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CBO

Health-Related Options for Reducing the Deficit: 2014 to 2023

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Notes

This document is a reprint of Chapter 5 of Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), www.cbo.gov/publication/44715.

Unless otherwise indicated, all years referred to in this report regarding budgetary outlays and revenues are federal fiscal years, which run from October 1 to September 30.

The numbers in the text and tables are in nominal (current year) dollars. Those numbers may not add up to totals because of rounding.

The baseline budget projections discussed in this report are those published in Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2013 to 2023* (May 2013), www.cbo.gov/publication/44172, with some updates as described in Congressional Budget Office, letter to the Honorable Paul Ryan providing an analysis of the Administration's announced delay of certain requirements under the Affordable Care Act (July 30, 2013), www.cbo.gov/publication/44465. The projections over the longer term are those published in Congressional Budget Office, *The 2013 Long-Term Budget Outlook* (September 2013), www.cbo.gov/publication/44521.

The estimates for the various options shown in this report may differ from any previous or subsequent cost estimates for legislative proposals that resemble the options presented here.

The budget functions to which the options apply are functions 050 (national defense), 550 (health), 570 (Medicare), and 700 (veterans benefits and services).

The Affordable Care Act comprises the Patient Protection and Affordable Care Act; the health care provisions of the Health Care and Education Reconciliation Act of 2010; and, in the case of this report, the effects of subsequent related judicial decisions, statutory changes, and administrative actions through November 1, 2013.

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Health-Related Options for Reducing the Deficit: 2014 to 2023

The federal government's net outlays for mandatory health care programs, combined with the subsidies for health care that are conveyed through reductions in federal taxes, exceeded $1.0 trillion in fiscal year 2013, the Congressional Budget Office (CBO) estimates. Net outlays for Medicare and Medicaid, the two largest federal health care programs, totaled an estimated $760 billion, roughly one-quarter of all federal spending in 2013. Other mandatory health care programs include 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. In addition, the federal tax code gives preferential treatment to payments for health insurance and health care, primarily through the exclusion of premiums for employment-based health insurance from income and payroll taxes. CBO estimates that the tax expenditure for that exclusion (accounting for income and payroll taxes together) was about $250 billion in 2013. The federal government also supports many health programs that are funded through annual discretionary appropriations: Taken together, funding for public health activities, health and health care research initiatives, health care programs for veterans, and certain other health-related activities totaled about $115 billion in 2013. (In addition, the federal government makes contributions for health insurance premiums for active civilian and military workers, but that funding is part of each agency's budget and is not included in that figure.)

Under current law, federal budgetary costs related to health will increase considerably starting in 2014, as some people become newly eligible for Medicaid and others qualify for tax subsidies to purchase coverage through new health insurance exchanges. Policy changes relating to health could reduce federal deficits by lowering outlays for mandatory health care programs and by limiting tax preferences for health care. Reductions in discretionary spending on health programs would reduce total appropriations if the statutory caps set by the Budget Control Act of 2011 were reduced as well, or if appropriations were provided at levels below those caps.

Trends in Spending and Revenues Related to Health

Spending for Medicare and Medicaid has grown quickly in recent decades, in part because of rising enrollment. Rising costs per enrollee also have driven spending growth in those programs—much like growth in private spending for health care. In 1975, a decade after the enactment of legislation creating the Medicare and Medicaid programs, federal spending on those programs, net of offsetting receipts, accounted for 1.2 percent of gross domestic product (GDP).[1] That share rose to 2.0 percent of GDP by 1985 and has more than doubled since then, as net federal spending for the two programs grew to 4.6 percent of GDP in 2013, by CBO's estimates. Between 1985 and 2013, the share of the population enrolled in Medicare rose from 13 percent to 16 percent, and average annual enrollment in Medicaid rose from 8 percent to 18 percent of the population. Including the smaller CHIP (which was established in 1997), 20 percent of the population was enrolled in either Medicaid or CHIP, on average, in 2013, according to CBO's estimates.

Per capita spending for health care in this country has been rising in recent decades. A key reason has been the emergence, adoption, and widespread diffusion of new medical technologies and services. Other factors contributing to the growth of health care spending include increases in personal income and the expanded scope of health insurance coverage. Altogether, health care

1. Net Medicare spending includes the federal government's receipts from premium payments by beneficiaries and amounts paid by states from savings on Medicaid's prescription drug costs.

spending per person has expanded more rapidly than the economy for a number of years, although the rate of increase in health care spending has slowed recently.

The tax expenditure stemming from the exclusion from taxable income of employers' contributions for health care and workers' premiums for health insurance and long-term-care insurance—described in this report as the exclusion for employment-based health insurance—also depends on health care spending per person. That tax expenditure equaled 1.5 percent of GDP in 2013, CBO estimates.

Discretionary spending related to health also has grown significantly in recent decades. From 1973 to 1998, it rose at an average annual rate of about 7 percent, and that rate increased to 10 percent between 1998 and 2004.[2] Since then, health-related discretionary spending has risen more slowly overall—at an average annual rate of about 5 percent—although spending in different program areas has grown at markedly different rates. For example, from 2004 to 2012, outlays for veterans' health care rose at an average annual rate of 8 percent, whereas spending for health research and training (mostly by the National Institutes of Health) grew by an average of about 3 percent per year.

Over the next decade, the government's health care programs will be a continuing source of budgetary pressure—primarily because of a sharp increase in the numbers of beneficiaries enrolled in those programs but also because of ongoing growth in health care costs per beneficiary. Assuming that current laws governing those programs generally do not change, net federal spending for Medicare, Medicaid, CHIP, and subsidies for premiums and cost sharing in the health insurance exchanges is projected by CBO to reach 5.9 percent of GDP in 2023, compared with 4.6 percent in 2013 (see Figure 1).[3] By comparison, outlays for Social Security are projected to be 5.3 percent of GDP in 2023. The tax expenditure for employment-based insurance (including income and payroll taxes) will remain close to 1.5 percent of GDP during the coming decade, CBO projects. Although health care costs per person are expected to continue to grow faster than the economy, which will tend to push up the tax expenditure relative to GDP, an excise tax on high-cost employment-based plans (set to begin in 2018) will work in the opposite direction.

The projected rise in the number of beneficiaries of federal health care programs has two main causes. First is the aging of the population—particularly the retirement of the baby-boom generation—which, over the next 10 years, will result in an increase of about one-third in the number of people who receive benefits from Medicare. Second is the expansion of federal support for health insurance under current law, which will boost the number of Medicaid recipients and make other people eligible for subsidies as they purchase health insurance through exchanges. Despite the significant expansion of federal support for health care for lower-income people over the next 10 years, only about one-fifth of federal spending for the major health care programs in 2023 will finance care for able-bodied, nonelderly people. CBO projects that roughly another one-fifth will fund care for people who are blind or disabled, and about three-fifths will go toward care for people who are 65 or older.

Projecting the growth of per capita spending for health care is particularly challenging in light of the recent slowdown in that growth. A key question is the extent to which the slowdown can be attributed to temporary factors such as the recession and the slow recovery, and the extent to which it instead reflects more enduring developments in the health care system. In CBO's judgment, per capita health care spending will continue to

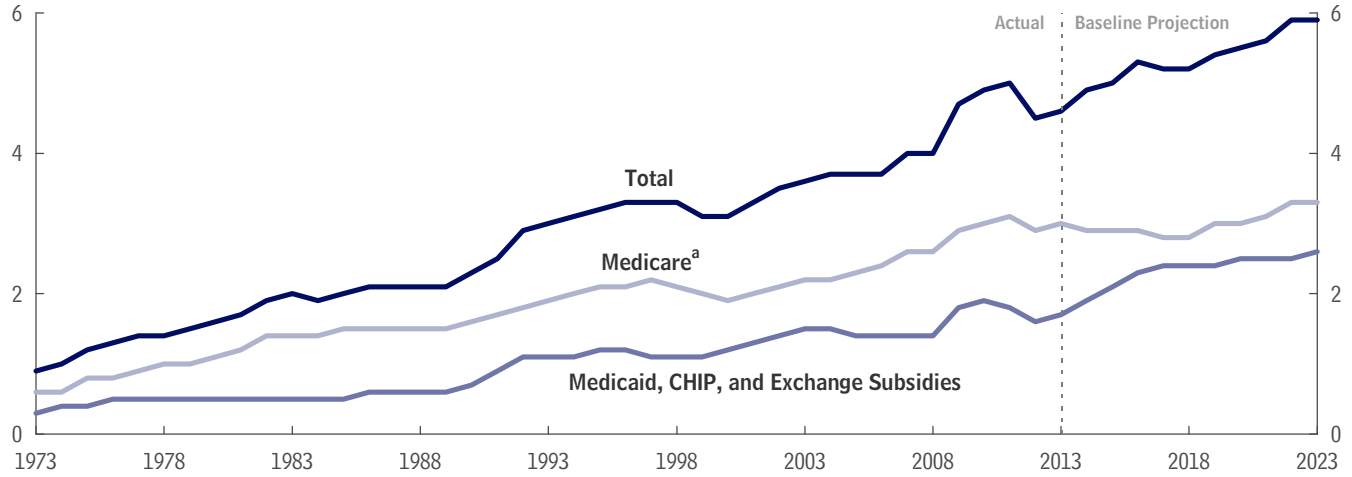
2. Those growth rates apply to discretionary spending in budget function 550 (health), budget subfunction 703 (hospital and medical care for veterans), and budget subfunction 571 (administrative costs for Medicare). They do not include the government's cost for health insurance for federal civilian or military employees.

3. Subsidies for health insurance coverage purchased through the exchanges will take two forms: tax credits to cover a portion of the premiums and additional subsidies to reduce cost-sharing payments. The premium subsidies are structured as refundable tax credits, and CBO expects that, in most cases, the amount of those credits will exceed the amount of federal income tax that recipients would otherwise owe; the amounts that offset those taxes are classified as revenue losses, and the amounts that exceed the taxes that would otherwise be owed are classified as outlays. Subsidies for the cost sharing of enrollees in exchange plans are also categorized as outlays.

Figure 1.

Federal Spending on Major Health Care Programs, by Category, 1973 to 2023

(Percentage of gross domestic product)



Source: Congressional Budget Office (as of May 2013).

Note: CHIP = Children's Health Insurance Program.

a. Net Medicare spending (includes offsetting receipts from premium payments by beneficiaries and amounts paid by states from savings on Medicaid's prescription drug costs).

grow slowly over the next decade.[4] Accordingly, during the past few years, CBO has substantially reduced its projections of spending on Medicare and Medicaid for the coming decade and slightly lowered its estimate of the underlying rate of growth for health care spending per person for the country as a whole.

Methodology Underlying Estimates Related to Health

CBO and the staff of the Joint Committee on Taxation (JCT) estimated the budgetary effects of the options in this report related to mandatory spending and revenues relative to CBO's projections of spending and revenues if current laws generally remained unchanged. Those baseline projections 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, ongoing changes to the nation's health care and health insurance systems that are occurring under current law. In particular, the projections incorporate the effects of several provisions of law that will constrain the rates that Medicare pays health care providers, among them the following:

- Payment rates for physicians' services, which are governed by the sustainable growth rate mechanism, are set to decline by about 24 percent in January 2014. CBO projects that, if current law remains in place, those payment rates will increase by small amounts in most subsequent years but will remain below 2013 levels throughout the 2014–2023 period.

- Annual updates to payment rates for health care providers other than physicians in Medicare's fee-for-service program will be restrained by a number of provisions in current law. Other provisions will slow the growth in payment rates for beneficiaries enrolled in the private insurance plans that provide Medicare benefits.

4. Studies have generally concluded that a portion of the observed reduction in growth cannot be linked directly to the weak economy, and CBO's own analysis has found no link between the recession and slower growth in spending for Medicare. For additional discussion, see Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513.

- Most Medicare payments to providers for services furnished from April 2013 to March 2022 will be reduced as a result of the automatic procedures (known as sequestration, or the cancellation of funding) in the Budget Control Act.[5]

Savings for options related to discretionary spending were estimated relative to CBO's baseline projections for such programs.

Options in This Report

Most of the 16 options in this report would either decrease federal spending on health programs or increase revenues (or equivalently, reduce tax expenditures) as a result of changes in tax provisions related to health care. 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.

Eleven of the options are similar in scope to those in CBO's previous volumes of budget options. For each of those options, the text provides background information, describes the possible policy change or changes, presents the estimated effects on spending or revenues, and summarizes arguments for and against the changes.

The other five options address broad approaches to changing federal health care policy, all of which would offer lawmakers a variety of alternative ways to alter current law. For each of those options, the amount of federal savings and the consequences for stakeholders—beneficiaries, employers, health care providers, insurers, and states—would depend crucially on which of the alternatives were chosen.The five broad approaches are the following:

- Impose caps on federal spending for Medicaid,
- Convert Medicare to a premium support system,
- Change the cost-sharing rules for Medicare and restrict medigap insurance,
- Bundle Medicare's payments to health care providers, and
- Reduce tax preferences for employment-based health insurance.

Another option for reducing federal spending on health care would be to repeal the provisions of the Affordable Care Act that expand Medicaid coverage and provide subsidies for health insurance purchased through exchanges, along with other related changes in law. That option is not included in this report, but the budgetary savings from repealing those coverage provisions would be close to their net costs, which CBO and JCT estimated most recently to be about $1.4 trillion over the 2014–2023 period.[6] In addition to the budgetary effects, the repeal of those provisions would greatly increase the number of people who would be uninsured over the next decades compared with the number under current law, and would have many other effects as well. Repeal of the entire law, which includes provisions that will reduce other spending and boost revenues, would, on net, increase budget deficits, CBO and JCT estimate.

In addition to their effects on the federal budget, the 16 options examined in this report would have a variety of other consequences. Some options are designed to affect people's behavior as they participate in the health care system. Some focus on influencing the actions of health care providers or health care plans. Still others would change the ways the government paid providers or alter the role of the federal government or the states in paying for health care services. One option would have major consequences for health researchers around the country, and one would promote better health in the population—along with increasing federal revenues—through an increase in the excise tax on cigarettes. A number of the 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

5. The annual effects of the sequestration on Medicare spending are described in Congressional Budget Office, "Medicare—May 2013 Baseline" (May 2013), www.cbo.gov/publication/44205.

6. See Congressional Budget Office, "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline" (May 2013), www.cbo.gov/publication/44190. CBO and JCT made a small update to those estimates a few months later; see Congressional Budget Office, letter to the Honorable Paul Ryan providing an analysis of the Administration's announced delay of certain requirements under the Affordable Care Act (July 30, 2013), www.cbo.gov/publication/44465.

of higher quality than it would be otherwise would hinge on the responses of those affected.

CBO and JCT estimated the budgetary impact of each option independently of the others, without consideration of potential interactions among them. The agencies accounted for the time that would be required to implement each policy and for the time needed for the effects to fully phase in. If an option would be straightforward and could be implemented fairly rapidly, it was assumed to take effect in 2014 or 2015 (depending on the specific features of the option). If a policy would take longer to implement, then few effects, if any, on federal spending or revenues were estimated for the early part of the 10-year projection period.

Subsequent cost estimates by CBO or revenue estimates by JCT for legislative proposals that resemble the options in this report could differ from the estimates shown here because the policy proposals forming the basis of those later estimates might not precisely match the options. In addition, although the estimates in this report rely on CBO's and JCT's current analysis of and judgment about the responses of individuals, businesses, and health care providers to changes in the health care system, more detailed future analyses—or the availability of new data or research results—could result in different estimates. Moreover, the baseline budget projections against which such proposals ultimately would be measured might differ because of legislative or administrative actions or because of other changes in CBO's estimates. Finally, in some cases, CBO has not yet developed specific estimates of secondary impacts for some options that would primarily affect mandatory or discretionary spending or revenues but that also could have other, less direct, effects on the budget.

Option 1 **Function 550**

Impose Caps on Federal Spending for Medicaid

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Caps on Overall Spending												
Change in Mandatory Outlays												
Base growth of caps on the CPI-U	0	0	-10	-25	-36	-48	-61	-74	-90	-106	-71	-450
Base growth of caps on per capita NHE	0	0	*	-9	-13	-14	-15	-16	-18	-20	-22	-105
Caps on Spending per Enrollee												
Change in Mandatory Outlays												
Base growth of caps on the CPI-U	0	0	-28	-45	-57	-69	-81	-94	-108	-124	-130	-606
Base growth of caps on per capita NHE	0	0	-16	-28	-34	-37	-38	-40	-43	-46	-78	-282

Notes: This option would take effect in October 2015.

* = between -$500 million and zero; CPI-U = consumer price index for all urban consumers; NHE = national health expenditures.

Overview of the Issue

The Medicaid program covers acute and long-term care for low-income families with dependent children, elderly people, people with disabilities, and, at states' option starting in January 2014, all nonelderly adults with family income up to 138 percent of the federal poverty guidelines. Under current law, the federal and state governments share in the administration of Medicaid. The federal government is responsible for establishing broad statutory, regulatory, and administrative parameters for state Medicaid programs to operate within, including determining which individuals and medical services must be covered and which may be covered at a state's discretion. The federal government also monitors states' compliance with the parameters it sets. For their part, states decide which of the eligibility and service options to adopt and are responsible for administering the daily operations of the program. Because of the discretion that states have, their Medicaid programs vary widely in terms of the optional eligibility groups and services covered, the rates used for paying health care providers, and other program elements.

Medicaid is also financed jointly by the federal and state governments; in 2012, states received $251 billion from the federal government for Medicaid and also spent $181 billion of their own funds on the program. Under current law, almost all of the federal funding is provided on an open-ended basis, meaning that increases in the number of enrollees or in costs per enrollee automatically generate more federal payments to states. For people now enrolled in Medicaid, the federal government pays about 57 percent of program costs, on average (that share varies by state from 50 percent to a current high of 73 percent). For the optional Medicaid expansion beginning in 2014, the federal share of costs will start at 100 percent in all states and phase down to 90 percent by 2020.

Spending on the Medicaid program has grown rapidly over time, consuming an increasing share of the federal budget and representing a growing percentage of gross domestic product (GDP)—trends 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 a little over 6 percent a year, because of general growth in health care costs, mandatory and optional expansions of program eligibility and covered services, and states' efforts to increase federal payments for Medicaid. CBO expects federal Medicaid spending to grow at a higher rate over the next decade, an average of

8 percent a year, largely because of the optional coverage expansion authorized by the Affordable Care Act (in which many, though not all, states are expected to participate). By comparison, GDP is projected to increase by about 5 percent a year over the next decade, and general inflation is expected to average about 2 percent a year. Under current law, CBO projects, Medicaid will go from accounting for 8 percent of the federal government's noninterest spending in 2013 to accounting for 11 percent in 2023.

Lawmakers could make various structural changes to Medicaid to decrease federal spending for the program. Those changes include reducing the scope of covered services, eliminating eligibility categories, repealing the Medicaid expansion due to start in 2014, lowering the federal government's share of total Medicaid spending, or capping the amount that each state receives from the federal government to operate the program. This option focuses on that last approach, although the other approaches' effects on federal and state spending or on enrollees could be similar to the effects of caps on federal Medicaid payments, depending on how states were allowed to, and decided to, respond to such a policy change.

Capping federal payments for Medicaid could have several advantages relative to current law. It could generate savings for the federal budget if the caps were set below current projections of federal Medicaid spending. (Caps that were significantly lower than current projections could produce large savings.) Setting an upper limit on spending would also make federal costs for Medicaid more predictable. In addition, federal spending caps would reduce states' current ability to increase federal Medicaid funds—an ability created by the open-ended nature of federal financing for the program and by the relatively high share of costs paid by the federal government. Because the relative benefit of state spending on an open-ended program such as Medicaid is higher than the relative benefit of state spending on other programs that do not receive federal funds, states have considerable incentive to devote more of their budgets to Medicaid than they would otherwise and to shift activities that had been funded entirely by the states themselves to Medicaid. Finally, if spending limits were accompanied by significant new flexibility for states—as many proposals for Medicaid caps envision—such flexibility might give states the opportunity to develop their own strategies for reducing program costs.

Caps on federal Medicaid spending could also have several disadvantages relative to current law. If the limits on federal payments were set low enough, they would shift additional costs—perhaps substantial costs—to states and cause state Medicaid budgets to become less predictable. In response, states would have to commit more of their own revenues to Medicaid or reduce services, restrict eligibility or enrollment, cut payment rates for health care providers, or (to the extent feasible) develop ways to deliver services more efficiently, each of which would raise various concerns. Moreover, depending on the structure of the caps, Medicaid might no longer serve as a countercyclical source of federal funds for states during economic downturns (meaning that a state might not automatically receive more federal funding if a downturn caused more state residents to enroll in Medicaid). In addition, because states differ significantly in the size of their Medicaid programs—and because spending varies widely (and grows at varying rates) for different types of enrollees within a state—policymakers could find it difficult to set caps at levels that accurately reflect states' costs. Finally, it might be difficult to set caps that balanced the competing goals of creating incentives for program efficiency and generating federal budgetary savings, on the one hand, and providing enough funding that states could generally maintain the size of their current Medicaid programs, on the other hand.

Key Design Choices That Would Affect Savings

A wide variety of design specifications could significantly affect the amount of savings that caps on federal Medicaid spending would produce. The key specifications include the following: whether the caps would be set on an overall or a per-enrollee basis; what portions of Medicaid spending and what eligibility categories would be included in the spending limits; what year's spending the initial caps would be based on and what percentage rate (or growth factor) would be used to increase the caps over time; how much new flexibility states would be given to make changes to Medicaid; and whether the optional coverage expansion authorized by the Affordable Care Act (ACA) would be subject to the caps (which would create some special complexities because that expansion has not yet been implemented). Those various design choices could interact in complicated ways.

Overall Cap or per-Enrollee Cap. Two principal ways to limit federal Medicaid spending through caps would be to cap overall federal spending for the program or to cap spending per enrollee. In general, overall spending caps

would consist of a maximum amount of funding that the federal government would give each state to operate Medicaid. Once established, those caps would generally not change in response to changes in enrollment or (depending on how the caps were set to increase over time) in response to changes in the cost of providing medical services.

Per-enrollee spending caps—sometimes referred to as per capita caps—would consist of an upper limit on the amount that states could spend per Medicaid enrollee, on average. Under that type of cap, 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, total federal funding for each state would be limited to the number of enrollees multiplied by the per-enrollee spending limit. (Individual enrollees who incurred high costs could still generate additional federal payments, as long as the total average cost per enrollee was less than the per capita cap.) Unlike overall spending caps, this approach would provide additional funding to states if Medicaid enrollment rose (as it does when states choose to expand eligibility or during an economic downturn) and would provide less funding to states if Medicaid enrollment fell (as it does when states restrict enrollment or when the economy is strong).

Overall caps on federal Medicaid spending could be structured in two main ways. The federal government could provide states with fixed block grants that, in general, would not increase if states' costs rose or decrease if states' costs fell. Alternatively, the federal government could maintain the current financing structure of Medicaid, in which it pays for a specific share of total spending, but it could set a limit on the amount of federal funding that could be sent to the states. In that case, states would bear all of the additional costs for any spending that exceeded the federal caps, but both the states and the federal government would share the savings if spending was less than the caps. However, if caps were lower than current projections of federal Medicaid spending, such savings would be unlikely, in CBO's view. Given states' incentives to maximize federal funding, CBO expects that states would generally structure their Medicaid programs so as to qualify for all of the available federal funds up to the amount of the caps.

Per-enrollee spending caps could also be structured in different ways. One method would be to establish fixed federal payments per enrollee per month, similar to the capitation payments that managed care companies receive from public or private payers for each enrollee. Another method would be to base caps on average federal spending per enrollee for each of the four principal categories of people eligible for Medicaid: the elderly; the blind or disabled; children; and nonelderly, nondisabled adults. To determine the spending limit for each eligibility category, the federal government would count the number of enrollees in a category and multiply it by the specified per-enrollee spending amount for that category. In effect, the overall limit on Medicaid spending for each state would be the sum of the four limits for the four groups. A similar but more flexible approach would be to set one total limit based on the sum of the limits for the four groups as above, but allow states to cross-subsidize groups (spend more than the cap for some eligibility groups and less than the cap for others) as long as a state's overall cap was maintained.

Spending Categories Included Under the Caps. Policy options to cap federal Medicaid spending could target all of that spending or spending for specific types of services. In Medicaid, most federal spending covers acute care ($152 billion in 2012) and long-term care ($71 billion in 2012), both of which could be broken into various subcategories. Other types of federal Medicaid spending include payments to hospitals that serve a disproportionate share of Medicaid enrollees and uninsured patients (known as DSH payments); spending under the Vaccines for Children (VFC) program; and administrative costs. (Together, those three categories totaled $28 billion in 2012.) In general, the more spending categories included under the caps, the greater the potential for savings to the federal government.

