characteristics of the two sets of caps were the same).

Per-enrollee caps could establish one average per-person cost limit for all enrollees or establish separate limits for different types of enrollees. If there was more than one per-enrollee cap, separate caps could be established for any number of specific categories. For example, past proposals have considered separate caps for the elderly, people with disabilities, children, and nondisabled, non-elderly adults. Separate caps also could be established for pregnant women, adults added as a result of the expansion of Medicaid under the ACA, or other particular groups.

The choice of creating only one or more than one per-enrollee cap (and if so which groups to select for each cap) could affect whether and to what extent the states would have an incentive to maximize enrollment of some groups over others. A single cap for all enrollees would average the costs of groups without regard to substantial differences in health status between some groups, thus creating financial incentives for states to enroll people whose costs were expected to be below the cap. For example, per-enrollee spending for children and nonelderly, nondisabled adults, on average, is below that for elderly patients and people with disabilities. Therefore, the enrollment of every additional child and nonelderly, non-disabled adult would help a state to remain below its total spending limit, and the enrollment of every additional elderly or disabled enrollee would make that goal more difficult to achieve. However, the degree to which states could effectively maximize enrollment of people in one category compared with another would depend on the degree of flexibility states were given to keep their costs below the caps.

Base-Year Spending. Establishing caps on federal spending for Medicaid would generally begin with selecting a recent year of Medicaid outlays as a “base year” and calculating that year's total spending for the service categories and eligibility groups to be included. The base year is not necessarily the first year in which the caps take effect, which could be any year in the budget window, but the year from which the future cap amounts are projected (as described in the next section). Thus, for overall and per-enrollee spending caps alike, the selection of the base year is important: A higher base-year amount would lead to higher caps (and lower federal savings) than a lower base-year amount would.

An important consideration in selecting a base year is whether to use a past or future year. Most proposals use a past year because Medicaid expenditures are known and because states cannot increase spending in the base year to boost their future spending limits (by raising payment rates for providers and health plans, making additional one-time supplemental payments, or moving payments for claims from different periods into the base year).

Choosing a past year as a base also essentially locks in the spending that resulted from prior choices regarding the design of a state's Medicaid program, including the choice of whether to expand Medicaid. Once caps were set on the basis of states' past choices, states would find it

increasingly difficult to make changes that increased spending, for example, by significantly raising payment rates or voluntarily adding covered services (which some might consider a desirable outcome if a principal goal of the cap is to constrain state spending). In contrast to the case under current law, those changes would not lead to higher federal payments. In addition, states that have made efforts to operate their programs efficiently to keep costs low would receive caps that reflected that efficiency and were, all else equal, lower than the caps of states with inefficient programs. Therefore, those efficient states would have less flexibility to reduce spending to comply with the caps while inefficient states would have more flexibility. Ways to address this issue would include supplementing base-year spending amounts or assigning higher growth rates for low-spending states to give them more room to change their programs over time. However, that approach would reduce the federal savings generated by the caps.

Growth Factors. The growth factor sets an annual rate of increase to inflate the spending limits in future years. The growth factor could be set to meet specific savings targets or achieve specific policy purposes. For example, if a growth factor was set roughly equal to the rate of increase projected for Medicaid spending under current law, little or no budgetary savings might be anticipated, but some other policy objective could be met, such as protecting the federal government from unanticipated cost increases in the future. Alternatively, a growth factor could be set to make the increase in federal Medicaid spending—overall or per enrollee—match changing prices in the economy as measured, for example, by the consumer price index for all urban consumers (CPI-U). Policymakers also could set a rate to reflect the growth in health care costs per person, perhaps as measured by the per capita increase in national health expenditures, or a rate that was consistent with economic growth as measured by the increase in per capita GDP. Growth factors that were tied to price indexes or to overall economic growth, however, would not generally account for increases in the average quantity or intensity of medical services of the sort that have occurred in the past.

For overall spending caps, which would not provide additional funds automatically if Medicaid enrollment rose, the growth factor could be tied to some measure of population growth (such as the Census Bureau's state population estimates) or changes in the unemployment rate to account for increases in enrollment. A growth factor also

could be any legislated rate designed to produce a desired amount of savings.

In general, the lower the growth factor relative to CBO's projected growth rate for federal Medicaid spending under current law, the greater would be the projected federal budgetary savings. But the lower the growth factor, the greater the possibility that federal funding would not keep pace with increases in states' costs per Medicaid enrollee or (in the case of overall caps) with increases in Medicaid enrollment, thus raising the likelihood that states would not be able to maintain current services or coverage. Under proposals that led to significant reductions in federal funding, many states would find it difficult to offset the reduced federal payments solely through improvements in program efficiency. Those states would have three potential approaches available to them: Raise additional revenues; cut other state programs to transfer resources to Medicaid; or change the program through some combination of reducing payments to providers and health plans, curtailing covered services, and decreasing enrollment. If reductions in federal revenues were large enough, states would probably resort to a combination of all such approaches.

New Flexibility for States. Some proponents of caps consider additional state flexibility an essential feature of proposals to limit Medicaid spending. However, the structure of Medicaid's financing and the degree of state flexibility are, in principle, separate issues: Under a federal spending cap, the flexibility available under current law could remain the same or be altered to give states more or fewer options. (Under current law, states' flexibility could be increased or decreased as well.) If spending caps were coupled with new state flexibility, the federal government could cede more control to states for a range of program features, including administrative requirements, managed care contracting rules, ways to deliver health care, cost-sharing amounts, work requirements, eligibility categories, and covered medical services. That new flexibility would make it easier for states to adjust their spending in response to limits on federal funding. Alternatively, federal spending caps could include a maintenance-of-effort requirement that would prevent states from changing eligibility categories or covered medical benefits before the caps took effect. In either case, the degree of state flexibility would be unlikely to affect the federal savings created by the caps; CBO expects that states would structure their programs to draw federal payments up to the caps' amount.

The Optional Medicaid Expansion. Since January 2014, states have been permitted to extend eligibility for Medicaid to most people whose income is below 138 percent of the federal poverty guidelines. Under the terms of the ACA, the federal government currently covers a much larger share of the cost of providing Medicaid coverage to people made eligible by the expansion than it does for other Medicaid enrollees. That higher federal share is set at 100 percent through 2016 and then declines gradually to 90 percent by 2020, where it remains thereafter. The Medicaid expansion adds complexity to the design of federal spending caps, particularly for states that choose to adopt the expansion after the base year.

For states that have not yet adopted the ACA expansion, data from a prior base year would reflect spending only for groups of people who were eligible before expansion. Should any of those states subsequently adopt the expansion, the annual limits imposed by an overall spending cap would fail to account for the spending of expansion enrollees. For per-enrollee caps, the additional enrollment from the coverage expansion would generate additional federal spending, but average per capita spending for adults in the base year would not account for the higher federal payment for newly eligible people or for any differences in expected costs related to the health status of those new enrollees compared with costs for people who would have been eligible before the expansion.

In designing Medicaid caps, lawmakers could address those issues in one of several ways:

- Select a base year far enough in the future to allow time for states that chose to do so to adopt the expansion and for enrollment to become fairly stable. Using a future base year, however, could allow states to boost their spending that year, thus increasing federal spending limits and reducing federal savings.
- Leave spending uncapped for people who enrolled as a result of the expansion, but cap spending only for nonexpansion enrollees. That approach would remove most of the complications created by the optional-coverage group, but it also would leave a large amount of Medicaid spending uncapped and reduce the potential federal savings. (CBO projects that federal spending for adults made eligible by the ACA will total \$134 billion, or 21 percent of total Medicaid spending, in 2026.)

- Allow the Secretary of Health and Human Services to add an estimate of future spending attributable to the expansion for states that chose to adopt the expansion after the base year. For overall caps, the Secretary could adjust the spending limits to reflect the estimated additional costs of newly eligible people and previously eligible people who would enroll only in response to the expansion. For per-enrollee caps, the Secretary could modify the caps for newly eligible adults to reflect the higher federal matching rates for that group and to allow for any differences in expected costs related to the health status of that group compared with people who enrolled under the existing eligibility rules. The Secretary also could establish an entirely separate per-enrollee cap for the newly eligible enrollees that was based on estimated costs for their coverage.
- Base the caps on total combined federal and state spending to avoid the complexity of differing matching rates for expansion and pre-expansion adults. For overall caps, the upper spending limit would still require an adjustment to reflect the additional anticipated enrollment attributable to the expansion. For per-enrollee caps, combining federal and state spending limits would circumvent problems associated with the use of different matching rates but would not account for differences in expected health costs between the two groups.

Another question related to the optional expansion concerns whether capping federal Medicaid spending might cause some states that would otherwise expand coverage to reject the option instead. Limits on federal Medicaid payments represent a potential shifting of costs to states, which in turn would affect states' budget processes and program decisions. States could reduce Medicaid costs and lessen financial risk by dropping the optional expansion or deciding to adopt it later. CBO anticipates that the more that caps reduce federal funding below the amounts projected under current law, the greater the likelihood that states would discontinue or reject the optional expansion unless the cap's structure was such that participating in the expansion did not make complying with the cap more difficult.

To the extent that states responded to caps by terminating or rejecting the optional expansion, most of the new or potential enrollees would lose access to Medicaid coverage, although some would gain access to the health insurance marketplaces established by the ACA. Specifically,

people whose income was between 100 percent and 138 percent of the federal poverty guidelines who lost Medicaid eligibility would qualify for premium assistance tax credits to buy coverage through the marketplaces. Most of the people whose income was below the federal poverty guidelines but who no longer had access to Medicaid would become uninsured; the rest would enroll in other coverage, principally through an employer. For overall caps, enrollment changes would not affect the Medicaid savings, but would reduce net budgetary savings because of increased spending on marketplace subsidies and decreased revenues from additional employer coverage. For per-enrollee caps, the net budgetary effect of fewer states' adopting the expansion would be to increase federal savings, CBO estimates, because the savings from the reduction in Medicaid coverage would be larger than the increase in spending for marketplace subsidies and revenue loss from additional employer coverage.

Specific Alternatives and Estimates

CBO analyzed two types of limits on federal Medicaid spending: overall spending caps and per-enrollee caps. For both types, CBO chose 2016 as the base year. Overall caps would take effect in October 2019; per-enrollee caps would take effect one year later. That additional year would be the minimum necessary to allow for the complex data gathering needed to arrive at state-specific caps for each enrollee group (as discussed below in the section on data availability). For overall and per-enrollee caps alike, federal matching rates would continue as they are under current law, but Medicaid's DSH and VFC spending would be excluded. DSH spending is already capped and VFC spending covers vaccinations for some children who might not be Medicaid enrollees. The caps also would exclude the spending that Medicaid incurs for Medicare cost sharing and premiums of enrollees who are eligible for both programs. Administrative spending would be financed in the same manner as under current law.

To illustrate a range of savings, CBO used a pair of alternative growth factors for each type of cap: either the annual change in the CPI-U or the change in the CPI-U plus one percentage point (referred to here as CPI-U plus 1). Under each alternative, states would retain their current-law authority concerning optional benefits, optional enrollees, and payment rates for providers and health plans.

For the per-enrollee spending caps, CBO assumed that separate spending limits would be set for each of the four main Medicaid eligibility groups in each state: the elderly, people with disabilities, children, and nondisabled, nonelderly adults. States would not be permitted to cross-subsidize groups. CBO also assumed that the Secretary of Health and Human Services would make a new data source available to capture the necessary spending and enrollment information for the four groups.

To address the complexities related to the optional Medicaid expansion, CBO assumed that the Secretary would adjust each type of cap to reflect estimated additional spending in any state that adopted the expansion after the base year. Per-enrollee caps would be imposed on combined federal and state spending (overall caps would not). By that method, if combined federal and state spending exceeded the caps, the percentage of the excess spending above the cap would be cut from the federal payment to states: If a state overspent its per-enrollee cap by 5 percent, for example, the federal payment to the state would be reduced by the same amount.

Under the specifications listed here, CBO estimates that the overall caps would generate gross savings to the federal government of \$709 billion between 2019 and 2026 under the CPI-U growth factor or \$506 billion under the CPI-U plus 1 growth factor, for savings of about 17 percent and 12 percent, respectively, from the current-law projection of total federal Medicaid spending for the period. Gross savings from the two varieties of overall caps would represent about 23 percent and 16 percent, respectively, of projected federal Medicaid spending in 2026.

The gross savings under this option would be partially offset. Reductions in federal Medicaid spending resulting from the overall caps would represent large reductions in revenues for states. Therefore, in CBO's assessment, the states would take a variety of actions to reduce a portion of the additional costs that they would face, including restricting enrollment. For people who lose Medicaid coverage, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that roughly three-quarters would become uninsured. The rest of that group of people would instead obtain subsidized coverage through the health insurance marketplaces established under the ACA or, if available, choose to enroll in employment-based health insurance. For the CPI-U alternative, the agencies estimate that the additional marketplace and

employment-based coverage would increase outlays by \$20 billion and decrease revenues by \$10 billion from 2019 to 2026. For the CPI-U plus 1 alternative, the agencies estimate that the additional coverage would increase outlays by \$13 billion and decrease revenues by \$6 billion over the same period. The effects on revenues stem from decreases in taxable compensation associated with increases in employment-based insurance and decreases in tax liability associated with increases in the number of people receiving tax credits to purchase health insurance through the marketplaces. As a result, the net effect on the deficit would be a savings of \$680 billion between 2019 and 2026 under the CPI-U growth factor or \$486 billion under the CPI-U plus 1 growth factor.

CBO estimates that per-enrollee caps would generate gross savings for the federal government of \$598 billion between 2020 and 2026 using the CPI-U growth factor or \$383 billion using CPI-U plus 1, for savings of about 16 percent and 10 percent, respectively, from the current-law projection of total federal Medicaid spending for the period. The gross savings would represent about 20 percent and 12 percent, respectively, of projected federal Medicaid spending in 2026.

Some of the difference in gross savings between the overall and per-enrollee caps results from the later start for per-enrollee caps. If the overall caps also took effect in 2020, the gross savings would be \$673 billion for the alternative using the CPI-U and \$480 billion for the one using the CPI-U plus 1.

The gross savings under this option would be partially offset because, as with overall caps, the federal savings associated with per-enrollee caps would represent large reductions in revenues for states, and CBO expects that states would take a variety of similar actions to offset a portion of the additional costs that they would face. Although per-enrollee caps provide additional federal payments for each enrollee, per-enrollee caps below projections of federal per-enrollee spending would create a loss of revenues to states for each enrollee. Therefore, CBO anticipates that some states also would take action to restrict enrollment under per-enrollee caps. As with overall caps, CBO and JCT estimate that roughly three-quarters of enrollees who lost Medicaid coverage would become uninsured. The remainder would instead either obtain subsidized health insurance through the marketplaces or enroll in an employment-based plan. For the CPI-U alternative, the agencies estimate that the

additional coverage would increase outlays by \$15 billion and decrease revenues by \$7 billion from 2020 to 2026. For the CPI-U plus 1 alternative, the agencies estimate that the coverage would increase outlays by \$9 billion and decrease revenues by \$4 billion over the same period. As a result, the net effect on the deficit would be a savings of \$576 billion between 2020 and 2026 under the CPI-U growth factor or \$370 billion under the CPI-U plus 1 growth factor.

Other Considerations

Because caps on federal Medicaid spending would represent a fundamental restructuring of Medicaid financing, several other considerations would need to be addressed. In addition to their consequences for the federal budget, the limits on federal spending would require new administrative mechanisms for full implementation. The Centers for Medicare & Medicaid Services (CMS, the federal agency within the Department of Health and Human Services that administers Medicaid) would need to establish a mechanism for enforcing the caps to account for the delayed availability of the necessary data to calculate the final limits. Administrative data on Medicaid spending and enrollment do not currently provide enough information to establish per-enrollee caps such as those modeled in this option. Such data would need to be developed. Beyond the challenges of implementation, the caps on Medicaid spending could have significant consequences for states and enrollees.

Enforcement. Before overall or per-enrollee caps could take effect, CMS would need to establish mechanisms to ensure state compliance. The nature of that enforcement would depend on legislative direction given to the Secretary for establishing the caps. If the growth factors for either type of cap were based on the value of some specific measure of economic activity, such as the CPI-U (as opposed to a fixed growth factor that consisted of an annual increase of a certain percentage), CMS would not know the final spending limits until after the end of the fiscal year, when the measure would be finalized, unless growth from some earlier period was used instead. Per-enrollee caps would require additional delays because final enrollment data for any year would not be available for at least several months after the fiscal year's end. In addition, states usually make accounting adjustments to a prior year's spending long after the end of the fiscal year. Such delays would prevent CMS from calculating and states from determining the final limits on a current year's spending until well into the next fiscal year. Although

states could attempt to forecast the limits and could update those forecasts over the course of a year, it would be difficult to precisely target spending to remain below the caps; states therefore could face reductions in funding triggered by spending above the caps.

Data Availability. States currently report enough data for CMS to determine per-enrollee spending in only two eligibility categories: newly eligible adults and all other enrollees combined. To set per-enrollee caps on the basis of currently available data, lawmakers could establish either a single overall per-enrollee cap that represented average spending in all Medicaid eligibility categories or two caps—one for each of the groups of enrollees for which data were available. As stated above, broad categories for per-enrollee caps create incentives to favor the enrollment of people in eligibility categories with lower rather than higher costs. Alternatively, if lawmakers wanted to establish caps for the four principal groups considered under this option (the elderly, people with disabilities, children, and nondisabled, nonelderly adults), they could direct the Secretary to rely on internal state data regarding enrollment among and spending for the four groups, or they could direct the Secretary to make available a new uniform state-reported data source for the relevant information. Relying on state-submitted data might create an incentive for states to submit enrollment and spending data that would maximize the caps, whereas requiring the Secretary to establish a new uniform data set would require additional time to design, develop, and implement the new system.

Effects on States. Capping federal Medicaid spending would fundamentally change the program's federal-and-state division of financing. In particular, if the maximum federal commitment under the caps was below the federal expenditures that would have otherwise occurred (as would be the case for the alternatives discussed above), such caps would shift responsibility for the program's costs to the states.

In the CPI-U or CPI-U plus 1 alternatives, the savings to the federal government would represent lost revenues to states, and those losses would increase over time as the gap grew larger between the states' costs and the federal payments.

The caps on federal Medicaid payments also would expose states to increased financial risk arising from changes in the marketplaces or in the broader economy—elements

over which the states have little control, if any. If overall caps were adopted and the economy entered a recession, for example, the growth of federal Medicaid payments would be unlikely to keep pace with the rising enrollment and need for services. (Between 2007 and 2010, Medicaid enrollment increased by about 14 percent.) Under a system of per-enrollee caps with growth based on the CPI-U or CPI-U plus 1, federal payments would rise with enrollment but would not respond if cost growth for health care exceeded growth in the index. If the growth of per-enrollee caps was based on a health care-specific index, such as national health expenditures per capita, payments would adjust to average changes in the nationwide health care system but not to idiosyncratic changes in any particular state's health care system—and the federal savings would be smaller than those under the alternative using the CPI-U.

