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**INSURE THE UNINSURED
PROJECT**

A Summary of

**CBO Budget Options
Volume I: Health Care**

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The Congressional Budget Office (CBO) regularly composes a biannual report of budget options to help inform lawmakers on policy alternatives and their implications. This year the CBO divided its *Budget Options* into two sections, with the first volume devoted entirely to health care. The 115 budget options summarized here include wide-ranging policies related to financing, delivery, and access within federal programs and the health care system as a whole; in addition it focuses on improved health outcomes, long-term care, and increased provider efficiencies.

CBO highlights the urgency to address the ever-increasing share of health care GDP, which the authors state will be key to closing the nation's fiscal gap. The authors also point out that these concerns are even more pressing, for evidence suggests that the increase in spending has not shown similar improvements in quality or health outcomes. This fact, coupled with clear geographic variations in health care spending, suggest that there is potential to reduce expenditure and improve quality of care. The report offers several incremental approaches to address the 45 million American who lack health insurance.

Federal legislation with increases in expenditures must meet the “pay-go” test, meaning that it must be accompanied by an equivalent savings measure or tax increase. For example, S-CHIP reauthorization was accompanied by an increase in the tobacco tax. The summaries of options are divided into chapters and include a brief description on the option, plus the net 10-year effect. These summaries expose a broad spectrum of choices that may be mixed and match within the federal policy debates. Please refer to the full CBO Report for more in-depth analyses, arguments for and against the option, and stratified budget effects.

Source: *Budget Options Volume I: Health Care*, Congressional Budget Office, The Congress of the United States, December 2008. Available in multiple formats on CBO's website www.cbo.gov.

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I. The Private Health Insurance Market

1. Foster the Formation of Association Health Plans

Allow health insurance carriers to sell coverage to small employers through federally certified Association Health Plans (AHPs). Covers an additional 600,000 persons in 2014.

- 10-year cost: \$220M

2. Allow Individuals to Purchase Nongroup Health Insurance Coverage in Any State

Permit an insurance carrier to choose one state in which to become licensed as long as the carrier's individual policies complied with the laws and regulations of that state. The carrier would be allowed to sell those policies in other states and be exempted from other states' regulations. Covers an additional 400,000 persons in 2014.

- 10-year savings: \$7.4B

3. Impose a "Pay-or-Play" Requirement on Large Employers

Employers with over 50 employees must either pay a \$500 fee per employee or offer coverage that meets a minimum standard and contributes at least 50% of premium costs. Covers an additional 330,000 persons in 2014.

- 10-year revenue increase: \$48.3B

4. Establish a National High-Risk-Pool Program

Require that all states establish high-risk pools providing full federal subsidies to enrollees with criteria used by existing state pools. Enrollees would be responsible for premiums up to 150% of standard rate, with the federal government paying any excess costs. Covers an additional 175,000 persons in 2014.

- 10-year cost: \$16B

5. Establish a National Reinsurance Program to Provide Subsidies to Insurers and Firms for Privately Insured Individuals

Alternative 1: Federal government reimburses all insurers and firms that self-insure for 75% of claims above \$50,000 in one year for any single worker and dependents. Covers an additional 2.6 million people by 2014.

- 10-year cost: \$752B

Alternative 2: Provide the same subsidy but only to insurers in the nongroup market and to firms in the group market with fewer than 100 employees. Covers an additional 2.1 million people in 2014.

- 10-year cost: \$265B

6. Require States to Use Community Rating for Small-Group Health Insurance Premiums

Pure community rating for states, allowing variation in premiums only on the basis of geography. Reduces coverage in small-group market by 400,000.

- 10-year savings: \$5.1B

7. Create a Voucher Program to Expand Health Insurance Coverage

Create vouchers that uninsured persons under 250% FPL could use to purchase coverage in individual market that meets a standard. The voucher covers up to 70% of costs with indexed caps at \$1,500 for individuals and \$3,000 for families. Covers an additional 2.2 million people in 2014.

- 10-year cost: \$65.5B

8. Limit Awards from Medical Malpractice Torts

Impose nationwide curbs on medical malpractice torts (breaches of duty that results in personal injury). Limits include caps on awards for noneconomic damages and punitive damages, statute of limitations of one year for adults and three years for children, and other cost-reducing limits.

- 10-year savings: \$5.6B

II. The Tax Treatment of Health Insurance

9. Reduce the Tax Exclusion for Employment-Based Health Insurance and the Health Insurance Deduction for Self-Employed Individuals

Limit the extent to which employer-paid premiums, flexible spending account and health saving account contributions could be excluded from income/payroll tax based on 75th percentile for health insurance premiums. Increases the number of uninsured by 3.2 million in 2014.