Eligibility Categories Included Under the Caps. Besides determining what types of Medicaid spending to cap, policymakers would face choices about which groups of enrollees to include. In general, the more eligibility categories covered by spending limits, the greater the potential for savings to the federal government. For example, caps could limit federal Medicaid spending on children and certain adults (either on an overall or on a per-enrollee basis) but could leave spending on the elderly and the disabled uncapped. However, because the elderly and the disabled currently account for about 65 percent of Medicaid spending—and are projected to account for about 50 percent in 2023, after the ACA's expansion of coverage for nonelderly, nondisabled adults—caps that did not apply to those two groups would save far less than

caps that covered all eligibility groups (assuming that the other characteristics of the two sets of caps were the same).

Base-Year Spending. Establishing caps on federal spending for Medicaid would generally begin with selecting a recent year of Medicaid outlays—the base year—and calculating that year's total spending for the service categories and eligibility groups to be included in the caps. Those spending totals would then be inflated (as described in the next section) to calculate the spending limits in future years. Thus, for both overall and per-enrollee spending caps, the selection of the base year is important because the level of spending in that year would help determine future spending caps: A higher base-year amount would lead to higher caps (and lower federal savings) than a lower base-year amount would.

Another important choice in selecting a base year is whether to use a past or future year. Most cap proposals that include base years use a past year for which Medicaid expenditures are known. The main reason for using a past year is that states cannot raise payment rates for providers, make additional one-time supplemental payments, or move payments for claims from different periods into the base year to maximize Medicaid spending and thereby boost their future spending limits. However, policymakers might want to choose a future base year in situations in which a past year would not adequately reflect an upcoming program change, such as the implementation of the optional coverage expansion starting in 2014.

Another consideration is that using a prior base year would essentially lock in states' past choices about their Medicaid programs and perpetuate those choices. (As an example of the differences among state Medicaid programs, in 2010, federal spending per disabled enrollee ranged from a low of about $5,000 in Alabama to a high of about $17,600 in the District of Columbia.) Once caps were set on the basis of states' prior choices, it would be increasingly difficult over time for states to significantly raise their payment rates or voluntarily add covered services because, unlike under current law, such changes would not lead to higher federal payments. (One way to address that issue would be to add supplemental amounts to base-year spending levels for states defined as "low spending," which would give them more room to expand their programs over time. That approach would reduce the savings from the caps, however.)

Growth Factor. The growth factor is the annual rate of growth that would be applied to base-year spending to determine the caps on (and rate of increase for) federal Medicaid spending in future years. The growth factor could be set to achieve different purposes and different levels of savings. For example, a growth factor that was roughly equal to the growth rate that CBO projects for Medicaid under current law would result in little or no budgetary savings relative to CBO's spending projections, but it could achieve other policy aims. Alternatively, a growth factor could be set to make the increase in federal Medicaid spending—overall or per enrollee—consistent with the general rate of inflation (as measured by the consumer price index for all urban consumers, or CPI-U, for example), consistent with the growth rate of health care costs per person (as measured by the increase in national health expenditures, or NHE, per person, for example), or consistent with the rate of economic growth per person (as measured by the increase in per capita GDP). However, growth factors tied to price indexes or overall economic growth 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 include a measure of population growth (such as the Census Bureau's state population estimates) to account for increases in enrollment. The growth factor could also be any legislatively specified 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 the federal budgetary savings. But the lower the growth factor, the greater the possibility that it would not keep pace with increases in costs per Medicaid enrollee and (in the case of overall caps) with increases in Medicaid enrollment, thus raising the likelihood that states would not be able to maintain their current levels of services or coverage.

Using a growth factor that incorporated the annual change in the CPI-U or in per capita NHE would mean that changes in federal Medicaid funding for states could vary considerably from year to year—although such funding could still vary less than it does under current law. As inflation, overall economic growth, or the growth of health care costs changed over time, growth factors based on those measures would cause federal Medicaid

payments to rise and fall in tandem with those changes. Policymakers could address that potential volatility by using a three-year or five-year average of the growth factor in question, or they could limit the amount of annual fluctuation by allowing the growth factor to change by no more than a certain percentage.

Efforts to reduce the degree of variability in the growth factor, however, would diminish the factor's responsiveness to changes in economic conditions. For example, if a period of low inflation, which caused only modest increases in a growth factor based on the CPI-U, gave way to a period of higher inflation, using a multiyear average for the growth factor or limiting annual changes in that factor would delay the full increase in federal Medicaid payments to states that would otherwise occur when inflation picked up. That delay would leave states with higher costs but not commensurately higher federal payments. Conversely, during a period when inflation declined—as it did in the most recent recession—mechanisms to dampen the volatility of the growth factor would slow the decrease in federal payments that would otherwise occur with per-enrollee caps. Overall, a range of adjustments are possible to mitigate those effects, but none would completely counter the effect of increased volatility without some loss of responsiveness to current economic conditions.

New Flexibility for States. Another important consideration in capping federal funding for Medicaid is how much new flexibility states would be granted. States have considerable flexibility under current Medicaid law to choose among optional services and eligibility groups; set payment rates for providers; and establish methods for delivering care, such as managed care and home- and community-based long-term care. However, states' flexibility under current law is limited in significant ways, and obtaining waivers from certain program rules can be cumbersome and time-consuming even if the waivers are ultimately granted. In principle, the structure of Medicaid's financing and the degree of state flexibility are separate issues: With a federal spending cap, the flexibility available under current law could remain the same or be altered to give states more or fewer options, and states' flexibility could be increased or decreased under the current financing structure. Nonetheless, some proponents of caps consider additional state flexibility an essential feature of proposals to limit Medicaid spending.

If spending caps were coupled with new state flexibility, states could be given more discretion over a number of program features, such as administrative requirements, ways to deliver health care, cost-sharing levels, and covered eligibility categories and medical services. New flexibility would make it easier for states to adjust their Medicaid spending in response to a limit on federal funds. The degree of new flexibility that states received would be particularly important if the federal spending caps were significantly lower than CBO's projection of Medicaid spending under current law.

Alternatively, federal spending caps could include a "maintenance of effort" requirement that would prevent states from changing the eligibility categories and medical benefits they covered before the caps took effect. That approach would ensure that key characteristics of the program in the base year—such as eligibility criteria, covered services, and the amount, duration, and scope of those services—would continue, preventing states from significantly curtailing their Medicaid programs after caps had been set.

Although the degree of new state flexibility included with caps could have a significant impact on states' ability to adjust their programs in response to the caps, it would affect federal savings on Medicaid only if three things happened: states had enough flexibility to scale back their programs to the point where federal spending was less than the caps; federal funding remained linked to the level of state funding, as under current law; and some states chose to do such scaling back. If, instead, all states drew federal payments up to the amount of the caps—as CBO expects would generally happen—the degree of state flexibility would not affect the federal savings from the caps (although it might alter the scale and effectiveness of the Medicaid program, as discussed below).

The Optional Medicaid Expansion. Beginning in 2014, states have the option to expand eligibility for Medicaid to most individuals with income below 138 percent of the federal poverty guidelines. The federal government will cover a much higher share of the cost for those people than for other types of Medicaid enrollees: 100 percent initially, phasing down to 90 percent by 2020. That optional expansion creates added complexities for federal spending caps. Data from a past base year would reflect spending only for current eligibility groups, which, when increased using the growth factor, would fail to account for future spending for the expansion group (in states that

adopt the optional expansion). Average per capita amounts also could differ for new eligibility groups.

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

- Select a base year far enough in the future to allow time for states to adopt the expansion (if they choose to) and for enrollment to reach a fairly stable level. Using a future base year, however, would give states the opportunity to inflate spending in that year, thus increasing their federal spending limits and reducing federal savings.

- Leave spending attributable to the optional expansion group uncapped and limit spending only for non-expansion enrollees. That approach would remove most of the complications created by the optional coverage group; however, it would not account for future spending for people already eligible for Medicaid who are not enrolled now but who are expected to enroll starting in 2014 (either because of the ACA's mandate to obtain health insurance coverage or because of publicity about the Medicaid expansion). One way to account for the enrollment of that group would be to add an amount to the growth rate in the early years of the expansion. Another way would be to adjust the cap levels after several years of experience to account for the additional enrollees who were previously eligible but not enrolled, although knowing how much spending was attributable to that group would be difficult.

- Cap spending for all enrollees but add a large enough amount to the growth factor to account for the enrollment of both newly eligible people and those who were previously eligible but not enrolled. Determining the size of those add-on factors would be challenging, however, and would be unlikely to provide the precise amounts of additional cap room needed to match those enrollees' costs (the caps could end up being too low or too high).

Another issue related to the optional expansion is that 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 would affect their budget processes and decisions. One of the ways in which states could lower their Medicaid costs and reduce their financial risks would be to drop the optional expansion or fail to adopt it in the future (if not already implemented). CBO anticipates that the more that caps reduced federal funding below the level projected under current law, the greater the likelihood that states would turn down the optional expansion.

To the extent that states responded to caps by declining the optional expansion, some people would lose access to Medicaid coverage, although some of them would gain access to the health insurance exchanges as a result. Specifically, people with income between 100 percent and 138 percent of the federal poverty guidelines who lost their Medicaid eligibility would qualify for premium assistance tax credits to buy coverage through the exchanges. Of the people with income below the federal poverty guidelines who no longer had access to Medicaid, most would become uninsured, and the rest would enroll in other types of coverage, principally employment-based insurance. The net budgetary effect would be to increase the federal savings from the cap policy, CBO estimates, because the savings from the reduction in Medicaid coverage would be larger than the increase in spending for exchange subsidies for the share of people who would qualify for those subsidies.

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 assumed that the caps would take effect in October 2015 and would be based on spending in 2013 (excluding Medicaid's DSH and VFC spending because the former is already capped and the latter provides vaccines for some children who may not be enrolled in Medicaid). In addition, for both types of caps, CBO excluded projected spending for the optional Medicaid expansion beginning in 2014 to avoid the complications discussed above. To illustrate a range of possible savings, CBO used two alternative growth factors for each type of cap: the annual change in the CPI-U or in per capita NHE. Other than the caps on spending, financing for the program would remain the same as under current law, with the federal government basing its share of total Medicaid spending on states' expenditures (up to the caps). Under all of the alternatives, states would not receive any new programmatic flexibility but would retain the flexibility they have now to make decisions about optional benefits, optional enrollees, and payment rates for providers.

For the overall spending caps, CBO added 1 to 3 percentage points per year to the growth factors in 2014 through 2016 to account for previously eligible people who were not enrolled but would be induced to enroll by the changes introduced by the ACA. (CBO anticipates that most such effects would be fully in place by 2016.) Those add-on factors represent the percentage of Medicaid program growth under CBO's baseline attributable to enrollment by that group. Those overall caps would save the federal government $450 billion between 2016 and 2023 using the CPI-U growth factor or $105 billion using the per capita NHE growth factor, CBO estimates. Those amounts represent savings of about 12 percent and 3 percent, respectively, of CBO's projection of total federal Medicaid spending in that period under current law. By 2023, annual savings from the two varieties of overall caps would represent about 19 percent and 4 percent, respectively, of projected federal Medicaid spending in 2023 under current law.

For the per-enrollee spending caps, CBO assumed that separate spending limits would be set for each state for each of the four main Medicaid eligibility groups: the elderly; the blind or disabled; children; and nonelderly, nondisabled adults. States would not be permitted to cross-subsidize groups. CBO used the same growth factors as for the overall caps but did not include add-on factors for the previously eligible but not enrolled because per-enrollee caps would allow for additional payments on behalf of those enrollees. With those design parameters, the per-enrollee caps would save the federal government $610 billion through 2023 using the CPI-U growth factor or $280 billion using the per capita NHE growth factor, CBO estimates. Those amounts represent savings of about 17 percent and 8 percent, respectively, of total projected federal spending for Medicaid between 2016 and 2023 under current law. By 2023, the savings would represent about 23 percent and 8 percent, respectively, of projected federal Medicaid spending in that year under current law.

CBO's estimate that per-enrollee caps would save more than overall caps on Medicaid spending (holding other factors equal) reflects some unusual economic circumstances. Under more typical economic conditions, overall caps would save more than per-enrollee caps because, with overall caps, Medicaid spending would increase only by the specified growth factor, whereas with per-enrollee caps, spending would rise by both the growth factor and increases in Medicaid enrollment. In its baseline forecast for the 2014–2023 period, however, CBO projects that Medicaid enrollment by nonexpansion adults and children will decline in some years because of the relatively rapid economic growth that is expected to occur as the U.S. economy recovers from its recent weakness. Those projected declines in enrollment lead to less Medicaid spending under per-enrollee caps but do not alter CBO's estimate of federal payments under overall caps, thus increasing the relative savings from per-enrollee caps.

Other Considerations

Limits on federal Medicaid spending would affect not only the federal budget but also the operations of the Centers for Medicare & Medicaid Services (CMS), states' role in the Medicaid program, and, potentially, enrollees' Medicaid eligibility and the extent of covered services.

Implementation Issues. For both the overall and per-enrollee spending caps, CMS would have to establish new enforcement mechanisms to ensure compliance with the spending limits. The nature of those enforcement mechanisms would depend on the way in which authorizing legislation directed CMS to establish the caps.

If the caps were based on the actual values of the CPI-U or per capita NHE, CMS would not know the final spending limits until after the end of the fiscal year, when the growth rates for those measures were finalized. In addition, for per-enrollee caps, CMS would need to wait until final Medicaid enrollment for the year was known to determine the spending limits for Medicaid's four main eligibility groups. Because it currently takes up to two years to finalize states' reports of enrollment, CMS would need to establish more timely reporting of enrollment to avoid large adjustments well after the close of the year. Regardless of how long it took to determine the final spending limits, CMS would need to adopt a reconciliation process to enforce compliance with the caps, either disallowing expenditures over the caps or lowering the following year's caps by the same amount.

As an alternative to waiting to finalize a given year's caps until after the end of the year, the caps could be based on projections of the CPI-U or per capita NHE. That way, states would know their cap amounts well before the end of the fiscal year and could plan accordingly, although then the caps would not account for changes to those measures that might occur later in the year.

Effects on States. Capping federal Medicaid spending would fundamentally change the federal-state financial relationship in the program. A capped federal commitment would mean that the responsibility for any growth in the program's costs that exceeded the growth factor (in this case, the increase in the CPI-U or per capita NHE) would be shifted to the states. CBO expects Medicaid costs to grow faster than the CPI-U or per capita NHE between 2015 and 2023, so the federal payments to states under this option would be lower than the payments projected under current law. Those savings to the federal government would represent lost revenues to states, and the losses would increase over time as the gap between federal payments under a capped program and under the current program grew larger.

Besides shifting some of the federal government's existing financial responsibility to the states, caps on federal payments would leave states at greater risk than they are now for changes in the health care marketplace and in the broader economy—elements over which they have limited control. In the case of overall spending caps, if the economy went into a recession, the growth of federal Medicaid payments would fail to keep pace with the rising need for services. (Between 2007 and 2010, for example, Medicaid enrollment increased by a total of about 14 percent.) With per-enrollee caps whose growth was based on the CPI-U, federal payments would rise in response to increases in enrollment, but payments would not respond when the growth of health care costs exceeded the growth of the CPI-U. With per-enrollee caps whose growth was based on per capita NHE, payments would adjust to average changes in the nationwide health care system but not to idiosyncratic changes in states' health care systems—and the federal savings from that alternative would be much smaller than from the approach examined here that would use the CPI-U.

With less federal funding and more budgetary uncertainty, states would have a stronger incentive than under current law to lower the cost 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 several forms. States could be permitted to run their programs without having to meet some or all of CMS's current administrative requirements, they could be given more autonomy to experiment with new ways to deliver health care to Medicaid enrollees, and they could be granted discretion to reduce coverage of mandatory services and eligibility groups.

Proponents of caps point to several ways in which additional administrative flexibility could enable states to operate their Medicaid programs more efficiently. Depending on the nature of the flexibility provided, states might be able to implement administrative procedures that would require fewer employees or reduce the number of reports submitted to CMS for oversight purposes. However, administrative costs accounted for only about 5 percent of states' total Medicaid spending in 2012, which suggests that even significant administrative efficiencies would save only modest amounts relative to total state spending on Medicaid. Proponents of caps also argue that giving states more flexibility could help them create incentives for Medicaid enrollees to use fewer services, such as through the use of increased cost sharing or of higher deductibles coupled with health savings accounts. In addition, some states might use extra flexibility to adjust the level of benefits provided to some enrollees so that, instead of receiving comprehensive benefits, as required under current law, those enrollees would receive a smaller set of targeted services to meet critical needs.

Under alternatives that would lead to significant reductions in federal funding, many states would find it difficult to offset the losses solely through the potential efficiencies described above. Such states would have three potential approaches open to them: raise additional revenues, cut other state programs to devote a greater share of their resources to Medicaid, or produce additional savings by lowering payment rates to providers, reducing covered services, or decreasing the number of enrollees. States already have some ability to adjust those elements of their Medicaid programs, but more flexibility would give them the opportunity to offset the larger losses of federal funding estimated under this option without having to raise additional revenues or cut other state programs. CBO expects that states would adopt a mix of those various approaches. Whether states would have enough flexibility to prevent declines in the number of people served by Medicaid or in the services that people received would depend largely on the size of the spending cuts that states would have to make to stay below the caps.

Effects on Enrollees. The ways in which Medicaid spending caps would affect individual enrollees would depend greatly on how an enrollee's state responded to the caps.

In states that chose to leave their Medicaid programs unchanged by finding other ways to offset the loss of federal funds, enrollees would experience little or no noticeable change in their Medicaid coverage. By contrast, in states that opted to reduce payment rates for providers, covered services, or Medicaid eligibility within the parameters of current law—or to a greater extent, if given the flexibility—enrollees would probably face several consequences. If states reduced payment rates, enrollees might find fewer providers willing to accept Medicaid patients, especially given that Medicaid already pays significantly lower rates than Medicare or private insurance in many cases. If states reduced the optional benefits they covered, some enrollees might pay out of pocket for those services or might forgo them entirely. And if states reduced the optional eligibility categories they covered (including the optional expansion slated to begin in 2014), those optional enrollees would lose access to Medicaid coverage.

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

Option 2 **Function 550**

Add a "Public Plan" to the Health Insurance Exchanges

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays	0	0	1	-2	-4	-5	-6	-6	-7	-8	-5	-37
Change in Revenues	0	0	3	10	14	16	18	19	21	21	27	121
Net Effect on the Deficit	0	0	-3	-12	-17	-21	-23	-26	-27	-29	-32	-158

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

Note: This option would take effect in January 2016.

Under current law, individuals and families will be able to purchase private health insurance coverage for 2014 and later years through the newly established health insurance exchanges. Certain participants in the exchanges will be eligible for federal subsidies, in the form of tax credits to cover a portion of their premiums and additional subsidies to reduce cost-sharing amounts (out-of-pocket payments under their insurance policies). To qualify for the tax credits, people generally must have household income between 100 percent and 400 percent of the federal poverty guidelines and not have access to certain other sources of health insurance coverage (such as "affordable" coverage through an employer, as defined in the Affordable Care Act, or coverage from a government program, such as Medicaid or Medicare). The size of the tax credit (or premium subsidy) that someone will receive will be based in part on the premium of the second-lowest-cost "silver" plan—a plan that pays about 70 percent of the costs of covered benefits—offered through the exchange in the person's area. To qualify for the cost-sharing subsidies, people must have household income below 250 percent of the federal poverty guidelines.

Small employers that provide health insurance have the option to let their workers buy that insurance through the exchanges; beginning in 2017, states may grant large employers that option as well. Such workers will still be considered to have employment-based health insurance and thus will not be eligible for exchange subsidies. However, their employers' contributions for their insurance, and typically their own payments, will be excluded from income when calculating income and payroll taxes (as is the case for other employment-based health insurance).

Under this option, the Secretary of Health and Human Services would establish and administer a public health insurance plan that would be offered through the exchanges, alongside private plans, starting in 2016. The public plan would have to charge premiums that fully covered its costs, including administrative expenses. The plan's payment rates for physicians and other individual practitioners would be set 5 percent higher than Medicare's rates in 2013 and would rise in later years to reflect estimated increases in physicians' costs; those payment rates would not be subject to the future reductions required by Medicare's sustainable growth rate formula. The public plan would pay hospitals and other providers the same amounts that would be paid under Medicare, on average, and would set payment rates for prescription drugs through negotiations with drug manufacturers. Health care providers would not be required to participate in the public plan in order to participate in Medicare or Medicaid.

In the Congressional Budget Office's estimation, premiums for the public plan would be between 7 percent and 8 percent lower, on average, during the 2016–2023 period than premiums for private plans offered in the exchanges—mainly because the public plan's payment rates for providers would generally be lower than those of private plans. In addition, the public plan would be likely to have lower administrative costs than private plans. However, CBO expects that the public plan would be less inclined than private plans to use benefit management techniques (such as narrow provider networks, utilization review, and prior-approval requirements) to control spending. The public plan would also tend to cover people who were, on average, less healthy—and therefore more costly—than the average enrollee in a private plan. (The effects of that difference would be partly offset, however, by the risk-adjustment mechanism established by the Affordable Care Act, which will transfer funds from plans with healthier enrollees to plans with less healthy enrollees.) The extent to which premiums for the

public plan differed from average premiums for private plans would vary across the country, largely because differences between the plans' payment rates for providers would be likely to vary geographically.

Adding a public plan to the exchanges in the manner described in this option would reduce federal budget deficits by $158 billion through 2023, according to estimates by CBO and the staff of the Joint Committee on Taxation (JCT). That figure reflects a $37 billion reduction in outlays (mostly from a decrease in exchange subsidies) and a $121 billion increase in revenues (mainly from changes in employment-based health insurance coverage). Those estimates include the option's effects on other spending and revenues related to health insurance coverage, such as outlays for Medicaid and penalty payments by large employers who do not offer "affordable" health insurance and by people who do not obtain insurance.

Exchange subsidies would be an estimated $39 billion lower between 2016 and 2023 under this option than under current law. Although the premium subsidies are structured as refundable tax credits, in most cases the amounts of those credits will exceed the total amount of federal income tax that recipients owe, and the amounts above the tax owed by recipients are classified as outlays. The cost-sharing subsidies for enrollees in exchange plans are also categorized as outlays. The $39 billion estimated reduction in subsidies consists of a $35 billion reduction in outlays and a $4 billion increase in revenues.

The decline in exchange subsidies would stem from several factors. CBO estimates that in many parts of the country, premiums for the public plan would be lower than the second-lowest premium among private "silver" plans, so introducing the public plan in those areas would reduce federal subsidies that are tied to that benchmark. In addition, the existence of a public plan with substantial enrollment would tend to increase the competitive pressure on insurers selling plans through the exchanges to lower their premiums, which would further reduce federal subsidies. Some of the savings from those two factors would be offset by an increase in subsidy payments caused by higher enrollment in exchange plans overall.

Revenues would be higher under this option than under current law mainly because two changes would cause a greater share of employees' compensation to take the form of taxable wages and salaries rather than nontaxable health benefits, thereby boosting tax revenues. First, because the public plan would make the exchanges more attractive to individual purchasers, some employers would forgo offering coverage, thus reducing their spending on employment-based health insurance and increasing the share of compensation devoted to taxable wages and salaries. Second, the availability of a relatively inexpensive public plan would lead some other employers to buy lower-cost coverage for their workers through the exchanges, further increasing the percentage of total compensation paid as taxable wages and salaries. Revenues would also increase under this option because, as noted above, a portion of the savings on exchange subsidies would take the form of higher revenues rather than lower outlays. Further, because fewer employers would offer health insurance to their workers under this option, penalty payments by large employers that did not offer coverage would increase. Those effects would be slightly offset by a reduction in revenues from two factors: people newly enrolling in health insurance plans would no longer pay a penalty for not having insurance, and more small employers would take advantage of the tax credits available when buying coverage through the exchanges.

The number of people who would enroll in the public plan under this option would depend on several things, including the difference between the plan's premiums and those of private plans and the number and types of providers who decided to participate in the public plan. Taking all of the relevant factors into account, CBO estimates that about 35 percent of the people who would get insurance through the exchanges—either individually or through an employer—would enroll in the public plan.

In all, about 2 million more people would obtain individually purchased coverage under this option than under current law, CBO estimates, and about 2 million fewer people would have employment-based coverage in each year. Small employers offering health insurance to their workers would be more likely to obtain it through the exchanges than they would under current law. The option would have minimal effects on the number of people with other sources of coverage and on the number of people who would be uninsured.

The current estimate of savings from this option is higher than the savings that CBO and JCT estimated for the same option in the previous version of this report (published in 2011). The change in the estimate primarily reflects two factors. First, CBO now estimates a larger

reduction in the number of people receiving health insurance coverage through their employers under this option. As a result, CBO and JCT project that adding a public plan to the exchanges would lead to larger increases in tax revenues, as well as bigger increases in penalty payments by large employers that did not offer insurance, compared with the previous estimate. Second, since the 2011 estimate was published, preliminary tax data have shown that small businesses have been slower than expected to take advantage of the Affordable Care Act's small-employer tax credits to reduce the cost of health insurance. Therefore, although CBO estimates that a similar number of people would newly obtain employment-based coverage through the exchanges, it expects a smaller share of employers to apply for the tax credits than previously estimated. Both factors increase savings compared with CBO and JCT's 2011 estimate.