With lower federal funding and greater budgetary uncertainty, states would have a stronger incentive than under current law to reduce the costs of their Medicaid programs. To help states reduce costs, some proponents of Medicaid caps consider new programmatic flexibility for states to be an essential feature of such a policy. That flexibility could take various forms: States could be permitted to administer their programs without the need to meet some or all of CMS's current administrative requirements; experiment with new ways to deliver health care to enrollees; or reduce payment rates to providers and health plans, eliminate services, or reduce coverage for current-law eligibility groups. Greater flexibility could permit states to offset the losses of federal funding estimated under this option without having to raise additional revenues or cut other state programs. Whether states would have enough flexibility to prevent cuts in enrollment or in services would depend largely on how much states needed to cut spending to stay below the caps.

Effects on Enrollees. The ways in which Medicaid spending caps affected individual enrollees would depend greatly on how states responded to the caps, which in turn would be affected by the particular structure of their programs. If a state chose to leave its Medicaid programs unchanged and instead found other ways to offset the loss of federal funds, enrollees would notice little or no change in their Medicaid coverage. By contrast, enrollees could face more significant effects if a state reduced providers' payment rates or payments to managed care plans, cut covered services, or curtailed eligibility—either in

keeping with current law or to a greater extent, if given the flexibility. If states reduced payment rates, fewer providers might be willing to accept Medicaid patients, especially given that, in many cases, Medicaid's rates are already significantly below those of Medicare or private insurance for some of the same services. If states reduced payments to Medicaid managed care plans, some plans might shrink their provider networks, curtail quality assurance, or drop out of the program altogether. If states reduced covered services, some enrollees might decide

either to pay out of pocket or to forgo those services entirely. And if states narrowed their categories of eligibility (including the optional expansion under the ACA), some of those enrollees would lose access to Medicaid coverage, although some would become eligible for subsidies for private coverage through the marketplaces or could choose to enroll in employment-based insurance, if available, which would affect federal revenues, as discussed previously.

RELATED OPTION: Mandatory Spending, Option 13

RELATED CBO PUBLICATION: *Federal Grants to State and Local Governments* (March 2013), www.cbo.gov/publication/43967

Health—Option 3

Function 550

Limit States' Taxes on Health Care Providers

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
Lower the safe-harbor threshold to 5 percent	0	-1.4	-1.5	-1.6	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2		-6.1	-15.9
Lower the safe-harbor threshold to 4 percent	0	-3.4	-3.7	-4.0	-4.2	-4.4	-4.6	-4.9	-5.2	-5.6		-15.3	-39.9

This option would take effect in October 2017.

Medicaid is a joint federal-and-state program that pays for health care services for low-income people in various demographic groups. State governments operate the program under federal statutory and regulatory oversight, and the federal government reimburses a portion of each state's costs at matching rates that generally range from 51 percent to 80 percent, depending on the per capita income of the state and on the share of enrollees (if any) in each state that became eligible for Medicaid as a result of the optional expansion of that program under the Affordable Care Act. The rest of the funding must come from state revenues, either from general funds or from another source. Most states finance at least a portion of their Medicaid spending through taxes collected from health care providers. In the early 1990s, the Congress required states that taxed health care providers to collect those taxes at uniform rates from all providers of the same type. Those rules were created because some states were taxing Medicaid providers either exclusively or at higher rates than other providers of the same type (hospitals, for example) with the intention of returning the collected taxes to those providers in the form of higher Medicaid payments. Such “hold harmless” provisions were leading to large increases in federal Medicaid outlays but not to concordant increases in states' Medicaid spending, despite the expectation created under Medicaid's matching-rate formula.

However, federal law grants a “safe harbor” exception to hold-harmless provisions when a state collects taxes that do not exceed 6 percent of a provider's net patient revenues. This option would lower the safe-harbor threshold, starting in October 2017, to 5 percent or 4 percent. The Congressional Budget Office estimates that capping the threshold at 5 percent would reduce mandatory

spending by \$16 billion between 2017 and 2026 and that capping it at 4 percent would reduce mandatory spending by \$40 billion over that period.

Lowering the safe-harbor threshold would reduce the amount of taxes that states could collect from providers without incurring reductions in federal payments. Under the new limits, states would need to decide whether to continue spending the same amount (and make up the difference out of other revenues) or to cut spending by the difference between the old and new thresholds. In the first case, states might replace lost revenue by raising additional general revenues or by reducing spending elsewhere in their budgets and transferring those amounts to Medicaid spending. In that case, the federal government would continue to match the same amount of state spending, and there would be no change in federal spending. Alternatively, states could decide not to replace the lost revenue and instead cut their Medicaid spending. That choice would reduce federal spending because the matched amounts would be smaller.

CBO expects that different states would respond to a lower safe-harbor threshold in different ways along a continuum. Most states would probably not replace all of the revenues lost as a result of the lower threshold for the taxation of providers. The health care providers being taxed directly benefit from higher Medicaid payment rates, making the imposition of such taxes an easier choice for states than alternative choices for replacing such revenues. However, most states would be unlikely to cut Medicaid spending by the full amount of the lost revenues because they might deem other choices to be preferable. CBO anticipates that, on average, states would replace half of the lost revenues, but that estimate is highly uncertain.

The main rationale for this option is that it would lower Medicaid spending by limiting a state financing mechanism that has inflated federal payments to states for Medicaid beyond the amount the federal government would have paid in the absence of such taxes. An argument against this option is that, to the extent that states cut back spending on Medicaid in response to the lost

revenues, health care providers could face lower payment rates that might make some of them less willing to treat Medicaid patients. Moreover, some Medicaid enrollees could face a reduction in services or possibly lose their eligibility for the program if states restricted enrollment to curtail costs.

Health—Option 4

Function 550

Repeal All Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays ^a	0	-110	-157	-169	-184	-197	-210	-223	-235	-248	-621	-1,733
Change in Revenues ^b	0	-30	-39	-42	-50	-56	-61	-67	-73	-79	-161	-498
Decrease in the Deficit	0	-81	-118	-127	-134	-141	-149	-156	-162	-169	-460	-1,236

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2018.

- a. Estimates include effects on Social Security outlays, which are classified as off-budget.
- b. Estimates include effects on Social Security payroll tax receipts, which are classified as off-budget.

The federal government currently regulates and subsidizes health insurance coverage through various provisions, many of them included in the Affordable Care Act (ACA). Although the ACA has numerous other provisions as well, the following elements specifically concern insurance coverage:

- Subsidized health insurance is now available to many individual people and families, who can purchase that coverage through designated marketplaces.
- Insurers who sell plans either through the marketplaces or directly to consumers must provide specific benefits and amounts of coverage. They cannot deny coverage or vary premiums because of an enrollee’s health status, and they can vary premiums only on the basis of age, tobacco use, and geographic location.
- States are permitted but not required to expand eligibility for Medicaid to include adults whose income is up to 138 percent of the federal poverty guidelines (also called the federal poverty level), with the federal government paying nearly all of the costs for expanding Medicaid coverage to those new enrollees.
- Under a provision known as the individual mandate, most citizens of the United States (and noncitizens who are lawfully present in the country) must obtain health insurance or pay a penalty for not doing so.
- Under a provision known as the employer mandate, employers with 50 or more employees generally must either offer health insurance coverage that meets specific standards or pay a penalty for declining to do so.

- A federal excise tax is scheduled to be imposed on certain employment-based health plans with relatively high premiums.

All of those provisions have led to significant increases in the number of people with insurance coverage, but they also have been controversial, and there have been proposals to repeal some or all of them. This option, which would take effect in January 2018, would repeal all of the ACA’s insurance coverage provisions—including but not limited to the subsidies, regulations, penalties, and taxes described above.¹ This option would not repeal the ACA entirely, however. In particular, the increases in taxes and the reductions in federal payments for Medicare and other programs resulting from other provisions of the ACA would remain in force.

This option would reduce the deficit by \$1,236 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. Those net savings would largely result from the repeal of the new subsidies for Medicaid and for plans purchased through

1. For additional details, see Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), p. 15, www.cbo.gov/publication/51385. For an analysis of the potential effects of a full repeal, see Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), www.cbo.gov/publication/50252. Although the savings from repealing the insurance coverage provisions could be used to finance an alternative system of subsidies, and the act’s regulatory provisions could be replaced with others designed to reduce premiums or increase insurance coverage, analysis of such options (which could be designed in myriad ways) is beyond the scope of this report.

the marketplaces (gross savings of \$1,751 billion through 2026, consisting of a reduction in outlays and an increase in revenues) that would be partially offset by a repeal of penalties and taxes and by other effects (totaling \$516 billion through 2026).

The largest amount of gross savings comes from reducing federal outlays for Medicaid and the Children's Health Insurance Program (\$950 billion), and the next largest comes as a result of eliminating the federal subsidies for insurance purchased through the marketplaces or a related program, the Basic Health Program (\$794 billion). Because the premium subsidies for marketplace plans are structured as refundable tax credits, a portion of the savings would take the form of reduced outlays (to the extent that the credit amounts exceed enrollees' income tax liability); the remainder would take the form of higher tax revenues.

The gross savings generated under this option would be partially offset by the effects of eliminating several of the ACA's provisions that are projected to reduce federal deficits under current law. The elimination of those provisions would affect both revenues and outlays. Significant sources of costs include the repeal of the provisions that impose penalties on some employers (\$169 billion) and uninsured people (\$35 billion) and those that impose an excise tax on certain high-premium insurance plans (\$79 billion). Increases in employment-based coverage stemming from a repeal would reduce revenues as well because most payments for that coverage are exempt from income and payroll taxes.

Repealing the insurance coverage provisions of the ACA also would cause large changes both in the number of people with health insurance and in the sources of that coverage. CBO and JCT estimate that this option would boost the number of people under age 65 who are uninsured by about 23 million in most years before 2026—from about 28 million under current law to about 51 million in 2026. In 2026, the number of people with employment-based coverage would increase by about 10 million, the number with coverage purchased individually (including through the marketplaces) would decrease by 14 million, and the number of people with coverage through Medicaid would decrease by 19 million.

Under this option, CBO and JCT anticipate that, on average, premiums also would be lower in the nongroup

market (in which health insurance is purchased directly by people) than they are under current law. That effect would arise from reductions in the scope of benefits covered and in the share of costs covered by health insurance (resulting in a corresponding increase in out-of-pocket costs for insured people). Moreover, the people who obtained health insurance in the nongroup market would be expected to be healthier, on average, than those obtaining such coverage under current law because less healthy people could be denied coverage altogether under this option or could face substantially higher premiums that could make such coverage unaffordable.

One argument in favor of this option is that it would rescind the current-law individual mandate along with its associated penalties, which hurt some people financially. (Under that mandate, people generally must either purchase health insurance or pay a penalty.) For the reasons discussed above, premiums in the nongroup market would be lower, on average, under this option.

Another argument in favor of this option is that it is likely to increase employment-based insurance coverage for some workers, in part because the narrower choices for obtaining insurance outside the workplace would encourage employers to offer coverage and employees to take up that coverage. In addition, it would reduce costs for some employers: They would no longer be subject to a penalty if they did not offer insurance, and they would not incur the costs of reporting to the Internal Revenue Service on their employees' insurance coverage.

An additional argument in favor of this option is that both the total number of hours worked and gross domestic product would rise. In previous work, CBO projected that the labor force would be smaller by about 2 million full-time-equivalent workers in 2025 under the ACA than it would have been in the absence of that law. Under this option, those effects would largely be reversed.

An argument against this option concerns the resulting large increases in the number of people who would end up without health insurance. On average, out-of-pocket costs in the nongroup market would rise, and the availability of affordable insurance would fall for people who are in poor health or have low income. In many cases, older people and those in poor health would be denied coverage altogether in the nongroup market. The lack of subsidies for coverage would render insurance unaffordable for many people who, under current law,

could purchase nongroup coverage. Moreover, repealing the subsidies for purchases in the nongroup market would create a tax inequity: Employment-based health insurance would continue to receive favorable tax treatment; insurance bought by individual people generally would not.

Another rationale against this option is that its largest effects would fall on low-income adults who, once the Medicaid expansion was rescinded, might lose access to comprehensive health insurance. Low-income adults generally have less access to employment-based health insurance than other adults do because many of them work part time or for employers that do not offer coverage.

RELATED OPTION: Health, Option 5

RELATED CBO PUBLICATIONS: *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 24, 2016), www.cbo.gov/publication/51385; letter to the Honorable Mike Enzi regarding the budgetary effects of H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act, as passed by the Senate on December 3, 2015 (December 11, 2015), www.cbo.gov/publication/51090; *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 2015), www.cbo.gov/publication/50252; Edward Harris and Shannon Mok, *How CBO Estimates the Effects of the Affordable Care Act on the Labor Market*, Working Paper 2015-09 (December 2015), www.cbo.gov/publication/51065

Health—Option 5

Function 550

Repeal the Individual Health Insurance Mandate

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays	0	-22	-34	-37	-42	-44	-46	-49	-52	-55	-134	-381
Change in Revenues ^a	0	4	6	5	4	3	3	3	4	4	18	35
Decrease in the Deficit	0	-26	-39	-42	-45	-47	-50	-53	-56	-59	-152	-416

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2018.

a. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance that meets specified standards. People who have no health insurance (and who are not exempt from the mandate) must pay a penalty that is collected by the Internal Revenue Service in the greater of two amounts: either a fixed charge for every uninsured adult in a household plus half that amount for each child, or an income-based assessment set at 2.5 percent of the household's income above the filing threshold for its income tax filing status. The dollar-amount penalty is \$695 per uninsured adult in 2016 and is set to rise annually with the rate of general inflation. Penalties are subject to caps and are prorated for people who are uninsured for only part of a year.

Under current law, the individual mandate and its associated penalties increase federal deficits by encouraging people to obtain subsidized coverage—through Medicaid, the health insurance marketplaces established under the ACA, or employment-based plans (which receive indirect subsidies to the extent that premiums for that coverage are excluded from taxable compensation). Penalty payments from uninsured people partially offset those costs. Between 2017 and 2026, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) project, the federal government will collect \$38 billion in penalty payments from uninsured people.

Beginning in January 2018, this option would eliminate the individual mandate; the ACA's other provisions (including marketplace subsidies) would remain in place. CBO and JCT estimate that this option would reduce

federal budget deficits by \$416 billion between 2018 and 2026. Under this option, the loss of penalty revenue would be more than offset by the savings from reduced spending on federal subsidies for health insurance coverage.

This option would decrease outlays by \$381 billion between 2018 and 2026, CBO and JCT estimate. Most of that amount (about \$279 billion) would come from a drop in Medicaid enrollment. In addition, between 2018 and 2026, federal spending on subsidies for insurance purchased through the marketplaces would decline by \$96 billion. (Those subsidies fall into two categories: those that cover a portion of participants' health insurance premiums and those that reduce out-of-pocket payments required under insurance policies.) Other effects would account for the remaining \$6 billion reduction in outlays.

CBO and JCT estimate that this option would increase revenues by \$35 billion between 2018 and 2026. The removal of the mandate would increase tax revenues by about \$56 billion because reductions in employment-based coverage would result in more taxable compensation for employees. Revenues would increase by an additional \$16 billion because a portion of the decrease in marketplace subsidies for health insurance premiums would be provided in the form of increases in recipients' tax payments. (The subsidies for health insurance premiums are structured as refundable tax credits: The portions that exceed taxpayers' other income tax liabilities are classified as outlays; those that reduce tax payments are classified as reductions in revenues.) The increase in revenues over the period from 2018 to 2026 would be partially offset by a \$35 billion loss from eliminating the individual

mandate's penalties. Other effects would account for an additional \$1 billion reduction in revenues.

A repeal of the individual mandate would cause a substantial reduction in the number of people with health insurance, CBO and JCT estimate. Under current law, about 28 million people under age 65 in the United States would be uninsured in 2026. This option would change that number as follows: About 2 million fewer people would have employment-based coverage, about 6 million fewer people would obtain nongroup policies (insurance people can purchase directly either in the marketplaces or from insurers outside the marketplaces), and about 7 million fewer people would have coverage under Medicaid. All together, the agencies estimate, 43 million people would be uninsured in 2026.

CBO and JCT estimate that a repeal of the individual mandate also would result in higher premiums for coverage purchased through the nongroup market. Health plans in the nongroup market would still be required to conform to the ACA's rules for that coverage. Insurers could not deny coverage or vary premiums because of an enrollee's health status nor limit coverage because of pre-existing medical conditions. They would be permitted to make only limited adjustments to premiums because of age, tobacco use, and geographic location. Those features are most attractive to applicants who expect to have relatively high costs for health care, and CBO and JCT anticipate that repealing the individual mandate would tend to cause smaller reductions in coverage among older and less healthy people and larger reductions among younger and healthier people, thus increasing premiums in the nongroup market.

The effects of such adverse selection, however, would be mitigated somewhat by other factors—including the marketplace subsidies (which make health insurance less costly and more attractive to younger and healthier enrollees who are eligible for those subsidies) and the annual open-enrollment periods in the nongroup market (which reduce the incentive for people to wait until they become ill to obtain coverage). Moreover, the available

subsidies would greatly reduce the effect of premium increases on coverage among subsidized enrollees. CBO and JCT estimate that adverse selection would increase premiums for policies in the nongroup market, whether purchased through the marketplaces or not, by roughly 20 percent relative to premiums under current law. That change, in turn, would increase federal per capita costs for people receiving subsidies through the marketplaces.

Many proponents of this option argue that the decision to obtain health insurance is a private matter that should be beyond the reach of the federal government. Another argument in the option's favor is that the mandate and its associated penalties reduce the financial well-being of some people. Because of the rating rules in place for nongroup coverage, young and healthy enrollees without large subsidies effectively cross-subsidize older, less healthy enrollees when they are required to purchase insurance or pay a penalty. An additional concern is that the current system uses the Internal Revenue Service to enforce the mandate, increasing the complexity of the tax system and interfering with other efforts to increase tax compliance. Finally, the mandate necessitates reporting requirements that raise the costs of complying with the tax code both for individual enrollees and for their insurers.

Many opponents of the option point to the reductions in coverage and increases in premiums that are likely to occur and argue that it is appropriate for the government to require people to have health insurance in order to prevent those outcomes. Another argument against the option holds that penalizing people who do not obtain coverage improves economic efficiency. In particular, by increasing the private costs of being uninsured, the individual mandate encourages people to obtain coverage and, in that way, might reduce the social costs of caring for people without insurance. In some cases, uninsured people pay less than the costs of the care they receive, resulting in lower payments to providers or higher costs for others. In the absence of a mandate, those social costs would probably increase relative to the case under current law.