- 10-year revenue increase: \$452B

10. Replace the Income Tax Exclusion for Employment-Based Health Insurance with a Deduction

A single deduction for premiums replaces the current tax exclusion for employer-paid premiums and self-employed deduction, which phases out at the \$80,000 level for unmarried and \$160,000 for married couples. Increases the number of uninsured by 1.5 million in 2014.

- 10-year revenue increase: \$552.2B

11. Replace the Income and Payroll Tax Exclusion with a Refundable Credit

The refundable tax credit replaces exclusions on employer-paid premiums and self-employed deductions, equal to 25% of the premium. This credit could be claimed even if they did not work for an employer that offered insurance and will phase out with incomes above \$80,000/\$160,000. Increases the number of uninsured by 2.6 million in 2014.

- 10-year revenue increase: \$606B

12. Allow Self-Employed Workers to Deduct Health Insurance Premiums from Income That Is Subject to Payroll Taxes

Exclude premiums paid by the self-employed from taxable income under payroll taxes, thus treating their premiums and those paid by employers in a comparable manner.

- 10-year revenue decrease: \$37B

13. Expand Eligibility for an “Above-the-Line” Deduction for Health Insurance Premiums

Expand eligibility for tax deductibility to include all individuals who purchase health insurance in the nongroup market. Covers an additional 700,000 people in 2014.

- 10-year revenue decrease: \$65B

14. Disallow New Contributions to Health Savings Accounts

Disallow any further HSA contributions, but allow existing HSAs to continue to accumulate tax-free earnings and make qualified, nontaxable distributions.

- 10-year revenue increase: \$10.5B

15. Allow Health Insurance Plans with Coinsurance of at Least 50% to Qualify for the Health Savings Account Tax Preference

Expand the definition of an HSA-qualified health plan requiring enrollees to pay at least 50% on coinsurance in lieu of a minimum deductible requirement.

- 10-year revenue decrease: \$300M

16. Levy an Excise Tax on Medigap Plans

Levy an excise tax on each policy equal to 5% of the premium. The insurer pays the tax on a quarterly basis, and revenues are deposited in the Medicare Hospital Insurance Trust Fund.

- 10-year revenue increase: \$12.1B

III. Changing the Availability of Health Insurance Through Existing Federal Programs

17. Raise the Age of Eligibility for Medicare to 67

Raise the eligibility age by two months every year beginning in 2014 until the it reaches 67 in 2025, similar to increases currently scheduled for the normal retirement age in Social Security.

- 10-year spending decrease: \$92.4B

18. Create a Medicare Buy-In Program for Individuals Ages 62 to 64

Allow those in this age group who did not have employment based insurance or Medicaid to enroll voluntarily in Medicare. Covers an additional 80,000 people in 2014.

- 10-year cost: \$1.2B

19. Eliminate or Reduce Medicare's 24-Month Waiting Period for Recipients of Social Security Disability Benefits

Alternative 1: Eliminate waiting period entirely, making eligibility for Medicare simultaneous with eligibility for SSDI.

- 10-year cost: \$110B

Alternative 2: Reduce the waiting period from 24 months to 12 months.

- 10-year cost: \$62B

Alternative 3: Eliminate waiting period for individuals who did not have access to private insurance that met or exceeded a specified standard (including COBRA).

- 10-year cost: \$56B

Alternative 4: Eliminate waiting period only for uninsured individuals.

- 10-year cost: \$28B

20. Create a Medicaid Buy-In Program

Create a program allowing uninsured individuals with a family income up to 300% FPL to purchase Medicaid coverage for acute care services. Covers an additional 1.1 million people.

- 10-year cost: \$7.8B

21. Require States to Adopt Premium Assistance Programs for Medicaid Enrollees

Require states to provide premium assistance to Medicaid-eligible individuals who had access to employment-based insurance. States would be eligible to receive federal matching payments. Up to 1.2 million individuals could transition from Medicaid to an employment-based plan.

- 10-year savings: \$2.1B

22. Expand Eligibility for Medicaid Family Planning Services

Require states to cover family planning services for women 15-44 who were not pregnant, up to 200% FPL. Covers an additional 2.3 million women in 2014.

- 10-year savings: \$160M

23. Expand Medicaid Eligibility to Include Young Adults with Income Below the Federal Poverty Level

Require states to expand eligibility to adults 19-23 with incomes below \$10,400 and \$17,600 for a family of three. Covers an additional 1.1 million people in 2014.