One rationale for adding a public plan to the exchanges is that it would help reduce premiums for some individuals, families, and employers who would buy insurance through the exchanges but would not qualify for subsidies. Premiums would be reduced both because the public plan would be one of the lowest-cost plans available in many areas and because adding a low-cost option would increase the competitive pressure on private plans, leading them to decrease their premiums.

A potential drawback of this option is that the public plan's payment rates to providers might be much lower than the rates paid by private plans in many parts of the country, which could lead some providers who participated in the public plan to reduce the quality of the care they furnished. Although providers' participation in the public plan would be voluntary, enrollment in the plan could be large enough that providers would face substantial pressure to participate.

Another possible drawback of this option is that if the public plan attracted high-cost enrollees and could not collect enough in premiums to cover its costs, the federal government would have to pay for the plan's losses (although the plan would be required to build up a contingency fund). More generally, adding a public plan to the exchanges would imply a greater federal role in providing health insurance.

RELATED OPTION: Option 3

Option 3 **Function 550**

Eliminate Exchange Subsidies for People With Income Over 300 Percent of the Federal Poverty Guidelines

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014-2018	2014-2023
Change in Mandatory Outlays	0	-6	-14	-18	-20	-21	-22	-23	-24	-25	-59	-173
Change in Revenues	0	-1	-5	-7	-8	-8	-8	-8	-9	-10	-21	-64
Net Effect on the Deficit	0	-5	-9	-11	-12	-13	-14	-15	-15	-15	-37	-109

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

Note: This option would take effect in January 2015.

Under current law, individuals and families will be able to purchase private health insurance coverage for 2014 and later years through the newly established health insurance exchanges. Certain participants in the exchanges will be eligible for federal subsidies, in the form of tax credits to cover a portion of their premiums and additional subsidies to reduce cost-sharing amounts (out-of-pocket payments under their insurance policies). To qualify for the tax credits, people generally must have household income between 100 percent and 400 percent of the federal poverty guidelines (commonly known as the federal poverty level, or FPL) and not have access to certain other sources of health insurance coverage (such as "affordable" coverage through an employer, as defined in the Affordable Care Act, or coverage from a government program, such as Medicaid or Medicare). To qualify for the cost-sharing subsidies, people must have household income below 250 percent of the FPL.

The size of the tax credit (or premium subsidy) that someone will receive will be based in part on the premium of the second-lowest-cost "silver" plan—a plan that pays about 70 percent of the costs of covered benefits—offered through the exchange in the person's area. The premium subsidy is designed to keep the cost to an enrollee of that second-lowest-cost silver plan at or below a specified percentage of the enrollee's income. For example, in 2014, the subsidy will be calculated so that people with income between 100 percent and 133 percent of the FPL will pay no more than 2 percent of their income to enroll in the second-lowest-cost silver plan; people with higher income will pay a larger share of their income, up to 9.5 percent for enrollees with income between 300 percent and 400 percent of the FPL. (The poverty guidelines vary by family size. In 2013, 300 percent to 400 percent of the FPL represents income of $34,470 to $45,960 for an individual, $46,530 to $62,040 for a family with two members, and $70,650 to $94,200 for a family with four members.)

This option would cap the income level at which premium subsidies were available in the exchanges at 300 percent of the FPL beginning in 2015. Accordingly, starting in that year, people with income between 300 percent and 400 percent of the FPL who bought insurance through the exchanges would no longer qualify for those subsidies. Eligibility for cost-sharing subsidies would remain capped at 250 percent of the FPL.

Under current law, roughly 1 million exchange enrollees in 2015 will have income between 300 percent and 400 percent of the FPL, according to estimates by the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT), and about 70 percent of them will receive premium subsidies. The remaining 30 percent are not expected to receive subsidies, either because the premium for the second-lowest-cost silver plan in their area will not exceed the percentage of their income specified in the Affordable Care Act or because they will not qualify for subsidies for other reasons. This option would have no direct effect on enrollees who would be unsubsidized under current law.

Lowering the income ceiling for premium subsidies to 300 percent of the poverty guidelines would reduce federal budget deficits by $109 billion between 2015 and 2023, CBO and JCT estimate. That budgetary impact would stem partly from the direct effect of not providing subsidies to people with income between 300 percent and 400 percent of the FPL and partly from a reduction in the number of people with income below that range who would obtain insurance (and subsidies) through the

exchanges. Specifically, employers who are deciding whether to offer health insurance generally weigh the attractiveness to their workers of alternative sources of coverage, and a lower income ceiling for premium subsidies would make the exchanges less appealing for some workers. As a result, CBO and JCT expect that this option would increase the number of employers who offer health insurance to their workers, relative to the number expected to do so under current law, and thus would reduce the number of people at all income levels who would obtain insurance through the exchanges or other programs.

By CBO and JCT's estimates, this option would increase the number of people covered by employment-based health insurance in years after 2015 by about 4 million. During those years, the option would reduce the number of people enrolled in exchange plans by about 3 million to 4 million, reduce the number of people enrolled in Medicaid or the Children's Health Insurance Program (CHIP) by about half a million, and decrease the number of uninsured people by less than half a million. That slight decline in the number of people without insurance is the net effect of two factors: On the one hand, more employers would be likely to offer health insurance under this option, so some people who would otherwise be uninsured would have the chance to obtain employment-based coverage. On the other hand, some of the people with income between 300 percent and 400 percent of the FPL who would no longer get premium subsidies would become uninsured instead of enrolling in an unsubsidized plan.

The estimated $109 billion in savings from this option through 2023 is the net effect of a $173 billion reduction in outlays, largely stemming from a decrease in exchange subsidies, and a $64 billion reduction in revenues, mainly resulting from a decline in taxable income because of the increase in employment-based insurance coverage.

Exchange subsidies would be $182 billion lower between 2015 and 2023 under this option than under current law, CBO and JCT estimate. Although the premium subsidies are structured as refundable tax credits, in most cases the amounts of those credits will exceed the total amount of federal income tax that recipients owe, and the amounts above the tax owed by recipients are classified as outlays. The cost-sharing subsidies for enrollees in exchange plans are also categorized as outlays. The estimated $182 billion reduction in subsidies consists of a $161 billion decrease in outlays and a $21 billion increase in revenues.

Reductions in the number of people enrolled in Medicaid and CHIP and other small effects on spending would reduce federal outlays by a further $12 billion, on net.

Revenues would be lower under this option than under current law mainly because the increase in the number of people who would enroll in employment-based plans would cause a greater share of employees' compensation to take the form of nontaxable health benefits rather than taxable wages and salaries, thereby lowering tax revenues. At the same time, because more employers would offer health insurance to their workers, payments of penalties by large employers that did not offer insurance would decrease; and because slightly fewer people would be uninsured, individuals' payments of penalties for not having health insurance would also fall. Those declines in revenues would be partly offset by an increase in revenues from the reduction in exchange subsidies discussed above.

The main advantage of this option is that capping exchange subsidies at 300 percent of the FPL would reduce the deficit without increasing the number of people without health insurance. Because this option would lead to greater availability of employment-based health insurance, higher enrollment in such insurance among people in various income groups would more than offset the number of people with income between 300 percent and 400 percent of the FPL who would choose not to have insurance coverage if it was not subsidized.

One argument against this option is that most family policyholders who would lose exchange subsidies would receive smaller tax subsidies for obtaining employment-based health insurance instead. Employment-based insurance is excluded from income and payroll taxes, and the tax subsidy created by those exclusions increases with taxpayers' marginal tax rates—and thus generally with taxpayers' income. By contrast, premium subsidies in the exchanges decrease with income. CBO estimates that in 2015, a family of four with income equal to 350 percent of the FPL that was enrolled in a plan purchased through an exchange would receive an average premium subsidy of $7,000. If that family instead received a comparably priced health plan through a family member's employer, the average tax subsidy would be worth roughly $5,500. (The premiums and benefits of employment-based

insurance could differ, however, from those of insurance sold in the exchanges.)

Another argument against this option is that most people would face a substantial drop in premium subsidies at exactly 300 percent of the FPL. Under current law, a single policyholder enrolled in a second-lowest-cost silver plan costing $5,000 a year who sees his or her income rise from just below 400 percent of the FPL to just above that amount will lose an exchange subsidy of about $500. Under this option, by comparison, a single policyholder enrolled in a similar plan whose income rose from just below 300 percent of the FPL to just above that amount would lose a much larger exchange subsidy: about $1,600. That larger "cliff" would reduce the incentive for people with income near 300 percent of FPL to work more and would lead to greater efforts to reduce reported taxable income in other ways as well.

At the same time, exchange subsidies have their own disincentive effects: The fact that they are tied to a percentage of income creates an effective tax on additional income equal to the percentage threshold—9.5 percent in 2014 for people with income between 300 percent and 400 percent of the FPL. Eliminating exchange subsidies for that group would remove the current disincentive effects of the subsidies for those workers.

RELATED OPTION: Option 2

RELATED CBO PUBLICATION: *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), www.cbo.gov/publication/43082

Option 4 **Function 550**

Limit Medical Malpractice Torts

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays[a]	-0.1	-1.1	-3.5	-5.3	-6.4	-7.1	-7.5	-8.0	-8.8	-9.3	-16.4	-57.1
Change in Revenues[b]	*	0.1	0.3	0.5	0.8	0.9	1.0	1.0	1.1	1.1	1.6	6.7
Change in Discretionary Outlays	*	*	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.5	-1.8

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

Notes: This option would take effect in January 2014.

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

a. Estimates include potential 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.

Individuals may pursue civil claims against physicians, hospitals, and other health care providers for alleged torts, which, in the medical field, primarily include breaches of duty that result in personal injury. That system of tort law has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for losses they incur (such as lost wages, medical expenses, and pain and suffering) because of an injury caused by negligence. Malpractice claims are generally pursued through state courts, and states have established various rules by which those claims are adjudicated.

To protect against the risk of having to pay a very large malpractice claim, nearly all health care providers obtain malpractice insurance. The cost of that insurance results in higher medical costs because providers charge their patients higher fees to pay for their insurance premiums. In addition, providers' efforts to reduce the risk of malpractice claims lead to greater use of health care than would be the case in the absence of that risk.

This option would limit medical malpractice torts nationwide in several ways:

- Capping awards for noneconomic damages (also known as pain and suffering) at $250,000.
- Capping awards for punitive damages at $500,000 or at two times the value of awards for economic damages (such as for lost income and medical costs), whichever is greater.
- Shortening the statute of limitations to one year from the date of discovery of an injury for adults and to three years for children.
- Establishing a fair-share rule (in 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 (in which all of the defendants are individually responsible for the entire amount of the award).
- Allowing evidence of income from collateral sources (such as life insurance payouts and health insurance) to be introduced at trial.

Many states have enacted some or all of those limits, whereas other states have very few restrictions on malpractice claims.

Limiting malpractice torts nationwide would reduce total health care spending in two ways. First, tort limits would lower premiums for malpractice insurance by decreasing the average size of malpractice awards (which would also have the effect of decreasing the number of tort claims filed). That reduction in the cost of malpractice insurance paid by providers would flow to health plans and patients in the form of lower prices for health care services. Second, research suggests that placing limits on malpractice torts would decrease the use of health care services to a small extent because providers would prescribe slightly fewer services if they faced less pressure from potential malpractice claims. Together, those two factors would

cause this option to reduce total health care spending by about 0.5 percent, the Congressional Budget Office estimates. (For this option, CBO expects that changes enacted in January 2014 would take four years to have their full impact, as providers gradually modified their practice patterns.) Spending for Medicare would decline by a larger percentage than spending for other federal health care programs or national health care spending, CBO projects. That difference is based on empirical evidence that states' restrictions on malpractice torts have had a greater impact on the use of health care services in Medicare than in the rest of the health care system.

The changes in this option would reduce mandatory spending—for Medicare, Medicaid, the Children's Health Insurance Program, subsidies for coverage purchased through health insurance exchanges, and health insurance for retired federal employees—by $57 billion between 2014 and 2023, CBO estimates. Savings in discretionary spending, such as for health insurance for current federal employees, would amount to $2 billion over that 10-year period, if the amounts appropriated for federal agencies were reduced accordingly.

By decreasing spending on health care in the private sector, this option would also affect federal revenues. Much private-sector health care is provided through employment-based health insurance, which is a nontaxable form of compensation. Because the premiums that employers pay for that insurance are excluded from employees' taxable income, lowering those premiums would increase the share of employees' compensation that was taxable. That shift would increase federal tax revenues by an estimated $7 billion over the next 10 years.

A rationale for tort limits is the reduction in national health care spending that they would bring about. Another rationale is that, by leading to lower premiums for malpractice insurance, tort limits could help alleviate shortages of certain types of physicians in some parts of the country. For example, annual malpractice premiums for obstetricians exceed $200,000 in some areas.[1] Such high premiums may deter some obstetricians from practicing in those areas or from practicing at all.

An argument against this option is that limits on torts could make it harder for people to obtain full compensation for injuries caused by medical negligence. Another argument against tort limits is that reducing the amount of money that could be collected in the case of a medical injury might cause health care providers to exercise less caution, which could increase the number of medical injuries attributable to malpractice. However, the evidence is mixed about whether tort limits have an adverse effect on health outcomes. Some researchers found that when the risk of litigation declined, the use of health care services decreased and mortality rates increased. Another study found that changes to joint-and-several liability had positive effects on health but that caps on noneconomic damages had negative effects. Other studies concluded that tort limits had no impact on mortality or other measures of health.

1. Premiums charged by Physicians' Reciprocal Insurers for obstetricians practicing in certain counties in New York State, as reported in "Annual Rate Survey," *Medical Liability Monitor,* vol. 38, no. 10 (October 2013).

RELATED CBO PUBLICATIONS: 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; and 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

Option 5 **Function 550**

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

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays												
MERHCF	0	-1.4	-2.0	-2.2	-2.4	-2.5	-2.7	-2.8	-3.0	-3.2	-8.0	-22.2
Medicare	0	-0.2	-0.5	-0.9	-1.0	-1.1	-1.1	-1.2	-1.3	-1.3	-2.6	-8.6
Total	0	-1.6	-2.5	-3.1	-3.4	-3.6	-3.8	-4.0	-4.3	-4.5	-10.6	-30.7

Notes: This option would take effect in January 2015.

MERHCF = Department of Defense Medicare-Eligible Retiree Health Care Fund.

TRICARE for Life (TFL) was introduced in 2002 as a supplement to Medicare for military retirees and their family members who are eligible for Medicare. 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 people receiving care to pay deductibles or copayments up to a specified threshold. In 2012, DoD spent $8.7 billion for the care delivered through TFL by both military treatment facilities and civilian providers (in addition to the amount spent for those beneficiaries through Medicare).

This option would introduce minimum out-of-pocket requirements for TFL beneficiaries. For calendar year 2015, TFL would not cover any of the first $550 of an enrollee's cost-sharing payments under Medicare and would cover only 50 percent of the next $4,950 in such payments. Because all further costs would be covered by TFL, enrollees would not be obligated to pay more than $3,025 in 2015. 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 TRICARE for Life because higher out-of-pocket costs would lead beneficiaries to use somewhat fewer medical services. Altogether, this option would reduce the federal spending devoted to TFL beneficiaries by $31 billion between 2015 and 2023, the Congressional Budget Office estimates. About one-third of those savings would come from reduced spending for medical services 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 would be that the change 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: Options 7 and 12

RELATED CBO PUBLICATIONS: *Approaches to Reducing Federal Spending on the Defense Health System* (forthcoming); *Long-Term Implications of the 2014 Future Years Defense Program* (forthcoming); and *The Effects of Proposals to Increase Cost Sharing in TRICARE* (June 2009), www.cbo.gov/publication/41188

Option 6 **Function 570**

Convert Medicare to a Premium Support System

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Without a Grandfathering Provision												
Change in Mandatory Outlays												
Second-lowest-bid alternative	0	0	0	0	-31	-43	-45	-48	-52	-56	-31	-275
Average-bid alternative	0	0	0	0	2	-8	-14	-15	-16	-17	2	-69
With a Grandfathering Provision												
Change in Mandatory Outlays												
Second-lowest-bid alternative	0	0	0	0	-1	-4	-8	-12	-16	-20	-1	-61
Average-bid alternative	0	0	0	0	*	-1	-3	-4	-6	-7	*	-22

Notes: This option would take effect in January 2018. It would not apply to dual-eligible beneficiaries (people who are jointly enrolled in Medicare and Medicaid).

* = between zero and $500 million.

Overview of the Issue

Nearly 30 percent of Medicare beneficiaries are enrolled in the Medicare Advantage program, or Part C, under which private health insurers assume the responsibility for, and the financial risk of, providing Medicare benefits. Almost all other Medicare beneficiaries receive care in the traditional fee-for-service (FFS) program, which pays providers a separate amount for each service or related set of services covered by Part A (Hospital Insurance) or Part B (Medical Insurance). Federal payments to Medicare Advantage plans depend in part on the bids that the plans submit (indicating the per capita payment they will accept for providing the benefits covered by Parts A and B) and in part on how those bids compare with predetermined "benchmarks." Under a method that will be fully phased in by 2017, Medicare Advantage benchmarks depend on per capita spending in the FFS program at the county level. (Private insurers also participate in a separate bidding process that is used to determine payments under Part D, Medicare's prescription drug benefit program.)

The current system ties federal payments for Medicare Advantage enrollees to spending in the FFS program, limits the degree of competition among plans, and does not require the FFS program and private insurers to compete on the same terms. Some policymakers and analysts have proposed replacing the current Medicare system with a premium support system, in which Medicare beneficiaries would buy insurance coverage from one of a number of competing plans—potentially including the FFS program—and the federal government would pay part of the cost of the coverage.

Key Design Choices That Would Affect Savings

The effects of a premium support system on federal spending and on beneficiaries' total payments (premiums and out-of-pocket costs for medical care) would depend crucially on how the system was designed. Important choices include setting the formula for the federal contribution, determining whether the traditional FFS program would be included as a competing plan, setting eligibility rules for the premium support system, and designing the features of the system that would influence beneficiaries' choices among plans.

This discussion assumes that a premium support system would retain certain features of the current Medicare program—namely, insurers could not refuse to enroll a Medicare beneficiary because of the person's health, age, or other characteristics; federal payments to insurers would be adjusted to account for differences in enrollees' health; and all enrollees in a given plan and geographic area would pay the same premium for the same coverage (except that, as under current law, higher-income beneficiaries would pay more to enroll in Part B). Changes to

any of those features could have major consequences for federal spending and for beneficiaries' total payments under a premium support system.

The Federal Contribution. Two general approaches are possible for determining how much of the cost of health insurance coverage the federal government would pay for under a premium support system: The amount could be derived either from the bids of participating health plans or through a mechanism designed to achieve a specified path for federal spending on Medicare. Either approach could be applied in many different ways. Some recent proposals would base the federal contribution on the second-lowest bid or on the average bid in a region, although many other possibilities exist. Setting the federal contribution to achieve a specific path for Medicare spending would require setting an initial amount per person and increasing it over time based on the growth of some particular economic or budgetary measure, such as per capita gross domestic product. In some cases, a hybrid of those two general approaches has been proposed: The federal contribution would be set on the basis of insurers' bids but its growth would be capped on the basis of some broader economic measure.

If the federal contribution was based on insurers' bids (but its growth was not capped), the contribution could be set to keep pace with insurers' costs of providing the benefits covered by Medicare. The contribution would therefore be sufficient in future years for beneficiaries to buy coverage from at least one health plan in each region at a premium that represented the same percentage of the total cost of coverage that was chosen at the outset. Setting the federal contribution to achieve a specific path for federal Medicare spending would give the government greater control over its spending, but beneficiaries might face much higher premiums if insurers' costs grew faster than the federal contribution did. The same issue could arise if the federal contribution was determined from insurers' bids but its growth was capped.

The Fee-for-Service Program. A key choice in designing a premium support system is whether Medicare's FFS program would be eliminated or retained as an option for beneficiaries, competing alongside private insurers. In the Congressional Budget Office's assessment, eliminating the FFS program and the rates that it would pay health care providers under current law would cause the rates that private insurers paid providers for their premium support enrollees to be much higher—with a concomitant increase in the costs of providing Medicare coverage—than if a premium support system included the FFS program as a competing plan. That assessment is based on the observation that although Medicare Advantage plans generally pay providers about the same rates as Medicare's FFS program, private insurers generally pay substantially higher rates for services provided to enrollees with private coverage. CBO expects that the presence of the FFS program as a competing plan would constrain the rates that private insurers paid for services provided to premium support enrollees, whereas eliminating the FFS program would cause those rates to rise toward the rates paid for enrollees with private coverage.

In a system in which the federal contribution was based on insurers' bids, eliminating the FFS program would result in higher bids, which would reduce federal savings and could even cause federal spending to be higher under a premium support system than under current law. CBO also expects that in some regions, the FFS program's bid would be among the lower bids, so getting rid of that program could directly reduce federal savings by raising the federal contribution in those regions. By contrast, in a premium support system in which the federal contribution was set to achieve a specific path for federal spending, eliminating the FFS program would not affect that spending, although the resulting increase in the cost of coverage for private plans would lead to higher premiums for beneficiaries.

Eligibility. Federal savings from a premium support system would depend partly on which beneficiaries were included in the new system. Some proposals include a "grandfathering" provision, under which all beneficiaries who became eligible for Medicare before the premium support system took effect would remain in the current-law Medicare program and only people who became eligible after that time would enroll in the new system. Although a grandfathering provision would keep current beneficiaries from having to adjust to a premium support system, it would reduce federal savings greatly, because only a small portion of the Medicare population would be covered by the new system initially, and that portion would increase only gradually over many years. Savings would be even more limited because average health care costs for newly eligible people entering the premium support system would be lower than the average for Medicare beneficiaries as a group (since those new entrants would be younger and, therefore, generally in better health).

Another key choice is whether and how dual-eligible beneficiaries—people who are jointly enrolled in Medicare and Medicaid—would be included in a premium support system. (CBO estimates that in 2009, those beneficiaries made up 19 percent of the Medicare population and accounted for 29 percent of total spending for Part A and Part B benefits.) Medicare covers some services for dual-eligible beneficiaries and Medicaid covers others, thus creating conflicting financial incentives for the federal and state governments (which jointly fund Medicaid) and for health care providers. Recent federal and state efforts have focused on integrating the two programs' funding streams and coordinating the often-complex care that many dual-eligible beneficiaries receive. Including that group in a premium support system would pose substantial additional challenges. For instance, it would be difficult to give dual-eligible beneficiaries incentives to choose low-bidding plans in a premium support system while also minimizing their total payments for medical care. Nevertheless, excluding such beneficiaries would reduce the potential savings that a premium support system could achieve.

Features of the System That Could Affect Enrollment Choices. Many features of a premium support system would influence beneficiaries' sensitivity to differences in plans' premiums, thus affecting insurers' incentives to reduce their bids. Two features of particular importance are how enrollees would initially select a plan and how much standardization would be required of the various plans.

One possible approach to structuring enrollment would be to have beneficiaries affirmatively choose a plan (possibly including the FFS program) when they entered the premium support system or else be assigned to a plan whose bid was at or below the benchmark. A second approach would be to allow beneficiaries who did not choose a plan when they entered the new system to remain in their current plan—or the FFS program, if that was their current source of coverage—or be assigned to a similar plan or to the FFS program if their current plan was unavailable. (An option for beneficiaries who were just entering Medicare and did not choose a plan would be to assign them to the FFS program.) The first approach would probably give insurers a greater incentive to lower their bids because they would anticipate that enrollments would rise more as a result. Under the second approach, beneficiaries would generally have less risk of being assigned to a plan that excluded their current providers from its network, but, depending on the region, some beneficiaries could unwittingly remain in plans that would require much higher premiums than they had paid before.

Another key question concerns the degree of standardization that would be required for benefit packages. Possible approaches include making all plans cover the same services and impose identical cost-sharing requirements; requiring all plans to cover the same services but allowing them to vary their cost-sharing requirements, as long as the benefit packages were actuarially equivalent (that is, each package covered the same percentage of total expenses for a given population); or letting plans vary both their covered services and cost-sharing requirements, as long as the benefits were actuarially equivalent. Federal costs under any of those approaches would depend crucially on whether the standard package had the same actuarial value as Medicare's current benefits or some different value. In general, greater standardization of benefits would make it easier for people to compare plans on the basis of price, thus enhancing competition and lowering bids. However, standardization would prevent plans from offering benefit packages that some people might prefer to a standard package specified by the federal government. It could also limit the extent to which insurers developed innovative cost-sharing arrangements that might result in lower costs, higher-quality care, or both.

