

NOTE: ALL ESTIMATES ARE OVER A 10-YEAR PERIOD, UNLESS OTHERWISE STATED

MEDICARE PART A

Post-Acute Provider Market Basket Freeze (-\$14 billion for one year freeze; -\$28 billion for two year freeze, CBO): Most Medicare fee-for-service providers receive an annual update, known as a “market basket update,” to reflect inflationary increases in the costs of items and services that are provided. The Affordable Care Act (ACA) reduced spending for these updates by requiring that they be adjusted downward for improvements in productivity, with some providers having additional downward adjustments in some years. This policy option would provide a payment freeze (a zero update) for one-year (2012) or two-years (2012-2013) to post-acute providers – e.g., skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs) and home health agencies (HHAs).

Discussion: The Medicare Payment Advisory Commission (MedPAC) recommends a payment freeze for 2012 for all post-acute providers, finding that indicators of payment adequacy are positive, even when considering the ACA adjustments. More specifically, MedPAC finds healthy 2009 Medicare margins of 18.1 percent for SNFs, 8.4 percent for IRFs, 5.7 percent for LTCHs, and 16.9 percent for HHAs. The provider communities will oppose this policy, arguing that many of their facilities have margins below the average. The SNF and HH industries will also point to recent regulatory actions taken to reduce overpayments (in the case of SNFs) or regulatory actions proposed to address unjustified coding increases (in the case of HHAs). Finally, it is worth noting that the Super Committee’s recommendations will be made after FY12 has started, so an FY12 market basket freeze will need to be implemented retroactively for SNFs, IRFs or LTCHs; alternatively, the full year’s payment effect will need to be applied over the months that remain after legislation is enacted, which will result in payments below a freeze for those months. HHAs are paid on a calendar year basis, but if legislation is enacted in late December, a delayed implementation date would likely also be necessary. However, precedent exists within the Medicare program for all such actions.

Accelerate Home Health Rebasing (-\$3 billion, CBO): The Affordable Care Act enacted a recommendation from the Medicare Payment Advisory Commission (MedPAC) to “rebase” payments to home health agencies. Since 1998, the number of visits per episode has declined from 31.6 visits per 60-day episode to 22 visits per episode in 2007. However, the rate is still set as if Medicare were paying for 31.6 visits per episode. The ACA requires a rebased payment level to be phased-in over four years starting in 2014. This proposal would accelerate the rebasing so that it is finished within the two-year period of 2014-2015. This proposal was included in the Simpson-Bowles recommendations.

Discussion: MedPAC recommends a two-year rebasing, beginning in 2013. At this point, it is not feasible to start in 2013, so this policy retains the ACA date of 2014 but accelerates the timeframe consistent with the MedPAC recommendation. The home health industry will argue that this adjustment is punitive, particularly when combined

with proposed regulatory changes that will lower payments in response to coding increases and a possible market basket freeze.

Increase SNF Cost-Sharing (-\$21.3 billion, CBO): Medicare covers up to 100 days of care in a skilled nursing facility (SNF) following a stay of three or more days in the hospital. There is no deductible for SNF care, and no copayment for the first 20 days. A daily copayment is required for days 21 through 100, set at 12.5 percent of the hospital inpatient deductible, or a projected daily SNF copay of \$148 in 2013. This option would impose a copayment for each of the first 20 days of care in a SNF equal to 5 percent of the inpatient deductible, an estimated \$59 per day in 2013; this proposal would affect beneficiaries who have been hospitalized and need continued skilled nursing care or rehabilitation services on a daily basis.

***Discussion:** Proponents of this policy will assert that it will discourage use of some, perhaps unnecessary, Medicare services. A further argument is that many Medicare beneficiaries have supplemental coverage so they will not directly feel the impact of this cost-sharing increase. However, new and increased SNF copays will increase the financial burden on the most financially vulnerable and sickest Medicare beneficiaries – e.g., those who do not have supplemental coverage (~8 percent of beneficiaries) and those who need continuing care after a hospitalization. It will also increase Medigap premiums for plans that cover the SNF cost-sharing, increase employers' costs for their supplemental coverage, and increase state Medicaid expenditures to cover cost-sharing for individuals dually eligible for Medicare and Medicaid. Increased SNF co-pays could also cause beneficiaries to forego needed care that would otherwise help to avoid further complications from surgery and could cause beneficiaries to choose to receive care through other Medicare benefits, such as home health, for which there is no copay.*