- 10-year cost: \$22B

24. Expand Medicaid Eligibility to Include Parents with Income Below the Federal Poverty Level

Require states to expand eligibility to all parents whose income is below the FPL and who had Medicaid-eligible children. Covers an additional 1.4 million people.

- 10-year cost: \$38B

25. Establish a Medicaid Outreach Program with Mandatory Funds

Provides \$100M annually for five years to finance outreach and enrollment campaigns directed at those eligible but not enrolled in Medicaid. Covers an additional 320,000 people.

- 10-year cost: \$9.0B

26. Permanently Extend the Transitional Medical Assistance Provision in Medicaid

Provides medical access for families whose income rise above Medicaid eligibility for 6-12 months. This category will expire on June 30, 2009. Covers an additional 570,000 people in 2014.

- 10-year cost: \$10B

27. Allow People and Firms to Buy Health Insurance Plans Through the Federal Employees Health Benefits Program

Allow individuals and private firms not affiliated with the federal government to purchase FEHB coverage. Purchasers would be directly responsible for the full cost of the premium and the new program would constitute a separate risk pool for nonfederal enrollees. Covers an additional 1.3 million people.

- 10-year cost: \$2.8B

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

Veterans are enrolled in one of eight priority care groups that are defined on the basis of income, disability status, and other factors, with Groups 7 and 8 composing of high-income veterans with no service-related injuries. This option will close enrollment and disenroll all veterans who are not poor and who do not have service-related medical needs, 90% of whom already have coverage elsewhere.

- 10-year savings: \$80.3B

29. Reopen Enrollment for VA Medical Care Among Priority Group 8 Veterans for Five Years

Enrollment in Priority Group 8, comprising high-income veterans with no service-related injuries, has been closed since 2003. This option requires VA to accept enrollment during the 200-2014 period restoring the freeze in 2014.

- 10-year cost: \$58.7B

IV. The Quality and Efficiency of Health Care

30. Bundle Payments for Hospital Care and Post-Acute Care

The unit of payment for acute care in hospitals would be redefined and expanded to include post-acute care both in hospital and non-hospital settings.

- 10-year savings: \$18.6B

31. Reduce Medicare Payments to Hospitals with High Readmission Rates

Require the public reporting of readmission rates and implement payment reductions for hospitals with excessive rates (relative to median hospital readmission rates, based on patient condition). Savings reflect a 20% payment reduction to hospitals with readmission rates above the median.

- 10-year savings: \$9.7B

32. Expand the Hospital Quality Incentive Demonstration to All Hospitals

All hospitals receive reduced Medicare payments for inpatient care for selected clinical conditions, coupled with the implementation of quality incentives including bonus payments between .75% and 1.5% based on submitted quality data.

- 10-year savings: \$2.9B

33. Deny Payment Under Medicaid for Certain Hospital-Acquired Conditions (HAC)

Applies Medicare's HAC rules for inpatient care covered by Medicaid.

- 10-year savings: \$45M

34. Establish Regional Centers for Excellence for Selected Surgical Procedures Covered by Medicare

Establish bundled payment rates for joint replacement surgery and bypass surgery at selected hospitals known for the quality of their care.

- 10-year savings: \$450M

35. Convert Medicare and Medicaid Disproportionate Share Hospital (DSH) Payment into a Block Grant

Convert federal DSH payments into a single grant to each state set at 90% of the current annual level of federal funding, and indexed to increase in the consumer price index (CPI) minus 1%.

- 10-year savings: \$84.6M

36. Consolidate Medicare and Federal Medicaid Payments for Graduate Medical Education Costs at Teaching Hospitals

Consolidate mandatory federal spending into a block grant to teaching hospitals, with payments apportioned according to number of residents and the hospital's Medicare/Medicaid patient days.

Alternative 1: Total funding for 2011 set at 90% of estimated payments in 2009, with inflation adjustment.

- 10-year savings: \$30B

Alternative 2: Total funding for 2011 based on a reduction of the indirect medical education (IME) adjustment from 5.5% to 2.2%, plus the 2009 levels of graduate medical education (GME) and direct graduate medical education (DGME).

- 10-year savings: \$57B

37. Allow Physicians to Form Bonus-Eligible Organizations and Receive Performance-Based Payments

Groups of providers meeting certain qualifications can voluntarily participate in Medicare as bonus-eligible organizations (BEOs), in order to better manage and coordinate care in order to reach a spending benchmark. Bonuses are based on differences between actual expenditure and benchmark spending.

- 10-year savings: \$5.3B

38. Pay Primary Care Physicians in Medicare Using a Partial-Capitation System, with Bonuses and Penalties

Assign each FFS Medicare beneficiary a PCP and change the payment system to a partial capitation model. PCPs receive $\frac{3}{4}$ of payments on a per-service basis and $\frac{1}{4}$ through capitation, with bonuses and penalties depending on total spending.