Specific Alternatives and Estimates

CBO examined four alternatives for converting Medicare to a premium support system. In all of the alternatives, the federal government's contribution would be determined from insurers' bids, and Medicare's FFS program would be a competing plan. The nation would be divided into regions within which competing private insurers would submit bids indicating the amounts they would accept to provide Medicare benefits to a beneficiary of average health. The FFS program's bid would be based on projected FFS spending in a given region for a beneficiary of average health. Insurers would bid on a benefit package that would cover the same services as Parts A and B of Medicare (with a few exceptions, as noted below) and that would have the same actuarial value as Parts A and B combined. (Medicare's prescription drug benefit, which is delivered through a competitive system under Part D, would be administered separately.)

The four alternatives would differ by whether they included a grandfathering provision and by which of two approaches they used to determine the benchmarks for setting the federal contribution:

- Under the second-lowest-bid approach, the benchmark in a region would be the lower of a pair of bids—the region's second-lowest bid submitted by a private insurer and Medicare's FFS bid.
- Under the average-bid approach, the benchmark in a region would be the weighted average of all bids, including the FFS bid. Each bid would be weighted by the proportion of beneficiaries enrolled in that plan in the preceding year.

For each enrollee of average health, the federal government would pay insurers an amount equal to the benchmark for the region minus the standard premium paid by enrollees (explained below); insurers would receive larger or smaller government payments for beneficiaries whose health was worse or better than average. Neither the amount nor the growth rate of the federal payment would be capped.

Beneficiaries who enrolled in a plan with a bid that equaled the benchmark would pay a standard premium directly to the insurer; the standard premium would equal one-quarter of the estimated per capita cost of providing Part B benefits for all Medicare beneficiaries and would be the same across the nation (which corresponds to the formula used under current law for Part B premiums). Beneficiaries who chose a plan with a bid less than the benchmark would pay the insurer a premium that was lower by the full amount of the difference between the bid and the benchmark, and those who chose a plan with a bid greater than the benchmark would pay a premium that was correspondingly higher. The income-related Part B premiums specified in current law for higher-income beneficiaries would continue and would be withheld from Social Security benefits.

Beneficiaries would choose a plan during an annual enrollment period and would be required to remain in that plan for a year. They would automatically continue to be enrolled in the plan in subsequent years unless they chose a different one. (When the premium support system went into effect, however, Medicare beneficiaries would not remain in their previous plan automatically.) Beneficiaries who did not select a plan when they entered the premium support system would be assigned (with equal probability) to a limited number of plans that presented bids at or below the benchmark, including the FFS program if it met that criterion.

CBO assumed that the premium support system would not affect certain portions of federal spending for Medicare. For example, dual-eligible beneficiaries would be excluded from the system under these alternatives, and CBO assumed that Medicare's spending for those beneficiaries would continue at the amounts projected under current law—as would spending for Part D (which would operate separately) and spending for certain items and services that are not covered by the bids that Medicare Advantage plans submit under current law. Those items and services include Medicare's additional payments to hospitals whose share of low-income patients exceeds a specified threshold and spending for medical education, hospice benefits, and certain benefits for patients with end-stage renal disease. CBO excluded those categories of spending from the premium support system to simplify the analysis. In 2012, those excluded categories made up about 35 percent of net federal spending for Medicare (total Medicare spending, including spending on dual-eligible beneficiaries and on prescription drugs under Part D, minus beneficiaries' premiums and other offsetting receipts).

For this option, CBO assumed that legislation establishing a premium support system would be enacted early in fiscal year 2014. To allow time for the federal government to develop the necessary administrative structures and for beneficiaries and insurers to learn about and prepare for the new system, CBO assumed that the system would be implemented in calendar year 2018. CBO also made many other detailed assumptions for these alternatives, which are described in Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013). Some specifications were chosen to illustrate the potential for savings from a highly competitive system; others were chosen for feasibility of implementation or to simplify the analysis.

Unlike the other options in this report, whose budgetary effects are measured against CBO's May 2013 current-law baseline projections, estimates of the effects of these alternatives over the next 10 years are based on analyses that were largely conducted using CBO's March 2012 baseline projections of Medicare spending. Analysis of the longer-term effects of the alternatives is based on CBO's

June 2012 long-term projections of Medicare spending. (Those two sets of projections were the most recent ones available when much of the analysis was performed.) To estimate the budgetary effects of the alternatives over the next 10 years in dollar terms, CBO applied the estimated percentage changes in federal spending derived from the analyses based on its March 2012 baseline projections to its most recent projections of Medicare spending, which were released in May 2013.

Estimates of the budgetary impact of these alternatives over the next 10 years are highly uncertain, given the substantial changes to the Medicare program that a premium support system would entail, the government's lack of experience with similar systems, the rapid evolution of health care and health insurance, and the significant changes occurring in the Medicare program under current law. Estimates are even more uncertain for the period after 2023.

Budgetary Effects Without a Grandfathering Provision. If the premium support system covered people who were already eligible for Medicare as well as future beneficiaries (but excluded dual-eligible beneficiaries), the second-lowest-bid alternative would reduce net federal spending for Medicare by $275 billion between 2018 and 2023, CBO estimates, and the average-bid alternative would reduce net federal spending over that period by $69 billion. By 2020 (an illustrative year shortly after the premium support system would be implemented), the second-lowest-bid alternative would reduce net federal spending for Medicare by 6 percent, compared with projected spending under current law, and the average-bid alternative would reduce that spending by 2 percent.

Another way to measure the effects of these alternatives is to examine their impact on the federal government's net spending for affected beneficiaries—everyone, other than dual-eligible beneficiaries, who would have enrolled in Medicare under current law—for the benefits that would be included in the premium support system. (That measure consists of federal spending for affected beneficiaries—excluding spending for Part D benefits and the items and services noted above that are not covered by the bids of Medicare Advantage plans under current law—minus beneficiaries' premiums and other offsetting receipts.) With no grandfathering provision, the second-lowest-bid alternative would reduce net spending for affected beneficiaries in 2020 by 11 percent, and the average-bid alternative would reduce such spending by 4 percent, CBO estimates. Those percentages are larger than are the percentage reductions in total Medicare spending because these savings are measured relative to the portion of Medicare spending that would be covered under the premium support system, rather than relative to total Medicare spending.

Under either alternative, the savings to Medicare between 2018 and 2023 would be similar in percentage terms to the savings estimated for 2020, with one main exception. Under the average-bid alternative, federal spending for 2018 would be higher than under current law, CBO estimates. The main reason for that difference is that the FFS program's bid would receive a greater weight in constructing benchmarks in the first year of the new system than it would in later years (because CBO assumed that the weight would equal the proportion of beneficiaries enrolled in the FFS program under current law in 2017). Thus, under the average-bid option, most regions would have higher benchmarks in 2018 than they would later.

Looking beyond the next 10 years, CBO expects that, under either alternative, annual federal savings in percentage terms would remain roughly stable from 2023 through 2032, although the dollar amount of the savings would increase. Over the long term, the increase in price competition from the premium support system specified here would probably reduce the growth of Medicare spending by decreasing the demand for expensive new technologies and treatments and by increasing the demand for cost-reducing technologies. However, the potential for a premium support system to produce additional savings would be limited by provisions of current law that are designed to restrain the growth of Medicare spending. In particular, CBO anticipates, private insurers would not be able to hold down payments to health care providers to the extent required in the FFS program by the sustainable growth rate mechanism for physicians and by other current-law provisions that will limit payment increases for other providers.

Budgetary Effects With a Grandfathering Provision. Federal savings would be much smaller under a premium support system that excluded people already eligible for Medicare. CBO estimates that if the system applied only to people who turned 65 (or qualified for Medicare before age 65) in 2018 or later, and all other beneficiaries (including dual-eligible beneficiaries) remained in the current-law Medicare program, the system would cover only about 15 percent of the Medicare spending from

2018 through 2023 that it would cover if it did not have a grandfathering provision. With that system, the second-lowest-bid alternative would reduce net federal spending for Medicare by $61 billion through 2023, and the average-bid alternative would reduce such spending by $22 billion, CBO estimates.

Thus, modifying the second-lowest bid alternative to include a grandfathering provision would yield savings between 2018 and 2023 that are 22 percent of the savings that would be achieved without grandfathering. Under the average-bid alternative, the estimated savings over that period with a grandfathering provision are 32 percent of the savings that would be achieved without grandfathering. Those percentages are greater than the percentage of Medicare spending that would be covered by the premium support system because of a number of factors. Both with and without grandfathering, some factors would cause private insurers' bids under a premium support system to be lower than their bids under the Medicare Advantage program, and other factors would cause those bids to be higher (see CBO's September 2013 report for details). However, the factors that would cause bids to be higher would be relatively weaker with a grandfathering provision.

Grandfathering would also reduce, for an extended period, the incentives created by a premium support system to modify the development and adoption of new medical technologies. Thus, the restraints on the growth of Medicare spending that would probably occur under a premium support system would be substantially smaller for many years.

Other Considerations

The premium support alternatives would affect the premiums that Medicare beneficiaries paid for Part A and Part B benefits, their total payments for those benefits (premiums plus out-of-pocket spending), and the combined payments of the federal government and beneficiaries. CBO analyzed those effects in 2020, focusing on affected beneficiaries in the two alternatives without grandfathering—that is, on everyone enrolled in Medicare other than dual-eligible beneficiaries. (The agency has not yet completed such an analysis for the two alternatives with grandfathering.) The alternatives could also affect beneficiaries' access to care and the quality of care they receive; CBO does not have the tools to study such effects, however, and does not anticipate having them in the near future.

Effects on Beneficiaries' Premiums. CBO estimates that the premiums paid by affected beneficiaries for Medicare Part A and B benefits under the second-lowest-bid alternative in 2020 would be about 30 percent higher, on average, than the current-law Part B premium projected for that year. (Medicare beneficiaries generally do not pay premiums for Part A under current law.) In contrast, under the average-bid alternative, affected beneficiaries would pay premiums that were about 6 percent lower, on average, than the current-law Part B premium in 2020. The premiums paid by beneficiaries under each alternative would depend on the premiums charged by the available plans (which would vary by region) and on beneficiaries' choices of plans.

Under either of the alternatives without grandfathering, beneficiaries in each region would be offered at least one plan with a premium at or below the standard premium (given the manner in which benchmarks would be calculated), and in most cases, at least one plan with a premium below the standard premium would be offered. CBO expects that, depending on how bidding regions were defined, there might be some regions in which no private insurers would participate in the premium support system. In those places, the FFS program would be the only plan available, and enrollees would pay the standard premium.

The standard premium under either of those alternatives would be lower than the current-law Part B premium, CBO estimates, because both alternatives would reduce total Medicare spending, and the standard premium would equal the same share of spending that the Part B premium equals under current law. That reduction in the standard premium is the main reason that the average premium paid by beneficiaries under the average-bid alternative would be lower than the projected current-law Part B premium; the additional premiums paid by beneficiaries who enrolled in plans with bids above the benchmark would roughly offset the premium reductions for beneficiaries who enrolled in plans with bids below the benchmark. Under the second-lowest-bid alternative, however, the regional benchmarks would generally be lower than they would be under the average-bid alternative, so CBO expects that many beneficiaries would enroll in plans with bids above the relevant benchmark, resulting in a much higher average premium than under current law.

Most beneficiaries who wished to remain in the FFS program would pay much higher premiums, on average, under either alternative than they would for Part B under current law. The difference would be greatest in regions where FFS spending per beneficiary was highest. Beneficiaries in regions where such spending was lowest would pay a premium for the FFS program that was, on average, close to the projected current-law Part B premium.

Effects on Beneficiaries' Total Payments. CBO estimates that affected beneficiaries' total payments for benefits from Parts A and B in 2020 would be about 11 percent higher, on average, under the second-lowest-bid alternative without grandfathering than under current law. In general, the premiums paid by beneficiaries would increase under that option, but out-of-pocket costs for medical care would decline (because more beneficiaries would enroll in lower-bidding private plans, which would tend to reduce the total costs of care while maintaining the required actuarial value). The reduction in out-of-pocket costs would offset part, though not all, of the increase in premiums.

Under the average-bid alternative without grandfathering, beneficiaries' total payments for Part A and B benefits in 2020 would be about 6 percent lower, on average, than under current law. That reduction results from both lower average premiums and lower out-of-pocket costs for medical care. As in the previous alternative, the difference in out-of-pocket costs would be attributable primarily to increased enrollment in lower-bidding private plans.

The change in total payments for particular beneficiaries could differ markedly from the national average under either alternative. For example, people who chose to remain in the FFS program would generally face much higher premiums and would not see a reduction in their out-of-pocket costs.

Effects on Combined Spending by the Government and by Beneficiaries. The sum of net federal spending for Medicare and beneficiaries' total payments would be about 5 percent lower in 2020 under the second-lowest-bid alternative than under current law, CBO estimates, and about 4 percent lower under the average-bid alternative than under current law. (Those effects are measured as a percentage of projected net federal spending and beneficiaries' total payments, in each case focusing on affected beneficiaries and spending for benefits that would be covered by the premium support system.) The estimated reduction in total spending is slightly greater under the second-lowest-bid alternative because the federal contribution would be smaller under that alternative, which would increase competitive pressure, resulting in lower bids by private plans and causing a larger share of beneficiaries to enroll in low-bidding plans. The federal savings would be much larger under that alternative than under the average-bid alternative, but beneficiaries' payments would be higher.

RELATED CBO PUBLICATIONS: *A Premium Support System for Medicare: Analysis of Illustrative Options* (September 2013), www.cbo.gov/publication/44581; *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan* (March 2012), www.cbo.gov/publication/43023; *Long-Term Analysis of a Budget Proposal by Chairman Ryan* (attachment to a letter to the Honorable Paul Ryan, April 5, 2011), www.cbo.gov/publication/22085; *Designing a Premium Support System for Medicare* (December 2006), www.cbo.gov/publication/18258; and *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies* (June 2013), www.cbo.gov/publication/44308

Option 7 **Function 570**

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

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays												
Establish uniform cost sharing for Medicare	0	-3	-5	-5	-6	-6	-6	-7	-7	-7	-19	-52
Restrict medigap plans	0	-4	-5	-6	-6	-6	-7	-7	-8	-9	-21	-58
Both of the above policies[a]	0	-8	-11	-11	-12	-13	-14	-14	-15	-16	-42	-114

Note: This option would take effect in January 2015.

a. If both policies were enacted together, the total effects would be greater than the sum of the effects for each policy because of interactions between the approaches.

Overview of the Issue

For people who have health insurance, including Medicare and other types of coverage, payments for health care fall into two broad categories: premiums and cost sharing. A premium is a fixed, recurring amount paid in advance for an insurance policy (which then limits enrollees' financial risk by covering some or all of the costs they incur if they use health care services or goods). Cost sharing refers to out-of-pocket payments that enrollees are required to make when they receive health care. In general, premiums spread the cost of medical care across all enrollees, whereas cost sharing concentrates costs on people who use more medical care. To determine the cost-sharing obligations of their enrollees, insurance plans typically vary three basic parameters:

- The deductible, or initial level of spending below which an enrollee pays all costs;
- The catastrophic cap, or 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 by type of service).

Deductibles and catastrophic caps typically apply on an annual basis. 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 referred to as coinsurance) or as a fixed dollar amount for each item or service (in which case it is referred to as a copayment). If other aspects of an insurance plan are the same, lower cost-sharing requirements translate into higher premiums—because insurers must charge more to cover their higher share of medical spending—and higher cost-sharing requirements translate into lower premiums.

Research has shown that people who are not subject to cost sharing 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, which was conducted from 1974 to 1982, examined a nonelderly population and found 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 in between those points.[1] A variety of later studies also concluded that higher cost sharing led to lower health care spending—including a 2010 study that found that Medicare beneficiaries responded to increases in their cost sharing by reducing visits to physicians and 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

1. See Joseph Newhouse, *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.

people to additional financial risk and may deter some enrollees from obtaining valuable care, including preventive care that could limit the need for more expensive care in the future. 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 study 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 valuable 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; in 2015, that deductible will be $1,240, the Congressional Budget Office estimates. 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 is projected to be $142 in 2015. 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, 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 options for their treatment. Moreover, if Medicare patients incur extremely high medical costs, they 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 the majority of people under age 65. First, most private health insurance plans have a single, annual deductible that includes all or most medical costs, rather than the separate deductibles for hospital and outpatient services in 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. Because of those differences, fee-for-service Medicare's benefit design is more complicated and provides less protection from financial risk than many private insurance plans do. Medicare is not unique, however, in charging different cost sharing 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 quarter of Medicare enrollees choose private insurance plans (known as Medicare Advantage plans) over the fee-for-service program. Medicare requires Medicare Advantage plans to provide a catastrophic cap on cost sharing but gives insurers 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 requirements in Medicare Advantage plans are lower than those in the fee-for-service program and more closely resemble requirements in private insurance plans.

Part D of Medicare, which provides coverage for prescription drugs, is also administered by private insurers, who set each plan's cost-sharing requirements (subject to certain statutory and regulatory requirements). Once recently enacted changes are fully phased in, 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 cost-sharing parameters, Part D insurers have some ability to specify which drugs they cover and what cost sharing enrollees must pay, requiring more cost sharing for expensive, higher-tier brand-name drugs and less cost sharing for lower-tier generic drugs. Because private insurers administering Medicare Advantage and Part D plans have the freedom to specify cost-sharing requirements (within limits) and Medicare enrollees can choose between plans 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 discussion.

Supplemental Insurance for Medicare Enrollees. About 85 percent of people who enroll in fee-for-service Medicare have some form of supplemental insurance coverage that reduces or eliminates their cost-sharing obligations and protects them from high medical costs. (Such supplemental coverage of cost sharing is uncommon outside fee-for-service Medicare and thus is another difference between that program and typical private insurance.) About 15 percent of enrollees in fee-for-service Medicare receive coverage of Medicare's cost sharing from Medicaid, which is available to Medicare enrollees with low income and assets. About 40 percent of fee-for-service enrollees have supplemental coverage through a current or former employer, which tends to reduce, though not eliminate, their cost-sharing liabilities.[3] About 25 percent of enrollees buy medigap policies—individual insurance policies designed to cover most or all of Medicare's cost-sharing requirements—and 5 percent of enrollees have various other forms of supplemental coverage.

Federal law requires that medigap plans conform to one of 10 standard plan types. (There are also numerous discontinued plan types; plans of those types may keep their existing enrollees but cannot enroll new members.) The current plan types vary in the extent to which they cover Medicare's cost sharing, and one type offers only catastrophic coverage (which covers cost sharing only after a deductible of $2,110 has been reached). Even so, 60 percent of people with medigap insurance chose plans that offer "first-dollar" coverage—which pays for all deductibles, copayments, and coinsurance—and most other medigap enrollees chose plans that provide first-dollar coverage for Part A and cover all cost sharing above the deductible for Part B.

According to a recent study done for the Medicare Payment Advisory Commission, Medicare spends 33 percent more per person on enrollees who have medigap coverage, and 17 percent more per person on enrollees who have supplemental coverage from a former employer, than it does on enrollees without supplemental coverage.[4] 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 study 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 recent study concluded that spending by Medicare enrollees with supplemental coverage was growing at a faster rate than spending by enrollees without supplemental coverage.[5] Neither of those recent studies investigated the effects of supplemental coverage on enrollees' health.

Raw differences in spending between groups with and without supplemental coverage partly reflect differences in their health status, but studies have generally found that the differences in spending were still large after researchers attempted to account for enrollees' health status. Even so, people who have 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 how Medicare beneficiaries respond to increases in their cost sharing makes an important contribution because it more closely resembles such an experiment. That study also found that about 20 percent of the gross savings generated by higher cost sharing for physician visits and prescription drugs—stemming from reduced use of those services—was offset by increases in hospital spending, perhaps because people delayed treatment until their condition worsened.[6]

Collectively, those studies provide considerable evidence that Medicare enrollees who are subject to less cost sharing—because of more generous supplemental

3. 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 are typically enrolled only in Part A.

4. See Christopher Hogan, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly* (submitted by Direct Research, LLC, to the Medicare Payment Advisory Commission, June 2009), http://go.usa.gov/WrcY (290 KB).

5. 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.

6. 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.

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 would also alter how health care costs were distributed between healthier and less healthy enrollees.

In particular, four main sets of rules governing Medicare's cost sharing could be modified: deductibles could be increased, decreased, or combined; coinsurance rates and copayments could be changed; a catastrophic cap could be added; and 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 given catastrophic cap more quickly (and at a lower level of total spending), and limits on supplemental insurance would expose more enrollees to changes in Medicare's cost-sharing rules and thus increase the impact of those changes on Medicare spending. Policymakers could also "grandfather" current enrollees by maintaining existing rules for them and 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 pays. The Part A and Part B deductibles could be increased separately, or they could be combined into a single yearly deductible for all services provided by traditional fee-for-service Medicare. Depending on the dollar value 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 levels of the current Part A and Part B deductibles. That approach would tend to increase cost sharing for the roughly 70 percent of enrollees who use only outpatient care in a given year and decrease cost sharing for the roughly 20 percent of enrollees who are hospitalized. (About 10 percent of enrollees use no Part A or Part B services in a given year.) In principle, a combined deductible could also encompass drug spending under Part D, but doing that 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 manner as higher deductibles, shifting some costs from the federal government to Medicare enrollees and causing enrollees to forgo some care because of their 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 with little increase in patients' costs. 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 making wide-ranging changes to Medicare's cost-sharing rules, whereas other proposals would introduce 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. In general, copayments can give patients more certainty about their costs for treatment than coinsurance does, but copayments can also insulate patients from differences in the total cost of each service.

Catastrophic Caps. Most private insurance plans include a catastrophic cap that limits how much enrollees have to spend out of pocket, but Parts A and B of Medicare have no catastrophic cap on cost sharing. Thus, in the absence of 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 the cap, and possibly by increasing the amount of care sought by enrollees who exceed the cap because they would no longer face any cost for additional care. Generally, a higher cap would produce a smaller increase

in federal spending; past proposals have called for caps of more than $5,000 to limit their impact on federal costs.

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 if enrollees' 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 25 percent of enrollees in fee-for-service Medicare purchase medigap policies, and about 40 percent have retiree coverage through a 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 dollar limit, thus prohibiting medigap plans from offering first-dollar coverage. That limit could be set at the same amount as Medicare's deductibles, which would force all enrollees with medigap plans to pay for costs out of pocket until they reached those deductibles.

- 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 impact 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 choice for policymakers is whether changes to the rules for cost sharing and supplemental insurance would apply to all Medicare enrollees or only to new enrollees—in other words, whether existing enrollees and medigap policyholders would be grandfathered. One rationale for grandfathering medigap policyholders is that changing the terms of medigap policies that have already been 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 wait to purchase it until they develop health problems. Thus, many Medicare enrollees pay medigap premiums for years to ensure that they will have 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 multiple sets of rules would add to the program's administrative complexity.

Specific Alternatives and Estimates

CBO examined three alternative ways to reduce federal spending on Medicare by modifying the cost sharing that enrollees face. The alternatives would apply to all enrollees, with no grandfathering.

- The first alternative would replace Medicare's current mix of cost-sharing requirements with a single annual deductible of $550 covering 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 cap of $5,500 on each enrollee's total cost sharing. (Prescription drug coverage under Part D would not be changed.) If those changes took effect on January 1, 2015, and the dollar amounts of the various thresholds were indexed to increase in later years at the same rate as average fee-for-service Medicare costs per enrollee, that approach would reduce federal outlays by $52 billion between 2015 and 2023, CBO estimates.

- The second 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 $550 of an enrollee's cost-sharing obligations for calendar year 2015 and would limit their coverage to 50 percent of the next $4,950 of an enrollee's cost sharing. (Medigap policies would cover all further cost sharing, so policyholders would not pay more than $3,025 in cost sharing in 2015.) If this option took effect on January 1, 2015, and the various dollar thresholds were indexed as specified in the first alternative, federal outlays would be reduced by $58 billion from 2015 through 2023, CBO estimates.

- The third alternative combines the changes from the first two. Thus, all medigap plans would be prohibited from covering any of the new $550 combined deductible for Part A and Part B services, and the annual cap on an enrollee's out-of-pocket obligations (including payments by supplemental plans on an enrollee's behalf) would be limited to $5,500 in 2015. For spending that occurred after meeting the deductible but before reaching the cap, 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. Those provisions would limit the out-of-pocket spending of medigap enrollees (excluding medigap premiums) to $3,025 and the out-of-pocket spending of Medicare enrollees without supplemental coverage to $5,500 in 2015.

  If, like the other options, this combined alternative went into effect on January 1, 2015, and the various thresholds were indexed to the growth of per-enrollee Medicare costs thereafter, federal outlays would be $114 billion lower from 2015 through 2023 than they would be under current law, CBO estimates. (Those savings exceed the sum of the savings from the first two alternatives because medigap enrollees would not be entirely insulated by their supplemental coverage from the cost-sharing changes, as they would be in the first alternative, which would reduce their use of care and their cost to the federal government.)