Recoup FY11 SNF Overpayments (up to -\$4.5 billion, staff estimate based on CMS analysis): In FY11, Medicare implemented a refined payment system for skilled nursing facilities, known as RUG-IV (resource utilization groups version 4). Consistent with Medicare policy, CMS intended to implement the new system so that it was budget neutral to the amount of payments that would have otherwise been made under the old system. However, SNFs changed their behavior in response to the rule, causing payments in 2011 to increase by 12.6 percent as compared to FY10 payments, an increase of nearly \$4.5 billion. In CMS's final rule for FY12 they lowered payments by 11.1 percent below the FY11 payments in order to restore overall payments to their intended levels. Since CMS does not have the authority to make a retrospective adjustment, this proposal would recoup the FY11 overpayments.

***Discussion:** This policy recoups a windfall that SNFs received as a result of a new payment system being unexpectedly implemented in a non-budget neutral manner. It is important to note that MedPAC estimates healthy SNF Medicare margins of 18.1 percent in 2009. SNFs will argue that this money has already been spent to pay for costs incurred for FY11 and that this repayment will threaten their financial viability, given Medicaid cuts at the state level, and possibly cause them to cut jobs. While the policy is justified in terms of recouping funds the SNFs were not supposed to receive, it will be*

viewed by the industry going farther than the 2012 final rule, which they oppose and from which they are already considering requesting legislative relief.

New SNF Value-Based Purchasing/Readmissions Program (no score available). The Affordable Care Act created a new value-based purchasing (VBP) program for inpatient hospitals, effective FY13, which will reward hospitals with high or improving quality. VBP is implemented budget neutral, meaning that the amount of money collected from all hospitals equals the amount of money paid out in the form of bonuses received by some. ACA also created a new payment policy to encourage hospitals to lower the rate of preventable readmissions, which is effective FY13 and estimated to save -\$7.3 billion. The House-passed version of health reform also included post-acute providers in the readmissions policy, but that provision did not become law. This policy would implement SNF VBP in a *non-budget neutral manner*, that is, by awarding less in bonuses than is collected, resulting in cuts to SNF payments overall. Incentives to lower readmissions from SNFs to hospitals could be included in VBP, or pursued as a separate policy.

***Discussion:** SNFs are on the path to VBP, as CMS is required to submit a VBP implementation plan by 10/1/11. Additional legislative authority will be needed to move forward with CMS's plan. Implementing VBP in a non-budget manner breaks with the precedent created by the budget neutral hospital VBP program and will incite strong opposition from across the provider community because other providers on the path to VBP will fear that their VBP programs will also be implemented to yield savings. With regard to readmissions, the House-passed health reform bill proposed to hold SNFs accountable for their role in preventable readmissions by crafting a small penalty and directing CMS to develop the measures necessary to implement a program comparable to the hospital program. However, the tools are not there yet for knowing how to measure preventable readmissions from SNFs to hospitals and caution is needed to ensure the policy doesn't encourage SNFs to avoid patients at risk of readmission.*

New Home Health Copay (-\$40.1, CBO; -\$1 to -\$5 billion over five years, MedPAC): Medicare beneficiaries currently do not pay any cost-sharing for home health services. This policy would charge beneficiaries a 10 percent copayment for each home health episode, yielding an average increase in beneficiary costs of \$600. Alternatively, MedPAC recommends a copay of \$150 per episode, excluding low-use/low-visit and post-hospital episodes.

***Discussion:** Proponents of this policy, including MedPAC, argue that a copay will help to reduce unnecessary utilization. However, MedPAC also recognizes that a copay should not be set so high as to dissuade beneficiaries from seeking needed care or lead them to seek care in more expensive settings. MedPAC also recommends a number of exceptions, including that the copay not be applied to dual beneficiaries or to the first home health visit after a hospital discharge. Beneficiary groups will object to a new home health copay, as such a policy disproportionately affects older, sicker, female beneficiaries.*

Eliminate Rural Hospital Payment Add-Ons (-\$62.2 billion, CBO). Several categories of rural hospitals are exempt from Medicare’s inpatient hospital prospective payment system (IPPS) and instead receive special payments. These hospitals are known as Critical Access Hospitals (CAHs), Sole Community Hospitals (SCHs), and Medicare Dependent Hospitals (MDHs). These hospitals are instead paid at 101 percent of costs, in the case of CAHs, or a blend of IPPS rates and costs, in the case of SCHs and MDHs. According to CBO, hospitals benefiting from these special payments are paid about 25 percent more, on average, for inpatient and outpatient services than the payments that would otherwise apply. This policy would eliminate the special payments and instead pay the hospitals the regular prospective payment rate. Rep. Cantor’s slides on debt ceiling/deficit reduction options listed \$14 billion in payment reductions for rural hospitals.