- 10-year savings: \$5.2B

39. Pay for a Medical Home: for Chronically Ill Beneficiaries in Fee-For-Service Medicare

Implements the medical home benefit on a national basis rather than waiting for the results of the 2006 CMS demonstration project.

- 10-year cost: \$5.6B

40. Require Medicare Carriers to Provide Information About Peer Profiling to Physicians

Require Medicare to develop an open-source "episode grouper" software to measure physicians' use of health care resources and reduce payments to physicians with excessively high resource use.

- 10-year savings: \$1.7B

41. Require Prior Authorization for Imaging Services Under Medicare

Use radiology benefit managers to authorize use of and payment for advanced imaging services in Medicare.

- 10-year savings: \$1.1B

42. Encourage Wider Use of Patient Shared-Decision Aids by Physicians in Medicare

Direct CMS to experiment with different policy designs to determine how best to encourage appropriate use of patient shared decision making, when cases where multiple medically reasonable alternatives exist.

- No spending estimate: Unclear design parameters

43. Expand Medicare's Least Costly Alternative (LCA) Policy to Include Viscosupplements

Payments for supplements to treat osteoarthritis are subject to a LCA policy, limiting payment to the lowest-cost of equivalent products in the category.

- 10-year savings: \$490M

44. Require Drug and Device Manufacturers to Disclose Their Relationships with Physicians Who Participate in Medicare

All contacts are subject to disclosure, and CMS would publish the information of their website.

- Spending effects unclear, though potential for savings

45. Fund Research Comparing the Effectiveness of Treatment Options

Federal government provides mandatory funding for the research on alternative treatments.

- 10-year cost: \$860M

46. Create Incentives in Medicare for the Adoption of Health Information Technology

Alternative 1: CMS pays participating PCPs that use a qualifying HIT system a 5% bonus on top of normal payment.

- 10-year cost: \$1.1B

Alternative 2: CMS pays all participating physicians that use a qualifying HIT system a 2% bonus on top of normal payment.

- 10-year cost: \$825M

Alternative 3: CMS penalizes physicians who did not use a qualifying HIT system 5 years after policy inaction with a 5% payment reduction.

- 10-year revenue increase: \$4.75B

Alternative 4: Combine 2% bonus for implementation during the first five years, followed by a 5% penalty during the next five years.

- 10-year revenue increase: \$4.4B

47. Require the Use of Health Information Technology as a Condition of Participation in Medicare

Beginning in 2015, all physicians and hospitals are required to adopt HIT as a condition of participation in Medicare.

- 10-year physician savings: \$11.1B
- 10-year hospital savings: \$22.8B

48. Support Development of VistA to Meet Standards and Encourage Adoption

Develop and enhance adaptations of the Veterans Health Information Systems and Technology Architecture (VistA) to physicians outside the VHA.

- 10-year savings and revenue: \$200M

49. Sponsor Regional Markets for Health Information Technology

Sponsors solicit bids from HIT vendors and Web-hosting services to simplify providers' purchasing decision, and standardize EHR formatting/functional packaging.

- 10-year savings and revenue: \$60M

V. Geographic Variation in Spending for Medicare

50. Reduce Medicare's Fees for Physicians in Area with Unusually High Spending

Local spending targets for each micro-region of the country are set and used as the basis for reducing fees in unusually high spending areas.

- 10-year savings: \$5.3B

51. Reduce Medicare's Payment Rates for Hospitals in Areas with a High Volume of Elective Admissions

CMS designates certain Medicare severity diagnosis-related groups (MS-DRGs) as elective for at least 8% of current Medicare spending on short-stay hospitals. If CMS identifies statistical areas as having unusually high volumes of the MS-DRGs, hospitals in the area would have their payments reduced.

- 10-year savings: \$2.6B

52. Reduce Medicare's Payment Rates Across the Board in High-Spending Areas

FFS payment rates reduced in areas where relative spending was 10% or more above the national average.

- 10-year savings: \$51B

53. Impose a Surcharge on Medicare Cost Sharing in High-Cost Areas and Prohibit Medigap Plans from Covering the Surcharge

Beneficiaries living in areas with unusually high levels of spending (more than 10% above the national average) would face a cost-sharing surcharge.

- 10-year savings: \$21B

VI. Paying for Medicare Services

54. Reduce Annual Updates in Medicare Fee-for-Service Payments to Reflect Expected Productivity Gains

Use the same measure of productivity movement – the 10-year moving average of all-factor productivity – that is incorporated in the Medicare economic index (MEI), lowering the real costs of services in the market-basket indexes (MBIs).