The budgetary effects of changing Medicare's cost-sharing rules depend significantly on the specific parameters chosen. To illustrate the impact of varying some of those parameters, CBO estimated the effect on federal spending of modestly changing the deductible and catastrophic cap in the third alternative. Raising the 2015 deductible by $100 (to $650), while keeping the catastrophic cap at $5,500, would increase federal savings between 2015 and 2023 by an estimated $22 billion. Raising the catastrophic cap in 2015 by $500 (to $6,000), while keeping the deductible at $550, would add an estimated $31 billion to federal savings through 2023. Making both of those changes together would yield $53 billion in additional savings from 2015 through 2023, compared with the budgetary effects of the third alternative.

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 have an impact on Medicare enrollees, on supplemental insurance, and on the 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 is divided between the federal government and enrollees and among enrollees themselves. The restrictions on medigap coverage would also affect how much of enrollees' cost-sharing obligations medigap plans would cover, as well as the premiums that enrollees would pay for those plans.

Under current law, the average fee-for-service enrollee will cost Medicare $10,250 in 2015 and will be obligated to pay $1,700 in cost sharing, CBO estimates.[7] (Cost-sharing obligations may be paid by the enrollee directly out of pocket, by a supplemental insurer, or by some combination of the two.) Those averages mask substantial variation in individuals' cost-sharing obligations, stemming from differences in health and the use of medical care. For example, CBO estimates that one-quarter of

7. 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.

enrollees will have cost-sharing obligations of more than $1,900 in 2015; their obligations will average about $5,250, compared with an average of about $550 for the other three-quarters of fee-for-service enrollees.

Under the full set of changes included in this option (the third alternative), the average fee-for-service enrollee would cost Medicare $10,100 in 2015, CBO estimates, $150 less than under current law. However, under the specific cost-sharing changes and medigap restrictions in that alternative, enrollees' average cost-sharing obligations would not change—because the higher fraction of total health care costs that enrollees would pay as cost sharing would be offset, on average, by savings from the resulting reduction in their use of health care services. (Different combinations of deductibles, coinsurance rates, catastrophic caps, and medigap restrictions could increase or decrease the average cost-sharing obligations of enrollees.) Even so, that alternative would alter the distribution of cost-sharing obligations among enrollees. One-quarter of enrollees would face cost-sharing obligations of more than $2,300 in 2015; their obligations would average about $4,550, while the other three-quarters of enrollees would have average obligations of about $750. (Roughly 10 percent of enrollees would reach the option's $5,500 cap on cost-sharing obligations.) Those changes reflect a relatively large average decrease in obligations for enrollees who have serious illnesses that require extended care or hospitalization and a relatively small average increase in obligations for healthier enrollees who use less care.

The medigap restrictions in this option would increase the average amount of cost sharing that a medigap policyholder paid out of pocket and would decrease, to roughly the same extent, the average amount that 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, in any given year, some enrollees would face higher combined costs for medigap premiums and out-of-pocket payments under this option.

Beyond altering how and how much Medicare enrollees pay for care, the changes included in this option could have other effects on enrollees. Those changes would give people 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 both effective and ineffective health care. To avoid reductions in effective care, enrollees' costs could be selectively reduced or eliminated for high-value services—an approach known as "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 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 could lead to changes in medigap premiums and in enrollees' demand for medigap policies. If medigap plans were barred from paying the first $550 of an enrollee's cost-sharing liabilities and then from fully covering all cost-sharing requirements 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 today is to be protected 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 could cause some enrollees to not purchase supplemental insurance—especially healthier enrollees, who might expect to consume less health care, and thus spend less on cost sharing, than sicker enrollees. 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 and third alternatives, would also 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 very expensive enrollees. The net effect on an employer's costs for retiree coverage would depend on the extent of the coverage and the health of the employer's retirees. Additionally, the creation of a catastrophic cap in 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.

The unified deductible and catastrophic cap in the first and third alternatives would have similar effects on federal spending for Medicaid, which provides supplemental coverage for low-income Medicare enrollees. Those dual-eligible beneficiaries have a relatively high prevalence of expensive chronic conditions. Consequently, the introduction of a catastrophic cap would shift some of the cost for those expensive enrollees from Medicaid to Medicare. At the same time, the unified deductible and uniform coinsurance rate would shift some costs from Medicare to Medicaid.

Whether those effects would, on balance, increase or decrease Medicaid's spending on cost sharing for dual-eligible beneficiaries is unclear. Medicaid avoids paying some cost sharing for those beneficiaries by paying providers on the basis of its own rates, which in many cases are lower than rates paid by Medicare. Specifically, state Medicaid programs often limit the amount they pay for dual-eligible beneficiaries' cost sharing to the difference (if any) between what Medicare already paid and what Medicaid would pay for the same service—meaning that Medicaid often pays none or only a portion of the cost-sharing obligation. Consequently, a change in cost-sharing obligations for Medicare would not necessarily result in a corresponding change in cost-sharing payments by Medicaid. In addition, Medicare's payments to providers for bad debt (unpaid cost-sharing obligations) cover much of the cost-sharing obligations that Medicaid avoids, so a fraction of Medicaid's obligations is ultimately shifted back to the Medicare budget. For those reasons, CBO believes that the estimates shown here include the full federal budgetary effects of this option. (The estimates do not include the option's effects on states' Medicaid outlays, however.)

Administrative Issues. Altering the cost-sharing rules for Medicare and medigap plans would raise myriad administrative issues. Health care providers might experience some confusion about how much to collect from a Medicare enrollee during an office visit because it might be difficult to track whether the enrollee's cost sharing payments had reached the deductible or exceeded the 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 who 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 and the distribution of that debt among different types of providers, who are reimbursed by Medicare for bad debt in different ways. 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 supplemental insurers.

RELATED OPTION: Option 5

Option 8 **Function 570**

Raise the Age of Eligibility for Medicare to 67

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays												
Medicare	0	0	-1.1	-2.6	-4.2	-6.1	-8.3	-10.6	-13.6	-17.1	-7.8	-63.5
Other	0	0	0.8	1.9	3.1	4.4	5.7	7.2	8.0	9.5	5.7	40.5
Total	0	0	-0.3	-0.7	-1.1	-1.6	-2.6	-3.4	-5.6	-7.6	-2.1	-23.0
Change in Revenues	0	0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.7	-0.8	-0.9	-0.6	-3.9
Net Effect on the Deficit	0	0	-0.2	-0.5	-0.8	-1.2	-2.1	-2.8	-4.8	-6.7	-1.5	-19.1

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

Note: This option would take effect in January 2016.

The usual age of eligibility for Medicare benefits is 65, although certain people qualify for the program earlier. (Medicare is available, after a waiting period, to people under age 65 who are eligible for Social Security disability benefits or who have end-stage renal disease.) Because of increases in life expectancy, the average length of time that people are covered by Medicare has risen significantly since the program was created, in 1965. That trend, which increases the program's costs, will almost certainly continue.

This option would raise the age of eligibility for Medicare by two months every year, beginning with people who were born in 1951 (who will turn 65 in 2016), until the eligibility age reached 67 for people born in 1962 (who will turn 67 in 2029). Thereafter, the eligibility age would remain at 67. Those changes are similar to the ongoing increases in Social Security's full retirement age (FRA)—the age at which workers become eligible for full retirement benefits—except that scheduled increases in the FRA include a 12-year period during which the FRA remains at 66. (Unlike Medicare, which has a single eligibility age, Social Security allows workers to receive reduced retirement benefits as early as age 62, and the majority of eligible people choose to claim Social Security benefits before reaching the FRA.) Under this option, the eligibility age for Medicare would remain below Social Security's FRA until 2029, when both would be 67 for people born in 1962; from that point on, the two eligibility ages would be identical.

A change in the eligibility age for Medicare would affect people's sources of health insurance coverage, including Medicaid. States have the option under current law to expand their Medicaid programs to people with income below 138 percent of the federal poverty guidelines. Although that optional Medicaid expansion applies only to people under age 65, for this option, the Congressional Budget Office assumed that the age limit would increase in tandem with Medicare's eligibility age.

Implementing this option would reduce federal budget deficits by $19 billion between 2016 and 2023, according to estimates by CBO and the staff of the Joint Committee on Taxation. That figure represents the net effect of a $23 billion decrease in outlays and a $4 billion decrease in revenues over that period. The decrease in outlays includes a reduction in federal spending for Medicare as well as a slight reduction in outlays for Social Security retirement benefits. However, those savings would be substantially offset by increases in federal spending for Medicaid and for subsidies to purchase health insurance through the new insurance exchanges and by the decrease in revenues.

Outlays for Medicare would be lower under this option because fewer people would be eligible for the program than the number projected under current law. In addition, outlays for Social Security retirement benefits would decline slightly because raising the eligibility age for Medicare would induce some people to delay applying for retirement benefits. One reason is that some people apply for Social Security at the same time that they apply

for Medicare; another reason is that this option would encourage some people to postpone retirement to maintain their employment-based health insurance coverage until they became eligible for Medicare. CBO expects that latter effect would be fairly small, however, because of two considerations: First, the proportion of people who currently leave the labor force at age 65 is only slightly larger than the proportion who leave at slightly younger or older ages, which suggests that maintaining employment-based coverage until the eligibility age for Medicare is not the determining factor in most people's retirement decisions. Second, with the opening of the health insurance exchanges, workers who give up employment-based insurance by retiring will have access to an alternative source of coverage (and may qualify for subsidies if they are not eligible for Medicare). This option could also prompt more people to apply for Social Security disability benefits so they could qualify for Medicare before reaching the usual age of eligibility. However, in CBO's view, that effect would be quite small, and it is not included in this estimate.

Other effects of this option would add to budget deficits, but by smaller amounts. Federal spending for Medicaid would increase for two groups of people whose age was between 65 and the new eligibility age for Medicare: those who, under current law, will be dual-eligible beneficiaries (Medicare beneficiaries who also qualify, on the basis of income and assets, to receive benefits from Medicaid), and those who will be beneficiaries of Medicaid before turning 65 and will lose that eligibility under current law once they qualify for Medicare. 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.

Subsidies for health insurance coverage purchased through the exchanges would also increase under this option because some of the people whose eligibility for Medicare would be delayed would instead obtain insurance through the exchanges and would qualify for subsidies. (Those subsidies take two forms: tax credits to cover a portion of the premiums for policies bought through the exchanges and additional subsidies to reduce cost-sharing payments under those policies. The premium subsidies are structured as refundable tax credits, and CBO estimates that, in most cases, the amounts of those credits will exceed the total amount of federal income tax that recipients owe; the amounts that offset the taxes that recipients owe are classified as revenue losses, and the amounts that exceed the taxes owed are classified as outlays. Subsidies for the cost sharing of enrollees in exchange plans are also categorized as outlays.)

This option would also affect federal revenues, decreasing them by an estimated $4 billion between 2016 and 2023. That decline is the net result of several partly offsetting effects, the largest of which would be a reduction in federal revenues because of the increase in exchange subsidies. A small portion of those additional subsidies would take the form of reduced revenues rather than outlays, as discussed above.

Looking farther into the future, CBO estimates that by 2038, spending on Medicare would be about 3 percent less under this option than it would be under current law—4.7 percent of gross domestic product rather than 4.9 percent. On the basis of its estimates for 2016 through 2023, CBO projects that roughly two-thirds of those long-term savings from this option would be offset by the increases in federal spending for Medicaid and exchange subsidies and the reduction in revenues described above.

Although CBO anticipates that most people who would lose eligibility for Medicare under this option would continue their existing health insurance coverage or switch to other forms of coverage, the number of people without health insurance would increase slightly. For example, CBO estimates that of the 5.5 million people who would be affected by this option in 2023, about 50 percent would obtain insurance from their (or their spouse's) employer or former employer, about 15 percent would continue to qualify for Medicare on the basis of their eligibility for disability benefits, about 15 percent would buy insurance through the exchanges or in the nongroup market, about 10 percent would receive coverage through Medicaid, and about 10 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. CBO then adjusted those figures to account for changes in sources of health insurance coverage and in participation in the labor force as people age.

The estimate of savings to Medicare under this option is much lower than CBO's earlier estimates for proposals to raise Medicare's eligibility age, including for a similar option in the previous version of this report (published in 2011). That change in the estimate primarily reflects a

new assessment by CBO that some of the people whose eligibility for Medicare would be delayed under this option would not cost Medicare as much, under current law, as CBO previously projected. CBO's current estimate incorporates a detailed analysis of the cost of 65- and 66-year-old Medicare beneficiaries.

CBO's analysis highlighted two points. First, at ages 65 and 66, beneficiaries who enrolled in Medicare when they turned 65 tend to be in much better health—and thus are substantially less expensive, on average—than beneficiaries who were already enrolled upon turning 65 (because of disability or end-stage renal disease). Second, the many 65- and 66-year-old beneficiaries who are workers (or workers' elderly spouses) with employment-based health insurance are less costly to Medicare, on average, than other beneficiaries at those ages. For most of those workers, employment-based health insurance is the primary source of coverage, and Medicare is a secondary payer—meaning that Medicare's payments are limited to the cost-sharing obligations that beneficiaries face under their employment-based health insurance policies. Moreover, most beneficiaries for whom Medicare is a secondary payer wait to enroll in Parts B and D of Medicare until they (or their spouses) stop working. As a result, Medicare spends much less on Part A services for those beneficiaries than it does for beneficiaries for whom Medicare is the primary payer, and it does not pay for services covered under Parts B and D.

Taking into account both of those factors—differences in health status between beneficiaries who enroll in Medicare at age 65 and those already enrolled by 65, and the effect of secondary-payer status—caused a significant reduction in CBO's estimate of Medicare spending under current law for beneficiaries who would be affected by the increase in the eligibility age. Mostly as a result of those changes, CBO's present estimate of the net costs to Medicare of those beneficiaries under current law is roughly 60 percent lower than CBO's previous estimates.

By contrast, CBO's estimate of the extent to which this option would increase federal spending for Medicaid and exchange subsidies has not changed significantly. Compared with previous estimates, a similar proportion of beneficiaries who would lose Medicare eligibility under this option are estimated to enroll in Medicaid or the health insurance exchanges.

The much smaller reduction in Medicare spending, combined with a similar increase in non-Medicare spending, results in a net change in projected outlays that is much smaller than previously estimated. Additionally, the figures shown here include an estimate of the option's effects on federal revenues, which was not included in the previous version of this report.

A rationale for this option is that it would raise the eligibility age for Medicare to accompany increases in life expectancy. In 1965, a 65-year-old man could be expected 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 to 17.9 years for men and 20.2 years for women. CBO projects that by 2038, those figures will increase to 20.2 years and 22.5 years, respectively. Therefore, a commitment to provide people with a certain benefit in 2038 beginning at age 65 will be significantly more costly than is the same commitment made to today's beneficiaries. Another rationale for this option is that it would reinforce the incentive to delay retirement created by increases in Social Security's full retirement age.

An argument against this option is that it would shift costs that are now paid by Medicare to individuals and to employers that offer health insurance for their retirees. Some people would end up without health insurance under this option and as a result might receive lower quality care and pay more for care than they would have as Medicare beneficiaries. Many, though not all, of the people who would end up with a different source of insurance would pay higher premiums than they would have for Medicare and would spend more on copayments for medical care. In addition, states' spending on Medicaid would increase under this option.

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

Option 9 **Function 570**

Increase Premiums for Parts B and D of Medicare

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Change in Mandatory Outlays												
Increase basic premiums	0	-4	-10	-16	-25	-35	-40	-44	-49	-52	-55	-274
Freeze income thresholds for income-related premiums	0	0	0	0	0	0	-3	-4	-6	-7	0	-20
Both of the above policies[a]	0	-4	-10	-16	-25	-35	-42	-46	-52	-56	-55	-287

Note: The first and third alternatives would take effect in January 2015; the second alternative would take effect in January 2020.

a. If both policies were enacted together, the total effects would be less than the sum of the effects for each policy because of interactions between the approaches.

All enrollees in Part B of Medicare (which covers physicians' and other outpatient services) or Part D (which covers prescription drugs) are charged basic premiums for that coverage. Those premiums are currently $104.90 per month for Part B and $31.17 per month for Part D.[1] When the Part B program began, in 1966, the basic premium was intended to cover 50 percent of Part B costs per enrollee over age 65, with the rest of those costs funded by general revenues. Later legislation reduced that share, however, and collections of Part B premiums declined to less than 25 percent of those costs. The Balanced Budget Act of 1997 set the Part B premium at about 25 percent of Part B costs per enrollee over age 65. Part D, which began in 2006, covers prescription drugs not covered by Part B; the Part D benefit is delivered by private insurers. On average, premiums cover 25.5 percent of the per capita costs of the basic Part D benefit.[2] Enrollees with low income and few assets receive subsidies to cover some of their Part D premiums and cost-sharing payments.

Enrollees in Parts B and D who have relatively high income pay a higher premium known as the income-related premium (IRP). The amount of the IRP depends on an enrollee's modified adjusted gross income, or MAGI (the total of adjusted gross income and tax-exempt interest). The MAGI thresholds established for income-related premiums create four income brackets and premiums that correspond to them. For enrollees who pay IRPs, total monthly premiums in 2013 range from $146.90 to $335.70 for Part B and from $42.80 to $97.80 for Part D.[3] Those amounts are set to cover 35 percent to 80 percent of costs per enrollee in Part B and in Part D.

Changes over time in the thresholds for income-related premiums affect the number of Medicare enrollees who pay IRPs and the premiums they pay. Between 2008 and 2011, the thresholds for the Part B IRPs rose in line with increases in the consumer price index for urban consumers. The Affordable Care Act established IRPs for Part D beginning in 2011, and it froze through 2019 the income thresholds at which IRPs begin for both Parts B and D—at $85,000 for single beneficiaries and $170,000 for

1. The Part D figure is an average amount; the actual premiums that enrollees face are higher or lower depending on the drug plan they choose (and how much that plan's bid for covering the costs of prescription drugs differs from the average bid submitted by all plans).

2. The basic Part D benefit refers to a standard level of prescription drug coverage. For 2013, the basic benefit includes no coverage for the first $325 of drug spending (the deductible); coverage for 75 percent of drug costs between the deductible and an initial coverage limit of $2,970; some coverage for generic and brand-name drugs between the initial coverage limit and a catastrophic limit on out-of-pocket costs of $4,750 (the difference between those limits is referred to as the coverage gap, or "doughnut hole"); and coverage for 95 percent of drug spending above the catastrophic limit. The coverage gap is being closed so that, by 2020, the basic benefit will cover 75 percent of all drug costs between the deductible and catastrophic limit.

3. For Part B, the basic premium is the same for all enrollees, and income-related premiums are derived from the basic premium. For Part D, income-related premiums are also derived from the basic premium, but that basic premium depends on the plan in which a beneficiary enrolls. As a result, the total premium for a higher-income enrollee in Part D varies not only among but also within the income brackets, because enrollees in the same bracket may enroll in different plans with different basic premiums. (The figures reported here are based on averages across all Part D plans.)

married couples who file joint tax returns. Under current law, the income thresholds will revert in 2020 to the levels they would have reached had they been indexed for inflation since 2007. The Congressional Budget Office projects that the percentage of enrollees subject to income-related premiums will increase from 5 percent now to 10 percent in 2019, as income growth pushes more enrollees' income above the fixed thresholds. That percentage is projected to drop to 7 percent in 2020 (as the thresholds revert to the amounts they would have reached with indexing) and then increase gradually over time, reaching 8 percent in 2023, as the growth of income outpaces the overall growth of prices.

This option would raise the premiums for Parts B and D of Medicare in various ways:

- The first alternative would increase the 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 both programs' costs; that increase would occur gradually over a five-year period beginning in 2015. For Part B, the percentage of costs per enrollee covered by the basic premium would rise by 2 percentage points a year through 2019 and then remain at 35 percent. For Part D, that percentage would increase by 1.5 percentage points in the first year and 2 percentage points a year from 2016 through 2019 and then remain at 35 percent. By 2023, basic premiums would rise to $200 a month for Part B and $63 a month for Part D under this alternative. Those changes would have no effect on the total premiums of enrollees paying income-related premiums.[4] In all, this alternative would decrease net Medicare spending (total Medicare spending minus beneficiaries' premiums and other offsetting receipts) by $274 billion between 2015 and 2023, CBO estimates.

- The second alternative would freeze through 2023 all of the income thresholds for income-related premiums, extending the current freeze by four years. Under this alternative, CBO estimates, net Medicare spending would be reduced by $20 billion between 2020 and 2023, and the share of enrollees paying income-related premiums would rise from 10 percent in 2019 to 13 percent in 2023.

- The third alternative would combine the changes in the first two: increasing basic premiums for Parts B and D to 35 percent of costs per enrollee and freezing the income thresholds for income-related premiums. Those changes would reduce net Medicare spending by $287 billion through 2023, CBO estimates (slightly less than the sum of the savings from each alternative alone because of the ways in which the two policies would interact). The combined changes would raise premiums for most enrollees in Parts B and D and would increase the share of enrollees paying IRPs to 9 percent in 2023.[5]

One rationale for raising premiums is that it would shift some costs currently borne by all taxpayers to Medicare enrollees. Another rationale is that higher premiums for Part D would increase competitive pressure in the market for prescription drug plans by absorbing a larger share of enrollees' income and thus giving enrollees a stronger incentive to choose less expensive plans. Such pressure could cause prescription drug plans to lower their bids, which would generally lead to reductions in the premiums for those plans, in the federal government's costs, and in the total cost of drugs for elderly people. (Such effects, however, are not included in the estimates shown here.)

A disadvantage of this option is that it would reduce disposable income for most Medicare enrollees—although not for low-income enrollees whose Medicare premiums are paid by Medicaid or for higher-income enrollees who pay income-related premiums. However, state Medicaid programs would face higher costs for those Medicare enrollees whose premiums are paid by Medicaid, such as enrollees in the Part D low-income subsidy program (22 percent of Medicare beneficiaries) and certain low-income Part B enrollees with limited assets (about 17 percent of Medicare beneficiaries). Also, because people's income tends to rise over time, freezing all of the income thresholds (as in the second and third alternatives) would cause a growing share of enrollees to become subject to income-related premiums in later years.

4. The increases in the basic premiums under this approach would lead to corresponding reductions in the additional premiums paid by people with higher income, leaving their total premiums unchanged. Because the income-related premium for enrollees in the lowest IRP bracket equals 35 percent of costs per enrollee, this alternative would effectively phase out the first IRP for both Parts B and D.

5. Fewer enrollees would be subject to an income-related premium under the third alternative than under the second because (as in the first alternative) the increase in the basic premium to 35 percent of costs per enrollee would effectively phase out the first IRP bracket for both Parts B and D.

Option 10 **Function 570**

Bundle Medicare's Payments to Health Care Providers

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Change in Mandatory Outlays												
Bundle payments only for inpatient care	0	0	0	-0.4	-1.1	-1.9	-2.8	-3.2	-3.5	-3.6	-1.5	-16.6
Bundle payments for inpatient care and 90 days of postacute care	0	0	0	-1.2	-3.1	-5.4	-7.8	-9.1	-9.8	-10.2	-4.3	-46.6

Note: This option would take effect in January 2017.

Overview of the Issue

Although some steps have been taken to move toward other payment methods, most payments for health care—under the Medicare program and other forms of insurance—are made on a fee-for-service basis. In a fee-for-service system, separate payments are generally made for each office visit, lab test, surgical procedure, or other service that is delivered by doctors, hospitals, or other health care providers. The fee-for-service payment method tends to create incentives for providers to deliver more services (and more expensive services) but not to coordinate the care that patients receive. Many experts thus believe that the widespread use of fee-for-service payment has contributed significantly to the high costs and uneven quality of health care in the United States.

Those concerns have prompted considerable interest in the idea of bundling payments, in which single payments would be made for groups of related services. The broad concept of bundling could be applied in various ways, but one commonly discussed approach is to make fixed payments for each "episode of care"—that is, for all or most of the services that patients receive from various providers that are related to a particular disease or treatment over a defined period. Episode-based payment does not always involve multiple providers. For example, obstetricians often receive a fixed payment (or "case rate") for all of the care they provide to a pregnant patient; that payment does not cover the costs of hospital care for a birth or prenatal care delivered by other providers. However, this discussion focuses on episode-based bundled payments that encompass services delivered by a range of individuals and organizations during the course of a patient's treatment—an approach that offers more opportunities for savings but is more difficult to implement successfully.

In any system of bundled payments, the amount of the payments would differ depending on the diseases or treatments involved and would reflect the average costs of providing those treatments. In most proposals for bundling, however, payments would not vary with the number or mix of services provided to a particular patient. As a result, providers of care covered by a bundled payment would have an incentive both to limit the cost or reduce the number of services they provide and to coordinate care so as to avoid costly complications and the delivery of unnecessary services. At the same time, bundling payments could give providers an incentive to stint on care that is medically beneficial. And as with fee-for-service payment, episode-based payment would not encourage providers to keep patients healthy or to prevent episodes of care from occurring in the first place.