RELATED OPTION: Health, Option 4

RELATED CBO PUBLICATIONS: *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), www.cbo.gov/publication/51385; *Private Health Insurance Premiums and Federal Policy* (February 2016), www.cbo.gov/publication/51130

Health—Option 6

Function 550

Introduce Minimum Out-of-Pocket Requirements Under TRICARE for Life

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
MERHCF	0	*	*	-1.4	-2.4	-2.6	-2.8	-3.0	-3.2	-3.3		-3.7	-18.6
Medicare	<u>0</u>	<u>0</u>	<u>0</u>	<u>-0.4</u>	<u>-1.1</u>	<u>-1.3</u>	<u>-1.4</u>	<u>-1.4</u>	<u>-1.5</u>	<u>-1.6</u>		<u>-1.5</u>	<u>-8.7</u>
Total	0	*	*	-1.9	-3.4	-3.9	-4.1	-4.4	-4.7	-5.0		-5.2	-27.3

This option would take effect in January 2020.

MERHCF = Department of Defense Medicare-Eligible Retiree Health Care Fund; * = between zero and \$50 million.

TRICARE for Life (TFL) was introduced in 2002 as a supplement to Medicare for military retirees and their Medicare-eligible family members. The program pays nearly all medical costs not covered by Medicare and requires few out-of-pocket fees. Because the Department of Defense (DoD) is a passive payer in the program—it neither manages care nor provides incentives for the cost-conscious use of services—it has virtually no means of controlling the program’s costs. In contrast, most public and private programs that pay for health care either manage the care or require enrollees to pay deductibles or copayments up to a specified threshold. In 2015, DoD spent \$10 billion for the care delivered to Medicare-eligible beneficiaries by military treatment facilities and by civilian providers (in addition to the amount spent for those patients through Medicare).

This option would introduce minimum out-of-pocket requirements for TFL beneficiaries. For calendar year 2020, TFL would not cover any of the first \$750 of an enrollee’s cost-sharing payments under Medicare and would cover only 50 percent of the next \$6,750 in such payments. Because all further costs would be covered by TFL, enrollees would not be obligated to pay more than \$4,125 in 2020. Those dollar limits would be indexed to growth in average Medicare costs (excluding Part D drug benefits) for later years. Currently, military treatment facilities charge very small or no copayments for hospital services provided to TFL beneficiaries. To reduce beneficiaries’ incentives to avoid out-of-pocket costs by switching to military facilities, this option would require

TFL beneficiaries seeking care from those facilities to make payments that would be roughly comparable to the charges they would face at civilian facilities.

This option would reduce spending for Medicare as well as for TFL because higher out-of-pocket costs would lead beneficiaries to use somewhat fewer medical services. All together, including some small implementation costs in 2018 and 2019, this option would reduce federal spending devoted to TFL beneficiaries by \$27 billion between 2018 and 2026, the Congressional Budget Office estimates. About two-fifths of those savings would come from reduced spending for medical services both from Medicare and from the fund that pays for TFL expenditures because of reduced demand for those services. The rest would represent a shift of spending from the federal government to military retirees and their families.

An advantage of this option is that greater cost sharing would increase TFL beneficiaries’ awareness of the cost of health care and promote a corresponding restraint in their use of medical services. Research has generally shown that introducing modest cost sharing can reduce medical expenditures without causing measurable increases in adverse health outcomes for most people.

A disadvantage is that this option could discourage some patients (particularly low-income patients) from seeking preventive medical care or from managing their chronic conditions under close medical supervision, which might negatively affect their health.

RELATED OPTIONS: Health, Options 7, 15

RELATED CBO PUBLICATIONS: *Approaches to Reforming Military Health Care* (forthcoming); *Long-Term Implications of the 2017 Future Years Defense Program* (forthcoming); *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), www.cbo.gov/publication/44993

Health—Option 7

Function 570

Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
Establish uniform cost sharing for Medicare with daily inpatient copayments	0	0	0	-2.3	-2.9	-2.9	-2.7	-2.4	-2.3	-2.4	-5.2	-17.9	
Establish uniform cost sharing for Medicare	0	0	0	-2.4	-3.1	-3.0	-2.8	-2.6	-2.3	-2.4	-5.5	-18.6	
Restrict medigap plans	0	0	0	-4.8	-6.4	-6.6	-6.7	-6.6	-6.7	-6.7	-11.2	-44.5	
Combine the second and third alternatives above ^a	0	0	0	-7.5	-10.0	-10.1	-9.9	-9.6	-9.5	-9.6	-17.5	-66.2	

This option would take effect in January 2020.

a. If the second and third alternatives were enacted together, the total effect would be greater than the sum of the effects of each alternative because of interactions between them.

Overview of the Issue

For people who have Medicare or any other type of health insurance coverage, payments for health care fall into two broad categories: premiums and cost sharing. A premium is a fixed, recurring amount paid by an enrollee in advance for an insurance policy (which then limits financial risk by covering some or all costs of health care goods and services). Cost sharing consists of out-of-pocket payments that enrollees are required to make when they receive health care. The basic Medicare benefit can leave beneficiaries responsible for a substantial amount of cost sharing, so many people obtain supplemental coverage. Many beneficiaries obtain such coverage through a former employer or through a state Medicaid program. Others choose what is known as a medigap plan, an individual insurance policy that covers most or all of Medicare’s cost sharing.

In general, premiums distribute the cost of medical care among all enrollees; cost sharing concentrates costs on people who use more medical care. Insurance plans typically vary three basic elements to determine the cost-sharing obligations of their enrollees:

- The deductible, an initial amount of spending below which an enrollee pays all costs;

- The catastrophic cap, a limit on an enrollee’s total out-of-pocket spending; and
- The share of costs an enrollee pays between the deductible and the catastrophic cap (which may vary according to the type of service covered).

Deductibles and catastrophic caps typically apply on an annual basis. In between those points, the portion of the cost borne by the enrollee is usually specified as a percentage of the total cost of an item or service (in which case it is called coinsurance) or as a fixed amount for each item or service (in which case it is called a copayment). If other aspects of an insurance plan are the same, lower cost-sharing requirements translate to higher premiums—because insurers must charge more to cover their higher share of medical spending—and higher cost-sharing requirements translate to lower premiums.

Research has shown that people who are not subject to cost sharing tend to use more medical care than do people who are required to pay some or all of the costs of their care out of pocket. The RAND health insurance experiment conducted from 1974 to 1982 examined a nonelderly population and showed that health care spending was about 45 percent higher for participants without any cost sharing than for those who effectively faced a high deductible; average spending for people with intermediate levels of cost sharing fell between spending

for those two groups.¹ More recent studies also concluded that higher cost sharing led to lower health care spending: A 2010 study found that in response to higher cost sharing, Medicare beneficiaries reduced both the number of visits to physicians and the use of prescription drugs to a degree roughly consistent with the results of the RAND experiment.²

Those findings have driven interest in using additional cost sharing as a tool to restrain the growth of health care spending. However, increases in cost sharing expose people to additional financial risk and may deter some enrollees from obtaining necessary care, including preventive care, that could limit the need for more expensive care in the future.³ In the RAND experiment, cost sharing reduced the use of effective care and less effective care (as defined by a team of physicians) by roughly equal amounts. Although the RAND researchers found that cost sharing had no effect on health in general, among the poorest and sickest participants, those with no cost sharing were healthier by some measures than those who faced some cost sharing. In theory, to address the concern that patients might forgo necessary care, insurance policies could be designed to apply less cost sharing for services that are preventive or unavoidable and more cost sharing for services that are discretionary or that provide limited health benefits. In practice, however, that distinction can be difficult to draw, so trade-offs often occur between providing insurance protection and restraining total spending on health care.

Medicare's Current Cost Sharing. In the traditional fee-for-service portion of the Medicare program (Parts A and B), the cost sharing that enrollees face varies significantly depending on the type of service provided. Under Part A,

which primarily covers the services of hospitals and other facilities, enrollees are liable for a separate deductible for each "spell of illness" or injury for which they are hospitalized. That deductible will be \$1,316 in 2017. In addition, enrollees are subject to substantial daily copayments for extended stays in hospitals and skilled nursing facilities. Under Part B, which mainly covers outpatient services (such as visits to a doctor), enrollees face an annual deductible that will be \$183 in 2017. Once their spending on Part B services has reached that deductible amount, enrollees generally pay 20 percent of allowable costs for most Part B services, although cost sharing is higher for some outpatient hospital care. Certain services that Medicare covers—such as preventive care, certain hospice services, home health visits, and laboratory tests—require no cost sharing. Because of those variations, enrollees lack consistent incentives to weigh relative costs when choosing among treatment options. Moreover, Medicare patients who incur extremely high medical costs may be obligated to pay significant amounts because the program does not have a catastrophic cap on cost sharing.

Medicare's cost sharing differs in two significant ways from that of private plans, which provide health insurance for most people under age 65. First, private health insurance plans generally are less complicated because they typically have a single annual deductible that includes all or most medical costs rather than the separate deductibles for hospital and outpatient services under fee-for-service Medicare. Second, unlike fee-for-service Medicare, most private health insurance plans include a catastrophic cap on out-of-pocket costs that limits enrollees' annual spending—so those plans provide more protection from financial risk than Medicare does. Medicare is not unique, however, in charging different cost-sharing amounts for different types of services; many private insurance plans do that as well.

Although proposals to change Medicare's cost sharing generally focus on the traditional fee-for-service program, roughly a third of Medicare enrollees choose private insurance plans (known as Medicare Advantage plans) instead. In order to contract with the Medicare program, Medicare Advantage plans must provide catastrophic caps on cost sharing and meet other federal requirements. However, those plans have some flexibility in structuring other cost-sharing requirements as long as the overall value of the benefit is at least equal to the benefit that fee-for-service Medicare provides. In general, cost-sharing

1. See Joseph P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons From the RAND Health Insurance Experiment* (Harvard University Press, 1993).
2. See Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review*, vol. 100, no. 1 (March 2010), pp. 193–213, <http://dx.doi.org/10.1257/aer.100.1.193>.
3. CBO has examined the effects of expanding coverage for preventive services and generally found that doing so would generate savings from reduced use of other services that offset only a small portion of the costs of the preventive services. See Congressional Budget Office, letter to the Honorable Nathan Deal regarding the budgetary effects of expanding governmental support for preventive care and wellness services (August 2009), www.cbo.gov/publication/20967.

requirements in Medicare Advantage plans are lower than those in the fee-for-service program. Such features as out-of-pocket caps make Medicare Advantage plans more like plans in the private insurance market.

Part D of Medicare, which provides coverage for prescription drugs, also is administered by private insurers that set their plans' cost sharing (subject to certain statutory and regulatory requirements). By 2020, the standard Part D benefit will include a deductible, a range of spending over which enrollees face 25 percent coinsurance, and a catastrophic threshold above which enrollees are liable for 5 percent of their drug costs. Beyond those required elements, Part D insurers have some ability to specify which drugs are covered and the cost sharing enrollees must pay, requiring more cost sharing for expensive, brand-name drugs and less for generic drugs. Because private insurers administering Medicare Advantage and Part D plans can specify cost-sharing requirements (within limits) and Medicare enrollees can choose a plan on the basis of cost sharing and other factors, proposals to redesign Medicare's cost sharing generally do not focus on those parts of the program. Consequently, policies that would affect cost sharing in Medicare Advantage or Part D are not included in this option.

Supplemental Insurance for Medicare Enrollees. About 85 percent of people who enroll in fee-for-service Medicare have some form of supplemental insurance that reduces or eliminates their cost-sharing obligations and protects them from high medical costs. (Such coverage of cost sharing is uncommon outside fee-for-service Medicare and thus is another difference between that program and typical private insurance.) About 20 percent of enrollees in fee-for-service Medicare receive cost-sharing coverage from Medicaid, which is available to Medicare enrollees with low income and few assets. (Those enrollees often are referred to as dual-eligible beneficiaries.) About 40 percent of fee-for-service enrollees have supplemental coverage through a current or former employer, which tends to reduce, but not eliminate, their cost-sharing liability.⁴ About 20 percent of enrollees purchase medigap policies individually, and 5 percent have some other form of supplemental coverage.

4. Some Medicare enrollees are currently employed and have health insurance through their employer, in which case Medicare generally supplements that coverage. As a result, those workers might not benefit from enrolling in Part B of Medicare, so they typically enroll only in Part A.

Federal law requires medigap plans to conform to one of 10 standard plan types that vary by the extent of their coverage of cost sharing. Roughly half of medigap enrollees choose a plan that offers first-dollar coverage, which pays all deductibles, copayments, and coinsurance. Most other enrollees choose a plan that provides first-dollar coverage for Part A and covers all cost sharing above the deductible for Part B. Starting in 2020, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will prohibit new Medicare beneficiaries from purchasing the most popular types of supplemental plans—those that cover the Part B deductible.

According to a study for the Medicare Payment Advisory Commission, Medicare spends 27 percent more per person on enrollees who have medigap coverage and 14 percent more per person on enrollees who have supplemental coverage from a former employer than it does on enrollees without supplemental coverage.⁵ Those estimates are largely consistent with the results of older studies of the relationship between supplemental coverage and Medicare spending, and they take into account various ways in which medigap policyholders and other Medicare enrollees may differ. The researchers also concluded that those differences in spending were mainly attributable to higher use of discretionary or preventive services by people with supplemental coverage, particularly those with first-dollar coverage. Another study demonstrated that spending by Medicare enrollees with supplemental coverage was growing more rapidly than spending by enrollees without such coverage.⁶

Unadjusted differences in spending between groups with and without supplemental coverage partly reflect differences in their health status, but research has generally shown that the differences in spending were still large, even after adjusting for enrollees' health status. People with medigap policies may differ from other Medicare enrollees in other ways because medigap coverage is not assigned randomly, as it might be in a scientific experiment or trial. The 2010 study of Medicare beneficiaries'

5. Christopher Hogan, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly* (submitted by Direct Research to the Medicare Payment Advisory Commission, August 2014), <http://go.usa.gov/x8XvP> (PDF, 389 KB).

6. See Ezra Golberstein and others, "Supplemental Coverage Associated With More Rapid Spending Growth for Medicare Beneficiaries," *Health Affairs*, vol. 32, no. 5 (May 2013), pp. 873–881, <http://dx.doi.org/10.1377/hlthaff.2012.1230>.

response to increases in cost sharing is important because it more closely resembled an experiment. That study also showed that about 20 percent of the gross savings generated by higher cost sharing for physician visits and prescription drugs—stemming from reduced use—was offset by increases in hospital spending, perhaps because people delayed treatment until a condition worsened.⁷

Collectively, such research provides considerable evidence that Medicare enrollees who are subject to less cost sharing—because of more generous supplemental insurance—use more medical services than other enrollees do. Enrollees with supplemental coverage are liable for only a portion of the costs of any additional services they use (through any remaining cost sharing and through the effect on their premiums for supplemental coverage); taxpayers (through Medicare) bear most of the cost for the additional services.

Key Design Choices That Would Affect Savings

Policymakers could alter Medicare's cost sharing and restrict medigap coverage in various ways to produce savings for the federal government, reduce total health care spending, and create greater uniformity in cost sharing for Medicare enrollees. Those different ways also would alter the distribution of health care costs between healthier and less healthy enrollees.

In particular, there are four main ways to alter cost sharing in Medicare: Deductibles could be increased, decreased, or combined; coinsurance rates and copayments could be changed; a catastrophic cap could be added; and additional limits could be imposed on supplemental insurance coverage of Medicare's cost-sharing obligations. Such changes would interact in important ways. For example, higher deductibles or coinsurance rates would cause enrollees to reach a catastrophic cap more quickly (and at a lower amount of total spending), and limits on supplemental insurance would expose more enrollees to changes in Medicare's cost-sharing rules and thus increase the effects of those changes on Medicare spending. Policymakers also could grandfather current enrollees by applying changes only to new enrollees.

Deductibles. In general, raising the Part A and Part B deductibles would generate savings for the federal

government in two ways. First, higher deductibles would increase the initial cost borne by enrollees, leading to a corresponding reduction in the cost borne by the government. Second, some enrollees would choose to forgo some care because of its higher cost, decreasing the amount of health care for which the federal government would be required to pay. The Part A and Part B deductibles could be increased separately, or they could be combined into a single yearly deductible for all services covered by traditional fee-for-service Medicare. Depending on the dollar amount of that combined deductible, federal spending would decrease, increase, or remain the same.

Proposals for a combined deductible generally call for setting it between the current Part A and Part B deductibles. That approach would tend to increase cost sharing for the roughly 65 percent of enrollees who have only Part B spending in a given year and decrease cost sharing for the roughly 20 percent of enrollees who have some Part A spending (usually for an inpatient hospital stay). (About 15 percent of enrollees use no Part A or Part B services in a given year.) In principle, a combined deductible could also encompass spending for drugs under Part D, but such a change would be complicated because Part D is administered separately by private insurance plans.

Coinsurance and Copayments. Raising coinsurance rates and copayments would reduce federal spending in the same way that higher deductibles would, shifting some costs from the federal government to Medicare enrollees and causing enrollees to forgo some care because of higher out-of-pocket costs. Applying higher coinsurance or copayments to types of care that patients are likely to forgo at higher prices, such as elective surgery, would tend to emphasize that effect, decreasing the amount of care provided and thereby magnifying the budgetary effects. Conversely, applying higher cost sharing to types of care for which patients are particularly insensitive to price, such as emergency surgery, would tend to increase costs for enrollees with little effect on the amount of care provided. Some proposals envision wide-ranging changes to Medicare's cost-sharing rules, whereas others would apply changes more narrowly, by introducing coinsurance or copayments for specific services that do not currently require cost sharing, such as home health care, laboratory tests, or the first 20 days of a stay in a skilled nursing facility.

Policymakers face trade-offs in changing coinsurance and copayment rules to reduce Medicare's costs. Coinsurance

7. See Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *American Economic Review*, vol. 100, no. 1 (March 2010), pp. 193–213, <http://dx.doi.org/10.1257/aer.100.1.193>.

can make patients more sensitive to the cost of their care, but it also can give them less clarity about what the total costs will be. That trade-off is particularly important for someone facing a hospital admission, use of a particular drug, or other costly aspects of health care. Coinsurance can encourage patients to choose lower-cost services, but it can also significantly increase their financial burden. In addition, when coinsurance is combined with an out-of-pocket cap, all subsequent services will be exempt from cost sharing. Patients in that circumstance have no incentive to use services prudently. To manage that trade-off, many private health plans charge a daily copayment for hospital stays (subject to a limit) instead of collecting coinsurance. (Medicare also charges a daily copayment for hospital care, but only for extremely long stays.)

Catastrophic Caps. Most private insurance plans include a catastrophic cap that limits enrollees' out-of-pocket costs; Medicare Parts A and B have no catastrophic cap on cost sharing. Thus, without other changes to Medicare's cost-sharing rules, establishing a catastrophic cap would increase Medicare spending—by requiring the program to pay the entire cost of care above a cap and possibly by increasing the amount of care enrollees sought that exceeded the cap because they would no longer face costs for additional care. Generally, a higher cap would produce a smaller increase in federal spending.

For enrollees in fee-for-service Medicare who have supplemental coverage, adding a catastrophic cap to Medicare would reduce the costs paid by their supplemental policies, resulting in lower premiums for those policies but little change in enrollees' financial risk. For enrollees without supplemental coverage, establishing a cap would reduce financial risk and decrease out-of-pocket costs once their spending exceeded the cap. Imposing modest cost sharing above the catastrophic cap (as in Part D) could preserve some incentive for enrollees who exceeded the cap to use medical care judiciously (although supplemental coverage of that additional cost sharing would eliminate that incentive).