- 10-year savings: \$201B

55. Reduce the Update Factor for Hospitals' Inpatient Operating Payments Under Medicare by 1%

Reduce by 1% the prospective payment system (PPS) update factor for acute inpatient hospital services each year from 2011 through 2019.

- 10-year savings: \$93B

56. Reduce the Update Factor for Payments to Providers of Post-Acute Care Under Medicare by 1%

Change the update factors for each type of post-acute care provider to equal the rise in the market basket index minus 1% each year.

- 10-year savings: \$54.2B

57. Eliminate Inflation-Related Updates to Medicare's Payment Rates for Home Health Care for Five Years

Gradually narrow the gap between payment and costs (15% in 2006, 11% in 2008) in home health care.

- 10-year savings: \$50.3B

58. Reduce the Update Factor for Medicare's Payments for Skilled Nursing Facilities by 1%

Sets the update factor equal to the market basket index minus 1% each year from 2011 through 2019.

- 10-year savings: \$24B

59. Modify the Sustainable Growth Rate (SGR) Formula for Updating Medicare's Physician Payment Rates

Alternative 1: Freeze physician payment rates at their 2009 levels through 2019.

- 10-year cost: \$318B

Alternative 2: Replace the SGR targets with annual updates based on changes in the prices of inputs to provide services minus a productivity adjustment.

- 10-year cost: \$439B

Alternative 3: Expands on Alternative 2 by including a hold-harmless provision for premiums, where Part B premiums would not be adjusted to reflect changes in spending from the repeal of the SGR formula.

- 10-year cost: \$556B

60. Create Service-Specific Updates for Medicare’s Physician Payment Rates

Use existing SGP methodology to create service-specific spending targets and calculate separate annual updates to payment for each of those categories of service.

- 10-year cost: \$184B

61. Use the Medicare Economic Index (MEI) to Update Physician Payment Rates for Evaluation and Management Services and Create Four Service-Specific Updates for Remaining Services

Use the MEI to update payment rates as an alternative to modifying the SGR. The SGR will continue to be used for four distinct groups of service: major procedures, minor procedures, anesthesia, and imaging/tests.

- 10-year cost: \$253B

62. Modify the Equipment Utilization Factor for Advanced Imaging in Calculating Physicians’ Fees in Medicare

Alternative 1: Spread the costs of MRI and CT equipment over more units of service (resulting in smaller payments) by increasing the utilization factor from 50% to 75%.

- 10-year savings: \$1.94B

Alternative 2: Increase the utilization factor from 50% to 95%.

- 10-year savings: \$2.87B

63. Set the Benchmark for Private Plans in Medicare Equal to Local Per Capita FFS Spending

Lower the benchmark for private plans to Medicare’s FFS levels.

- 10-year savings: \$157B

64. Convert Medicare to a Premium Support System

A system where the federal government will contribute an amount that beneficiaries could use toward the purchase of Medicare coverage either through a traditional FFS program (with geographically-determined premiums) or through a private plan.

- 10-year savings: \$161B

65. Establish Benchmarks for the Medicare Advantage Program Through Competitive Bidding

Beneficiaries who enrolled in a plan whose bid was below the benchmark would receive the full difference in the form of benefits or premium rebates where additional payment is required for those enrolled plans above the benchmark.

- 10-year savings: \$158B

66. Eliminate the One-Sided Rebasing Process for Establishing Benchmarks for Medicare Advantage Plans

The benchmark would instead be set equal to local per capita FFS spending.

- 10-year savings: \$61B

67. Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Medicare Part D

Require brand-name drug manufacturers to pay the federal government a rebate equaling 15% of the average manufacturer price, with incentive to be designated as a “preferred” product in the prescription drug plans and Medicare Advantage plan formularies.

- 10-year savings: \$110B

68. Establish an Abbreviated Approval Pathway for Follow-On Biologics

Alternative 1: Establish a shorter regulatory pathway for approving follow-on biologics (complex molecules) equivalent to the generic approval process.

- 10-year savings: \$9.2B

Alternative 2: In addition to an abbreviated approval pathway, CMS will place follow-on biologics in the same billing code as the brand name, thus penalizing physicians who did not dispense the follow-ons when available.

- 10-year savings: \$12B

VII. Financing and Paying for Services in Medicaid and the State Children’s Health Insurance Program

69. Convert the Federal Share of Medicaid’s Payments for Acute Care Services into an Allotment

Alternative 1: Index each state’s allotment to annual increases in the consumer price index.

- 10-year savings: \$625B

Alternative 2: Index each state’s allotment to annual increases in the consumer price index as well as to changes in the state’s overall population.