Medicare already bundles some of its payments, but they typically cover services provided by a single individual or organization. For example, hospitals generally receive a fixed payment for each admission to cover all of the discrete goods and services they provide during a patient's stay. Likewise, home health care agencies receive a fixed payment to cover all of the visits they provide to a patient during a 60-day episode of care, and skilled nursing facilities (SNFs) are paid a per diem rate that covers all of the services they furnish to a resident in a day.

Nevertheless, a patient undergoing surgery typically generates a range of separate Medicare payments before, during, and after his or her hospital stay: to the hospital in which the procedure takes place; to the surgeon

performing the operation; to the anesthesiologist; to other doctors providing care while the patient is in the hospital; to doctors and labs for follow-up visits and tests after the patient is discharged; and to SNFs, home health care agencies, or other organizations providing postacute care (recuperation and rehabilitation services after a hospital stay). All told, CBO estimates, Medicare spent more than $170 billion in 2013 on services provided during a hospital stay or within 90 days of discharge. That total accounts for at least half of all nondrug spending in Medicare's fee-for-service program.

One rationale for bundling payments for those services is that Medicare's current costs often vary significantly for a given type of episode, and in many cases that variation does not seem related to differences in patients' illness or outcomes. One recent study found that Medicare's average payments for several common surgical episodes (hip replacement, heart bypass, back surgery, and colon surgery) frequently varied among hospitals by 10 percent to 40 percent, even after accounting for disparities in patients' health and for geographic differences in the prices that Medicare pays for specific services.[1] A large share of that variation in costs stemmed from spending on postacute care, but in many cases differences in total payments for the initial hospitalization and for readmissions were notable as well.

Similarly, an analysis by the Medicare Payment Advisory Commission (MedPAC) concluded that the extent and types of postacute care that patients receive after being discharged from a hospital "vary widely for reasons not explained by differences in beneficiaries' health status, indicating that, in aggregate, fewer services could be furnished to Medicare beneficiaries without necessarily compromising patient outcomes."[2] Examining 10 types of episodes that frequently involve postacute care, MedPAC found that spending on such care within 90 days of a hospital discharge commonly varied more than fourfold between higher-cost and lower-cost cases—a gap that averaged about $13,000 per case during the 2007–2008 period.[3]

Several demonstration projects to experiment with bundling Medicare payments have been launched over the years—most recently, the Bundled Payments for Care Improvement initiative, which the Centers for Medicare & Medicaid Services (CMS) began developing in 2011 under provisions of the Affordable Care Act and which has just started to operate. That initiative is exploring four models of episode-based bundled payments; the models differ in their scope and payment methods, but in all four, an episode of care is triggered by a hospital admission. Participation in the initiative is voluntary, and so far more than 300 organizations (mostly hospitals) have expressed interest in taking part. Results from that initiative will not be available for some time, and the voluntary nature of the initiative raises questions about how broadly applicable those results will prove to be. Earlier (but more limited) demonstration projects about bundling yielded some estimated savings for Medicare, at least on a preliminary basis, but they were also voluntary. The main problem in evaluating such voluntary initiatives is that the hospitals that opted to participate were probably more capable of changing the ways they deliver care, and more likely to succeed financially, than hospitals that decided not to take part. Thus, participants' experience with bundling seems likely to overstate the savings that would probably be achieved if all providers were required to adopt bundled payments.

In addition to Medicare's demonstration projects, private insurers and state Medicaid programs are exploring episode-based payment. However, their efforts are generally at an early stage as well.

Key Design Choices That Would Affect Savings

Payment bundling is a broad concept that could take many forms. The federal savings that could result from greater bundling would depend on many design specifications, such as the types of bundles constructed and their scope, the duration of the services covered by a bundle, the levels at which bundled payments were set and the mechanisms used to set them, the method of payment used, the schedule for implementing the bundling policy, and the terms of participation (in particular, whether bundling would be voluntary or mandatory).

1. David C. Miller and others, "Large Variations in Medicare Payments for Surgery Highlight Savings Potential from Bundled Payment Programs," *Health Affairs,* vol. 30, no. 11 (November 2011), pp. 2107–2115, http://dx.doi.org/10.1377/hlthaff.2011.0783.

2. Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2013), p. 59, http://go.usa.gov/WatW.

3. CBO's analysis of numbers generated by MedPAC (published in *Report to the Congress: Medicare and the Health Care Delivery System*), which compared the 25th and 75th percentiles of the distribution of costs per case.

In general, more extensive bundles encompass more spending and may provide more opportunities to generate savings. But they also expose health care providers to more financial risk, particularly when the total costs of the bundle depend on services delivered by a variety of providers who are not affiliated. Bundling payments for different providers can also raise significant administrative challenges, and some solutions to those challenges may weaken incentives to control costs. In addition, aggregating payments while giving doctors, hospitals, and other providers greater leeway to share savings among themselves could encourage those providers to generate more episodes of care.

Among the many design issues that arise, the levels of bundled payments and the rate-setting and payment mechanisms are perhaps the most important. Fundamentally, reducing federal spending through bundled payments would require providers to be paid less overall than they are under current law—either because they would be delivering fewer or less complex services to enrollees or because they would be receiving less money per service.

Types and Scope of Bundles Constructed. Recent proposals for bundling payments generally involve grouping services that are provided during an episode of care, either to treat a patient with a particular disease or to provide a particular treatment (such as a surgery) and its related care. In principle, nearly all of the services that patients receive could be grouped into episodes of care, but in practice, the wholesale adoption of episode-based payment would face many obstacles. For example, ongoing efforts to create all-encompassing "grouper" software that assigns each of the services received by Medicare patients to specific episodes have been hampered by the fact that Medicare patients are more likely than younger people to suffer from multiple health problems at the same time, which makes it harder to determine which services should be assigned to which episodes.

A more feasible approach to bundling may be to group only those payments that are related to a hospital admission—the approach being taken in CMS's demonstration project and in several private-sector initiatives. Under the demonstration, the scope of the bundles varies: One model (labeled "Model 4" by CMS) covers services that physicians and hospitals provide during an inpatient stay, another model ("Model 3") covers only postacute care provided after a hospital discharge, and yet another model ("Model 2") includes all care provided during an admission as well as postacute care.[4] Even with those distinctions, defining which services provided after a discharge are "related" to a hospital admission can be difficult. Excluding certain services from the bundle could give providers an incentive to deliver more of those services. But including more services and more types of providers in the bundle would add to the administrative complexity of the payment system.

Duration of Each Bundle. The amount of spending encompassed by a bundle—and the financial risk that providers would face under a bundled-payment policy—would also depend on the length of time that the bundled payment would cover. For chronic health problems that generally are not cured, such as diabetes or hypertension, episodes of care may extend for a full year. With episode-based bundles that center on a hospital admission, proposals that include postacute care generally cover services provided over periods that range from 30 days to 90 days after discharge. According to MedPAC's analysis of 10 common episodes that usually involve extensive postacute care, 84 percent of the spending that would be included if a bundled payment covered 90 days of services would also be included in a 30-day bundle. Similarly, CBO's analysis of payment data for a broader set of episodes, which CMS generated for the bundled-payment demonstration, found that about three-fourths of the spending incurred during a 90-day episode was captured by a 30-day episode. (Both findings reflect the fact that hospital payments usually constitute a majority of costs for such episodes.) Thus, extending the duration of bundles from 30 days to 90 days would capture more spending, but far less than three times as much.

MedPAC also examined the variability of the resources used to care for patients. That variability indicates the extent to which providers' costs for delivering care might deviate from the fixed payment they would receive and thereby sheds light on the degree of financial risk that providers might face under a bundled-payment policy. MedPAC found that the variability of resources used per episode of care was only slightly greater for 90-day

4. Model 1 of the CMS demonstration is more limited in scope. Under that model, Medicare pays participating hospitals a discounted amount for each admission, and the hospitals have more flexibility than they do under current law to share savings from changes in care delivery with the physicians who provide inpatient care. Otherwise, however, that model does not alter Medicare's methods for paying physicians or other providers.

episodes than for 30-day episodes—and was comparable to the variability of hospitals' own costs per admission under Medicare's current payment system for hospitals. (That system generally makes a fixed payment per admission that is based on the diagnosis-related group to which the patient is assigned.) Those findings suggest that providers would not bear undue financial risk under such a bundled-payment policy. But the degree of risk would also depend on how the rates for bundled payments were determined and on whether the payment system incorporated additional mechanisms to limit providers' financial exposure.

Payment-Setting Mechanism and Level. Once the scope and duration of bundles had been defined, a central question would be how to set the payment rate for each bundle. The federal savings generated by a bundling policy would largely depend on how those rates compared with Medicare's total payments to treat the same medical conditions under current law.

Two broad alternatives for rate setting are administered pricing and competitive bidding. Under the former approach, CMS could set payment rates for bundles using information about past Medicare costs or other factors (an approach that is common in fee-for-service Medicare). Such administered prices could be set below currently projected spending levels to generate savings for the federal budget, but those prices might initially overstate or understate the average savings that providers could actually achieve. Prices would need to be rebased periodically to keep payments in line with the costs of efficient providers. However, if the bundled payment rates for each group of providers reflected their average costs per episode (rather than a national or regional average of those costs), rebasing could undercut incentives to control costs per episode because providers would know that higher current costs would translate into higher bundled payment rates in the future.

Under a competitive bidding system, hospitals might submit bids in advance indicating the payment they would accept for each type of episode. CMS could then exclude high bidders from Medicare or use an average of the bids to set its payment rate. In theory, bidding systems can quickly reveal the costs that efficient providers incur. In practice, however, providers that are not already integrated to deliver the full spectrum of patients' care during an episode might have trouble determining an appropriate bid. As experience with bundled payments grew, those challenges could become more manageable; thus, one option might be for the payment-setting mechanism to evolve over time from administered pricing to competitive bidding. Even then, however, many hospitals and some medical specialists might not have strong incentives to bid their true costs, partly because of limited competition in their markets.

Method of Payment. The concept behind bundling payments is generally to make a fixed payment per bundle, so that providers collectively bear all of the excess costs if total spending exceeds the fixed payment and get to keep all of the savings if their costs are lower than that payment. One way to implement that approach would be to make a single, prospective payment to one individual or organization—such as the hospital responsible for the initial admission—and require that recipient to arrange payments to other providers delivering the care covered by the bundle. For bundles that applied only to services provided during a hospital stay (including physicians' services), that approach would seem relatively easy to administer; it is the payment method that CMS adopted for Model 4 of its current demonstration. For bundles that included services provided after discharge from a hospital, however, a single prospective payment to the hospital could prove complex to administer: The hospital would need to have payment arrangements with—and oversee—all of the various providers that might be involved in delivering care after a patient was discharged.

As an alternative to prospective payments, CMS could continue to make fee-for-service payments to providers (perhaps with a portion withheld) and later reconcile those total payments with the target payment rate for each bundle. In that case, CMS would have to distribute bonus payments or recoup overpayments if the total costs of the bundle were below or above the target. (A similar approach is being used in Model 2 of the current demonstration, which includes both inpatient and postacute care.) CMS would probably have to prorate the bonus payments and recoupments for all of the providers delivering services that were covered by the bundled payment, because the agency could not determine which providers were responsible for generating any savings or excess costs. Providers could develop selective arrangements among themselves to reallocate those bonuses and penalties (a process called "gain sharing"), but they would not be required to do so. (As with other provisions of a

bundled-payment system, payments could evolve over time—in this case, from a prorated system to prospective payment.)

For a simplified example of how that prorated method might work, suppose that a given episode of care typically cost Medicare $20,000 per patient ($12,000 for services provided by a hospital and $8,000 for postacute care) and that CMS set the spending target for that episode at $19,000. If the payments to the hospital remained unchanged but the payments for postacute care fell by half, to $4,000—perhaps by reducing the length of a stay in a skilled nursing facility or shifting to home health care instead—the episode would initially cost Medicare $16,000. In that case, the hospital and the postacute care provider would divide a bonus payment of $3,000, the difference between the initial cost and the $19,000 target. Of that bonus payment, $2,250 would go to the hospital (because it would account for three-fourths of the $16,000 cost) and $750 would go to the organization that provided postacute care. The outcome would be different if Medicare's fee-for-service payments rose instead of fell. If the hospital's payments remained at $12,000 but payments for postacute care increased from $8,000 to $12,000, the episode would initially cost Medicare $24,000. In that case, the hospital and the postacute care provider would each account for half of the episode's initial cost and thus would each owe Medicare $2,500, or half of the $5,000 difference between that initial cost and the $19,000 target.[5]

As the example illustrates, the way in which bundled payments, bonuses, and penalties were distributed would affect both providers' incentives to reduce costs per episode and the extent of financial risk that providers faced. In particular, prorating bonuses and penalties would mean that savings on payments to one provider might be shared by other providers and that higher initial payments to one provider might translate into penalties for other providers. Those features would weaken each individual provider's incentive to control costs per episode, but they might also reduce the risk that providers would face if their patients used above-average levels of care. Whether higher or lower costs incurred by providers would translate into changes in Medicare's initial payments would depend on the types of services involved. For example, higher costs for hospitals to coordinate patients' care would not trigger higher Medicare payments initially (although they could generate bonus payments if the use of other services for which Medicare pays individually, such as days in a skilled nursing facility, was reduced as a result). Similar issues can arise with bundled payments that are made prospectively, depending on how those payments are subsequently allocated among the providers delivering care during an episode.

Proposals for bundling payments may also include features designed to compensate providers for costs that are beyond their control or to encourage providers to treat high-cost cases (which they might otherwise be reluctant to do); such features would influence both the incentives and risks for providers. For example, payment targets could be risk adjusted to reflect predictable differences in the costs of treating patients who were healthier or sicker than average. Also, episodes that were extremely costly could generate additional "outlier" payments (as happens for Medicare's hospital payments under the current payment system). Finally, some proposals would have Medicare and providers share savings and losses when initial payments were below or above the payment target (for example, with a 50-50 split) rather than having providers keep all savings and bear all excess costs.

Implementation Schedule. Savings from a bundled-payment system would depend partly on how soon the new system began, how quickly it was phased in, and how comprehensive it ultimately became. Implementing a bundled-payment system and preparing to operate under it would probably take the government and health care providers a few years following enactment of the policy—in part because CMS would still be in the midst of implementing and learning from the current demonstration.

In that demonstration, CMS has designated 48 types of episodes encompassing treatments that seem most amenable to bundling and that together span about 25 percent of Medicare's diagnosis-related groups (DRGs). (Because the DRGs included are more common than other DRGs, those bundles would encompass about two-thirds of all DRG payments in fee-for-service Medicare if

5. If Medicare had withheld a portion of the initial payments, the withheld funds would be paid to providers who were involved in episodes with costs at or below the targets, and they would offset the penalties owed by providers who were involved in episodes with costs exceeding the targets. Although such calculations would be made for each individual episode of care, actual reconciliation of payments between CMS and a given provider could occur on a periodic basis using total net amounts of bonuses and penalties incurred.

they were applied nationwide.) Most participants in Models 2 and 4 of the demonstration are adopting bundled payments for only a few of the 48 types of episodes, which suggests that broader implementation should proceed gradually. However, adopting such bundling for only a limited set of episodes could expose providers to random fluctuations in costs if they delivered services for relatively few episodes of care, whereas with a larger range of episodes, random variations in costs would be more likely to average out. Those considerations might argue for implementing bundled payments in a more rapid and extensive way.

Terms of Participation. The budgetary effects of bundling would depend significantly on whether participation was voluntary or mandatory and on which providers (if any) were required to participate. Indeed, if participation was voluntary and the bundled payment was set to equal the national average of Medicare's costs, federal spending would probably rise because providers that expected to increase their total payments under that system would be much more likely to participate than providers that faced a cut in payments. In its demonstration, CMS avoids that problem by basing the payment targets for each participating hospital on Medicare's past costs for episodes of care initiated at that hospital; as a result, hospitals with below-average costs per episode would have to reduce their costs further to gain financially. Still, because the CMS demonstration might be expanded if it proves successful, some of the savings from bundling payments may be generated under current law—so enacting a bundling program under Medicare that was similar and voluntary might not save the federal government additional money. Legislation specifying a mandatory shift to episode-based bundled payment over the next several years, however, could generate federal savings because such a shift would probably represent a more aggressive approach than CMS will pursue under its current authority.

Another factor affecting federal savings is whether hospitals that Medicare currently pays on the basis of their own costs (rather than making fixed payments) would have to participate in the bundling policy. Such hospitals, which are designated "critical access hospitals," account for about 5 percent of Medicare's hospital payments.

Specific Alternatives and Estimates

To illustrate the budgetary effects of bundling Medicare payments, CBO examined two alternative approaches. In each, Medicare would set a target payment amount for specified episodes of care triggered by a hospital admission. The two approaches differ in several ways:

- In the first alternative, a bundled payment would cover services provided by hospitals and physicians during a patient's initial hospital stay and any related hospital readmissions occurring within 30 days of discharge. For each admission, the hospital would receive a prospective payment that was 3 percent lower than Medicare's projected average payments per episode for those services under current law.

- In the second alternative, the bundled payment would cover the same inpatient and physicians' services but would also include any postacute care (such as SNF, home health, or rehabilitation services or outpatient physical therapy) that was delivered within 90 days of discharge. Other services provided after discharge, including physician visits and lab tests, would be excluded from the bundle (on the grounds that payments for those services would generally constitute a small share of the total payments for each bundle and might represent unrelated services). In this alternative, CMS would pay claims on a fee-for-service basis, withholding 10 percent pending reconciliation of actual payments with the spending targets. Those targets would be 5 percent lower than Medicare's projected average payments per episode under current law.

The savings target of 3 percent in the first alternative equals the discount required of participants in Model 4 of the CMS bundling demonstration. Nationwide, less than 10 percent of hospitals chose to participate in any of those bundling models, which indicates that many hospitals and associated health care providers would face challenges in meeting such a target. The larger savings target of 5 percent in the second alternative reflects CBO's judgment that more opportunities would exist to economize on spending if postacute care was included. That judgment partly reflects the findings that spending on postacute care varies widely for reasons not explained by differences in patients' health, as well as studies indicating that the transition period after a hospital discharge presents substantial opportunities to improve the quality and efficiency of care. According to MedPAC's analysis of 10 common episodes, reducing spending on postacute care and on hospital readmissions within 90 days of discharge

by an average of 10 percent would decrease the overall costs of those bundles by 5 percent.

In both alternatives, the bundled-payment system would apply to all short-term acute care hospitals beginning in 2017 and would be phased in over four years, at which point it would cover the 48 types of episodes specified in the CMS demonstration. Admissions for other DRGs would remain exempt from bundling. CMS would have discretion about which bundles to implement first but would have to phase in the policy so that roughly equal increments of affected Medicare spending were added each year (thus covering 25 percent of that spending in 2017, 50 percent in 2018, 75 percent in 2019, and 100 percent in 2020). Once bundling began, the capitation amount or target payment—which would initially be based on an extrapolation of Medicare's past payment levels—would be updated using a weighted mix of the update factors that apply to the types of services included in each bundle. (Medicare's payment rates are generally updated each year to reflect increases in providers' input costs, which can vary for different services, and those updates may also be modified by statute.) Medicare's extra payments for graduate medical education and for hospitals that treat a disproportionate share of low-income patients would not be included in the target payment (or counted as part of the bundle's costs) and would continue as under current law.

CBO estimates that the first alternative—bundling payments only for inpatient care—would reduce Medicare spending by $17 billion through 2023. The second alternative—bundling payments for inpatient and postacute care—would produce larger savings: $47 billion through 2023. By that year, with the changes fully phased in, the savings from the first alternative would represent 0.5 percent of Medicare's net outlays for all nondrug services, and the savings from the second alternative would represent 1.4 percent of those outlays.

A primary factor determining the savings under this option is that the spending that would be bundled accounts for about one-fifth (for the first alternative) or one-third (for the second alternative) of gross nondrug outlays in Medicare's fee-for-service program. Savings would be greater if all DRGs were included; limiting bundling to the 48 types of episodes specified by CMS excludes about one-third of spending connected to hospital admissions. Savings would also be greater if the reductions used to determine the payment targets were larger than 3 percent and 5 percent, respectively, but achieving greater savings by economizing on services would become increasingly difficult for most providers.

Another factor affecting the estimated savings from both alternatives is that a bundled-payment policy would overlap or interact with several initiatives being pursued under current law, including CMS's latest bundling demonstration; penalties for hospitals with high rates of readmission for certain conditions (which would, in this option, be phased out for affected DRGs as bundled payments were phased in); and accountable care organizations, or ACOs (groups of providers that accept responsibility for managing the quality and total costs of patients assigned to them). ACOs are allowed to share savings with Medicare if the total costs of treating their patients are below certain targets; thus, those organizations might capture some of the savings generated by the broader application of bundling. CBO's estimates for the two bundled-payment alternatives take those overlaps into account. In addition, savings under Medicare's fee-for-service program would translate into lower federal payments for Medicare Advantage plans (private insurance plans that provide Medicare benefits); that effect is also included in the estimates above.

The way in which savings targets were set would affect the amount of savings that particular hospitals and other providers would need to achieve under a bundled-payment system. Those effects can be seen by comparing two approaches to implementing the second alternative that would yield roughly the same overall savings to Medicare but that would have very different implications for different providers. One approach—used in CMS's bundling demonstration—would set the payment target for a given episode of care at a different level for each hospital, reflecting Medicare's average historical payments for that type of episode initiated in *that* hospital. Another approach—which would more closely resemble the DRG payment system—would set the payment for each bundle of services using the national average of Medicare's payments for that bundle, adjusted only for geographic differences in Medicare's payment rates (which reflect geographic differences in providers' input costs, but not differences in the average quantity or intensity of services delivered).

The first approach (using hospital-specific targets) might make it easier for providers with high-cost practice patterns to achieve the target level of savings but might make

it harder for providers that were already operating at a lower cost to achieve the specified savings goal. The second approach (using national-average targets) would create greater challenges for high-cost providers, whereas low-cost providers could receive bonus payments even if they did not change their practice patterns under the new system. Specifically, data from one of the studies cited above indicate that, with national-average targets, about one-fourth of hospitals and associated providers would have to reduce their costs to Medicare for specific episodes of care by more than 10 percent to achieve a target that was 5 percent below the national average.[6] At the same time, about 40 percent of hospitals and associated providers would not have to reduce their average costs to Medicare at all to meet that target (and could see their payments increase). By contrast, with hospital-specific targets, all providers would need to reduce their average costs per episode by 5 percent to keep their costs in line with their payments. (As with other parameters of the option, a transition process could be specified that would shift the targets over time from hospital-specific to national-average amounts.)

Other Considerations

Bundling Medicare's payments for episodes of inpatient or postacute care, or both, would represent a significant change to the program's current payment system. That change would have myriad effects on health care providers, on Medicare beneficiaries, and on patients and programs outside Medicare. Many of those effects are difficult to predict precisely.

Effects on Medicare Providers. Adapting to a bundled-payment system would create both challenges and opportunities for affected health care providers. If Medicare's payments encompassed services delivered by a range of providers, those providers would probably want to enter into new organizational arrangements to manage patients' care and to allocate payments equitably. Prospective payments would effectively require the affected providers to contract with each other about payment terms and responsibilities, and providers would need to structure those contracts carefully so that participants' incentives were properly aligned with the overall goal of delivering high-quality care at a lower total cost. Making fee-for-service payments, reconciling them afterward, and distributing bonuses or penalties on a proportional basis would not *require* such arrangements to exist and thus would be easier to implement nationwide than prospective payments. But, as noted above, those payments might not match well with each provider's costs, and the proportional sharing of bonuses or penalties among participants would weaken their individual incentives to control the total cost of an episode of care. Consequently, hospitals would still be encouraged to make selected arrangements with doctors and postacute care providers to coordinate care and reallocate its financing.

Given those complexities, the effects of broadly bundling Medicare payments for services delivered by a range of individuals and organizations are uncertain. Under the first alternative described above, hospitals and physicians might collaborate to reduce input costs (for example, by consolidating purchases of medical devices and seeking volume discounts from their manufacturers) and then share the gains from doing so. Under the second alternative, hospitals would probably aim to reduce the quantity and intensity of postacute care that their patients received and to economize on the use of physicians' services during a hospital stay, but they would have flexibility about how to pursue those efforts.

The extent to which hospitals and other providers would be ready to undertake such changes, and ways in which they would react to a bundled-payment system, would naturally vary. Providers that were able to reduce their costs per episode could see meaningful improvements in their profit margins, whereas providers that were not able to reduce costs could see those margins decline significantly. In some cases, providers might respond by increasing the number of admissions and episodes of care that occurred; doctors and hospitals might have stronger incentives to do so than under current law because they could share savings on low-cost cases. Providers might also change their coding practices or take other steps to deliver more services that would be paid for outside the bundled payments.