Supplemental Coverage of Medicare's Cost Sharing. About 20 percent of enrollees in fee-for-service Medicare purchase medigap policies, and about 40 percent have retiree coverage through a current or former employer. By reducing or eliminating enrollees' cost-sharing obligations, those policies can mute the incentives for prudent use of medical care that cost sharing is designed to generate. Lawmakers could impose three types of restrictions

on supplemental coverage of Medicare's cost-sharing obligations:

- Supplemental policies could be barred from paying for care until an enrollee's out-of-pocket spending reached a specified amount, thus prohibiting medigap plans from offering first-dollar coverage. That limit could be set to match Medicare's deductibles, which would force all enrollees with medigap plans to pay for costs out of pocket until they reached those deductible amounts.
- The percentage or dollar amount of cost sharing above the deductible that medigap plans pay could be limited. Such limits could allow for a catastrophic cap—above which a medigap policy could cover all cost sharing—to reduce enrollees' financial risk. Both that and the previous restriction could be applied to retiree coverage as well as to medigap plans, but regulations on retiree coverage would be more complex to administer than those on medigap insurance.
- A surcharge could be imposed on enrollees who buy medigap policies with first-dollar coverage. (Retiree policies generally do not provide first-dollar coverage.) That surcharge, which could be a flat fee or a percentage of the policy's premium, could be designed to reflect the effect of such coverage on Medicare's costs. To the extent that enrollees continued to buy first-dollar policies, however, total spending on health care would be higher than it would be if such policies were prohibited.

Grandfathering. Another design question for policy-makers is whether changes to the rules for cost sharing and supplemental insurance should apply to all Medicare enrollees. One rationale for grandfathering medigap policyholders is that changing the terms of medigap policies already purchased could be considered unfair or unduly burdensome. Medicare enrollees who do not buy medigap insurance when they turn 65 may be charged much higher premiums for such insurance if they delay the purchase until they develop health problems. Thus, many Medicare enrollees pay medigap premiums for years to ensure access to the financial protection of supplemental insurance if their health deteriorates. In the near term, however, the effects on Medicare spending would be smaller if current enrollees were exempt from changes to cost sharing or restrictions on medigap plans,

and operating several sets of rules would add to the program's administrative complexity.

Specific Alternatives and Estimates

CBO examined four ways to reduce federal spending on Medicare by modifying its cost-sharing provisions for Part A and Part B services. (Prescription drug coverage under Part D would not change.) The alternatives would apply to all enrollees, with no grandfathering.

The first alternative would seek to simplify Medicare's current mix of cost-sharing requirements by replacing them with a single annual deductible of \$750 that would cover most Part A services and all Part B services, a uniform coinsurance rate of 20 percent for all spending above the deductible on those services, and an annual out-of-pocket cap of \$7,500. The only exception to those rules would be for inpatient hospital services, for which beneficiaries would be charged a copayment of \$250 per day—for up to five days for each hospital spell—instead of the current combination of deductibles and copayments. Medicare would cover all costs for inpatient care after the first five days of each spell. The inpatient hospital copayments would not count toward the combined deductible, but the cost of hospital copayments and all coinsurance would count toward a beneficiary's annual spending cap. CBO estimates that if those changes took effect in January 2020 and if the various thresholds were indexed to increase in later years at the same rate as average fee-for-service Medicare costs per enrollee, this approach would reduce federal outlays by \$18 billion between 2020 and 2026.

The second alternative would replace Medicare's current cost sharing with a single annual deductible of \$750 for all Part A and Part B services, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses), and an annual out-of-pocket cap of \$7,500. This benefit design is the same as the design in the first alternative except that hospital inpatient spending is subject to the 20 percent uniform coinsurance rather than daily inpatient copayments. CBO estimates that if those changes took effect in January 2020 and if the amounts of the various thresholds were indexed as specified in the first alternative, this approach would reduce federal outlays by \$19 billion between 2020 and 2026. Estimated savings are greater for this alternative than for the first alternative because Medicare would cover less of the cost for hospital inpatient spending.

The third alternative would leave Medicare's cost-sharing rules unchanged and would not affect employment-based supplemental coverage but would restrict current and future medigap policies. Specifically, it would bar those policies from paying any of the first \$750 of an enrollee's cost-sharing obligations for calendar year 2020 and would limit their coverage to 50 percent of the next \$6,750 of an enrollee's cost sharing. (Medigap policies would cover all further cost sharing, so policyholders would not pay more than \$4,125 in cost sharing in 2020.) CBO estimates that if this option took effect in January 2020 and if the various dollar thresholds were indexed as specified in the first alternative, federal outlays would be reduced by \$45 billion between 2020 and 2026.

The fourth alternative combines the changes from the second and third alternatives. All medigap plans would be prohibited from covering any of the new \$750 combined deductible for Part A and Part B services, and in 2020, the annual cap on an enrollee's out-of-pocket obligations (including payments by supplemental plans on an enrollee's behalf) would be \$7,500. For spending that occurred after the deductible was met but before the cap was reached, medigap policyholders would face a uniform coinsurance rate of 10 percent for all services, whereas Medicare enrollees without supplemental coverage would face a uniform coinsurance rate of 20 percent for all services. In 2020, those provisions would limit medigap enrollees' out-of-pocket spending (excluding medigap premiums) to \$4,125; Medicare enrollees without supplemental coverage would pay no more than \$7,500 out of pocket. If, like the other alternatives, this combined version took effect in January 2020 and if the various thresholds were indexed to the growth of per-enrollee Medicare costs thereafter, CBO estimates that federal outlays would be \$66 billion lower than under current law from 2020 to 2026. Those savings would exceed the sum of the savings from the second and third alternatives because the changes to the cost-sharing rules for Medicare and the restrictions on medigap policies interact, increasing medigap enrollees' exposure to cost sharing. In CBO's estimation, this alternative would further reduce their use of care and thus lower the federal government's costs.

The budgetary effects of changing Medicare's cost-sharing rules would depend to a large extent on the way each alternative was structured. To illustrate that variability, CBO estimated the effects on federal spending of making several types of changes to the deductible and the catastrophic cap in 2020, the first year in which the

alternatives would take effect. CBO examined modifications of the second alternative, which would establish uniform cost sharing for Medicare. Raising the deductible by \$100 (from \$750 to \$850) while keeping the catastrophic cap at \$7,500 would increase CBO's estimate of federal savings for 2020 through 2026 from about \$19 billion to \$35 billion. Raising the catastrophic cap by \$500 (from \$7,500 to \$8,000) while keeping the deductible at \$750 would increase the estimate to \$41 billion. Conversely, lowering the deductible by \$100 (from \$750 to \$650) while keeping the catastrophic cap at \$7,500 would reduce CBO's estimate of federal savings to \$1 billion. Reducing the catastrophic cap by \$500 (from \$7,500 to \$7,000) while keeping the deductible at \$750 would eliminate all savings and increase federal spending to about \$5 billion over the period.

Estimates of savings in these alternatives are lower than those that CBO has published in past versions of this volume. In 2014, for example, CBO estimated that changing Medicare's cost-sharing rules would save \$54 billion over 10 years and that changing medigap rules would save \$53 billion.⁸ Those differences arise for several reasons. First, because CBO now estimates that more time would be needed to implement such policies, the savings over the next 10 years for those alternatives would be smaller. Second, CBO made technical improvements in modeling cost-sharing liabilities for Medicare's beneficiaries that reduced the savings that could be achieved from changing Medicare cost-sharing rules. Third, some of MACRA's provisions now prohibit new Medicare beneficiaries from purchasing medigap plans to cover the Part B deductible; those provisions reduced the savings that could be achieved from making additional changes to the medigap rules.

Other Considerations

Substantial changes to the cost-sharing structure of fee-for-service Medicare and the coverage provided by medigap plans would not only reduce costs to the federal government but also would affect Medicare enrollees, other types of supplemental insurance, and administration of the Medicare program.

Effects on Enrollees. The cost-sharing and medigap changes included in this option would affect total health

care spending for Medicare enrollees (by changing the amount of health care services they use) and the way in which that spending was divided between the federal government and enrollees and among enrollees themselves. The restrictions on medigap coverage also would affect the premiums enrollees' would pay as well as how much of enrollees' cost-sharing obligations the plans would cover.

Under current law, CBO estimates, Medicare's costs for the average fee-for-service enrollee will be about \$13,000 in 2020 and the average enrollee will have about \$2,400 in cost-sharing obligations, which may be paid by the enrollee directly out of pocket, by supplemental insurance, or through some combination of the two.⁹ Those averages mask substantial variation in individuals' cost-sharing obligations, stemming from differences in health and the use of medical care. For example, in CBO's projections, only one-quarter of enrollees have cost-sharing obligations of more than \$2,600 in 2020; their obligations average about \$7,100, compared with an average of about \$750 for the other three-quarters of fee-for-service enrollees.

Under the fourth alternative, which combines changes in the Medicare benefit with changes in coverage by medigap policies, CBO estimates that Medicare's costs for the average fee-for-service enrollee would be \$12,800 in 2020, or \$200 below its estimate under current law. However, under the alternative's specific cost-sharing changes and medigap restrictions, enrollees' average cost-sharing obligations would not change because the higher fraction of total health care costs they paid as cost sharing would be offset, on average, by savings from the resulting reduction in their use of health care. (Various combinations of deductibles, coinsurance, catastrophic caps, and medigap restrictions could increase or decrease enrollees' average cost-sharing obligations.) Even so, that alternative would alter the distribution of cost-sharing obligations among enrollees: One-quarter would face cost-sharing obligations of more than \$3,200 in 2020; their obligations would average about \$6,100. The obligations of the other three-quarters would average about \$1,100.

8. See Congressional Budget Office, *Options for Reducing the Deficit: 2015 to 2024* (November 2014), p. 49, www.cbo.gov/publication/49638.

9. That estimate of the average cost per enrollee is based on gross outlays by the Medicare program, so it excludes enrollees' cost-sharing obligations and does not account for offsetting premium payments. The average net per-enrollee cost to Medicare, which accounts for premium payments, would be lower than that gross measure.

(Roughly 10 percent of enrollees would reach the \$7,500 cap on cost-sharing obligations.) Those changes reflect a relatively large average decrease in obligations for enrollees with serious illnesses that require extensive care or extended hospitalization and a relatively small average increase in obligations for healthier enrollees who use less care.

For the first alternative, which would add a daily inpatient copayment to a combined deductible and a catastrophic cap, CBO estimates that Medicare's costs for the average fee-for-service enrollee in 2020 would be \$12,900, or \$100 less than its current-law estimate. Cost-sharing obligations would increase for most beneficiaries, but those with inpatient hospital stays would, on average, pay less of their overall costs and consume slightly more inpatient care. Average cost sharing for beneficiaries with no inpatient hospital stays would rise from the current-law amount of \$1,200 to \$1,500 by 2020. For beneficiaries with any inpatient hospital stays, average cost sharing would decrease from \$7,300 under current law to \$5,200. Reductions in financial obligations would be particularly large for beneficiaries with hospital stays of more than 60 days; their average cost sharing would decrease from \$23,000 under current law to \$7,300 under the first alternative.

The medigap restrictions under the four alternatives would increase the average amount of cost sharing a medigap policyholder paid out of pocket and would decrease, to roughly the same extent, the average amount a medigap plan paid on an enrollee's behalf. Because medigap insurers must compete for business and are subject to state insurance regulations, they would most likely reduce premiums to reflect that reduction in their costs. Overall, most medigap policyholders would have lower health care expenses under this option because their medigap premiums would decrease more than their out-of-pocket payments would increase (mainly because most of a medigap plan's liabilities are generated by a small share of policyholders). However, under this option, in any given year, some enrollees would face higher combined costs for medigap premiums and out-of-pocket payments.

Beyond altering how and how much Medicare enrollees paid for care, the changes included in the alternatives CBO considered would have other effects on enrollees. The changes would give Medicare beneficiaries stronger incentives to use medical services more prudently.

However, as noted above, studies have shown that people who are subject to higher cost sharing reduce their use of effective health care and ineffective health care. To avoid reductions in effective care, enrollees' cost sharing could be selectively reduced or eliminated for high-value services—an approach called value-based insurance design. In practice, defining such services can be challenging, and the use of value-based design in private insurance plans has been limited. Furthermore, restricting medigap coverage would prevent Medicare enrollees from buying policies with the low levels of cost sharing that they have shown a preference for in the past. Although most medigap enrollees would have lower overall health care costs under this option, some enrollees would prefer the financial certainty and simplicity of a medigap plan that covered all of their cost-sharing obligations. Those enrollees would probably object to any legislation or regulation that denied them access to full supplemental coverage for their cost sharing.

Effects on Supplemental Insurance. Altering Medicare's cost-sharing structure and limiting supplemental coverage would probably lead to changes in medigap premiums and in enrollees' demand for medigap policies. If those plans were barred from paying the first \$750 of an enrollee's cost-sharing liabilities and then from fully covering all cost sharing up to a catastrophic cap—as in the second and third alternatives—the costs borne by medigap plans would decrease; as a result, so would premiums for those plans. On the one hand, lower premiums would make medigap policies more appealing. On the other hand, the restrictions on medigap benefits would reduce the value of such policies to enrollees.

A key reason that people buy medigap coverage is for protection against high out-of-pocket costs. Adding a catastrophic cap to Medicare would reduce financial risk for enrollees in the traditional fee-for-service program who lack supplemental coverage. Therefore, adding a catastrophic cap to Medicare and restricting the coverage provided by medigap plans would probably cause some enrollees, particularly healthier beneficiaries, to forgo purchasing supplemental insurance. Those beneficiaries would tend to consume less health care, and thus to have lower cost sharing, than sicker enrollees would. A decrease in medigap enrollment by relatively healthy people would increase average per-enrollee costs for medigap plans, leading to higher policy premiums (if everything else was equal).

Altering the cost-sharing structure of Medicare, as in the first, second, and fourth alternatives, also would affect costs for employers that provide supplemental coverage for retirees. A unified deductible would tend to increase costs for employers, but the introduction of a catastrophic cap would decrease their costs, particularly for retirees with very high costs for health care. The net effect on an employer's costs would depend on the extent of the coverage and on the health of the retirees. Additionally, the creation of a catastrophic cap for Medicare might cause some employers to scale back or discontinue supplemental coverage for current or future retirees, on the theory that their retirees would be sufficiently protected from financial risk by Medicare alone.

Changing the structure of Medicare cost sharing or supplemental plans also could affect enrollment in Medicare Advantage plans, which currently may provide first-dollar coverage and also must set out-of-pocket spending limits. Policy changes that prohibited medigap plans from providing first-dollar coverage would tend to make Medicare Advantage plans more attractive to some beneficiaries and increase Medicare Advantage enrollment. Setting catastrophic limits on spending, however, would tend to make Medicare Advantage less attractive and decrease Medicare Advantage enrollment. The net effects of changes in enrollment in Medicare Advantage plans on federal spending are unclear and would depend on which plans were affected.

CBO estimates that implementing a unified deductible and catastrophic cap as described above would decrease federal spending on Medicaid by a small amount between 2020 and 2026. Those provisions would have two largely offsetting effects. First, the introduction of a catastrophic cap would shift costs from Medicaid to Medicare for some enrollees with high medical expenses. Second, the unified deductible and uniform coinsurance rate would shift some costs from Medicare to Medicaid for enrollees with lower medical expenses. Under the alternatives examined above, CBO estimates, the net result of those offsetting changes would be a small overall decrease in federal spending on Medicaid.

Because the effects of changes in cost sharing would vary from one state to another, estimates of their implications for federal spending on Medicaid are highly uncertain. Many states cap cost-sharing payments to providers of Medicare services to keep the total amounts that providers receive at or below Medicaid's payment rates for the same services. Because the amounts that many state Medicaid programs pay providers are below those established for Medicare, some states end up covering only a small portion—if any—of Medicare beneficiaries' cost-sharing obligations. That constraint reduces the effects on Medicaid spending that would otherwise arise from a change in Medicare's cost sharing.¹⁰ CBO accounts for the average effects of state-level variation in Medicaid payment policies, but the agency's analysis does not incorporate detailed estimates of different states' cost-sharing limits.

Administrative Effects. Altering the cost-sharing rules for Medicare and medigap plans would raise myriad administrative issues. Health care providers might not know how much to collect from a Medicare enrollee during an office visit because it might be difficult to determine whether the enrollee's cost-sharing payments had reached the combined deductible or exceeded the new catastrophic cap. Moreover, administering the new cost-sharing structure would require coordination that currently does not exist among the organizations that review and process Medicare claims, insurers that provide supplemental coverage, and Medicare. In addition, changes to Medicare's cost-sharing structure could affect the total amount of bad debt from unpaid cost-sharing obligations owed to service providers. At the same time, lower enrollment in supplemental plans and reduced use of medical care by some enrollees with supplemental coverage would decrease the amount of billing paperwork for some insurers.

10. Some of those unpaid cost-sharing obligations ultimately are covered by Medicare's payments to providers for bad debt, which are also reflected in the savings estimate.

Health—Option 8

Function 570

Increase Premiums for Parts B and D of Medicare

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
Increase basic premiums	0	-5	-12	-20	-30	-42	-47	-49	-54	-59		-67	-318
Freeze income thresholds for income-related premiums	0	0	0	*	-1	-2	-3	-4	-5	-7		-1	-22
Both alternatives above ^a	0	-5	-12	-20	-31	-43	-48	-52	-57	-63		-68	-331

The first and third alternatives would take effect in January 2018; the second would take effect in January 2020.

* = between -\$500 million and zero.

a. If both alternatives were enacted together, the total effect would be less than the sum of the effects of each alternative because of interactions between them.

All enrollees in Medicare’s Part B (which covers physicians’ and other outpatient services) or Part D (the outpatient prescription drug benefit, which is delivered through private-sector companies) are charged basic premiums for that coverage. Under current law, the Part B premium is \$121.80 per month, or about 25 percent of the average costs per enrollee over age 65. (Premiums can be higher or lower for enrollees who receive Part B benefits through Medicare Advantage, the private insurance option for Medicare beneficiaries.) Currently, the average monthly premium for a standard Part D plan is \$34.10, which covers 25.5 percent of the average per capita costs of the basic benefit. Low-income enrollees and those with few assets receive subsidies to cover some or all of their premiums.

Enrollees with relatively high income pay an income-related premium (IRP) at an amount that is determined on the basis of the beneficiary’s modified adjusted gross income (adjusted gross income plus tax-exempt interest). In 2016, the combined monthly premiums range from \$170.50 to \$389.80 for Part B and from \$46.80 to \$107.00 for Part D. The amounts are set so that the basic premium and the IRP together will cover between 35 percent and 80 percent of an enrollee’s costs.