- 10-year savings: \$556B

Alternative 3: Index allotments to projected increases in total national health expenditures.

- 10-year savings: \$189B

70. Remove or Reduce the Floor on Federal Matching Rates for Medicaid Services

Alternative 1: Eliminate the 50% floor on federal matching rates for all Medicaid-covered services that are reimbursed at the FMAP rate.

- 10-year savings: \$228B

Alternative 2: Lower the FMAP floor to 45% in 2010.

- 10-year savings: \$131B

71. Equalize Federal Matching Rates for Administrative Functions in Medicaid at 50%

Phased in so that the highest rate would be 70% in 2010, 60% in 2011, and 50% in 2012.

- 10-year savings: \$20B

72. Restrict the Allocation to Medicaid of Common Administrative Costs

Limit reimbursement to the amount not included in the state's Temporary Assistance for Needy Families (TANF) block grant.

- 10-year savings: \$2.6B

73. Reduce the Taxes That States Are Allowed to Levy on Medicaid Providers

Decreases federal spending by gradually reducing the tax rate from 6% to 3% by 2012.

- 10-year savings: \$48.4B

74. Modify the Amount of the Brand-Name Drug Rebate in the Medicaid Program

Alternative 1: Eliminate the best-price provision and increase the flat rebate from 15.1% to 23.1%.

- 10-year savings: \$1.2B

Alternative 2: Eliminate the best-price provision and increase the flat rebate to an amount that would be budget neutral.

- Neutral effect on 10-year expenditure

Alternative 3: Leaves the best-price provision intact and increases flat rebate from 15.1% to 23.1%.

- 10-year savings: 10-year savings: \$7.2B

75. Apply the Fee-for-Service Medicaid Drug Rebate to Drugs Purchased for Medicaid Managed Care Enrollees

Alternative 1: Require manufacturers to pay rebate to the managed care organizations (MCOs).

- 10-year savings: \$9.1B

Alternative 2: Require manufacturers to pay rebate directly to states.

- 10-year savings: \$11B

76. Apply the Medicaid Additional Rebate to New Formulations of Existing Drugs

When a new, extended-release version of an existing drug is introduced, the additional rebate obligation would be either the average manufacturers price (AMP) under current law or the AMP price owed for the original drug, whichever is greater.

- 10-year savings: \$3B

77. Base Medicaid's Pharmacy Payment Formulas for Brand-Name Drugs on the Average Manufacturers Price

Requires states to change payment formulas for brand-name drugs that have no generic substitutes, basing them on the average manufacturers price (AMP) and to pay pharmacies no more than 104% of the AMP.

- 10-year savings: \$2.75B

78. Encourage Therapeutic Substitution in Medicaid by Applying Federal Upper Payment Limits to Two Classes of Drugs

Creates a payment system under Medicaid that would encourage substitution of generic alternatives for certain single-source brand name drugs.

- 10-year savings: \$400M

79. Eliminate Allotment Caps for the State Children's Health Insurance Program and Permit States to Expand Coverage up to 400% FPL

States could maintain their programs at current levels of eligibility or expand coverage to children in families with income up to 400% FPL, but not to parents or childless adults.

- 10-year cost: \$80.3B

80. Adjust Funding for the State Children's Health Insurance Program to Reflect Increases in Health Care Spending and Population Growth

Index SCHIP's funding to the rate of growth of per capita health expenditures and to the approximate rate of growth of the SCHIP-eligible population.

- 10-year cost: \$13.5B

VIII. Premiums and Cost Sharing in Federal Health Programs

81. Replace Medicare's Current Cost-Sharing Requirements with a Unified Deductible, a Uniform Coinsurance Rate, and a Catastrophic Limit

Replaces the current complicated mix of cost-sharing provisions with a single combined annual deductible covering all services in Parts A and B, a uniform 20% coinsurance above that deductible, and an annual cap on each enrollee's total cost-sharing liabilities.

- 10-year savings: \$26.4B

82. Restrict Medigap Coverage of Medicare's Cost Sharing

Bar Medigap policies from paying any of the first \$525 of an enrollee's cost-sharing liabilities for 2011 and limit coverage to 50% of the next \$4,725 in Medicare cost sharing.

- 10-year savings: \$41.4B

83. Combine Changes to Medicare's Cost Sharing with Restrictions on Medigap Policies

Bar Medigap policies from covering any of the new \$525 combined deductible and only 50% of the program's remaining cost-sharing requirements, which corresponds to the Medicare program's new cap.