Discussion: Arguments in favor of this proposal are that doing so would move Medicare toward a consistent payment policy for all hospitals and encourage greater efficiency. In addition, many of these facilities were exempt from ACA Medicare savings proposals or received increased payments under the ACA. Payments based on a prospective payment system, rather than costs, are more consistent with the delivery system reform goals in the Affordable Care Act of encouraging efficiency and value in health care over volume. Opponents of this proposal will argue that the special payments help to cover higher costs of doing business at lower volume facilities, and that eliminating special payments will harm access to care for rural beneficiaries. It is important to note that these policies can be dialed to achieve lower savings by shrinking (rather than eliminating) the special payments or reducing the number of providers eligible for special payments.

Eliminate or Phase-Down Reimbursement for Bad Debt. Medicare currently reimburses some providers for bad debt – defined as Medicare cost-sharing that beneficiaries fail to pay – at a rate of 70 percent for hospitals and skilled nursing facilities, 100 percent for some other providers, and 101 percent for certain small rural hospitals. This policy saves between \$15 to \$30 billion, depending on providers affected (e.g., if all providers are brought to the same percentage) and whether bad debt payments are reduced or entirely eliminated. Rep. Cantor’s slides on debt ceiling/deficit reduction options included \$14 to \$26 billion from cutting Medicare reimbursement for bad debt.

Discussion: Proponents of this policy argue that providers should do more to recoup these cost-sharing amounts owed by beneficiaries. Opponents of this policy point out that lowering or eliminating bad debt reimbursement disproportionately affects safety net and other institutions that serve a lot of low-income beneficiaries and who already were subject to substantial savings in the ACA (through PPS reductions, DSH cuts, etc.). Moreover, half of the Medicare bad debt incurred by providers is for beneficiaries dually eligible for Medicare and Medicaid in states where the state Medicaid program refuses to pay the Medicare cost-sharing. In that situation there is no one from whom the provider can recoup the money (since the state refuses to pay and even though the obligation is borne by the state Medicare program, not the beneficiary.). Versions of this policy were included in the Simpson-Bowles recommendations and were reportedly discussed in the Biden group.

Cut Reimbursement for Graduate Medical Education (up to -\$15 billion, CBO): Medicare reimburses hospitals for graduate medical education via two funding streams. Direct graduate medical education (DGME) pays Medicare's share of the direct cost of training medical residents, such as for a portion of salaries. Indirect medical education (IME) pays hospitals for the indirect costs associated with training residents, such as the additional time it takes to meet with patients. Policy proposals in this area would lower reimbursement for IME, lower or freeze DGME payments for all hospitals or only those in high cost areas, or shift some Medicare money for a new value-based GME program. Rep. Cantor's slides on debt ceiling/deficit reduction options included \$14 billion in GME cuts.

Discussion: MedPAC has found that payments for IME exceed the empirical justification for those payments. Opponents of IME cuts point out that MedPAC has always recommended that any savings from IME cuts be reinvested in the hospital sector. Opponents of IME cuts also argue that such cuts disproportionately affect tertiary care and safety net institutions that provide critical high-cost services to the entire community, such as trauma care and burn units, in addition to uncompensated care, etc. With regard to direct graduate medical education, proponents of cuts criticize current DGME levels by pointing out that some hospitals are reimbursed at more than 150 percent of the national median resident salary. Opponents of DGME cuts assert that the higher DGME rates at certain hospitals reflect the higher cost-of-living and resulting resident salaries in those communities. Opponents of GME cuts also point out that teaching hospitals are often our nation's safety net hospitals, and as such, bore a large share of the hospital cuts in the Affordable Care Act (nearly 1/4 of the \$155 billion in ACA hospital cuts were from safety net hospitals in the form of cuts to Medicare and Medicaid disproportionate share hospital (DSH) payments.) Versions of this policy were included in the Simpson-Bowles recommendations and were reportedly discussed in the Biden group. With regard to the value-based GME program, many health policy analysts agree with the goal of rewarding teaching hospitals for meeting certain goals (such as teaching residents to work in teams, use electronic health records or to practice evidence-based medicine), but question whether the metrics exist yet to measure achievement of those goals. Teaching hospitals will object to linking large portions of their financing to such an undefined program.