Under current law, the income thresholds for the higher premiums for Parts B and D are divided among four brackets, which are frozen through 2019. The lowest bracket is set at \$85,000 for single beneficiaries or \$170,000 for married couples filing joint tax returns. The thresholds will increase by about 2 percent in 2020 and

will be indexed after that for general price inflation. (The Medicare Access and CHIP Reauthorization Act of 2015 lowered certain income thresholds for the IRPs, so more beneficiaries are affected by them. That law also changed the thresholds’ rate of increase starting in 2020.)

The Congressional Budget Office currently projects that the share of enrollees subject to income-related premiums will increase from 8 percent in 2016 to 9 percent in 2019, as income growth pushes more enrollees’ income above the thresholds. That share is projected to rise gradually from 9 percent in 2020 to 10 percent in 2026 as growth in income for affected enrollees slightly outpaces indexing of the thresholds.

This option would raise the premiums for Part B and Part D under one of three alternative approaches:

- A first alternative would increase basic premiums from 25 percent of Part B costs per enrollee and 25.5 percent of Part D costs per enrollee to 35 percent of each program’s costs. That increase would take effect over five years, beginning in January 2018. For Part B, the share of costs per enrollee covered by the basic premium would rise by 2 percentage points each year through 2022 and then remain at 35 percent. For Part D, that share would increase by 1.5 percentage points in the first year and by 2 percentage points each year from 2019 through 2022 and then remain at 35 percent. By 2026, basic premiums would reach \$176 per month for Part B and \$62 per month (the average premium for a standard plan) for Part D.

Those changes would not affect the total premiums of enrollees paying the IRP. In all, this alternative would decrease net Medicare spending (total Medicare spending minus beneficiaries' premiums and other offsetting receipts) by \$318 billion between 2018 and 2026, CBO estimates.

- A second alternative, which would take effect in January 2020, would add seven years to the current freeze on the income thresholds for determining the IRPs, extending that freeze through 2026. CBO estimates that, as a result, net Medicare spending would be reduced by \$22 billion between 2020 and 2026, and the share of enrollees paying an IRP would rise from 9 percent in 2019 to 13 percent in 2026.
- A third alternative would combine the first two, starting in January 2018 and continuing in January 2020. It would increase basic premiums for Parts B and D to 35 percent of costs per enrollee and freeze the income thresholds for income-related premiums. Those changes would reduce net Medicare spending by \$331 billion through 2026, CBO estimates. (That amount is slightly less than the sum of the savings from the other two alternatives separately because of interactions between the two policies.) This alternative would raise premiums for most enrollees and would increase to 13 percent the share of enrollees paying an IRP in 2026.

One rationale in favor of this option is that it would reduce the pressure on the working-age population to pay

for benefits being received by older groups. (Because of demographic changes, the number of Medicare beneficiaries per worker has been increasing substantially as the baby-boom generation retires, thus increasing that pressure.) Another rationale is that by absorbing a larger share of enrollees' income, higher Part D premiums would increase competitive pressure in the market for prescription drug plans, thus giving enrollees a stronger incentive to choose less expensive plans. Such pressure could cause prescription drug plans to reduce their bids slightly, generally leading to lower premiums for those plans along with reducing the federal government's costs and lowering the total cost of drugs for Medicare beneficiaries. Similar effects on costs for hospital care or outpatient services could accrue if enrollees sought out lower-cost Medicare Advantage plans, although such effects are not included in the estimates shown here.

A disadvantage of this option is that it would reduce many enrollees' disposable income by increasing basic premiums and freezing all of the income thresholds. A growing share of enrollees would become subject to the IRP in later years because people's nominal income tends to rise over time (even though their purchasing power might not increase). Although the disposable income of low-income enrollees whose Medicare premiums are paid by Medicaid would not decrease, another disadvantage of this option is that state Medicaid programs would face higher costs for some enrollees, such as certain low-income Part B enrollees who have limited assets.

Health—Option 9

Function 570

Raise the Age of Eligibility for Medicare to 67

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
Medicare	0	0	0	-1.7	-3.4	-5.4	-7.4	-9.7	-12.3	-15.2	-5.1	-55.2	
Social Security ^a	0	0	0	-0.1	-0.3	-0.5	-0.7	-0.8	-1.0	-1.2	-0.4	-4.6	
Medicaid and subsidies through health insurance marketplaces	<u>0</u>	<u>0</u>	<u>0</u>	<u>1.0</u>	<u>2.2</u>	<u>3.6</u>	<u>5.1</u>	<u>6.8</u>	<u>8.7</u>	<u>10.4</u>	<u>3.2</u>	<u>37.8</u>	
Total	0	0	0	-0.8	-1.5	-2.3	-3.0	-3.7	-4.7	-6.0	-2.3	-22.0	
Change in Revenues ^b	0	0	0	-0.1	-0.2	-0.3	-0.5	-0.7	-0.8	-1.0	-0.3	-3.5	
Decrease in the Deficit	0	0	0	-0.7	-1.3	-2.0	-2.5	-3.1	-3.8	-5.0	-2.1	-18.4	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2020.

a. Estimates include the effects on Social Security outlays, which are classified as off-budget.

b. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

Under current law, the usual age of eligibility to receive Medicare benefits is 65, although younger people may enroll after they have been eligible for Social Security disability benefits for two years. The average period that people are covered under Medicare has increased significantly since the program’s creation because of a rise in life expectancy. In 1965, when Medicare was established, a 65-year-old man could expect to live another 12.9 years, on average, and a 65-year-old woman another 16.3 years. Since then, life expectancy for 65-year-olds has risen by more than four years—to 18.1 years for men and 20.6 years for women. That trend, which results in higher program costs, will almost certainly continue.

This option would raise the age of eligibility for Medicare by two months each year, starting in 2020 (people born in 1955 will turn 65 that year), until it reaches 67 for people born in 1966 (who would become eligible for Medicare benefits in 2033). It would remain at 67 thereafter. Social Security’s full retirement age, or FRA (the age at which workers become eligible for full retirement benefits), has already been increased from 65 to 66 and is scheduled to rise further during the coming decade, reaching 67 for people born in 1960; they will turn 67 in 2027. (People can claim reduced retirement benefits—but not Medicare benefits—starting at age 62, which is the most common age to do so.) Under this option,

Medicare’s age of eligibility would be below the FRA until 2033.

Implementing this option would reduce federal budget deficits between 2020 and 2026 by \$18 billion, according to estimates by the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT). That figure results from a projection of a \$22 billion decrease in outlays and a \$4 billion decrease in revenues over that period. The outlay reduction would stem from decreases in Medicare and Social Security spending, partially offset by increases in outlays for Medicaid and for federal subsidies for insurance purchased through the marketplaces established under the Affordable Care Act.

This option would lower Medicare outlays by reducing the number of people enrolled at any given time from that under current law. In calendar year 2020, when this option would take effect, about 3.4 million people will become eligible for Medicare coverage on the basis of their age, CBO estimates. Under this option, that group would see its benefits delayed by two months. By calendar year 2026, the benefits of 3.7 million people would be delayed by 14 months. Total spending on Medicare as a result would be \$55 billion lower between 2020 and 2026 than under current law.

CBO anticipates that most people who become eligible for Medicare after age 65 under this option would continue their existing coverage or switch to another form of coverage between age 65 and the new eligibility age. CBO also expects that the number of people without health insurance would increase slightly. CBO estimates that in 2026, about 45 percent of the 3.7 million people affected by this option would obtain insurance from their own or a spouse's employer or former employer, about 25 percent would purchase insurance through the nongroup market (insurance purchased directly either in the health insurance marketplaces or from insurers outside the marketplaces), about 25 percent would receive coverage through Medicaid, and about 5 percent would become uninsured. To develop those estimates, CBO examined data on the patterns of health insurance coverage among people a few years younger than Medicare's current eligibility age. The figures were then adjusted to account for changes in sources of health insurance and in participation in the labor force as people age.

The option also would reduce outlays for Social Security retirement benefits by an estimated \$5 billion over the 2020–2026 period because raising the eligibility age for Medicare would induce some people to delay claiming retirement benefits.

In CBO's estimation, the reduction in Social Security spending would be fairly small because raising Medicare's eligibility age would have little effect on people's decisions about when to claim retirement benefits. Historical evidence indicates that people are more likely to wait until reaching the FRA to claim retirement benefits than they are to claim such benefits when they reach the age of eligibility for Medicare.¹

CBO also expects future decisions about claiming retirement benefits to be less linked to Medicare's eligibility age than has historically been the case because of greater access to health insurance through Medicaid and through the nongroup market. Increased access through Medicaid stems from a provision of the Affordable Care Act that permits, but does not require, states to expand eligibility to include low-income adults under age 65. In the nongroup market, that increased access stems from

subsidies for plans purchased through the marketplaces and from the provision that prevents insurers from denying coverage or varying premiums on the basis of an enrollee's health status. (Insurers are, however, permitted to vary premiums by age, tobacco use, and geographic location.) As a result, it is now easier for some people who give up employment-based insurance upon retirement to qualify for Medicaid or to purchase health insurance in the nongroup market, in some cases with a federal subsidy. Because the federal government subsidizes those sources of insurance, the savings for Medicare and Social Security under the option would be substantially offset by increases in federal spending and by decreases in revenues.

Under this option, federal outlays for Medicaid would increase for two groups of people between the age of 65 and the new Medicare eligibility age: dual-eligible beneficiaries (Medicare enrollees who also are eligible for full benefits under Medicaid) and enrollees who would be Medicaid beneficiaries before turning 65 but who, under current law, would lose that eligibility once they qualified for Medicare at age 65. For this option, CBO assumed that the age limit for Medicaid would increase in tandem with Medicare's eligibility age. Hence, this option would cause Medicaid to remain the primary source of coverage for members of both groups until they reached the new eligibility age for Medicare. As a result, federal outlays for Medicaid between 2020 and 2026 would be \$20 billion higher under this option, CBO projects.

This option also would increase outlays for subsidies for health insurance coverage purchased through the marketplaces because some people, instead of obtaining Medicare coverage at age 65, would continue or newly obtain subsidized health insurance through the marketplaces when they were between age 65 and the new eligibility age for Medicare. In addition, the resulting increase in the average age of people purchasing health insurance coverage through the nongroup market would slightly increase premiums for all people enrolled in that market, which would in turn increase spending on subsidies for people purchasing coverage through the marketplaces. CBO and JCT estimate that this option would increase outlays for subsidies for coverage through the marketplaces between 2020 and 2026 by \$18 billion. (Those subsidies fall into two categories: subsidies to cover a portion of participants' health insurance premiums and subsidies to reduce the out-of-pocket payments required under insurance policies.)

1. Joyce Manchester and Jae Song, "What Can We Learn From Analyzing Historical Data on Social Security Entitlements?" *Social Security Bulletin*, vol. 71, no. 4 (November 2011), pp. 1–13, <http://go.usa.gov/xku5d>.

Under this option, revenues would decline because a portion of the increase in marketplace subsidies for health insurance premiums would be provided in the form of reductions in recipients' tax payments. (The subsidies for health insurance premiums are structured as refundable tax credits; the portions of such credits that exceed taxpayers' other income tax liabilities are classified as outlays, whereas the portions that reduce tax payments are classified as reductions in revenues.) Revenues also would decline because of a small net increase in employers' spending on nontaxable health insurance benefits, which in turn would reduce collections of income and payroll taxes. This option would reduce revenues between 2020 and 2026 by \$4 billion, CBO and JCT estimate.

All told, CBO estimates, by 2046, spending on Medicare (net of offsetting receipts) would be about 2 percent less under this option than it would be under current law, amounting to 5.6 percent of gross domestic product rather than 5.7 percent. On the basis of its estimates for 2020 through 2026, CBO projects that roughly three-fifths of the long-term savings from Medicare under this option would be offset by changes in federal outlays for Social Security, Medicaid, and subsidies for coverage through the marketplaces as well as by reductions in revenues.

An argument in favor of this option is that as life expectancy increases, the increase in the eligibility age for Medicare would help the program return to focus on the population it originally served—people in their last years of life—and support the services most needed by that group. CBO projects that by 2046, life expectancy for 65-year-olds will be 20.4 years for men and 22.8 years for women, compared with 12.9 years and 16.3 years in 1965. There is some evidence that, for many people, the increase in life expectancy has been accompanied by better health into old age.² Those findings suggest that raising Medicare's age of eligibility would not diminish its

ability to provide health benefits to people near the end of life.

An argument against this option is that it would shift costs that are now paid by Medicare to individual people, to employers that offer health insurance to their retirees, and to other government health insurance programs. About 300,000 more people would be uninsured under this option in 2026, CBO estimates, and they thus might receive lower quality care or none at all; others would end up with a different source of insurance and might pay more for care than they would have as Medicare beneficiaries. Employers' costs of providing group plans for their retirees would increase because those plans would remain the primary source of coverage until the retirees reached the new eligibility age for Medicare. In addition, states' spending on Medicaid and the federal costs of subsidies for health insurance purchased through the marketplaces would increase.

This option's net effect on national health care spending is unclear because of the potential difference in costs borne by different payers to provide coverage for people between age 65 and the new eligibility age for Medicare. One study showed that spending on some procedures declined when people switched coverage at age 65 from private health insurance to Medicare; the decline was driven mostly by price differences between private health insurance and Medicare.³

2. See for example, Michael Chernew and others, *Understanding the Improvement in Disability Free Life Expectancy in the U.S. Elderly Population*, Working Paper 22306 (National Bureau of Economic Research, June 2016), www.nber.org/papers/w22306.

3. Jacob Wallace and Zirui Song, "Traditional Medicare Versus Private Insurance: How Spending, Volume, and Price Change at Age Sixty-Five," *Health Affairs*, vol. 35, no. 5 (May 2016), pp. 864–872, <http://dx.doi.org/10.1377/hlthaff.2015.1195>.

RELATED OPTION: Mandatory Spending, Option 20

RELATED CBO PUBLICATION: *Raising the Ages of Eligibility for Medicare and Social Security* (January 2012), www.cbo.gov/publication/42683

Health—Option 10

Function 570

Reduce Medicare’s Coverage of Bad Debt

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays													
Reduce the percentage of allowable bad debt to 45 percent	0	-0.3	-0.8	-1.4	-1.8	-2.0	-2.1	-2.1	-2.3	-2.5		-4.3	-15.3
Reduce the percentage of allowable bad debt to 25 percent	0	-0.5	-1.6	-2.8	-3.5	-4.0	-4.1	-4.2	-4.7	-5.0		-8.5	-30.6

This option would take effect in October 2017.

When hospitals and other providers of health care are unable to collect out-of-pocket payments from their patients, those uncollected funds are called bad debt. Historically, Medicare has paid some of the bad debt owed by its beneficiaries on the grounds that doing so prevents those costs from being shifted to others (that is, to private insurance plans and people who are not Medicare beneficiaries). Bad debt that is partly paid for by Medicare is called allowable bad debt. In the case of dual-eligible beneficiaries—Medicare beneficiaries who also are eligible for Medicaid benefits—allowable bad debt also includes any out-of-pocket payments that remain unpaid by Medicaid. Under current law, Medicare reimburses eligible facilities—hospitals, skilled nursing facilities, various types of health centers, and facilities treating end-stage renal disease—for 65 percent of allowable bad debt. The Congressional Budget Office estimates that Medicare spending on bad debt was \$3.3 billion in 2015.

This option would reduce federal spending on Medicare by decreasing the share of allowable bad debt that the program reimburses to eligible facilities. The reductions would start to take effect in fiscal year 2018, and they would be phased in evenly over the course of three years.

CBO examined two alternatives. The first would reduce the percentage of allowable bad debt that Medicare reimburses participating facilities from 65 percent to 45 percent by 2020. That approach would save \$15 billion between 2018 and 2026, CBO estimates. The second would reduce the percentage from 65 percent to 25 percent, saving \$31 billion.

In both cases, CBO’s assessment was that providers’ responses to the changes would have negligible effects on the federal budget. If reducing federal payments for bad debt led hospitals to engage in cost shifting—that is, requiring private insurers to pay higher rates to make up for lost Medicare revenues—the cost of private insurance plans would rise, and so would the cost of federal subsidies for those plans. But research has shown that providers’ ability to engage in cost shifting is limited and depends on such factors as local market power and contracting arrangements with insurers. Furthermore, some research has demonstrated that Medicare payment reductions have led to *lower* private payment rates.¹

An argument for this option is that lowering Medicare’s reimbursement of bad debt would increase facilities’ incentive to collect funds from Medicare patients. Reducing coverage of bad debt could also encourage facilities to discuss treatment costs with Medicare patients ahead of time, examine their alternatives more carefully, and set up manageable payment plans as needed. In addition, Medicare currently reimburses facilities for allowable bad debt but does not reimburse doctors or other noninstitutional

1. See, for example, Chapin White and Vivian Yaling Wu, “How Do Hospitals Cope With Sustained Slow Growth in Medicare Prices?” *Health Services Research*, vol. 49, no. 1 (February 2014), pp. 11–31, <http://dx.doi.org/10.1111/1475-6773.12101>; Chapin White, “Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates,” *Health Affairs*, vol. 32, no. 5 (May 2013), pp. 935–943, <http://dx.doi.org/10.1377/hlthaff.2012.0332>; and Austin B. Frakt, “How Much Do Hospitals Cost Shift? A Review of the Evidence,” *Milbank Quarterly*, vol. 89, no. 1 (March 2011), pp. 90–130, <http://dx.doi.org/10.1111/j.1468-0009.2011.00621.x>.

providers, so this option would reduce that disparity. Also, the reimbursement of bad debt was originally intended to reduce the incentive for cost shifting—but as this discussion just noted, the evidence for cost shifting is mixed, possibly meaning that the need for such reimbursement is smaller than originally thought.

An argument against this option is that facilities might have difficulty collecting additional payments from enrollees or other sources—especially in the case of dual-eligible beneficiaries and enrollees without other supplemental coverage, such as private medigap plans or coverage from former employers. (Currently, Medicaid programs are frequently not required to pay

all out-of-pocket expenses for dual-eligible enrollees. As a result, the out-of-pocket expenses for those enrollees constitute a large portion of bad debt.) The option would therefore lead to an effective cut in Medicare's payment rates, just as reductions to the updates to Medicare payments continue to take place over the next few years. Also, institutional providers might try to mitigate the impact of this option by limiting their treatment of dual-eligible Medicare beneficiaries and for those without other supplemental coverage. The option could place additional financial pressure on institutional providers that treat a disproportionate share of those enrollees, potentially reducing their access to care or quality of care.

Health—Option 11

Function 570

Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Part D of Medicare for Low-Income Beneficiaries

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays	0	0	-7	-15	-18	-18	-19	-20	-22	-26	-40	-145

This option would take effect in January 2019.

Medicare Part D is a voluntary, federally subsidized prescription drug benefit program delivered to beneficiaries by private-sector plans. Federal subsidies for Part D drug benefits, net of the premiums paid by enrollees, totaled about \$63 billion in calendar year 2013. (Federal subsidies include payments to stand-alone prescription drug plans and Medicare Advantage plans; they exclude subsidies to employers for prescription drug coverage provided outside of Part D for retirees.) Private drug plans can limit their costs for providing benefits to their Part D enrollees by negotiating to receive rebates from manufacturers of brand-name drugs in return for charging enrollees smaller copayments for those drugs. The negotiation of rebate amounts is a business strategy for a Part D plan that is most effective when a few manufacturers' drugs are competing for market share in the treatment of a particular medical condition. The Congressional Budget Office estimates that in 2013, manufacturers' rebates paid to Part D plans amounted to about 18 percent of gross spending on all brand-name drugs under Part D.