Effects on Medicare Beneficiaries. The effects of payment bundling on Medicare beneficiaries are also uncertain. With an episode-based payment system, beneficiaries who were hospitalized could benefit from greater coordination of their care, particularly during the

6. CBO analysis based on David C. Miller and others, "Large Variations in Medicare Payments for Surgery Highlight Savings Potential from Bundled Payment Programs," *Health Affairs,* vol. 30, no. 11 (November 2011), pp. 2107–2115, http://dx.doi.org/10.1377/hlthaff.2011.0783, and on additional data provided by the authors.

transition from the hospital to postacute care. The incentive to avoid hospital readmissions would exist under both of the alternatives described above, but the incentive to limit other costs for postacute care would clearly be stronger under the broader bundling alternative. At the same time, hospitals might reduce the use of physicians' services or postacute care that was medically beneficial, which could have a negative effect on beneficiaries' health (although providers would still want to keep their patients from developing complications that generated additional costs for which they would not ultimately be reimbursed).

To address those concerns, implementation of a bundled-payment system could be accompanied by greater monitoring of the quality of patients' care, or the payment of any bonuses could be made conditional on achieving certain standards for care quality. Currently available measures of care quality are limited, however: They focus mostly on specific processes of care or on whether patients develop certain complications or need to have a surgery redone, but they generally do not reflect patients' health outcomes (such as improvements in health or avoidance of new medical problems). Although quality measurement is improving over time, developing new quality measures is generally a multiyear process. Achieving agreement about outcome-based measures can be especially challenging because poor outcomes may reflect both the performance of providers and the severity of patients' health problems—and disentangling those effects is difficult.

Beneficiaries' cost-sharing requirements would not change under this option, but their out-of-pocket costs could decline if episode-based payments reduced the use of services that require cost sharing (such as visits with physicians or stays in skilled nursing facilities that last longer than 20 days). Reductions in Medicare's payments for physicians' and outpatient services covered by Part B of the program would translate into lower Part B premiums for enrollees.

Broader Effects. Widespread application of a bundled-payment policy in Medicare could have a range of spillover effects on care and spending for other patients, but those effects could work in different directions. On the one hand, because Medicare is such a large payer, changing its payment methods could lead providers to adopt lower-cost practice patterns for all of their patients. (Medicare currently accounts for about one-fifth of national health expenditures and about one-fourth of all payments to hospitals.) In turn, those changes could reduce federal spending on the Medicaid program and the costs of federal tax subsidies for private health insurance. Moreover, private insurers and state Medicaid programs could find it easier to implement bundling policies of their own, which would tend to reinforce providers' incentives to limit the cost of episodes of care.

On the other hand, if providers could not reduce the cost of their care for Medicare patients to the target amounts, the policy change would hurt their financial situation, which they might respond to by trying to shift some of their costs to other payers. Similarly, payment bundling could lead to greater consolidation of providers—in an effort to deliver more integrated care and control the full range of episode costs more directly—which in turn could give providers more bargaining power to secure higher payments from private insurers. Higher private payment rates would translate into higher insurance premiums and would raise the costs of federal tax subsidies for health insurance. And if other payers did not adopt similar payment models, it might not be feasible for providers to change their practice patterns, because reducing the use of services would harm their finances overall.

More broadly, a concern about bundling payments for episodes of care is that—as with fee-for-service payment—providers would still lack clear financial incentives to prevent episodes from occurring and would have only limited incentives to provide less intensive forms of treatment. The amount of the bundled payment would depend mainly on the type of treatment provided; thus, it would be much larger for, say, a heart bypass operation than for an angioplasty to treat a blocked coronary artery. By itself, then, adopting a bundled-payment policy might not slow the development and spread of new medical treatments and technologies, which have historically been key drivers of the overall growth of health care costs. For those reasons, some experts question whether bundled-payment policies are a useful bridge to broader reform of health care payments or instead are a diversion from the efforts needed to develop broader payment models.

Incentives to keep patients healthy and to control total costs for care would be stronger with even broader bundles that encompassed all of the services that a patient receives during a month or a year—such as capitation payments or shared-risk arrangements with accountable care organizations or similar entities. (In shared-risk

arrangements, ACOs not only retain part of the savings if they reduce their patients' total costs for health care below a target amount but also are penalized for part of the added costs if total spending for their patients exceeds the target amount.) Many providers are not ready to accept such degrees of financial risk, however, so bundling payments for episodes of care and encouraging providers to control the costs of those episodes might constitute a useful step, at least for the interim.

RELATED CBO PUBLICATION: *Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment* (January 2012), www.cbo.gov/publication/42860

Option 11 **Function 570**

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

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Mandatory Outlays	*	-5	-13	-15	-15	-15	-15	-15	-14	-16	-48	-123

Notes: This option would take effect in January 2015.

* = between zero and $500 million.

Medicare's voluntary outpatient drug benefit, known as Part D, is delivered by private drug plans; federal subsidies for that coverage, net of the premiums that enrollees pay, totaled about $58 billion in calendar year 2012. (Those subsidies include payments to stand-alone prescription drug plans as well as to prescription drug plans associated with Medicare Advantage plans, but they exclude subsidies paid to employers for prescription drug coverage provided by their health plans for retirees.) One way that private drug plans limit the cost of providing Part D benefits is by negotiating rebates from the manufacturers of brand-name drugs in return for favorable coverage of those drugs, such as lower copayments for preferred drugs. That strategy is generally most effective for drugs that face competition from other drugs to treat the same medical condition. The Congressional Budget Office estimates that in 2011, manufacturers' rebates amounted to about 15 percent of gross spending on all brand-name drugs in Part D.

Before the establishment of Part D in 2006, Medicare beneficiaries who were also eligible for full benefits from Medicaid—known as "dual-eligible beneficiaries"—received drug coverage through Medicaid. That program requires drug manufacturers to pay state and federal governments a significant rebate on their sales to Medicaid enrollees. The rebate amount, which is set in statute, was raised in 2010 from 15.1 percent to 23.1 percent of the price that manufacturers receive for sales to retail pharmacies (known as the average manufacturer price, or AMP). Additional rebates are required if a drug's price rises faster than overall inflation. (Those inflation-based rebates can be significant; in 2011, for example, the average statutory rebate under Medicaid, weighted by the dollar amount of drug purchases, was 58 percent of the AMP, with about half of that amount coming from the inflation-based rebate.)

When Part D of Medicare was established, dual-eligible beneficiaries were enrolled automatically in a low-income-subsidy (LIS) program in Part D, which typically covers the premiums and most of the cost sharing required under the basic Part D benefit. LIS enrollees—most of whom are dual-eligible beneficiaries—account for about 35 percent of Part D enrollees and about 55 percent of Part D spending. Currently, the rebates for drugs used by LIS enrollees are established in the same way as those for drugs used by other Part D enrollees: through negotiations between private Part D plans and drug makers.

This option would require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the Part D LIS program, starting in 2015. As with the current rebate system for Medicaid, manufacturers would have to pay a total rebate of at least 23.1 percent of a drug's average manufacturer price, plus an additional rebate for price increases that exceeded the rate of inflation since the drug's introduction.[1] If a drug manufacturer already provides discounts or rebates to Part D plans that apply equally to all Part D enrollees, any difference between those discounts or rebates and the total rebate amount that the manufacturer would

1. Unlike with the current Medicaid rebate, however, this option would not have a "best price" feature (which requires manufacturers to pay a rebate that exceeds 23.1 percent of the AMP if the difference between the AMP and the best price obtained by a private purchaser, net of certain private rebates, is larger than 23.1 percent of the AMP).

owe under this option would be paid to the federal government.[2] If, however, the average Part D rebate for a drug already exceeded 23.1 percent of the AMP plus the inflation-based rebate, no rebate would be paid to the federal government for that drug. Manufacturers would be required to participate in this rebate program in order to have their drugs covered by Parts B and D of Medicare, by Medicaid, and by the Veterans Health Administration.

The rebates in this option would change the incentive for manufacturers to offer rebates to drug plans in exchange for preferred coverage of brand-name drugs and thus could change the average amount of rebates paid to drug plans. However, the impact on those rebates would be small because those rebates would count toward the total rebate amount owed to the federal government. Drug makers would also be expected to set higher "launch" prices for new drugs to limit the impact of the new rebate, particularly for new drugs that did not have close substitutes. Those higher launch prices would have varying effects on other drug purchasers: Employment-based health insurance plans would probably negotiate for larger rebates to offset some of the increase in launch prices, but state Medicaid programs would pay a higher price for new drugs, which in turn would raise federal spending for Medicaid. Even after accounting for such offsets, CBO estimates that this option would produce substantial savings for the federal government—a total of $123 billion through 2023.

The main advantage of this option is that Medicare would pay less for drugs used by beneficiaries of the Part D LIS program. A disadvantage is that the net reduction in the prices paid for drugs under Part D might lead manufacturers to reduce the amount of funds they invest in researching and developing new products. The development of "breakthrough" drugs would be least affected, however, because those drugs could be launched at prices that would offset much of the new rebate.

Because manufacturers paid rebates to Medicaid for drugs purchased by the dual-eligible population before 2006, when those beneficiaries were still enrolled in Medicaid's drug benefit, there is a recent precedent for requiring such rebates for that population. However, the new rebate would also apply to LIS enrollees who were not dual-eligible beneficiaries, so the total required rebate would be larger than when dual-eligible beneficiaries received their drug coverage through Medicaid (all else being equal). In addition, because the size of Medicaid's statutory rebate was increased in 2010, the adverse impact on manufacturers' incentives would probably be larger under this option than it was under the Medicaid rebate that applied to dual-eligible beneficiaries before the creation of Part D.

2. Drug makers are currently required to pay a 50 percent discount on purchases of brand-name drugs by non-LIS Part D enrollees whose total drug spending has reached specific thresholds. That discount would not reduce the rebates owed to the federal government under this option because the discount is provided only to the subgroup of Part D enrollees not eligible for the low-income subsidy program.

RELATED CBO PUBLICATIONS: *Costs Under Medicare's Prescription Drug Benefit and a Comparison with the Cost of Drugs Under Medicaid Fee-for-Service* (June 2013), www.cbo.gov/publication/44366; and *Spending Patterns for Prescription Drugs Under Medicare Part D* (December 2011), www.cbo.gov/publication/42692

Option 12 **Function 050**

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

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Modify TRICARE Enrollment Fees, Deductibles, and Copayments												
Change in Mandatory Outlays	0	*	*	*	*	*	*	*	*	*	-0.1	-0.3
Change in Revenues[a]	0	*	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.4	-1.6
Change in Discretionary Spending												
Budget authority	0	-1.0	-1.5	-2.0	-2.2	-2.4	-2.6	-2.8	-3.0	-3.3	-6.8	-21.0
Outlays	0	-0.8	-1.3	-1.9	-2.1	-2.3	-2.5	-2.7	-2.9	-3.1	-6.1	-19.7
Make Retirees Ineligible for TRICARE Prime												
Change in Mandatory Outlays	0	*	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5
Change in Revenues[a]	0	-0.2	-0.6	-1.0	-1.2	-1.3	-1.4	-1.5	-1.6	-1.6	-3.0	-10.5
Change in Discretionary Spending												
Budget authority	0	-3.7	-5.7	-7.8	-8.3	-8.8	-9.4	-9.9	-10.6	-11.2	-25.5	-75.4
Outlays	0	-3.0	-5.1	-7.1	-7.9	-8.4	-9.0	-9.6	-10.2	-10.8	-23.1	-71.0

Notes: This option would take effect in October 2014.

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

a. Negative numbers denote a reduction in revenues.

Nearly 10 million people are eligible for military health care, including 1.5 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 decade, more than doubling in inflation-adjusted terms since 2001; the Department of Defense (DoD) spent about $50 billion in 2012 for health care. About 30 percent of that total was spent on working-age retirees (in general, those who are under age 65 and thus not yet eligible for Medicare) and their family members—a total of 3.5 million beneficiaries. Some 1.6 million (or about 45 percent of that group) were enrolled in TRICARE Prime, a plan that operates like a health maintenance organization. Its enrollees pay an annual fee of $274 (for single coverage) or $548 (for family coverage). Military retirees who do not enroll in TRICARE Prime may receive benefits under TRICARE Extra (a preferred provider network) or Standard (a traditional fee-for-service plan) without paying an enrollment fee. (When beneficiaries choose an in-network provider for a given medical service they are covered under the Extra plan; if they choose an out-of-network provider for a different medical service—even within the same year—they are covered under TRICARE Standard.)

The Congressional Budget Office projects that DoD's health care costs will increase by 25 percent from 2013 to 2023 (after an adjustment for inflation). This option comprises two alternatives that would reduce future growth in military health care spending by requiring working-age retirees and their families to pay more for TRICARE.

The first alternative would raise the enrollment fees, deductibles, and copayments for working-age military retirees who want to use TRICARE, as follows:

- Beginning in 2015, beneficiaries with single coverage could enroll in TRICARE Prime by paying a $550 annual fee.

- For families, the enrollment fee would be $1,100 per year, which is approximately equivalent to the $460 fee first instituted in 1995 (after adjusting for the nationwide growth in health care spending per capita).
- The copayments for medical treatments under TRICARE Prime would increase.
- Single retirees (or surviving spouses) who used TRICARE Standard or Extra would have an annual deductible of $350; the annual deductible for families would be $700.
- In addition—and for the first time—users of TRICARE Standard or Extra would be required to enroll and pay an annual fee of $50 (for single coverage) or $100 (for family coverage).
- All of those new or increased fees, deductibles, and copayments would be indexed in the future to reflect the nationwide growth in per capita spending for health care.

The second alternative would make working-age military retirees and their families ineligible for TRICARE Prime, which is the most costly of the three programs for DoD. Those people could instead enroll in TRICARE Standard or Extra during the annual open-enrollment period or when a life event occurred (for example, a change in marital status). Enrollees in Standard or Extra would pay a monthly premium that would be set at 28 percent of the average cost of providing benefits for that group. In addition, the catastrophic cap (maximum out-of-pocket expenses) for military retirees and their dependents would be raised from the current $3,000 per family to $7,500 per family, the amount at which it was set before January 2002. That catastrophic cap would be indexed in the future to reflect the nationwide growth in per capita spending for health care.

CBO estimates that if TRICARE's fees, deductibles, and copayments were modified according to the first alternative, discretionary outlays would be reduced by $20 billion between 2015 and 2023, under the assumption that appropriations would be reduced accordingly. Under the second alternative, discretionary outlays would be reduced by $71 billion from 2015 to 2023. The budgetary impact of the second alternative would be substantially larger because it would affect more TRICARE Prime users. Under the first alternative, higher out-of-pocket costs would cause about 200,000 retirees and their family members to leave Prime, CBO estimates, many of them switching to other TRICARE plans that are less costly to the government. But under the second alternative, all 1.6 million retirees and their family members who are currently using Prime would be disenrolled from that program.

Both alternatives would also affect mandatory spending. Certain mandatory spending would increase because some retirees would rely more heavily on other federal health care programs, such as Medicaid (for those with low income) or the Federal Employees Health Benefits program (FEHB, for those who complete a career in the federal civil service after their military retirement). However, mandatory spending on retirees' health care costs would decrease for the Coast Guard, the uniformed corps of the National Oceanic and Atmospheric Administration, and the Public Health Service. (Health care costs for retired members of those three branches of the uniformed services are paid from mandatory appropriations. By contrast, DoD pays for the health care of its retirees out of its annual discretionary appropriations.) Overall, in CBO's estimation, mandatory spending would decline by $300 million between 2015 and 2023 under the first alternative (because spending for people in those three uniformed services would decrease by more than spending on Medicaid and FEHB retirees would rise) but increase by $500 million under the second alternative (because spending on Medicaid and FEHB retirees would increase by more than spending for the three uniformed services would fall).

CBO and the staff of the Joint Committee on Taxation estimate that, under the first alternative, federal tax revenues would drop by $2 billion between 2015 and 2023, because some military retirees would sign up for employment-based health care plans in the private sector and therefore experience a shift in compensation from taxable wages to nontaxable fringe benefits. Under the second alternative, because more retirees would be affected by this change, federal tax revenues would decrease by $11 billion over the same period.

One rationale for this option is that TRICARE coverage and space-available care at military treatment facilities were originally set up to supplement other health care for military retirees and their dependents (to ensure they had

a safety net), not to replace benefits offered by postservice civilian employers. The migration of retirees from civilian coverage to TRICARE is one factor behind the rapid increase in TRICARE spending since 2000. This option would begin to curtail the growth in DoD's health care costs, freeing up resources for other defense priorities, such as purchasing and maintaining weapon systems and other equipment.

An argument against changing access to TRICARE coverage for military retirees and their dependents is that those retirees initially joined the military and remained for their entire careers with the understanding that they would receive medical care for free or at a very low cost after retiring. Significantly limiting TRICARE coverage for military retirees and their dependents would impose a financial cost on many of those beneficiaries and could adversely affect military retention. Another potential disadvantage of this option is that the health of users who remained in TRICARE might suffer if they did not seek health care or treat their illnesses in a timely manner because of higher copayments. 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: Option 5

RELATED CBO PUBLICATIONS: *Approaches to Reducing Federal Spending on the Defense Health System* (forthcoming); *Long-Term Implications of the 2014 Future Years Defense Program* (forthcoming); and *The Effects of Proposals to Increase Cost Sharing in TRICARE* (June 2009), www.cbo.gov/publication/41188

Option 13 **Function 550**

Reduce or Constrain Funding for the National Institutes of Health

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total 2014–2018	Total 2014–2023
Restrict the Growth of Funding to 1 Percent a Year												
Change in Discretionary Spending												
Budget authority	0	-0.2	-0.6	-1.0	-1.4	-1.8	-2.3	-2.7	-3.1	-3.6	-3.1	-16.7
Outlays	0	*	-0.2	-0.6	-1.0	-1.4	-1.8	-2.3	-2.7	-3.1	-1.9	-13.1
Reduce 2015 Funding and Allow Growth at the Rate of Inflation												
Change in Discretionary Spending												
Budget authority	0	-3.2	-3.3	-3.3	-3.4	-3.5	-3.6	-3.7	-3.7	-3.8	-13.2	-31.5
Outlays	0	-0.8	-2.6	-3.1	-3.3	-3.4	-3.5	-3.6	-3.6	-3.7	-9.8	-27.6

Notes: This option would take effect in October 2014.

* = between -$50 million and zero.

The budget of the National Institutes of Health (NIH) has grown significantly over the past 15 years, primarily because of the large increases in NIH's appropriations (or budget authority) during the 1998–2003 period, when funding nearly doubled. In addition, NIH received $10 billion in supplemental funding provided in the American Recovery and Reinvestment Act of 2009. In 2012, NIH accounted for nearly half of all nondefense discretionary spending for research and development.

This option consists of two alternatives that would reduce NIH's appropriations relative to the amounts in the baseline budget projections of the Congressional Budget Office. One alternative would restrict the rate of growth in appropriations to 1 percent per year. That alternative would reduce projected appropriations by $17 billion from 2015 through 2023, thereby decreasing federal outlays by $13 billion, CBO estimates. The other alternative would reduce NIH's 2015 appropriation to the amount provided in 2003, the last year in which NIH had a large increase in its appropriation; after 2015, funding would grow at the rate of inflation assumed in CBO's baseline projections. That one-time cut of about 11 percent would decrease projected appropriations by $32 billion from 2015 through 2023, thus reducing federal outlays by $28 billion over that period.

An argument in support of this option is that such reductions would encourage increased efficiencies throughout NIH and more careful focus on priorities that will provide the greatest benefits. NIH has 27 institutes and centers that fund research on a wide array of health-related topics. In addition, it supports more than 300,000 scientists and research personnel affiliated with more than 3,100 organizations worldwide. Furthermore, spending by NIH nearly tripled from 1997 to 2010. With such a broad range of personnel and activities and a large increase in funding, inefficiencies and duplicative or wasteful efforts are likely. In a 2009 report, the Government Accountability Office "found gaps in NIH's ability to monitor key aspects of its extramural funding process."[1] Thus, some costs could probably be reduced or eliminated without harming high-priority research.

An argument against this option is that much of NIH's funding supports research that may improve people's health, thus enhancing people's well-being and providing economic benefits as well. NIH is a major source of funding for academic biomedical research (more than 80 percent of NIH's funding supports extramural

1. See Government Accountability Office, *National Institutes of Health: Completion of Comprehensive Risk Management Program Essential to Effective Oversight,* GAO-09-687 (September 11, 2009), p. 25, www.gao.gov/products/GAO-09-687.

research activities, which are not conducted by NIH staff or on the main NIH campus). Consequently, deep cuts to its budget could disrupt funding for programs already under way, both on and off the campus, and could discourage future researchers from doing academic biomedical research. Furthermore, although having more focused priorities is beneficial, it is difficult to know in advance which projects will yield the most useful results. Large cuts to the NIH budget could discourage innovation in agency-supported medical technologies that have the potential to improve people's health.

Option 14 **Function 700**

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

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Discretionary Spending												
Budget authority	0	-4.7	-4.9	-5.1	-5.2	-5.4	-5.6	-5.7	-5.9	-6.1	-19.9	-48.5
Outlays	0	-4.2	-4.8	-5.0	-5.2	-5.3	-5.5	-5.7	-5.8	-6.0	-19.2	-47.6
Change in Mandatory Outlays	0	2.3	2.4	2.5	2.6	2.6	2.7	2.8	2.9	3.0	9.7	23.8

Notes: This option would take effect in October 2014.

Discretionary savings accrue to the Department of Veterans Affairs; increases in mandatory outlays are projected for the Medicare and Medicaid programs and for federal subsidies to purchase health insurance through exchanges.

Veterans who seek medical care from the Department of Veterans Affairs (VA) are enrolled in one of eight priority groups that are defined on the basis of income, disability status, and other factors. The highest priority for access to health care is given to veterans who have service-connected disabilities (priority groups 1 through 3); the lowest priority is given to higher-income veterans who have no conditions that are disabling to the degree that VA provides compensation. Veterans in priority group 8 do not have compensable service-connected disabilities, and their annual income exceeds both VA's national income threshold and the (generally higher) geographic income threshold that pertains to the veteran's place of residence. Veterans enrolled in priority group 7 also have no compensable service-connected disabilities; either their income lies between the national and geographic thresholds, or their net worth exceeds VA's national threshold. As of 2012, about 2.3 million veterans who were enrolled in VA's health care system had been assigned to priority groups 7 and 8. In any given year, not all of the veterans in those groups seek medical care from VA.

Although veterans in priority groups 7 and 8 pay no annual enrollment fees, they make copayments for their care; if they have private health insurance, VA may bill those insurance plans for reimbursement. Copayments and private-plan billings cover about 18 percent of the cost of care for those veterans. In 2012, VA incurred $4.3 billion in net costs for those patients, or about 8 percent of the department's total spending for medical care (excluding spending from the medical care collections fund, in which amounts collected or recovered from first- or third-party payers are deposited and used for medical services for veterans). When the priority system was established, in 1996, the Secretary of the Department of Veterans Affairs was given the authority to decide which priority groups VA could serve each year. By 2003, VA could no longer adequately serve all enrollees, prompting the department to cut off new enrollment of veterans in priority group 8. Veterans who were already enrolled were allowed to remain in the program. VA eased that restriction in 2009 to allow some additional enrollment of priority group 8 veterans.

This option would end enrollment of veterans in priority groups 7 and 8 and cancel enrollment of all veterans currently in those two groups. Such action would curtail VA's health care spending for veterans who do not have service-related medical needs and who are not poor. To be eligible for VA's medical services under this option, a veteran would have to qualify for a higher priority group by demonstrating a service-connected disability, by documenting income and assets that are below the thresholds, or by qualifying under other criteria (such as having been exposed to Agent Orange, receiving a Purple Heart, being a former prisoner of war, qualifying for Medicaid, or having a catastrophic disability not connected to military service).

Canceling enrollment for all veterans in priority groups 7 and 8 would reduce discretionary outlays, on net, by $48 billion from 2015 through 2023, the Congressional Budget Office estimates. That estimate reflects the assumption that appropriations would be reduced accordingly. However, because this option would result in greater use of other government health care programs, implementing it would increase mandatory spending

for Medicare and Medicaid and for federal subsidies provided through the health insurance exchanges by $24 billion between 2015 and 2023.

An advantage of this option is that it would refocus VA's attention and services on its traditional group of patients—those with the greatest needs or fewest financial resources. Higher-income veterans gained access to the VA system only in the mid-1990s, when the federal budget was under less strain and experiencing less demand for services by higher-priority veterans. In 2012, nearly 90 percent of enrollees in priority groups 7 and 8 had other health care coverage, most notably Medicare and private health insurance. As a result, the vast majority of the veterans who would lose VA coverage under this option would continue to have access to other sources of coverage, and veterans without other health insurance options could qualify for coverage through the health insurance exchanges.