Recoup Overpayments from Inpatient Hospital Documentation and Coding Improvements (up to \$5 billion, staff estimate based on CMS analyses): In 2008, CMS moved to a more refined payment system for Medicare inpatient hospital payments. This new system added more payment categories and the expectation was that hospitals would improve their documentation and coding by more accurately accounting for complications and comorbidities in their patients. Both CMS and MedPAC estimated that this new system would result in improved (and higher) coding without any corresponding increase in severity of case mix, resulting in unwarranted overpayments. In order to keep the system budget neutral, CMS proposed a downward adjustment to remove the "coding creep" and avoid overpayment. Congress intervened to slow the downward adjustment, which is nearing completion of its phase-in. As of FY12, there will

only be an additional 1.9 percent downward adjustment necessary to complete the phase-in and the general expectation is the final adjustment will be made in FY13. However, in the intervening years that have occurred while Medicare has phased in the adjustment, the program has continued to overpay by approximately 3.9 percent (~\$2 billion) per year. This option would require hospitals to repay some or all of the overpayments received in FYS 2010 to 2012.

***Discussion:** MedPAC recommends gradually recovering all overpayments due to documentation and coding improvements, as doing so is necessary to ensure that the transition to the refined payment system is budget neutral. Hospitals will argue that the CMS and MedPAC methodology for calculating the “coding creep” is flawed, resulting in an estimate that is too high. They will also argue that this money has already been spent to pay for costs incurred and that hospitals cannot sustain the additional cut on top of the payment adjustments included in the ACA, and in light of their average Medicare margins of -5.2 percent.*

MEDICARE PART B

Subject Clinical Laboratory Tests to Deductible and Coinsurance (-\$24 billion, CBO):

Under current law, there is no cost-sharing for Medicare-covered lab services. This policy would subject laboratory services to the Part B deductible and 20 percent coinsurance requirements. Variations of this proposal would exclude laboratory services from the deductible and impose \$1 co-pays, or exclude certain low-cost services from the requirements, etc.

***Discussion:** Savings from this policy would reduce Medicare’s costs because of lower use of lab services and cost-shifting to beneficiaries. One rationale for imposing cost-sharing requirements is that beneficiaries might be less likely to undergo lab tests if they have to cover part of the costs themselves. However, beneficiaries don’t generally generate lab services (e.g., physicians order them) and forgoing necessary lab tests could hinder timely clinical decision-making and treatment. Furthermore, copayment for most lab services would be small, averaging about \$6. Industry argues that the administrative costs of collection for some services could exceed the actual copayment.*

Increase Utilization Rate of Advanced Imaging Equipment (-\$0.4 billion, CBO): This proposal increases the estimated amount of time advanced imaging equipment (such as CT and MRI) is in use. Under current law, reimbursement is based on an assumption that the imaging equipment is in use 75 percent of the time physician practices are open. The proposal would increase the estimated rate to 90 percent, phasing-in at 80 percent in 2012 and increasing to 90 percent in 2013 and thereafter. This policy was put forth by the Senate Finance Committee this past June as an offset for continuation of the Trade Adjustment Assistance (TAA) program, but later withdrawn.

***Discussion:** MedPAC recommends an increased utilization rate to discourage providers from acquiring costly imaging equipment unless they have sufficient usage to justify the purchase. CMS also has data supporting the change to a 90 percent utilization rate. Radiologists (ACR) and broader groups such as Access to Medical Imaging Coalition*

(AMIC), which includes provider organizations and manufacturers, oppose this proposal.

Require Prior Authorization for Advanced Imaging Services (-\$1.1 billion, CBO): Under this proposal, physicians would be required to obtain approval from radiology benefit managers (RBMs) before ordering certain imaging services. RBMs would determine whether to grant coverage approval based on criteria formulated from recommended clinical guidelines. This proposal was included in Rep. Cantor's slides on debt ceiling/deficit reduction options.