Before Part D took effect in 2006, dual-eligible beneficiaries—Medicare enrollees who also were eligible for full benefits under Medicaid—received drug coverage through Medicaid. Under federal law, drug manufacturers that participate in Medicaid (which is a joint federal-and-state program) must pay a portion of their revenues to the federal and state governments through rebates. In 2010, those rebates increased from 15.1 percent to 23.1 percent of the average manufacturer price (AMP) for a drug. (The AMP is the amount, on average, that manufacturers receive for sales to retail pharmacies.) If a drug's price rises faster than overall inflation, the drug manufacturer pays a larger rebate. And those inflation-based rebates can be significant: In 2013, for example, the average statutory rebate under Medicaid, weighted by the dollar amount of drug purchases, was 63 percent of the AMP; about half of that came in the form of inflation-based rebates.

When Medicare Part D was established, dual-eligible beneficiaries were automatically enrolled in its Low-Income Subsidy (LIS) program, which typically covers premiums and most cost sharing required under the basic Part D benefit. LIS enrollees—most of whom are dual-eligible beneficiaries—accounted for about 30 percent of Part D enrollment in 2013, and their drug costs represented about 50 percent of total spending for Part D enrollees' drugs in that year. Currently, the rebates on drug sales to LIS enrollees and on those sold to other Part D enrollees are set through negotiations between the Part D plans and the drug manufacturers.

Starting in 2019, this option would require manufacturers to pay a rebate to the federal government for brand-name drugs sold to LIS enrollees. As under Medicaid, the rebate would be at least 23.1 percent of the drug's AMP plus an additional, inflation-based amount if warranted. In many cases, a manufacturer might already have negotiated discounts or rebates that applied to all Part D enrollees equally. In those instances, any difference between the negotiated amount and the amount of the total rebate owed by the manufacturer would be paid to the federal government. If, however, the average Part D rebate for the drug was already more than 23.1 percent of the AMP plus the inflation-based rebate, the federal government would receive no rebate. Participation in the program would be mandatory for manufacturers who wanted their drugs to be covered by Part B (Medical Insurance) and Part D of Medicare, by Medicaid, and by the Veterans Health Administration.

CBO estimates that this option would reduce federal spending by \$145 billion through 2026 because, on average, the rebates negotiated for brand-name drugs are smaller than the statutory discounts obtained by Medicaid. However, drug manufacturers would be expected to set higher "launch" prices for new drugs as a way to limit the effect of the new rebate, particularly for new drugs

that do not have close substitutes. Over time, that response would reduce the savings to Medicare from this option. Those higher prices also would affect other drug purchasers: Employment-based health insurance plans would probably negotiate larger rebates to offset a portion of the higher prices, but state Medicaid programs would pay more for new drugs, which in turn would increase federal spending.

In addition, this option could change manufacturers' incentives to offer Part D plans rebates for existing drugs—but the pressures on those rebates would push in both directions, so CBO concluded that the average rebates would not change appreciably. In general, manufacturers offer rebates in exchange for preferred coverage of their drugs in order to increase sales and market share. A key provision of the option is that the amount of a rebate that a manufacturer paid to a Part D plan would count toward the total rebate that manufacturer owed the federal government. On the one hand, that provision would make it less costly for manufacturers to increase their rebates as a way to boost sales to non-LIS enrollees. On the other hand, the higher required rebate for sales of drugs to LIS enrollees would reduce the benefit to manufacturers of increasing those sales. The net effects of the reductions—in both the costs and in the benefits of offering rebates—are unclear and would vary by drug. But the overall effects on rebates for existing drugs would probably be negligible, in CBO's estimation.

An argument in favor of this option is that the Part D benefit could provide the same amount of drugs to Medicare beneficiaries at a lower total cost, particularly for brand-name drugs with no close substitutes whose

prices are less subject to market competition. An argument against the option is that the lower revenues that manufacturers receive for drugs under Part D could cause them to reduce their investments in research and development.

The development of "breakthrough" drugs would be least affected by any decline in investments, CBO expects, because purchasers of those drugs tend to be willing to pay more for them. Manufacturers initially can set a higher price for a breakthrough drug, which can offset a portion of the new rebate without substantially affecting sales. Consequently, Medicare's savings under this option would be limited for new drugs because of their higher launch prices, and, eventually, the savings on existing brand-name drugs would dissipate as those drugs lost patent protection and were replaced by less expensive generic versions.

There is a precedent for requiring rebates: Before 2006, manufacturers were already paying rebates to Medicaid for drugs purchased by the dual-eligible population (who were then enrolled under Medicaid's drug benefit). However, the new rules also would apply to drugs purchased by LIS enrollees who were not dual-eligible beneficiaries, and therefore (all else being equal) the total required rebate would be larger than it was when dual-eligible beneficiaries received drug coverage through Medicaid. In addition, because of the 2010 increase in the rebate required for drugs sold under coverage by Medicaid, the reduction in manufacturers' incentives to invest in research and development would probably be greater under this option than under the earlier system.

RELATED CBO PUBLICATIONS: *Competition and the Cost of Medicare's Prescription Drug Program* (July 2014), www.cbo.gov/publication/45552; *Spending Patterns for Prescription Drugs Under Medicare Part D* (December 2011), www.cbo.gov/publication/42692

Health—Option 12

Functions 550, 570

Consolidate and Reduce Federal Payments for Graduate Medical Education at Teaching Hospitals

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays	0	-1.1	-1.6	-2.1	-2.8	-3.4	-4.1	-4.8	-5.4	-6.4	-7.6	-31.9

This option would take effect in October 2017.

Hospitals with teaching programs receive funds from Medicare and Medicaid for costs related to graduate medical education (GME). The Medicare payments cover two types of costs: those for direct graduate medical education (DGME) and those for indirect medical education (IME). DGME costs are for the compensation of medical residents and institutional overhead. IME costs are other teaching-related costs—for instance, the added demands placed on staff as a result of teaching activities and the greater number of tests and procedures ordered by residents as part of the learning and teaching process. As for the Medicaid payments, the federal government matches a portion of what state Medicaid programs pay for GME. The Congressional Budget Office estimates that total mandatory federal spending for hospital-based GME in 2016 was more than \$10 billion, of which roughly 90 percent was financed by Medicare and the remainder by Medicaid. Teaching hospitals also receive funding from other federal agencies—which is discretionary rather than mandatory spending—as well as funding from private sources.

Medicare’s DGME payments are based on three factors: a hospital’s costs per resident in 1984, indexed for subsequent inflation; the hospital’s number of residents, which is subject to a cap; and the share of total inpatient days at the hospital accounted for by Medicare beneficiaries. Medicare’s IME payments are calculated differently: For every increase of 0.1 in the ratio of full-time residents to the number of beds in a hospital, they rise by about 5.5 percent. (To increase that ratio by 0.1, a 100-bed hospital, for example, would have to add 10 full-time residents.)

Beginning in October 2017, this option would consolidate all mandatory federal spending for GME into a grant program for teaching hospitals. Total funds available for distribution in fiscal year 2018 would be a fixed amount equaling the sum of Medicare’s 2016 payments for DGME and IME and Medicaid’s 2016 payments for

GME. Total funding for the grant program would then grow with inflation as measured by the consumer price index for all urban consumers (CPI-U) minus 1 percentage point per year. Payments would be apportioned among hospitals according to the number of residents at a hospital (up to its existing cap) and the portion of the hospital’s inpatient days accounted for by Medicare and Medicaid patients.¹

In CBO’s estimation, the option would reduce mandatory spending by \$32 billion between 2018 and 2026. By 2026, the annual savings would represent about 30 percent of projected federal spending for GME under current law. Over that period, most of the savings would stem from the slower growth in GME funding over time.

An argument for reducing the overall subsidy for GME is that federal payments under current law exceed hospitals’ actual teaching costs. The Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME adjustment is overstated. In its most recent analysis, MedPAC estimates that an IME adjustment about one-third the size of the current one would reflect the indirect costs that teaching hospitals actually incur. That analysis suggests that a smaller subsidy would not unduly affect hospitals’ teaching activities. A smaller subsidy also would remove an incentive for hospitals to have a greater number of residents than necessary. Another argument for this option is that consolidating federal funding for medical education would reduce the costs of administering the program for the government and teaching hospitals.

1. Aggregate federal payments would be fixed under this option, so the budgetary effects would not change if the option also removed the existing cap on the number of subsidized residency slots. Removing the cap might allow the existing slots to be allocated more efficiently among hospitals, but it also would create an incentive for hospitals to expand their residency programs in an attempt to receive a larger share of the fixed total. Because the net effects on hospitals’ residency programs would be difficult to predict, CBO chose to examine an option that retained the cap.

An argument against the option is that reducing the federal subsidy for GME could lead teaching hospitals to shift the composition of their residency programs toward specialists and away from primary care residents. In response to the caps on Medicare-funded residency slots, which were put into place in 1996, hospitals did not stop expanding their residency programs—but they did tend to favor specialists over primary care residents because employing specialists tends to be more financially attractive. If hospitals responded to further reductions in federal GME subsidies in the same way, shifting the mix of their residents even more toward medical specialties, they would exacerbate a recent trend that could limit the number of primary care doctors in the future. Alternatively, hospitals might respond to the reduced subsidy by

lowering residents' compensation and making them responsible for more of the cost of their medical training.

Another argument against the option is that some teaching hospitals use part of their GME payments to fund care for uninsured people. The option could therefore disproportionately affect hospitals that treat a larger number of uninsured patients. Furthermore, states could lose some discretion to direct Medicaid GME payments to hospitals because the federal government would be administering the grant program. Finally, even if payments were initially equal to hospitals' costs, the payments would grow more slowly than inflation and thus would probably not keep pace with increases in costs. Over time, therefore, hospitals and residents might bear an increasing share of the costs of operating a residency program.

Health—Option 13

Functions 550, 570

Limit Medical Malpractice Claims

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Change in Mandatory Outlays ^a	0	-0.2	-1.6	-4.3	-6.9	-7.6	-7.9	-8.1	-8.9	-9.5	-13.0	-54.9
Change in Revenues ^b	0	0.1	0.3	0.5	0.8	0.9	1.0	1.0	1.1	1.1	1.7	6.9
Decrease in the Deficit	0	-0.3	-1.9	-4.8	-7.7	-8.5	-8.9	-9.2	-10.0	-10.6	-14.7	-61.9
Change in Discretionary Spending												
Budget authority	0	*	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-1.9
Outlays	0	*	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.5	-1.9

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2018.

* = between -\$50 million and zero.

a. Includes estimated savings by the Postal Service, whose spending is classified as off-budget.

b. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

Sometimes people are harmed in the course of their medical treatment. In such cases, state laws permit patients to undertake legal action against physicians or other health care providers and to seek monetary compensation for their injuries. The laws that govern medical malpractice claims have twin objectives: to deter providers’ negligent behavior (by forcing those who are found at fault to pay damages) and to compensate patients for economic losses (such as lost wages and medical expenses) and noneconomic losses (often called pain and suffering). Malpractice claims are generally pursued in state, rather than federal, courts.

To reduce the risk of having to pay malpractice claims on their own, nearly all health care providers purchase malpractice insurance. Those purchases affect medical costs when they are passed along to health plans and patients in the form of higher charges for health care services. Providers’ efforts to reduce their risk of facing malpractice claims also can lead to patients’ using more health care services than would be the case in the absence of that risk.

Starting in 2018, this option would:

- Cap awards for noneconomic damages at \$250,000;

- Cap awards for punitive damages either at \$500,000 or at twice the value of awards for economic damages (such as for lost income and medical costs), whichever is greater;
- Shorten the statute of limitations to one year from the date of discovery of an injury for adults and to three years for children;
- Establish a fair-share rule (under which a defendant in a lawsuit is liable only for the percentage of a final award that is equal to his or her share of responsibility for the injury) to replace the current rule of joint-and-several liability (under which each defendant is individually responsible for the entire amount of an award);
- Allow evidence of claimants’ income from collateral sources (such as life insurance payouts and health insurance reimbursements, which can reduce the costs to claimants of being harmed) to be introduced at trial; and
- Cap attorneys’ fees. (Typically, attorneys charge fees equal to one-third of total awards and waive their fees if no award is made; the cap would reduce that percentage for larger awards.)

Some states place limits such as these on malpractice claims; others have fewer restrictions. This option would help standardize medical malpractice laws across the country.

Placing federal limits on malpractice claims would reduce total health care spending in two ways, the Congressional Budget Office estimates. First, premiums for malpractice insurance would cost less as average malpractice awards became smaller and fewer people filed claims (because of the diminished incentive to sue), and that cost reduction would generally accrue to health plans and patients in the form of lower charges for health care services. Second, research suggests that placing limits on malpractice claims would decrease the prescription, and therefore the use, of health care services to a small extent because providers who faced a smaller risk of legal action might order fewer diagnostic procedures, for example.

Together, those two factors would cause this option to reduce total health care spending by about 0.5 percent, CBO estimates. (For this option, CBO expects that changes enacted in late 2017 would take full effect after about four years, allowing time for insurance companies to adjust malpractice insurance rates and providers to modify their practice patterns.) Because study results differ on whether the effects on Medicare spending would be proportionally larger or smaller than those for other payers, CBO estimated that the percentage reduction in total spending would be the same for all payers, including Medicare. On the one hand, Medicare's spending is largely determined by the costs of providing care in the fee-for-service part of the program, which does not generally use the mechanisms employed by many private plans to limit the use of services that offer little or no benefit to patients. By itself, that consideration would suggest that the effects of the option on Medicare spending would be larger. On the other hand, Medicare beneficiaries are much less likely to sue for malpractice (all other factors equal), suggesting that the effects would be smaller.

This option would reduce mandatory spending by \$55 billion between 2017 and 2026, CBO projects. That estimate accounts for the effects on outlays for Medicare and Medicaid, subsidies for nongroup coverage purchased through the health insurance marketplaces

established under the Affordable Care Act, and health insurance for retired federal employees. Savings in discretionary spending, including outlays for health insurance for current federal employees, for example, would amount to approximately \$2 billion over that 10-year period if the amounts appropriated for federal agencies were reduced accordingly.

By decreasing private-sector spending on health care, this option also would affect federal revenues. A substantial amount of health care is covered under employment-based health insurance, a nontaxable form of compensation. Because the premiums that employers pay are excluded from employees' taxable income, lowering that cost to employers would boost the share of employees' income that was subject to taxation. That shift, combined with the effect on revenues of the reduction in premium tax credits for coverage purchased through the marketplaces, would increase federal tax revenues by about \$7 billion over the next 10 years, CBO estimates.

A rationale in favor of this option is that the resulting lower cost of malpractice insurance would help increase the supply of some specialists in certain regions of the country. For example, some obstetricians, who could be deterred from practicing in places where the annual cost of malpractice insurance is particularly high (premiums can exceed \$200,000 in some areas), might relocate or leave the practice of medicine altogether. Limits on malpractice claims also could curtail the provision of unnecessary or redundant services. Yet another rationale is that such limits could discourage some lawsuits in cases where negligence did not actually occur.

An argument against this option is that limiting malpractice claims could make it harder for people to obtain full compensation for injuries that are caused by medical negligence. Another argument is that reducing the size of awards might cause health care providers to exercise less caution, which could increase the number of medical injuries attributable to malpractice. However, conclusions published in the economic literature about the effects of changes in malpractice laws on health are mixed—perhaps because some types of limits on medical malpractice claims cause providers to reduce the intensity of services

but also avert the risk of unintended, harmful side effects of those services. Some people might oppose this option because it would be a federal preemption of state laws.

Currently, many states either specify higher limits on liability, loss, or damage claims than those proposed in this option or do not limit such claims at all.

RELATED CBO PUBLICATIONS: Cost estimate for H.R. 5, Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011 (March 10, 2011), www.cbo.gov/publication/22053; letter to the Honorable Bruce L. Braley responding to questions on the effects of tort reform (December 29, 2009), www.cbo.gov/publication/41881; letter to the Honorable John D. Rockefeller IV providing additional information on the effects of tort reform (December 10, 2009), www.cbo.gov/publication/41812; letter to the Honorable Orrin G. Hatch about CBO's analysis of the effects of proposals to limit costs related to medical malpractice (October 9, 2009), www.cbo.gov/publication/41334

Health—Option 14

Function 050

End Congressional Direction of Medical Research in the Department of Defense

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Discretionary Spending													
Budget authority	0	-1.2	-1.2	-1.3	-1.3	-1.3	-1.4	-1.4	-1.4	-1.4	-5.0	-11.9	
Outlays	0	-0.1	-0.5	-0.9	-1.1	-1.2	-1.3	-1.3	-1.3	-1.4	-2.6	-9.2	

This option would take effect in October 2017.

Savings for this option are measured against CBO’s baseline, which takes the most recent appropriation and increases it for future years by the agency’s projection of inflation in the economy. For most other budget options for national defense, savings are measured in relation to the Department of Defense’s 2017 Future Years Defense Program and CBO’s extension of that plan.

The Department of Defense (DoD) typically plans to conduct modest amounts of medical research and development (R&D), focusing on areas of inquiry that are relevant mainly to the armed services. Past projects have included the testing of hard body armor and studies of traumatic brain injury and other conditions that are more prevalent among service members than in the general population. The Congress often makes additional, unrequested appropriations and directs DoD to undertake other research. Over the past three fiscal years, for example, DoD has requested a total of \$2.4 billion and the Congress has appropriated \$5.5 billion for medical R&D. During those years, the Congress funded projects to develop treatments for several diseases that are no more common among military personnel than they are in the general U.S. population—breast cancer, ovarian cancer, and prostate cancer, for example. The Congress also has requested research on diseases that either would disqualify potential recruits or would provide grounds for medical discharge—amyotrophic lateral sclerosis, muscular dystrophy, and multiple sclerosis, for example.

This option, which would take effect in October 2017, would end Congressional direction of the department’s medical R&D, and it would end Congressional appropriations above DoD’s requests for that budget account. The Congressional Budget Office estimates that the option would reduce the need for discretionary budget authority by \$12 billion from 2018 through 2026. Outlays would decrease by \$9 billion. Those savings would be realized so long as the projects were not transferred directly to the

National Institutes of Health (NIH) or some other part of the federal government.

An advantage of this option is that it would end the practice of having DoD conduct research on diseases and conditions that are unrelated to military service and for which the military health system may not have particular expertise. That research could be conducted by NIH, although a simple redirection of the research effort to NIH would not achieve savings in the federal budget. If the research was transferred to NIH, the Congress could direct that the research focus on those narrowly defined topics or it could require their funding out of NIH’s discretionary appropriation if that agency determined the projects to have more promise or greater value than other proposed research. This option also would help DoD to comply with the caps on discretionary spending for national defense under the Budget Control Act, although research redirected to NIH would be subject to the corresponding caps for nondefense discretionary spending.