- 10-year savings: \$73B

84. Impose Cost Sharing for the First 20 Days of a Stay in a Skilled Nursing Facility Under Medicare

Impose a copayment for each of the first 20 days of care equal to 5% of the inpatient deductible, or \$57.40 per day in 2011.

- 10-year savings: \$26.8B

85. Require a Copayment for Home Health Episodes Covered by Medicare

Charge beneficiaries a copayment amounting to 10% of the total cost of each episode (a 60-day period of services) starting January 1, 2011.

- 10-year savings: \$46.8B

86. Impose a Deductible and Coinsurance for Clinical Laboratory Services Covered by Medicare

Make laboratory services subject to the Part B standard deductible and to coinsurance requirements beginning on January 1, 2011.

- 10-year savings: \$23.8B

87. Increase the Basic Premium for Medicare Part B to 35% of the Program's Cost

Raise the basic Part B premium from 25% of the program's cost per enrollee to 35% over five years, beginning in 2010.

- 10-year savings: \$217B

88. Permanently Extend the Provision That Provides Cost-Sharing Assistance for Qualifying Individuals Under Medicaid

Permanently fund the QI provision, set to expire on December 31, 2009.

- 10-year cost: \$8.7B

89. Eliminate the “Doughnut Hole” in Medicare’s Drug Benefit Design

Completely eliminates the doughnut hole in the standard benefit by extending the benefit’s initial 25% coinsurance up to the point at which the catastrophic threshold is reached.

- 10-year cost: \$134B

90. Institute a Premium for Higher-Income Enrollees Under Medicare’s Drug Benefit Similar to That Used in Part B

Alternative 1: Implement the same formula currently used by Part B, using the same income cutoffs and scheduled adjustments for inflation.

- 10-year savings: \$7.84B

Alternative 2: Same approach, but eliminate the scheduled inflation adjustments to income thresholds after 2010, effectively applying the premium to a greater number of enrollees over time.

- 10-year savings: \$10B

91. Increase the Fraction of Beneficiaries Who Pay an Income-Related Premium for Part B of Medicare

Apply higher Part B premiums to more enrollees by eliminating the scheduled adjustments to the income thresholds for inflation after 2010.

- 10-year savings: \$20.5B

92. Base Federal Retirees’ Health Benefits on Length of Service

Reduce premium subsidies for retirees who had relatively short federal careers, preserving their right to participate in the FEHB program. The government share of premium costs (now at 72%) for new retirees after January 1, 2010 would be cut by 2% for every year of service less than 20 years.

- 10-year savings: \$1.1B

93. Adopt a Voucher Plan for the Federal Employees Health benefits Program

Offer a voucher for the FEHB program to cover the first \$4,300 on an individual employee/retiree or the first \$9,900 of a family’s premiums, increasing those amounts annually at the rate of inflation rather than the average weighted rate of change for FEHB premiums.

- 10-year mandatory savings: \$36.5B
- 10-year discretionary savings: \$33.1B

94. Require Federal Employees Health Benefits Plans to Subsidize Premiums for Medicare Part B and reduce Coverage of Medicare Cost Sharing by an Equivalent Amount

Require FEHB health plans to modify the benefit packages they offered who also had Medicare coverage so that their Part B premiums would be subsidized. In return, the plans would reduce their coverage of Medicare cost sharing by an equivalent amount.

- 10-year savings: \$11.1B

95. Increase Health Care Cost Sharing for Family Members of Active-Duty Military Personnel

DoD would provide active-duty personnel who have dependents with a \$500 cash allowance for health expenses while at the same time increasing out-of-pocket costs.

- 10-year savings: \$6.5B

96. Introduce Minimum Out-of-Pocket Requirements Under TRICARE For Life (TFL)

Reduce costs of TFL and Medicare by introducing out-of-pocket requirements of \$525 for calendar year 2011 and limit coverage to 50% of the next \$4,725 in Medicare cost sharing, with these amounts indexed to growth in average Medicare costs.

- 10-year savings: \$39.7B

97. Increase Medical Cost Sharing for Military Retirees Who Are Not Yet Eligible for Medicare

Raise enrollment fees, copayments, and deductibles for younger military retirees who wish to use TRICARE.

- 10-year savings: \$21B

98. Require Copayments for Medical Care Provided by the Department of Veterans Affairs to Enrollees Without a Service-Connected Disability

Increase out-of-pocket costs for veterans in Priority Group 5 – those who do not have service-connected disabilities and whose income is below a VA-defined threshold.

- 10-year savings: \$6.6B

IX. Long-Term Care

99. Increase States' Flexibility to Offer Home and Community-Based Services Through Medicaid State Planning Amendments

Alter the current authority to cover HCBS through a state plan amendment by raising the ceiling on the income limit to 300% of the SSI threshold and permitting the Secretary of HHS to approve coverage for additional services.