***Discussion:** Medicare has never used prior authorization with respect to physician services, so instituting this policy would be an unprecedented departure from current practice for physicians and beneficiaries alike. An argument for prior authorization is that there has been a steady and significant increase in imaging services and reduction in use of advanced imaging services that are of little or no clinical benefit would lower Medicare's expenditures and shield beneficiaries from unnecessary imaging services. MedPAC has recommended a limited prior authorization program for practitioners who order substantially more imaging services than their peers. However, evidence is unclear whether RBMs significantly reduce unnecessary utilization of imaging services. Private plans that employ RBMs have reported drops in use of imaging services immediately after implementing a prior authorization approach, but increases in use as physicians adapt to the new approval procedures. In many cases the growth of spending returned to its previous pace.*

Reform the Quality Improvement Organizations (QIO) Program (-\$0.3 billion, CBO): QIOs are private, mostly not-for-profit organizations, staffed by health care professionals, that review beneficiary complaints about quality of care and also work with providers to improve quality of care. These proposals would improve the QIO program's administrative operations and introduce competition and performance incentives. The proposals enhance QIO contract review and termination processes; allow other organizations to compete for QIO contracts; alleviate peer review conflict of interest concerns; and require the Secretary to determine the geographic scope of the QIOs, fostering contract efficiencies. These QIO proposals were presented in the President's FY 2012 Budget and also mentioned in Rep. Eric Cantor's slides on debt ceiling/deficit reduction options.

***Discussion:** MedPAC finds that the current QIO program has not shown effectiveness in improving quality of care and that the level of expertise at QIOs may be unequal to the task. MedPAC makes recommendations similar to those above and recommends that funding for technical assistance be given directly to providers and communities.*

Align Payments for Retail and Mail Order Pharmacies for Diabetic Testing Supplies (-\$0.6 to -\$0.8 billion, CBO): While national mail-order diabetic testing supplies are included in the competitive bidding program for durable medical equipments (DME), the same supplies provided in a retail setting are not subject to competitive bidding and are paid at higher rates.

The proposal would apply prices determined under competitive bidding, beginning in 2013, to all diabetic testing supplies regardless of whether they are purchased from a mail-order or retail pharmacy. Preliminary scores for this proposal range from \$800 million if all retail pharmacies are included to \$600 million if community pharmacies are exempt from the competitive bidding prices. A proposal on retail diabetic testing strips with a \$0.2 billion score was noted in Rep. Eric Cantor's slides on debt ceiling/deficit reduction options.

Discussion: While aligning payments for diabetic testing supplies is a justifiable policy, independent community pharmacies argue that they do not have the business volume to be able to provide supplies at prices determined under competitive bidding and that decreased prices for retail supplies will limit beneficiary choice for purchasing supplies in person.

Strengthen Medicare Program Integrity Efforts (-\$0.7 billion, CBO). Legislative proposals to intensify program integrity efforts include penalizing providers who do not update their enrollment records, validating physician orders prior to payment for certain high-risk services, and requiring prepayment review for all power wheelchairs. (A Medicare Advantage program integrity proposal regarding erroneous payments is discussed separately further below.) These program integrity proposals were included in the President's FY 2012 Budget and also mentioned in Rep. Eric Cantor's slides on debt ceiling/deficit reduction options.

Discussion: While the ACA provides many tools to control fraud, waste and abuse, there is continued bipartisan interest to do more. Industry will likely oppose many of the suggested proposals. For instance, the American Association for Homecare spoke out against prepayment review for power wheelchairs, arguing that the contractors that would do the review do not know what is clinically appropriate, and the review would delay beneficiary access to power wheelchairs. Physician groups may balk at the validation proposal.

Reduce Payments for Drugs Administered in a Physician's Office (-\$3.2 billion, CBO): Under current law, certain drugs are provided in a physician's office and are covered under Medicare Part B (instead of Part D). This coverage generally only applies to drugs that are infused or injected (provided "incident to" physician services). Physicians are reimbursed for the office visit and are paid an additional amount for the drug they are administering. Physicians negotiate with pharmaceutical manufacturers and other entities to acquire these drugs. The Medicare program pays physicians the Average Sales Price (ASP) of the drug + 6 percent, regardless of the price the physicians actually pay. Large physician practices are often able to purchase these drugs at prices lower than ASP + 6 percent and make a sizeable profit. Some smaller physician practices have a difficult time receiving the same discounts and do not make as much profit off the sale of the drug as the larger practices. The Biden group discussed reducing the Medicare reimbursement for these drugs from ASP + 6 percent to ASP + 3 percent.