A disadvantage of this option is that research projects would be forgone that might have led to improved treatments or even cures for various diseases. Although those diseases may have low prevalence among the military population, their prevalence would be higher not only in the general U.S. population but perhaps also among military family members or among military retirees and their families.

Health—Option 15

Function 050

Modify TRICARE Enrollment Fees and Cost Sharing for Working-Age Military Retirees

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Discretionary Spending													
Budget authority	0	*	-1.4	-2.0	-2.1	-2.3	-2.4	-2.6	-2.8	-2.9	-5.4	-18.4	
Outlays	0	*	-1.1	-1.9	-2.1	-2.2	-2.4	-2.5	-2.7	-2.9	-5.0	-17.8	
Change in Mandatory Outlays	0	0	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4	
Change in Revenues ^a	0	0	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.6	-2.0	
Increase in the Deficit	0	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.4	1.6	

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2019.

* = between -\$50 million and \$50 million.

a. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

More than 9 million people are eligible to receive health care through TRICARE, a program run by the military health care system. Among its beneficiaries are 1.4 million members of the active military and the other uniformed services (such as the Coast Guard), certain reservists, retired military personnel, and their qualified family members. The costs of that health care have been among the fastest-growing portions of the defense budget over the past 15 years, more than doubling in real (inflation-adjusted) terms since 2001. In 2015, the Department of Defense (DoD) spent about \$50 billion for health care, and over the next 15 years, the Congressional Budget Office projects, DoD’s health care costs will increase by 36 percent in real terms.

In 2015, about 25 percent of military health care spending was for working-age retirees (generally, beneficiaries who, although retired from military service, are under age 65 and thus not yet eligible for Medicare) and their family members: 3.2 million beneficiaries in all. Some 1.6 million people (or about 50 percent of that group) were enrolled in TRICARE Prime, which operates like a health maintenance organization. Subscribers pay an annual enrollment fee of \$283 (for individual coverage) or \$565 (for family coverage). Working-age retirees who do not enroll in TRICARE Prime may participate in TRICARE Extra (a preferred provider network) or Standard (a traditional fee-for-service plan) without enrolling or paying an enrollment fee. (A beneficiary who

chooses an in-network provider for a given medical service is covered under Extra; if he or she chooses an out-of-network provider for a different medical service—even in the same year—that service is covered under TRICARE Standard.)

Starting in January 2019, and indexed thereafter to nationwide growth in per capita spending on health care, under this option TRICARE’s enrollment fees, deductibles, and copayments for working-age military retirees would increase as follows:

- Beneficiaries with individual coverage could pay \$650 annually to enroll in TRICARE Prime. The annual cost of family enrollment would be \$1,300. (That family enrollment fee is about equivalent to what would result from increasing the \$460 annual fee first instituted in 1995 by the nationwide growth in health care spending per capita since then.)
- For the first time, retired beneficiaries in TRICARE Standard or Extra would have to enroll and pay \$100 for individual or \$200 for family coverage for a year.
- The annual deductible for individual retirees (or surviving spouses) for TRICARE Standard or Extra would rise to \$500; the family deductible would be \$1,000 annually.

- All copayments for medical treatments under TRICARE Prime would increase. For example, the copayment for a medical visit to a Prime provider in the civilian network would rise from the current \$12 to \$30 in 2019. Then, copayments would grow in line with the nationwide growth in health care spending per capita.

CBO estimates that, combined, those modifications would reduce discretionary outlays by \$18 billion between 2018 and 2026, under the assumption that appropriations would be reduced accordingly. Under this option, CBO estimates, about 200,000 retirees and their family members would leave TRICARE Prime because of the higher out-of-pocket costs they would face. Many would switch to Standard or Extra, which are less costly to the government.

This option would have partially offsetting effects on mandatory spending. On the one hand, mandatory spending would increase when some retirees enrolled in other federal health care programs, such as Medicaid (for low-income retirees) or the Federal Employees Health Benefits program (FEHB, for those who complete a career in the federal civil service after military retirement). On the other hand, mandatory spending would decrease as a result of the new cost sharing for retirees of the Coast Guard, the uniformed corps of the National Oceanic and Atmospheric Administration, and the Public Health Service. (TRICARE's costs for those three uniformed services are paid from mandatory appropriations; DoD's costs are paid from annual discretionary appropriations.) Overall, in CBO's estimation, mandatory spending would decline by \$400 million between 2019 and 2026 under this option because spending for people in

those three uniformed services would fall by a larger amount than spending for Medicaid and FEHB annuitants would rise.

CBO and the staff of the Joint Committee on Taxation estimate that under this option, federal tax revenues would decline by \$2 billion between 2019 and 2026 because some retirees would enroll in employment-based plans in the private sector and therefore experience a shift in compensation from taxable wages to nontaxable fringe benefits.

One rationale for this option is that the federal government established TRICARE coverage and space-available care at military treatment facilities to supplement other health care for military retirees and their dependents as a safety net rather as a replacement for benefits offered by postservice civilian employers. The migration of retirees from civilian coverage into TRICARE is one factor in the rapid increase in TRICARE spending since 2000.

An argument against this option is that current retirees joined and remained in the military with the understanding that they would receive free or very low cost medical care in retirement. Imposing new cost sharing might have the effect of making health care coverage unaffordable for some military retirees and their dependents; it also could adversely affect military retention. Another potential disadvantage is that the health of users who remained in TRICARE might suffer if higher copayments led them to forgo seeking needed health care or timely treatment of illnesses. However, their health might not be affected significantly if the higher copayments fostered more disciplined use of medical resources and primarily discouraged the use of low-value health care.

RELATED OPTION: Health, Option 6

RELATED CBO PUBLICATIONS: *Approaches to Reforming Military Health Care* (forthcoming); *Long-Term Implications of the 2017 Future Years Defense Program* (forthcoming); *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), www.cbo.gov/publication/44993

Health—Option 16

Function 700

End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Discretionary Spending													
Budget authority	0	-5.4	-5.5	-5.7	-5.9	-6.0	-6.2	-6.4	-6.6	-6.8	-22.5	-54.6	
Outlays	0	-4.8	-5.4	-5.6	-5.8	-6.0	-6.2	-6.4	-6.6	-6.8	-21.7	-53.5	
Change in Mandatory Outlays	0	2.5	2.5	2.6	2.7	2.8	2.9	3.0	3.1	3.2	10.3	25.2	

This option would take effect in October 2017.

Discretionary savings accrue to the Department of Veterans Affairs; increases in mandatory outlays are projected for the Medicare and Medicaid programs and federal spending on subsidies to purchase insurance through the health insurance marketplaces established under the Affordable Care Act.

Veterans who seek medical care from the Veterans Health Administration (VHA) are assigned to one of eight priority groups on the basis of disability status and income, among other factors. For example, enrollees in priority groups 1, 2, and 3 have compensable service-connected disabilities, their income is not considered, and their care is mostly free. Veterans in priority group 7 have no service-connected disabilities, and their annual income is above a national income threshold set by VHA but below a (generally higher) geographic threshold. Those in priority group 8 have no service-connected disabilities, and their income is above both the national and the geographic thresholds. In 2015, about 2 million veterans were assigned to priority groups 7 and 8.

Although veterans in priority groups 7 and 8 pay no enrollment fees, they are charged copayments and VHA can bill their private insurance plans for reimbursement. Together, the copayments and insurance cover about 17 percent of VHA’s costs of care for that group. In 2015, VHA incurred \$5.2 billion in net costs for those patients, or about 9 percent of the department’s total spending for medical care (excluding spending from the medical care collections fund, which collects or recovers funds from first- or third-party payers to help pay for veterans’ medical care). When priority groups were established in 1996, the Secretary of the Department of Veterans Affairs was given the authority to decide which groups VHA could serve each year. By 2003, VHA could no longer

adequately serve everyone, and the department cut off enrollment in priority group 8, although anyone already enrolled could remain. The rules changed again in 2009 to reopen certain new enrollments in that group.

Starting in fiscal year 2018, this option would close priority groups 7 and 8: No new enrollments would be accepted, and current enrollments would be canceled. The action would curtail spending for veterans who have no service-connected disabilities and whose incomes are above the national threshold. Discretionary outlays would be reduced, on net, by \$54 billion from 2018 through 2026, the Congressional Budget Office estimates. Because this option would increase use of other federal health care programs, mandatory spending would rise by \$25 billion for Medicare, Medicaid, and federal subsidies provided through the health insurance marketplaces established under the Affordable Care Act.

An advantage of this option is that VHA could focus on the veterans with the greatest service-connected medical needs and the fewest financial resources. In 2015, nearly 90 percent of enrollees in priority groups 7 and 8 had other health care coverage, mostly through Medicare or private health insurance. As a result, the vast majority of veterans who would lose access to VHA would have other sources of coverage, including the health insurance marketplaces.

A disadvantage of the option is that veterans in priority groups 7 and 8 who have come to rely on VHA, even in part, might find their health care disrupted. Some

veterans—particularly those with income just above the thresholds—might find it difficult to locate other affordable care.

RELATED CBO PUBLICATIONS: *Comparing the Costs of the Veterans' Health Care System with Private-Sector Costs* (December 2014), www.cbo.gov/publication/49763; testimony of Heidi L.W. Golding, Analyst, before the Senate Committee on Veterans' Affairs, *Potential Costs of Health Care for Veterans of Recent and Ongoing U.S. Military Operations* (July 27, 2011), www.cbo.gov/publication/41585; *Potential Costs of Veterans' Health Care* (October 2010), www.cbo.gov/publication/21773

Health—Option 17

Increase the Excise Tax on Cigarettes by 50 Cents per Pack

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total		
											2017–2021	2017–2026	
Change in Mandatory Outlays ^a	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.9
Change in Revenues ^b	3.0	3.7	3.5	3.5	3.4	3.4	3.4	3.4	3.4	3.3		17.1	34.0
Decrease in the Deficit	-3.0	-3.7	-3.6	-3.6	-3.5	-3.5	-3.5	-3.5	-3.5	-3.4		-17.4	-34.9

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2017.

* = between –\$50 million and zero.

a. Estimates include the effects on Social Security outlays, which are classified as off-budget.

b. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

Both the federal government and state governments tax tobacco products. Currently, the federal excise tax on cigarettes is \$1.01 per pack, and the average state excise tax on cigarettes is \$1.53 per pack. In addition, settlements that the major tobacco manufacturers reached with state attorneys general in 1998 require the manufacturers to pay fees (which are passed on to consumers) that are equivalent to an excise tax of about 60 cents per pack. Together, those federal and state taxes and fees boost the price of a pack of cigarettes by \$3.14, on average.

This option would raise the federal excise tax on cigarettes by 50 cents per pack beginning in 2017. That rate increase would also apply to small cigars, which are generally viewed as a close substitute for cigarettes and are currently taxed by the federal government at the same rate as cigarettes. The Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate that the option would reduce deficits by \$35 billion from 2017 to 2026: Revenues would rise by \$34 billion, and outlays would decline by almost \$1 billion, mainly as a result of reduced spending for Medicaid and Medicare. (Because excise taxes reduce the income base for income and payroll taxes, an increase in excise taxes would lead to reductions in revenues from those sources. The estimates shown here reflect those reductions.)

Extensive research shows that smoking causes a variety of diseases, including many types of cancer, cardiovascular diseases, and respiratory illnesses. Tobacco use is considered to be the largest preventable cause of early death in the United States. CBO estimates that a 50 cent increase in the excise tax would cause smoking rates to fall

by roughly 3 percent, with younger smokers being especially responsive to higher cigarette prices. Smoking rates would remain lower in the future than they would be under current law because a smaller share of future generations would take up smoking. As a result, the higher tax would lead to improvements in health, not only among smokers themselves but also among nonsmokers who would no longer be exposed to secondhand smoke. Those improvements in health would, in turn, increase longevity.

Although the budgetary impact of raising the excise tax on cigarettes would stem largely from the additional revenues generated by the tax (net of the reductions in income and payroll taxes noted above), the changes in health and longevity also would affect federal outlays and revenues. Improvements in the health status of the population would reduce the federal government's per-beneficiary spending for health care programs, which would initially reduce outlays for those programs. But that reduction in outlays would erode over time because of the increase in longevity; a larger elderly population would place greater demands on federal health care and retirement programs in the future. The effect of greater longevity on federal spending would gradually outweigh the effect of lower health care spending per beneficiary, and federal outlays would be higher after that than they are under current law. In addition to the direct effect of the excise tax, revenues also would rise as a result of improvements in health, which would lower premiums for private health insurance. The corresponding reduction in employers' contributions for health insurance premiums, which are not subject to income or

payroll taxes, would ultimately be passed on to workers in the form of higher taxable compensation, raising federal revenues.¹

One rationale for raising the excise tax on cigarettes is that tobacco consumers may underestimate the addictive power of nicotine and the harm that smoking causes. Teenagers, in particular, may not have the perspective necessary to evaluate the long-term effects of smoking. Raising the tax on cigarettes would reduce the number of smokers, thereby reducing the damage that people would do to their long-term health. However, many other choices that people make—for example, to consume certain types of food or engage in risky sports—also can lead to health damage, and those activities are not taxed. Also, studies differ on how people view the risks of smoking,

with some research concluding that people underestimate those risks and other research finding the opposite.

Another rationale for raising the excise tax on cigarettes is that smokers impose costs on nonsmokers that are not reflected in the before-tax cost of cigarettes. Those costs, which are known as external costs, include the damaging effects that cigarette smoke has on the health of nonsmokers and the higher health insurance premiums and greater out-of-pocket expenses that nonsmokers incur as a result. However, other approaches—aside from taxes—can reduce the external costs of smoking or make individual smokers bear at least some of those costs. For example, many local governments prohibit people from smoking inside restaurants and office buildings.

An argument against raising the tax on cigarettes is the regressive nature of that tax, which takes up a larger percentage of the earnings of lower-income families than of middle- and upper-income families. The greater burden of the cigarette tax on people with lower income occurs partly because lower-income people are more likely to smoke than are people from other income groups and partly because the amount that smokers spend on cigarettes does not rise appreciably with income.

1. When estimating legislative proposals and policy options that would reduce budget deficits, CBO and JCT generally assume that gross domestic product would not change. CBO relaxed that assumption in its 2012 report *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget*. Thus, the budgetary effects shown in that report also included the revenues from the increase in labor force participation that would result from a healthier population.

RELATED OPTION: Revenues, Option 38

RELATED CBO PUBLICATION: *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget* (June 2012), www.cbo.gov/publication/43319

Health—Option 18

Reduce Tax Preferences for Employment-Based Health Insurance

Billions of Dollars	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total	
											2017–2021	2017–2026
Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions for Employment-Based Health Insurance Set at the 50th Percentile of Premiums												
Change in Mandatory Outlays	0	0	0	4	6	6	7	7	8	9	10	47
Change in Revenues ^a	0	0	0	24	49	61	70	80	90	101	73	476
Decrease in the Deficit	0	0	0	-20	-44	-55	-63	-73	-82	-92	-64	-429
Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions for Employment-Based Health Insurance Set at the 75th Percentile of Premiums												
Change in Mandatory Outlays	0	0	0	2	2	2	3	3	4	3	4	19
Change in Revenues ^a	0	0	0	8	18	23	28	33	38	44	27	193
Decrease in the Deficit	0	0	0	-7	-16	-21	-25	-30	-35	-41	-23	-174
Replace the Excise Tax With a Limit on Only the Income Tax Exclusion for Employment-Based Health Insurance												
Change in Mandatory Outlays	0	0	0	3	3	4	4	4	5	5	6	29
Change in Revenues ^a	0	0	0	14	30	37	42	47	54	60	44	283
Decrease in the Deficit	0	0	0	-12	-26	-33	-38	-43	-48	-55	-38	-254

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2020.

a. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

Overview of the Issue

The federal tax system provides preferential treatment for health insurance that people buy through an employer. Unlike cash compensation, employers' payments for employees' health insurance premiums are excluded from income and payroll taxes. In most cases, the amounts that workers pay for their own share of health insurance premiums is also excluded from income and payroll taxes. Contributions made to certain accounts to pay for health costs are excluded from income and payroll taxes as well. In all, that favorable tax treatment cost the federal government about \$275 billion in forgone revenues in 2016, and that cost will probably rise over time as the cost of health care rises. The tax preferences will continue even after a new excise tax takes effect in 2020 and somewhat reduces their consequences.

Further reducing the tax preferences for employment-based health insurance would raise federal revenues. It also would reduce the number of people with employment-based coverage, boost enrollment in the

health insurance marketplaces established under the Affordable Care Act, and increase the number of people without insurance. And it would make total spending on health care lower than it would have been otherwise.

Current Law. The federal tax system subsidizes employment-based health insurance both by excluding employers' premium payments from income and payroll taxes and by letting employees at firms that offer "cafeteria plans" (which allow workers to choose between taxable cash wages and nontaxable fringe benefits) pay their share of premiums with before-tax earnings. The tax system also subsidizes health care costs *not* covered by insurance by excluding from income and payroll taxes the contributions made to various accounts that employees can use to pay for those costs. Examples include employers' contributions to health reimbursement arrangements (HRAs), employees' contributions to flexible spending arrangements (FSAs), and employers' and employees' contributions to health savings accounts (HSAs). On

average, people with higher income or more expensive health insurance plans receive larger subsidies.

The favorable tax treatment of employment-based health benefits is the largest single tax expenditure by the federal government. (Tax expenditures are exclusions, deductions, preferential rates, and credits in the tax system that resemble federal spending in that they provide financial assistance to specific activities, entities, or groups of people.) Including effects both on income taxes and on payroll taxes, that exclusion is projected to equal 1.5 percent of gross domestic product over the 2017–2026 period.

The excise tax that is due to start in 2020 will effectively reduce the tax subsidy for employment-based health insurance. It will be levied on employment-based health benefits—consisting of employers’ and employees’ tax-excluded contributions for health insurance premiums and contributions to HRAs, FSAs, or HSAs—whose value exceeds certain thresholds. The excise tax will thus curtail the current, open-ended, tax exclusions. (Even when the excise tax is in effect, however, employment-based health insurance will still receive a significant tax subsidy, and that subsidy will still be larger for people with higher income.)

The excise tax will equal 40 percent of the difference between the total value of tax-excluded contributions and the applicable threshold. If employers and workers did not change their coverage in response to the tax, roughly 5 percent to 10 percent of people enrolled in an employment-based health plan in 2020 would have some tax-excluded contributions in excess of the thresholds, according to estimates of the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT). (However, CBO and JCT do expect people’s responses to the tax to reduce that share, discussed below.)

In 2020, CBO and JCT project, the thresholds will be \$10,800 for individual coverage and \$29,100 for family coverage. (Those thresholds will be slightly higher for retirees who are 55 to 64 years old and for workers in certain high-risk professions. Further adjustments will be made for age, sex, and other characteristics of an employer’s workforce.) After 2020, the thresholds will be indexed to the growth of the consumer price index for all urban consumers (CPI-U), which measures inflation. Because health insurance premiums will probably continue to rise faster than inflation, the excise tax will prob-

ably affect a growing number of people over time. As a result, CBO and JCT project, revenues stemming from the tax will rise from \$3 billion in 2020 to \$20 billion in 2026.