- 10-year cost: \$8.1B

100. Make Home and Community-Based Services a Mandatory Benefit Under Medicaid

States would be required to provide HCBS to all qualified Medicaid beneficiaries, eliminating all waiting lists for services provided under the HCBS waiver authority.

- 10-year cost: \$89.8B

101. Increase the Federal Matching Rate for Home and Community-Based Services and Decrease the Federal Matching Rate for Nursing Home Service

Increase the FMAP for HCBS by 5% to encourage states to increase the number of individuals served in community settings, while decreasing the match by 5% for nursing home services.

- 10-year cost: \$13.4B

102. Clarify Medicaid’s Definition of Permissible Asset Transfers

Clarify permissible transfers for long-term care eligibility such as financial assistance for educational expenses, medical expense assistance, financial crisis assistance, caregiver assistance, and charity donations.

- 10-year cost: \$5.9B

103. Increase the “Look-Back” Period for Transfers of Assets in Medicaid

Further extend that period from 60 months to 84 months for transfers made on or after October 1, 2009.

- 10-year savings: \$220M

104. Implement Policies That Encourage the Use of Advance Directives

Make portable consumer-completed advance directives, establish a national advance-directive-assistance service, and develop a nationwide campaign to educate people about advance directives.

- 10-year cost: \$16M

105. Require Deposits to Individual Accounts for Purchasing Long-term Care Insurance

Create a stable source of funding for long-term care by requiring workers to contribute 1.2% of their pretax wages to an individual account reserved for long-term care insurance.

- 10-year cost: \$214B

X. Health Behavior and Health Promotion

106. Impose an Excise Tax on Sugar-Sweetened Beverages

Impose a federal excise tax of 3 cents per 12 ounces on “sugar-sweetened” beverages.

- 10-year revenue increase: \$50.4B

107. Increase the Excise Tax on Cigarettes

Raise the federal excise tax on cigarettes by one dollar per pack.

- 10-year revenue increase: \$94.9B

108. Increase All Taxes on Alcoholic Beverages to \$16 per Proof Gallon

Standardizes the base on which the federal excise tax is levied by using the proof gallon as the measure for all alcoholic beverages, equal to about 25 cents per ounce of alcohol.

- 10-year revenue increase: \$59.9B

109. Reduce Medicare Payment Rates for Primary Care Physicians Who Do Not Meet Benchmarks for Influenza Vaccination

PCPs who did not meet a threshold vaccination rate of 60% in the previous flu season would see a reduction on 1.5% in all fees that Medicare paid.

- 10-year savings: \$620M

110. Base Medicare’s Coverage of Preventive Services on Evidence of Effectiveness

Allow the Secretary of HHS to modify Medicare’s coverage of preventive services to which the United States Preventive Services Task Force (USPSTF) has assigned a grade other than A or B.

- 10-year savings: \$850M

XI. Closing the Gap Between Medicare’s Spending and Receipts

111. Increase the Payroll Tax Rate for Medicare Hospital Insurance by 1%

Alternative 1: Raise the HI tax rate on all earnings by 1% (a payroll tax increase to 1.95% for employers/employees and 3.9% for self-employed).

- 10-year revenue increase: \$592.2B

Alternative 2: Raise the HI tax rate by 1% on earning above \$150,000 and index the earnings threshold for inflation thereafter.

- 10-year revenue increase: \$77.2B

112. Limit Growth in Medicare Per Capita Spending to Growth in per Capita Gross Domestic Product Plus 1%

Create a target that would limit annual growth to yearly per capita growth in GDP plus 1%, giving the Secretary of HHS authority to make program changes to reduce spending to targeted levels.

- 10-year savings: \$2.5B

113. Design an Enforcement Mechanism for the Medicare Funding Warning

Establish a fail-safe mechanism that would be activated once the trustees determined that the percentage of funding from general revenues exceeded 45% in the prior fiscal year, applying a 1% reduction in payments in the Medicare FFS structure.

- 10-year savings: \$73.5B

114. Set a Savings Target to Reduce Spending for Medicare by 1%

Set annual targets for Medicare of a 1% reduction in outlays and give the Secretary of HHS authority to make changes in the program to achieve that specified amount.

- 10-year savings: \$55.5B

115. Increase Funding for the Health Care Fraud and Abuse Control Program in Medicare and Medicaid

Alternative 1: Provide a one-time \$100 million in appropriated funding for HCAFC.

- 10-year savings: \$60M

Alternative 2: Provide \$100 million each year over the next 10 years.

- 10-year savings: \$520M