Discussion: Several oncology groups and other provider organizations have raised concern that this policy change could result in access problems for Medicare

beneficiaries. Medicare experts believe that large physician practices will continue to operate as they do now and beneficiary access will not change. For smaller physician practices, Medicare experts believes that some of these practices may choose not to administer drugs in their offices and will instead refer patients to hospital outpatient facilities. This could be inconvenient for Medicare beneficiaries who prefer to receive these drugs in their doctor's office, but Medicare beneficiaries would still retain access to these drugs. Original proposals regarding ASP proposed ASP without any additional percentage add-on; there is no empirical justification for the six percent, though providers have become accustomed to receiving it.

MEDICARE ADVANTAGE AND PART D

Recover Erroneous Payments Made to Insurers Participating in Medicare Advantage (-\$2.6 billion, CBO): Under current law, CMS is required to risk adjust payments to Medicare Advantage (MA) plans to reflect variation in health risk, and thus cost, of different beneficiaries. In 2008, CMS announced a pilot program to audit a sample of plans' records to validate the accuracy of the adjusted payments. Under this pilot program, CMS evaluates the medical records of beneficiaries (validation audits). The President's FY 2011 and FY 2012 budgets included a policy that would require CMS to extrapolate the error rate found in the risk adjustment validation audits to the entire Medicare Advantage plan payment for a given year.

***Discussion:** This policy option would ensure that Medicare is accurately paying Medicare Advantage plans by identifying – and correcting – both overpayments and underpayments. To date, the health insurance industry has not raised concerns about this policy option since it would identify both overpayments and underpayments. However, in budget briefings and elsewhere, Republican staff have registered concerns about the proposal.*

Establish a Part D Rebate for Dual Eligible Medicare Beneficiaries and Low-Income Subsidy Recipients (-\$120 billion, CBO): This policy option would require drug manufacturers to provide rebates for Part D prescription drugs used by beneficiaries dually eligible for Medicare and Medicaid and low-income subsidy (LIS) recipients. Prior to the establishment of Medicare Part D in 2006, dual eligibles received their drugs through state Medicaid programs. Drug manufacturers were required to provide rebates on these drugs, which resulted in substantially discounted rates. Effective 2006, the Medicare Modernization Act of 2003 shifted drug coverage for these beneficiaries to the Medicare Part D program, but the rebate policy did not follow the people. This policy option would restore rebates for dual eligible beneficiaries and apply it to low-income subsidy recipients as well. The rebate would build off of the rebates the pharmaceutical industry is already providing to individual Part D plans. The industry would simply need to provide a total rebate of 23.1 percent for these beneficiaries, plus an additional rebate for price increases that exceeded the rate of inflation since the drug's introduction. For example, if a manufacturer was already providing a rebate of 18 percent to the plans, they would simply pay the difference between 18 percent and 23.1 percent, plus the inflation-based rebate to the federal government. If a manufacturer was already providing a rebate that was higher than the sum of 23.1 percent plus the inflation-based rebate, no payment

would be necessary. The inflation-based component is critical to avoid having the industry game the rebate by simply raising prices. This policy was included in the House-passed health reform bill and the Bowles-Simpson Deficit Commission plan.

***Discussion:** The pharmaceutical industry has raised concerns about this policy option because they assert it would reduce their profits, dampen investment in research and development and raise premiums. However, virtually all of the Medicare beneficiary advocate groups (including AARP) have endorsed this policy option and do not believe it would raise Medicare premiums. In addition, John Hopkins University economist Gerry Anderson has stated that he does not believe this policy option would hurt investment in R&D or raise premiums.*

GENERAL MEDICARE

Increase Cost-Sharing/Premiums or Impose Excise Tax on Beneficiaries with Medigap Coverage (-\$12.1 Billion to -\$53.4 billion, CBO): CBO and various health analysts have proposed several options that would affect Medigap coverage. One option scored by CBO in 2011 would prohibit Medigap policies from providing “first dollar” coverage. First dollar coverage generally means that the beneficiary does not pay any additional costs beyond a premium (i.e., their cost-sharing is completely covered, starting at the “first dollar,” by this supplemental insurance). This option would prohibit Medigap plans from paying any of the first \$550 of an enrollee’s cost-sharing and would also limit coverage to 50 percent of the next \$4,950 in Medicare cost-sharing. Currently, the two most popular Medigap policies offer this type of coverage and roughly 5.5 million Medicare beneficiaries would be affected by this policy. CBO estimated that this policy would save \$53.4 billion over ten years. A different and earlier option prepared by CBO in 2008 would apply an excise tax of 5 percent of the premium on *all* Medigap insurance plans, regardless of the extent to which the plan covers first dollar coverage. This policy option raised \$12.1 billion over five years. A third option under discussion would require Medicare beneficiaries with a Medigap policy that provides first dollar coverage to pay a supplemental Part B premium. This option was not scored, but it is important to note that the vast majority of Medicare beneficiaries have their Part B premiums directly deducted from their Social Security checks. The addition of a supplemental premium would further reduce their Social Security checks.