A disadvantage of the option is that veterans enrolled in priority groups 7 and 8 who have come to rely on VA for at least part of their medical care might find their health care disrupted by the change in enrollment rules. Some of those veterans—particularly those with income just above the thresholds—might have difficulty finding other affordable sources of care. In addition, because of the relatively low out-of-pocket cost to veterans for VA health care, veterans switching to alternative sources of care might pay more than they would have paid at VA facilities.

RELATED CBO PUBLICATIONS: 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; and *Potential Costs of Veterans' Health Care* (October 2010), www.cbo.gov/publication/21773

Health—Option 15

Reduce Tax Preferences for Employment-Based Health Insurance

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Accelerate and Expand the Excise Tax on High-Cost Plans												
Change in Outlays	0	*	1	3	3	3	3	4	4	4	8	26
Change in Revenues	0	11	20	25	24	25	31	37	43	50	79	266
Net Effect on the Deficit	0	-10	-19	-21	-21	-22	-28	-34	-39	-46	-72	-240
Replace the Excise Tax With a Limit on the Tax Exclusions for Employment-Based Health Insurance												
Change in Outlays	0	2	6	8	9	10	10	10	11	11	25	77
Change in Revenues	0	21	42	51	58	66	76	88	100	112	173	613
Net Effect on the Deficit	0	-19	-36	-44	-49	-55	-66	-78	-89	-101	-147	-537

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

Notes: This option would take effect in January 2015.

* = between zero and $500 million.

Overview of the Issue

The federal tax system provides preferential treatment for health insurance that people buy through their employer. Employers' payments for health insurance are a form of compensation, but unlike cash compensation, those payments are exempt from income and payroll taxes. In most cases, the amounts that workers pay for their own share of health insurance premiums are also excluded from income and payroll taxes. In all, that favorable tax treatment costs the federal government about $250 billion in forgone revenues each year.

The subsidies provided by those tax preferences encourage firms to offer employment-based health insurance and encourage workers to enroll in such insurance. By pooling risks within groups of workers and their families, and by reducing the administrative costs of marketing insurance policies and collecting premiums, employment-based health insurance is a relatively efficient way to provide coverage—even apart from the tax preferences. Those preferences, however, give employment-based insurance an additional advantage. As a result, in 2012, 85 percent of private-sector employees worked for an employer that offered health insurance coverage; 78 percent of those employees were eligible for their employer's coverage (the rest were ineligible for various reasons, such as working only part time); and 76 percent of the eligible workers chose to enroll.

At the same time, the open-ended nature of the tax exclusions has increased health care spending by encouraging the provision of more comprehensive health insurance than would be the case if there were no tax preferences. In addition, the value of the tax exclusions is generally larger for workers with higher income, even though such workers are more likely to purchase coverage anyway.

A new excise tax that will reduce the tax subsidy for employment-based health insurance is scheduled to begin in 2018. It will be levied on employment-based health benefits whose value exceeds certain thresholds, curtailing the open-ended nature of the current tax exclusions. Even when the new 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 higher-income people.

Reducing the tax subsidy for employment-based health insurance would raise federal revenues and would also affect people's sources of health insurance coverage—decreasing the number of people with employment-based coverage, boosting enrollment in the new health insurance exchanges, and increasing the number of people without insurance. In addition, policies to reduce the tax subsidy would lower total spending on health care relative to what it would be otherwise.

Current Law. The federal tax system subsidizes employment-based health insurance both by exempting 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 pretax earnings. The tax system also subsidizes health care costs *not* covered by insurance by exempting from income and payroll taxes the contributions made to other types of employee accounts that can be used to pay for those costs. Examples include employers' contributions to health reimbursement arrangements (HRAs), employees' contributions to flexible spending arrangements (FSAs), and both employers' and employees' contributions to health savings accounts (HSAs).

The favorable tax treatment of employment-based health insurance 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 by providing financial assistance to specific activities, entities, or groups of people.) Excluding employment-based health insurance from both income and payroll taxes will cost the government $248 billion in 2013, CBO estimates. In addition, the federal government incurs a tax expenditure of about $6 billion a year by allowing self-employed people to deduct the costs of health insurance from their taxable income for the individual income tax (though not for payroll taxes).

The excise tax due to start in 2018 will be imposed on employment-based health benefits whose total value—including employers' and employees' tax-excluded contributions for health insurance premiums and contributions made through HRAs, FSAs, or HSAs for other health care costs—is greater than specified thresholds. The staff of the Joint Committee on Taxation (JCT) and CBO project that those thresholds will be $10,200 for single coverage and $27,500 for family coverage in 2018 (with slightly higher thresholds for retirees ages 55 to 64 and for workers in certain high-risk professions, and with further adjustments for the age, sex, and other characteristics of an employer's workforce). The excise tax will be equal to 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 one out of every five people enrolled in an employment-based health plan in 2018 would have some tax-excluded contributions in excess of the thresholds, JCT and CBO estimate. (However, JCT and CBO expect people's responses to the tax to reduce that share, as discussed below.)

In 2019, the thresholds for the excise tax will be indexed to the growth rate of the consumer price index for all urban consumers (CPI-U) plus 1 percentage point. In subsequent years, the thresholds will be indexed solely to the growth of the CPI-U. Because health insurance premiums will probably continue to rise faster than inflation, the excise tax will probably affect a growing number of people over time. As a result, revenues stemming from the tax are projected by JCT and CBO to rise from $5 billion in 2018 to $22 billion in 2023.

Effects of the Current Tax Treatment. The tax subsidy for employment-based health insurance reduces the problem of "adverse selection," in which less healthy people are more likely to buy health insurance (or to buy specific types of plans) than healthier people are. Adverse selection can cause health insurance markets to break down or to operate inefficiently. Most people would be willing to pay an insurance premium that was somewhat higher than their expected costs for health care in order to avoid the financial risks from unexpected and costly health problems. However, it is difficult and expensive for insurers to determine, and tailor their premiums to, an individual's expected health care costs.

In markets where everyone pays the same premium, health insurance tends to attract enrollees with above-average costs, for whom insurance provides more benefit, and to be less attractive to people with below-average costs, for whom insurance provides less benefit. Thus, in the absence of subsidies or a mandate to purchase coverage, markets for health insurance usually end up offering limited coverage (which less healthy people do not find as appealing), denying coverage to people with high expected costs (to the extent that insurers can determine them), charging high premiums (to cover the costs of less healthy enrollees), or some combination of those outcomes. That situation tends to occur today in markets for individually purchased health insurance, although states' regulations matter crucially for those markets.

Employment-based health insurance limits those market problems 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. Therefore, pooling risks across a workforce (and its family members) reduces the variability of average health care spending for the group. The current tax exclusions encourage employers to offer health insurance; in turn, when employers pay a large share of premiums, employees' share tends to be small relative to their expected health care costs, which encourages them to buy insurance and thereby reduces adverse selection. The tax exclusions also mitigate increases in premiums that might occur because of adverse selection by directly reducing the after-subsidy price of insurance.

The Affordable Care Act made several changes to health insurance markets that, together, will substantially reduce the traditional problems in individual markets discussed above, thus weakening the rationale for subsidizing employment-based insurance:

- The new insurance exchanges will enable individuals and families to buy insurance if they lack other sources of coverage that are deemed affordable. Depending on their income, people may receive refundable tax credits to limit the amount they pay for that coverage. (With a refundable tax credit, if the amount of the credit exceeds the amount of income tax owed before the credit is applied, the taxpayer receives the excess as a payment.)

- Most legal U.S. residents will be required to obtain insurance coverage or potentially be liable for a penalty tax.

- Insurance purchased individually (through the exchanges or directly from insurers) will be available on a guaranteed-issue basis—meaning that policies will be offered to all applicants regardless of their health status—and premiums will not be allowed to vary according to policyholders' health status or sex. In addition, variation in premiums by age will be limited. (Without the subsidies and the requirement to obtain insurance, those provisions alone would increase adverse selection in the market for individually purchased insurance.)

Although the current tax preferences for employment-based health insurance reduce adverse selection, those preferences also encourage workers to favor health care over other goods and services they could purchase and thus contribute to the growth of health care spending. That outcome occurs 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. And because the value of the tax subsidy increases with an insurance plan's premium (up to the threshold for the excise tax in 2018 and beyond), enrollment is especially encouraged in plans that cover a greater number of services, cover more expensive services, or require enrollees to pay a smaller share of the costs of the services they receive. 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 health insurance has shifted toward plans that require workers to pay a higher share of health costs (notwithstanding the incentive created by the exclusions for premium payments). For example, almost one-third of people under age 65 with employment-based coverage reported enrolling in a high-deductible health plan in 2013, up from about one-sixth in 2008.

Another concern about the tax exclusions arises from how their subsidy is distributed among workers at different income levels. 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 purchase coverage, the exclusions do not yield the maximum gains in insurance coverage for the tax dollars forgone. Thus, the tax 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 self-insured employers, but economic theory and empirical evidence suggest that it will be passed on to employers who purchase or provide insurance that is subject to the tax—and then ultimately passed on to workers. JCT and CBO expect that many employers and workers will shift to health plans with premiums below the thresholds to avoid paying the tax, resulting in higher taxable wages for affected workers or higher taxable profits for employers. Workers will pay income and payroll

taxes on any additional wages they receive, and because workers with higher income will pay higher marginal tax rates on those wages, the regressive nature of the tax exclusions will be somewhat lessened.

For employers and workers who do not shift to lower-cost health plans to avoid the excise tax, the costs of the 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 are more likely to have their subsidy reduced (either by being subject to the tax or by changing to a lower-cost plan).

Thus, the new excise tax will decrease the net tax subsidy for workers with health benefits whose value exceeds the thresholds—with the reduction slightly greater for higher-income workers, on average. However, the majority of workers will have health benefits whose value is below the thresholds and therefore will be largely unaffected by the excise tax. Consequently, the net impact of the existing tax preferences and the new excise tax will be to continue subsidizing employment-based health insurance and providing larger subsidies to higher-income people, who would be more apt to purchase coverage even without the subsidy.

Key Design Choices That Would Affect Savings

Lawmakers who wanted to reduce the tax subsidy for employment-based health insurance could take several approaches, which would have differing effects on federal revenues, on the amount of taxes owed by people at various income levels, and on employers' and employees' choices about health insurance plans and their resulting health care costs. Two broad approaches would involve modifying the excise tax on high-cost plans that is due to begin in 2018 and modifying the current tax exclusions. The parameters of both the new tax and the current exclusions could be adjusted to yield larger or smaller amounts of additional revenues or to alter the impact on different types of people, employers, and health insurance plans. A third approach would be to replace the current tax exclusions with an income tax credit for employment-based health insurance, which could also be designed to generate specific amounts of revenues or to have other specific effects.

In general, reducing the tax subsidy for employment-based health insurance would tend to lower the number of people with such insurance and increase cost sharing, which in turn would decrease spending on health care and increase the financial burden on people with substantial health problems. The precise impact, however, would depend on the specific features of any policy change.

Timing and Scope of the Excise Tax on High-Cost Plans. While keeping the current design of the excise tax, lawmakers could increase its impact by moving up the starting date or by slowing the indexing of the threshold amounts. For example, the tax could take effect as soon as 2015, or the specified thresholds could be frozen in nominal terms (that is, not indexed to rise with inflation) so that a larger share of health insurance plans would become subject to the tax over time than would be the case under current law. Lowering the amounts of the thresholds at which contributions begin to be taxed or raising the 40 percent tax rate would also increase the impact of the tax.

In addition, the design of the excise tax could be modified in various ways. Current law allows for different thresholds based on characteristics of an employer's workforce but does not explicitly vary the thresholds by the extent to which an insurance plan encourages health care spending. One alternative to setting a threshold value for premium contributions would be to apply the excise tax to certain types of health insurance plans and exempt others. For example, lawmakers could exempt plans whose actuarial value (the percentage of health care spending for a given population that the plan would pay for) was below a certain amount. Such exemptions, however, would require additional reporting of information by insurers and employers and would be difficult to administer. Moreover, the relationship between a health plan's actuarial value and the extent to which it encourages health spending is not direct. For instance, plans offered by health maintenance organizations often have higher actuarial values than other types of insurance plans, but they may have lower overall costs and result in less health care spending because they manage the use of care more tightly or contract with lower-cost doctors and hospitals.

Scope of the Tax Exclusions. Alternatively, lawmakers could remove the excise tax scheduled to take effect under current law and instead subject contributions for health insurance premiums that are currently tax-preferred to income taxes, payroll taxes, or both. On average, enrollees in employment-based plans face slightly higher federal income tax rates than payroll tax rates. Specifically, JCT and CBO estimate that the average marginal income tax

rate (the rate that applies to the last dollar of someone's earnings) for workers with employment-based coverage is about 16 percent, whereas the average marginal payroll tax rate (including both the employer's and employee's shares of payroll taxes) is about 14 percent. Thus (if everything else stayed the same), including contributions to health insurance premiums in taxable income for income tax purposes would raise slightly more revenue than including them in taxable income for payroll tax purposes, and doing both would raise the most revenue.

Whether to include only some, rather than all, of those contributions in employees' taxable income would be a key design issue. For example, the exclusions could be capped for all taxpayers, or they could be phased out for higher-income people. Such caps or thresholds could also be allowed to vary according to other characteristics of employees, such as age, sex, or occupation. The forthcoming excise tax includes several adjustments of that sort, including assigning higher thresholds to some groups of people with higher average health care costs.

Tax Credit Versus Tax Exclusions. Yet another approach to reducing the tax subsidy for employment-based health insurance would be to replace the current income tax exclusion (or income and payroll tax exclusions) with an income tax credit. If the credit was a fixed dollar amount and was refundable—so that people for whom the credit exceeded the amount of federal income tax owed could receive money back from the government—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. As an alternative to fixing the dollar amount of the credit, its size could be phased down for people at higher income levels. With any of those designs, the credit would have a set dollar value for a given worker, so that person could not increase his or her tax subsidy by purchasing more extensive or more costly insurance.

In setting the value or rate schedule for a tax credit, lawmakers would face various trade-offs. For example, a larger credit would increase the number of people who obtained health insurance but would reduce the amount of tax revenues collected. As another example, phasing down the credit for people at higher income levels would focus the tax preference on people who would be less likely to obtain insurance in the absence of a tax subsidy, but that approach would also raise effective tax rates on income in the phase-out range.

Specific Alternatives and Estimates

CBO and JCT analyzed two alternatives for reducing the tax subsidy for employment-based health insurance: accelerating and expanding the excise tax on high-cost plans or replacing that tax with a limit on the current tax exclusions. Both of those policy changes would increase the tax liability and affect the behavior of people with large before-tax contributions for employment-based health plans, but the specific increases in taxes and changes in behavior would be different under the two approaches.

In the first alternative, implementation of the excise tax would be sped up by three years, to 2015, and the thresholds at which contributions would become subject to the tax would be lower in 2018 and beyond than they would be under current law. Specifically, the thresholds in 2015 would be set at $7,970 for individual coverage and $19,910 for family coverage—which represent JCT and CBO's estimate of the 75th percentile for health insurance premiums to be paid by or through employers in that year. After 2015, the thresholds would be indexed for inflation as measured by the CPI-U. In 2019, they would be $8,700 for individual coverage and $21,750 for family coverage, compared with $10,550 and $28,400, respectively, under current law. As in current law, the tax would equal 40 percent of the difference between total tax-excluded contributions and the applicable threshold. Similar to the provisions of current law, the thresholds would be 10 percent higher for retirees ages 55 to 64 and for workers in designated high-risk professions, but other adjustments provided under current law (such as those for age and sex) would be eliminated to simplify administration.

That alternative would reduce federal deficits by $240 billion between 2015 and 2023, JCT and CBO estimate. Like the excise tax in current law, the modified tax would generate revenues in two ways. First, it would produce additional excise tax revenues for employment-based plans whose premiums remained above the thresholds. Second, it would generate additional income and payroll tax revenues because of people's responses to the tax: Many employers and workers would probably change to lower-cost insurance plans, and some employers would be discouraged from offering health insurance to their workers. The resulting reduction in payments of health

insurance premiums would lead to higher taxable wages for those employees or higher taxable profits for their employers.

The increase in excise tax collections and the tax's indirect effects on tax receipts would boost revenues by $266 billion from 2015 to 2023. However, outlays would also rise over that period, by $26 billion, primarily because more people would receive subsidies for insurance coverage purchased through the exchanges (as discussed below). Although premium subsidies for exchange plans are structured as refundable tax credits, in most cases the amounts of those credits will exceed the amount of federal income tax that recipients owe, and the amounts above the tax owed by recipients are classified as outlays. Cost-sharing subsidies for enrollees in exchange plans are also categorized as outlays.

By decreasing the tax subsidy for employment-based health insurance, that alternative would result in about 2 million fewer people with employment-based insurance in 2019 than the number projected under current law. In that year, roughly one and a half million more people would buy coverage through the exchanges, and about half a million more people would be uninsured. After 2019, the tax subsidy for employment-based insurance would decline further, so fewer people would have such insurance. By 2023, about 3 million fewer people would have employment-based coverage, and about 1 million more people would be uninsured, than under current law.

The second alternative would eliminate the excise tax and instead impose a limit on the extent to which employer-paid health insurance premiums and contributions to FSAs, HRAs, and HSAs could be excluded from income and payroll taxation. Specifically, starting in 2015, any contributions that employers or workers made for health insurance and for health care costs (through FSAs, HRAs, and HSAs) that together exceeded $6,420 a year for individual coverage and $15,620 for family coverage would be included in employees' taxable income for both income and payroll taxes. Those limits, which are based on the estimated 50th percentile for health insurance premiums paid by or through employers in 2015, would be indexed in subsequent years for inflation using the CPI-U. The same limits would apply to the deduction for health insurance available to self-employed people. Capping the tax exclusions at lower thresholds than the ones scheduled to take effect for the excise tax would reduce federal tax subsidies. For example, in 2019, the caps for individual and family coverage under that alternative would be $7,000 and $17,000, respectively, whereas the current-law thresholds for the excise tax would be $10,550 and $28,400, respectively, in that year.

That alternative would decrease federal deficits by $537 billion between 2015 and 2023, JCT and CBO estimate. The reduction in the tax subsidy for employment-based health insurance would cause about 6 million fewer people to have employment-based coverage in 2019 than under current law. In that year, about 4 million more people would buy coverage through the exchanges, about half a million more people would enroll in Medicaid or the Children's Health Insurance Program (CHIP), and an additional one and a half million people would be uninsured.

The reduction in the deficit from that alternative stems from several, partly offsetting, changes in revenues and outlays. Income and payroll tax revenues would rise by $681 billion through 2023 because the number of people with employment-based coverage would decline and because many of those who kept such coverage would receive a smaller tax subsidy. (For example, the capped tax exclusions would reduce the combined federal income and payroll tax liability of people with individual coverage by an average of $1,827 in 2019, compared with an average reduction of $2,330 for such people under the current exclusions.) However, other effects of that alternative would also affect revenues. Additional tax credits for coverage purchased through the exchanges and the repeal of the excise tax would reduce revenues, whereas additional penalty payments by certain employers and individuals resulting from changes in health insurance coverage would increase revenues by a small amount. In all, revenues would be $613 billion higher through 2023 than under current law. The policy changes would boost federal outlays by $77 billion through 2023, primarily because of increased spending on exchange subsidies and Medicaid.

Other Considerations

Reducing the tax subsidy for employment-based health insurance would affect many aspects of the U.S. health care sector, including the growth of health care costs, the health of the population, the coverage choices of employers and workers, and the number of people without health insurance.

Effects on Health Care Costs. Expanding the forthcoming excise tax on high-cost insurance plans or replacing that tax with a limit on the current tax exclusions would reduce health care spending relative to what it will be under current law. As discussed above, the current tax preferences for employment-based insurance encourage overconsumption of health care relative to other goods and services. Those tax preferences give health insurance plans an incentive to cover a greater number of services, cover more expensive services, and require enrollees to pay a smaller share of the costs of the services they receive. The excise tax will effectively scale back those tax preferences to some degree. Under both of the alternatives examined here, the tax increases would start sooner and would apply to a larger share of employment-based plans than the excise tax will under current law. As a result, employers and their workers would have less incentive to buy expensive health insurance, which would reduce upward pressure on the price of health care and use of health care services and would encourage greater use of cost-effective types of care. The effects on health care spending would be larger in areas with higher health care costs.

Effects on People's Health. By reducing the incentive to purchase expensive health insurance coverage, both of the policy alternatives analyzed here would probably limit some people's access to health care and cause them to forgo some care. In a health insurance experiment conducted by the RAND Corporation from 1974 to 1982, nonelderly participants were randomly assigned to health insurance plans. The experiment found that greater cost sharing—which is a key mechanism through which insurance plans can lower their premiums—reduced the use of effective care and less effective care (as defined by a team of physicians) by roughly equal amounts. Although the study 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. Thus, the reduction in health care spending prompted by these alternatives could be accompanied by worse health for some people.

Effects on Employers and Workers. By raising the tax liability of people enrolled in high-cost employment-based plans, 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 new taxes by shifting to plans with lower premiums and higher cost-sharing requirements, which would increase out-of-pocket costs the most for those workers (and their dependents) who used the most services.

Under both 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. In addition, because the alternative to expand the excise tax would not adjust the thresholds for workers' age, firms would be more likely to face the tax if they had an older workforce. That situation might decrease employers' willingness to hire older workers or cause employers to reduce other forms of compensation for older workers, such as cash wages or contributions to pension plans.

Effects on the Number of Uninsured People. The tax increases envisioned in this option would lead fewer employers to offer health insurance, thus increasing the number of uninsured workers. Most people whose employers stopped offering health insurance coverage would purchase it in the individual market, including in the health insurance exchanges. The federal subsidies available through the exchanges would give many low-income people an affordable alternative to employment-based coverage, and the tax penalty for lacking insurance would give many high-income people who lost employment-based coverage an incentive to buy insurance in the exchanges even without a subsidy. Nevertheless, some workers whose employers ceased to offer health insurance under this option would forgo coverage, CBO and JCT expect.

RELATED CBO PUBLICATION: *The Distribution of Major Tax Expenditures in the Individual Income Tax System* (May 2013), www.cbo.gov/publication/43768

Option 16

Increase the Excise Tax on Cigarettes by 50 Cents per Pack

											Total	
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014–2018	2014–2023
Change in Outlays	*	*	*	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Change in Revenues	3.3	4.0	3.9	3.7	3.7	3.7	3.6	3.6	3.6	3.6	18.6	36.8
Net Effect on the Deficit	-3.3	-4.0	-3.9	-3.8	-3.8	-3.8	-3.7	-3.7	-3.7	-3.7	-18.8	-37.4

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

Notes: This option would take effect in January 2014.

* = between -$50 million and zero.

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 $1.51 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 $3.12, on average.

This option would raise the federal excise tax on cigarettes by 50 cents per pack beginning in 2014. 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 staff of the Joint Committee on Taxation (JCT) and the Congressional Budget Office estimate that the option would reduce deficits by $37 billion from 2014 to 2023: Revenues would rise by $37 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 will be the case 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 would also 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 would also rise as a result of the 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 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, 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 pretax 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.

Some observers also object to using the cigarette tax as a mechanism for changing people's behavior regarding smoking. In particular, some observers argue that consumer protection is a specious justification for cigarette taxes when many other choices that people make—for example, to consume some types of food or engage in risky sports—can also cause health damage.

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 the healthier population.

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

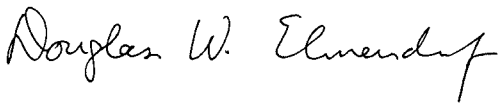
About This Document

At the request of the House and Senate Committees on the Budget, the Congressional Budget Office periodically issues a compendium of budget options to help inform federal lawmakers about the implications of possible policy choices. This report reprints the 16 health-related options from the most recent compendium, *Options for Reducing the Deficit: 2014 to 2023* (November 2013), www.cbo.gov/publication/44715.

The options discussed in this report come from a variety of sources, including legislative proposals, various Administrations' budget proposals, Congressional staff, other government entities, and private groups. The options are intended to reflect a range of possibilities rather than to provide a ranking of priorities or a comprehensive list. The inclusion or exclusion of a particular policy change does not represent an endorsement or rejection by CBO. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

This report is the result of work by numerous people at CBO, whose names are listed on the following pages, as well as by the staff of the Joint Committee on Taxation. Various experts outside of CBO (also listed) reviewed selected portions of the report in draft. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

The report is available on CBO's website (www.cbo.gov/publication/44906).



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The spending estimates that appear in this report were prepared by the staff of the Congressional Budget Office's Budget Analysis Division (supervised by Peter Fontaine, Theresa Gullo, Holly Harvey, Tom Bradley, Jean Hearne, Sarah Jennings, and Sam Papenfuss) and Health, Retirement, and Long-Term Analysis Division (supervised by Linda Bilheimer, Jessica Banthin, James Baumgardner, Phil Ellis, and Joyce Manchester). Most of the revenue estimates were prepared by the staff of the Joint Committee on Taxation.

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