Effects of Current Law. The tax exclusions have effects that include encouraging the use of employment-based insurance, making it likelier that healthy people will buy health insurance (which lowers the average cost of insurance), and increasing spending on health care. Another effect is that higher-income workers receive larger subsidies than lower-income workers do.

Encouraging the Use of Employment-Based Insurance. By subsidizing employment-based health insurance, the tax preferences encourage firms to offer it and workers to enroll in it. Such insurance would be attractive to employers and employees in any case, because it pools risks within groups of workers and their families and reduces the administrative costs of marketing insurance policies and collecting premiums. But the preferences give employment-based insurance additional appeal. In 2015, according to a Medical Expenditure Panel Survey, 84 percent of private-sector employees worked for an employer that offered health insurance coverage; 76 percent of those employees were eligible for that coverage (the rest were ineligible for various reasons, such as working only part time); and 75 percent of the eligible workers chose to enroll.

Reducing Adverse Selection. A major problem that can occur in insurance markets is adverse selection, in which less healthy people are likelier to buy health insurance (or to buy certain types of plans) than healthier people are. Adverse selection occurs because insurance provides more benefit to enrollees with above-average costs—and is therefore more attractive to them—and less benefit to people with below-average costs. As premiums increase to cover the less healthy enrollees, the healthier ones may stop buying insurance, which results in another price increase—a spiral that may continue until the market is very small or nonexistent. Adverse selection also can reduce markets’ efficiency by making it harder for insurers to predict costs for a group of potential enrollees.

Employment-based health insurance and the tax preferences that encourage its use limit adverse selection in several ways. Employers generally select a workforce on the basis of criteria other than health care costs, so most workforces consist of a mix of healthier and less healthy

people. Pooling risks across such a workforce reduces the variability of average health care spending for the group. Also, once employers are offering health insurance, they tend to pay a large share of premiums in order to encourage employees to enroll—making the employees' share small in relation to their expected health care costs, encouraging them to buy insurance, and reducing adverse selection. The tax exclusions also limit adverse selection by reducing the after-subsidy price of insurance, encouraging even the healthy to enroll.

Recent changes in regulations governing markets for nongroup (that is, individually purchased) health insurance—which are separate from markets for employment-based insurance—reduce the problem of adverse selection in that market. In addition, subsidies are now available in the nongroup market. Those changes have weakened the rationale for subsidizing employment-based insurance because the nongroup market now provides an alternative way of providing insurance—one that is available to people regardless of their health and that subsidizes their coverage. Nevertheless, employment-based insurance is still a relatively efficient way of providing insurance because its administrative costs are much lower than those in the nongroup market.

Increasing Health Care Spending. The tax preferences for employment-based health insurance contribute to the growth of health care spending. That occurs because the preferences encourage workers to favor health care over other goods and services that they could purchase and also because the tax exclusions encourage employers to compensate their workers with a combination of health insurance coverage and cash wages rather than entirely with cash wages (which the employees would be unlikely to spend on health care to the same extent). Furthermore, the tax exclusions are currently open-ended (and will be until the excise tax takes effect in 2020). That is, their value increases with an insurance plan's premium, encouraging people to enroll in plans that cover a greater number of services, cover more expensive services, or require enrollees to pay a smaller share of costs. As a result, people use more health care—and health care spending is higher—than would otherwise be the case.

Concern about that effect has lessened somewhat in recent years because employment-based insurance plans that require workers to pay a higher share of health costs have become more common. For example, 29 percent of people with employment-based coverage reported

enrolling in a high-deductible health plan in 2016, up from 8 percent in 2008.

Subsidizing Workers With Different Income Differently. Another concern about the tax exclusions is that they subsidize workers with different income differently. The value of the exclusions is generally larger for workers with higher income, partly because those workers face higher income tax rates (although they may face lower rates of payroll taxation) and partly because they are more likely to work for an employer that offers coverage. Because larger subsidies go to higher-income workers, who are more likely to buy insurance even without the tax exclusions, and smaller subsidies go to lower-income workers, who are less likely to buy coverage, the exclusions are an inefficient means of increasing the number of people who have health insurance, and they are regressive in the sense of giving larger benefits to people with higher income.

The forthcoming excise tax will be levied on insurers and on employers who offer their own insurance plans, but economic theory and empirical evidence suggest that the cost will ultimately be passed on to workers. CBO and JCT expect that in many cases, that will occur when employers and workers decide to avoid paying the tax by shifting to health plans with premiums below the thresholds. In those cases, the money that would otherwise have been used to pay for the more expensive premiums would generally increase either workers' wages or employers' profits, both of which are taxable. Because workers with higher income will pay higher marginal tax rates on those increased wages, the result will be a reduction in the tax exclusions' regressive nature. When employers and workers do not shift to lower-cost health plans to avoid the excise tax, the costs of that tax will be spread equally among workers, JCT and CBO expect. However, workers with higher income are more likely to be enrolled in high-cost plans and thus more likely to have their subsidies reduced in the first place.

Most workers will have health benefits whose value is below the thresholds and therefore will be largely unaffected by the excise tax. Consequently, the existing tax preferences and the new excise tax will continue to subsidize employment-based health insurance and to provide larger subsidies to higher-income people.

Key Design Choices That Would Affect Savings

Lawmakers who wanted to design laws to reduce the tax preferences for employment-based health insurance could

take various approaches. Those approaches would have different effects on federal revenues, on the taxes owed by people at various income levels, on employers' and employees' choices about health insurance plans, and on their resulting health care costs. One approach would involve modifying both the current tax exclusions and the upcoming excise tax. Another approach—one that is not examined in this volume—would replace the current tax exclusions with an income tax credit for employment-based health insurance.

In general, reducing the tax preferences for employment-based health insurance would tend to lower the number of people with such insurance. It also would increase out-of-pocket payments by people enrolled in employment-based insurance, which would decrease spending on health care and increase the financial burden on people with substantial health problems. The precise effect, however, would depend on the specific features of any policy change.

Modifying the Tax Exclusions and the Excise Tax.

Lawmakers could cancel the excise tax that is scheduled to take effect under current law and instead subject contributions for health insurance premiums, along with contributions to various health-related accounts, to income or payroll taxation. If lawmakers did that, they would have to decide whether to tax all of the contributions or only some of them. For example, the exclusions could be retained, but with an upper limit that applied to all taxpayers, or the exclusions could be phased down for higher-income people. Such limits also could be allowed to vary according to other characteristics of employees that are associated with average health costs, such as age, sex, or occupation. (The forthcoming excise tax includes several adjustments of that sort. For instance, the threshold above which health care costs are taxed is higher for some groups of people whose average costs are high because they work in dangerous occupations.)

Lawmakers also would need to decide whether to subject the contributions to income taxation, payroll taxation, or both. On average, enrollees in employment-based plans face slightly higher federal income tax rates than payroll tax rates. Specifically, CBO and JCT estimate that those workers' average marginal income tax rate—that is, the rate that applies to the last dollar of their earnings—will be about 20 percent in 2020, whereas their average marginal payroll tax rate (including both the employer's and the employee's shares of payroll taxes) will be about 14 percent. Therefore, subjecting contributions to

income taxation would raise slightly more revenue than subjecting them to payroll taxation, all else being equal, and doing both would raise the most revenue.

Even if the average income tax rate and the average payroll tax rate for enrollees in employment-based plans were the same, subjecting contributions to income taxation and to payroll taxation would have very different effects on the tax liability of people in different income groups. Higher-income people are likely to have higher marginal income tax rates but lower marginal payroll tax rates than lower-income people. Among people with employment-based insurance, therefore, subjecting contributions to income taxation would raise the tax liability of higher-income people more than that for lower-income people. The opposite would be true if contributions were subjected to payroll taxation.

Subjecting contributions to taxation would reduce insurance coverage, but the reduction would be smaller if the contributions were subjected to income taxation than if they were subjected to payroll taxation (provided that the same upper limit applied in each case). That difference is primarily attributable to the fact that lower-income people are more likely than higher-income people to forgo insurance when the after-tax price of their insurance goes up. (Higher-income people are more likely to stay enrolled in insurance—because they tend to have more assets to protect, higher demand for health services, and a larger penalty to pay if they forgo insurance.) Also, for lower-income people, the average marginal tax rate is smaller for income taxes than for payroll taxes. Subjecting their contributions to income taxation would not reduce their after-tax compensation (and thus increase the after-tax price of their health insurance) as much as subjecting their contributions to payroll taxation would. They would be less likely to forgo insurance, and overall reductions in insurance coverage would be smaller. At the same time, because higher-income people, on average, face a higher marginal income tax rate than marginal payroll tax rate, more higher-income people would stop enrolling in insurance if their contributions were subjected to income taxation than if they were subjected to payroll taxation. However, that reduction in insurance coverage for higher-income people would be smaller than the reduction for lower-income people because higher-income people are less responsive to price changes in health insurance.

Replacing the Tax Exclusions With a Tax Credit.

Another approach to reducing tax preferences for

employment-based health insurance would be to replace the current tax exclusions with an income tax credit. If the credit was a fixed dollar amount for everyone and was refundable—so that people could receive money back from the government if their credit exceeded the amount of federal income tax that they owed—all workers would receive the same value from the credit, regardless of their tax bracket or their health care costs. If the credit was a fixed dollar amount but was nonrefundable, low-income workers, who have little or no income tax liability, would benefit much less. Alternatively, the credit's value might not be a fixed dollar amount; it could be phased out for people with higher income. In any of those designs, the credit would have a set dollar value for a given worker, so that the worker could not increase it by purchasing more extensive or more costly insurance.

Lawmakers would face various trade-offs as they set the value of such a tax credit. A larger credit would increase the number of people who obtained health insurance, but would reduce the amount of tax revenues collected. Phasing down the credit for people with higher income would focus it on people who would be less likely to obtain insurance otherwise, but that approach also would raise effective income tax rates for people whose credit was being phased down, potentially distorting their decisions about how much to work.

One disadvantage of switching to a refundable tax credit is that administering it would be substantially more complex than administering the current tax exclusions. A potential drawback of a flat tax credit is that it would offer the same benefit to everyone, regardless of their health status. The current tax exclusions, by contrast, offer an extra benefit to people who are less healthy, because those people tend to use more health services and to enroll in plans with higher premiums.

Specific Alternatives and Estimates

CBO and JCT analyzed three alternatives for reducing the tax preference for employment-based health insurance. Each alternative would take effect in 2020, and all would follow the first approach outlined above, replacing the excise tax on high-cost plans with a limit on the tax exclusions. Two alternatives would limit the exclusions from income and payroll taxation; the third would limit the exclusion from income taxation but continue the unlimited exclusion from payroll taxation. Those policy changes would increase the tax liability and affect the behavior of people with high premiums for

employment-based health plans, but the specific increases in taxes and changes in behavior would be different under each approach.

Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions Set at the 50th Percentile of Premiums. The first alternative would eliminate the excise tax and instead impose a limit on the extent to which employers' and employees' contributions for health insurance premiums—and to FSAs, HRAs, and HSAs—could be excluded from income and payroll taxation. Specifically, starting in 2020, contributions that exceeded \$7,700 a year for individual coverage and \$19,080 for family coverage would be included in employees' taxable income for both income and payroll taxes. Those limits, which are equal to the estimated 50th percentile of health insurance premiums paid by or through employers in 2020, would be indexed for inflation after 2020 by means of the CPI-U. The same limits would apply to the deduction for health insurance available to self-employed people. Because the limits would be lower than the thresholds scheduled to take effect for the excise tax—for example, \$10,800 for individual coverage in 2020—federal tax subsidies would be lower as well.

This alternative would decrease cumulative federal deficits by \$429 billion by 2026, CBO and JCT estimate. By reducing the appeal of employment-based health insurance, it also would cause about 4 million fewer people to have such coverage in 2026 than would have it under current law. Of those people, about 2 million would buy coverage through the health insurance marketplaces, fewer than 500,000 would enroll in Medicaid, and about 1 million would be uninsured. (Those numbers do not add up to the total because of rounding.)

The reduction in the deficit would stem from several changes in revenues and outlays that partially offset each other. Income and payroll tax revenues would rise by \$547 billion through 2026 because the number of people with employment-based coverage would decline and because many of those who retained such coverage would receive a smaller benefit from the tax exclusion. (For example, in 2026, the capped tax exclusions would reduce the combined federal income and payroll tax liability of people with employment-based coverage by an average of \$1,420; that reduction would be \$5,280 under current law.) Additional penalty payments by certain employers and individuals resulting from changes in health insurance coverage also would increase revenues,

although only by a small amount. However, additional tax credits for coverage purchased through the marketplaces would reduce revenues, as would the repeal of the excise tax. In all, revenues through 2026 would be \$476 billion higher than under current law. The alternative also would boost federal outlays by \$47 billion through 2026, primarily because of increased spending on Medicaid and on subsidies for insurance purchased through the marketplaces.

Replace the Excise Tax With a Limit on the Income and Payroll Tax Exclusions Set at the 75th Percentile of Premiums. Just as the first alternative would, the second alternative would eliminate the excise tax and impose limits on the extent to which contributions could be excluded from income and payroll taxation. In this alternative, however, the limits would be higher: \$9,520 a year for individual coverage and \$23,860 for family coverage. Those limits are equal to the estimated 75th percentile of health insurance premiums paid by or through employers in 2020. Again, they would be indexed for inflation by means of the CPI-U after 2020.

The second alternative would decrease cumulative federal deficits by \$174 billion by 2026, CBO and JCT estimate. Specifically, it would increase revenues by \$193 billion and outlays by \$19 billion. Also, like the first alternative, this one would reduce the appeal of employment-based health insurance, causing about 2 million fewer people to have it in 2026 than would have it under current law. In that year, about 1 million more people would buy coverage through the marketplaces, fewer than 500,000 more people would enroll in Medicaid, and about 1 million more people would be uninsured.

Replace the Excise Tax With a Limit on Only the Income Tax Exclusion Set at the 50th Percentile of Premiums. The third alternative would eliminate the excise tax and impose a limit on the extent to which contributions could be excluded from income taxation; exclusions for payroll taxation would remain unlimited. Specifically, starting in 2020, contributions that employers or workers made for health insurance—and for health care costs through FSAs, HRAs, and HSAs—that exceeded \$7,700 a year for individual coverage and \$19,080 for family coverage would be included in employees' taxable income for income taxes. Those are the same limits as the ones in the first alternative, and once again, they would be indexed for inflation in subsequent years by means of the CPI-U. As the discussion

above explained, limiting the tax exclusion for income taxes only would raise more revenue, and reduce insurance coverage less, than limiting the exclusion for payroll taxes only would (so long as the same limit applied in each case).

The third alternative would decrease cumulative federal deficits by \$254 billion by 2026, CBO and JCT estimate: Revenues would be \$283 billion higher, and outlays would be \$29 billion higher. That alternative would cause about 3 million fewer people to have employment-based insurance in 2026 than would have it under current law. Of those people, about 2 million would buy coverage through the health insurance marketplaces, fewer than 500,000 would enroll in Medicaid, and about 1 million would be uninsured.

Other Considerations

Reducing tax preferences for employment-based health insurance would affect many aspects of health care in the United States, including the growth of health care costs, the health of the population, the decisions that employers and workers make about insurance coverage, and the number of people without health insurance.

Effects on Health Care Costs. Replacing the excise tax with a limit on the tax exclusions that is lower than the excise tax thresholds would make health care spending lower than it would be under current law. The current tax preferences for employment-based insurance give health insurance plans an incentive to cover more services, to cover more expensive services, and to require enrollees to pay a smaller share of the costs than would be the case otherwise. The excise tax will effectively scale back those tax preferences. The alternatives examined here would increase taxes for a larger share of employment-based plans than the excise tax will—giving employers and their workers less incentive to buy expensive health insurance, reducing upward pressure on the price and use of health care, and encouraging greater use of cost-effective care.

Effects on People's Health. By reducing the incentive to buy expensive coverage and increasing the incentive to buy insurance plans in which people pay more out of pocket, all three of the alternatives analyzed here would reduce the amount of care received and worsen some people's health. That conclusion is supported by an experiment conducted by the RAND Corporation from 1974 to 1982 in which nonelderly participants were

randomly assigned to health insurance plans.¹ The experiment showed that plans requiring more out-of-pocket payments reduced the use of both effective and less effective care, as defined by a team of physicians. Differences in out-of-pocket requirements had no effect on most participants' health, but among the poorest and sickest participants, those who faced no requirements of that kind were healthier by some measures than those who did.

Effects on Employers and Workers. By increasing the tax liability of people enrolled in high-cost employment-based plans more than the excise tax will, the alternatives considered here would probably increase the financial burden on some people with substantial health problems. In particular, some employers and workers would avoid the increased tax liability by shifting to plans with lower premiums and requirements for more out-of-pocket payments, which would increase costs the most for people who used the most services.

In general, workers with higher income face higher income tax rates and are more likely to enroll in plans with high premiums. Therefore, limiting the exclusion from income taxation, as the third alternative does, would reduce that benefit more for people with higher income. The two alternatives that limit the exclusion not only for income taxation but also for payroll taxation would still increase tax liabilities more for higher-income people, on average, because they tend to enroll in plans with higher premiums.

Under all three alternatives, employees of firms that had a less healthy workforce or that operated in an area with above-average health care costs would be more likely to

see their tax liability increase. In higher-cost areas, those increases in people's tax liability might exert pressure on health care providers and insurers to reduce prices or decrease unnecessary care.

Although these alternatives would reduce total spending on health care, they would increase after-tax premiums for some people enrolled in employment-based insurance, particularly those whose premiums were above the limits imposed by each alternative and who therefore would newly be paying taxes on that portion of their premiums. In addition, because all three alternatives would impose a limit on the exclusion that was lower than the excise tax thresholds that exist under current law, employers would have a heightened incentive to keep premiums low, which could cause them to refrain from hiring older workers (who tend to spend more on health care and to raise average premiums) or to reduce the compensation of older workers. That effect would be particularly likely among employers with fewer employees over whom to spread risks.

Effects on the Number of Uninsured People. The tax increases in these alternatives would lead fewer employers to offer health insurance, thus increasing the number of uninsured workers. Most people whose employers stopped offering coverage would buy it in the nongroup market, either in the health insurance marketplaces or elsewhere. The federal subsidies available to low-income people through the marketplaces would give many of those people an affordable alternative to the employment-based coverage that they had lost, and the penalty for lacking insurance would give many high-income people an incentive to buy insurance even without a subsidy. Nevertheless, some workers whose employers stopped offering health insurance would forgo coverage, CBO and JCT anticipate.

1. See Joseph Newhouse, *Free for All? Lessons From the RAND Health Insurance Experiment* (Harvard University Press, 1993).

RELATED CBO PUBLICATIONS: *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026* (March 2016), www.cbo.gov/publication/51385; *The Distribution of Major Tax Expenditures in the Individual Income Tax System* (May 2013), www.cbo.gov/publication/43768