***Discussion:** Economists and some other analysts believe that first dollar coverage results in greater health care utilization (induced demand). Strengthening incentives for more prudent use of services could limit costs. However, studies have shown that cost-sharing increases discourage both necessary and unnecessary services. In addition, there are many complications with any of the proposals. For example, if the option to eliminate the coverage is pursued, will it apply retroactively or just prospectively? If the tax option were pursued, insurers would pass along the tax in the form of higher premiums, so this could be viewed as a tax increase for seniors. The supplemental premium, again, will result in lower Social Security checks. A final point is that it seems difficult to craft a comparable policy for employer retiree coverage that wraps-around Medicare, which covers a substantial portion of the Medicare population.*

Raise Medicare eligibility age to 67 (-\$124.8 billion, CBO). While various permutations are possible, one option is to phase-in an increase of the eligibility age by two months per year, achieving age 67 by 2027.

Discussion: Raising the Medicare eligibility age would be a radical departure from current policy and is only possible if the ACA is retained. If ACA were subsequently repealed or otherwise substantially changed, this policy would result in a significant increase in the number of near-elderly uninsured persons. Even assuming current law with respect to the ACA, some people over age 65 who are subject to the new policy may become uninsured if they no longer have access to employer sponsored insurance (ESI) and cannot afford coverage through the exchanges. Furthermore, this policy does nothing to control costs, it simply shifts substantial costs from Medicare to other parts of government and to private and public employers. More specifically, this policy would increase costs for employers as more near-elderly retain employer-sponsored insurance. It will increase Medicaid costs, as more low-income near-elderly would remain on Medicaid for longer and others who would become eligible for coverage through the exchange may be eligible for the new Medicaid expansion through the ACA. It would also increase government costs for subsidies in the exchanges, because some people who would otherwise receive Medicare will remain in the exchanges for longer. It would increase premiums in the exchanges – raising costs for other individuals and raising government spending for the tax credits – as the risk pool gets a little worse when the population shifts to be slightly older and more costly. Similarly, this policy may also slightly increase Medicare per capita costs as the population shifts to be slightly older than it is today by excluding the youngest and generally healthiest beneficiaries. This policy idea was floated by the President near the end of the debt ceiling debate.

Freeze Income Thresholds for High-Income Beneficiaries and Increase Premium Shares (-13.7 billion, CBO): Under current law, while most beneficiaries pay a premium equal to 25 percent of Part B costs, those with incomes above \$85,000/year (\$170,000 for couples) pay a monthly Part B premium equal to 35, 50, 65 or 80 percent of total cost, depending on their income. This policy change was created by Republicans in the MMA of 2003 and took effect in 2007. For 2011, in addition to the standard Part B monthly premium of \$115.40, these beneficiaries pay premium surcharges ranging from \$46.10 to \$253.70. The ACA applied a similar income-related structure to Part D, which has resulted in Part D premium surcharges ranging from \$12 to \$69.10 in 2011. The ACA also froze income thresholds for these higher premiums for both Parts B and D through 2019. Proposals to do more income-relating of Part B and D premium include: (1) extending the freeze of income thresholds from 2019 to 2021 (\$5.4 billion); and (2) increasing premium share by 10 percent for each category of high-income beneficiaries (e.g., a 35 percent premium becomes 38.5 percent, a 50 percent premium becomes 55 percent, etc.), beginning in 2015 (\$7.2 billion). Together, the proposals would yield \$13.7 billion in savings. Other suggested proposals include lowering the income thresholds and increasing coinsurance. In his speeches on the debt ceiling/deficit reduction negotiations, the President made statements that were supportive of additional means-testing policies that required wealthier Medicare beneficiaries to pay higher shares of costs.

***Discussion:** Proponents of these policies argue that higher income beneficiaries are capable of paying more Medicare costs, and should do so in light of the nation's financial challenges. Opponents argue that higher income beneficiaries paid substantially more into Medicare over the course of their working life since, unlike Social Security, there is no payroll tax cap. Moreover, higher income beneficiaries already pay significantly more under the existing income related premiums, and more and more beneficiaries will fall into this category given the lack of indexation through 2019. Under current law, an estimated 7.8 million beneficiaries will pay the income-related Part B premium by 2019. Freezing income thresholds would subject an additional 2 million beneficiaries to premium surcharges in each year of 2020 and 2021, creating an AMT-like problem for Medicare. Finally, it is important to note that health and wealth generally correlate. Some of the savings from income-relating proposals are generated because some of the people subject to the higher premiums opt-out of Medicare. Because they are often healthier, this leaves behind a lower- and middle-income population with potentially higher health costs. Aggressive income-relating runs the risk of turning Medicare into Medicaid, albeit at the federal level.*

Chained CPI (-\$7.3 billion in Medicare savings from lower provider updates, more savings given the other Medicare implications, and substantially more government-wide): Moving to a chained consumer price index (CPI) creates a government-wide ripple that affects both revenues and eligibility and payments for many public programs, including Social Security, Medicare, Medicaid, ACA subsidies and tax credits and others. In Medicare, this translates into reduced provider payments for those systems that employ a CPI-based update. This includes cuts for clinical labs, ambulatory surgical centers, and durable medical equipment suppliers. It also means that more beneficiaries will be subject to income-related premiums under Parts B and D when indexing resumes (because the indexing will rise more slowly, leaving lower thresholds than under CPI). Moving to chained CPI would also lower the IPAB spending growth targets for Medicare, potentially triggering additional Medicare provider cuts. In the health world, it would also de facto reduce eligibility for Medicaid, CHIP, ACA tax credits and cost-sharing subsidies. A move to chained CPI was included in the Simpson-Bowles recommendations, though only for Social Security benefits. The President also indicated support for this policy during the debt ceiling debate.

***Discussion:** This is a complex, extremely controversial proposal with wide-ranging – and in some cases, not well understood or anticipated – effects. It would result in benefit cuts, reductions in provider payments, tax increases and reductions in eligibility and payments for many programs that serve predominantly lower- and middle-income families. The Committee has serious concerns with the proposal. In addition, as recently as 8/18/11, Rep. Upton seemed to indicate opposition to it.*

Medicare Improvement Fund (-\$0.9 billion, CBO): The Medicare Improvement Fund (MIF) has been used in recent years as a venue to “store” excess Medicare savings so that they could be used in the future to pay for needed Medicare policy (e.g., SGR patches, Medicare extenders, etc). Under current law, the Recovery Act created penalties for Medicare providers that have

failed to adopt and meaningfully use electronic health records by 2015. In 2019 and beyond, those penalties are put into the MIF. This proposal would remove them from the MIF to make them available for deficit reduction or to offset other spending the package.

Discussion: This policy is justifiable and there are no known opponents. However, these and any other Medicare savings generated should first be used to help offset SGR and other expiring Medicare provisions that need to be extended at the end of the year (e.g., therapy caps and others).

Proposals relating to the Affordable Care Act

Republicans may offer a variety of proposals for reducing the deficit that would significantly scale back the ACA significantly. Staff can facilitate a discussion of these options and ramifications at the caucus. Options Republicans might pursue range from repealing individual responsibility requirement to reducing or eliminating tax credits and cost-sharing subsidies for Exchange-eligible individuals and families. They could also include many more insidious proposals like changing income definitions or other more subtle, but important, levers. These options would come at the expense of lower- and middle-income working families and possibly even states. They would also lead to a substantial increase in the number of uninsured relative to current law projections.

A significant deficit reducing proposal that the Republicans would object to is adding a public plan option to the federal and state exchanges. Such a proposal would result in \$88 billion in deficit reduction in 2012 through 2021 according to JCT and CBO. The proposal scored by JCT and CBO sets physician reimbursement rates at 5 percent above Medicare, reimbursement at Medicare rates for other providers, allows the plan to negotiate drug prices with pharmaceutical companies, and does not require providers to participate in the public option plan in order to participate in Medicare. Strengthening the public option further would yield additional deficit reduction. CBO and JCT believe that the public plan option could switch approximately 1.5 million individuals out of employer-sponsored insurance and in to the public plan option.