

## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

January 27, 2006

### S. 1932 Deficit Reduction Act of 2005

*Conference agreement, as amended and passed by the Senate on December 21, 2005*

#### SUMMARY

The Congressional budget resolution for fiscal year 2006 (H. Con. Res. 95) instructed several committees in both the House of Representatives and the Senate to recommend legislative changes that would reduce outlays from direct spending by about \$35 billion over the 2006-2010 period. That process is known as reconciliation and its results are embodied in S. 1932. (The budget resolution also called for a reconciliation bill that would reduce collections of federal revenues; that legislation is being considered separately by the Congress.)

Enacting S. 1932 would reduce direct spending by about \$39 billion over the 2006-2010 period and by approximately \$99 billion over the 2006-2015 period, CBO estimates, through changes in a variety of programs. Those changes include increases in offsetting receipts (which are recorded in the budget as a credit against direct spending).

The Deficit Reduction Act contains two apparent errors in legislative language: one in section 8006 regarding direct loans to parents of postsecondary students, and one in section 10002 regarding bankruptcy fees. If those apparent errors were changed in subsequent legislation, the estimated five-year savings would rise by about \$700 million, and the estimated 10-year savings would increase by about \$2 billion

The largest budgetary effects of S. 1932 over the next five years would stem from changes in federal student loan programs. Those changes include both decreases and increases in education spending and, on balance, would account for \$11.9 billion of the estimated net savings through 2010. Other budget savings over the next five years would accrue from a host of changes to both the Medicare and Medicaid health care programs (for net savings of \$11.2 billion over five years), changes in the authority to auction licenses to use the electromagnetic spectrum and to spend a portion of auction proceeds (for net savings of \$7.4 billion over five years) changes in federal pension insurance (five-year savings of \$3.6 billion), and changes to several other programs (five-year savings of \$4.8 billion).

The estimates of the budgetary impact of the various provisions of this act are measured relative to CBO's March 2005 baseline projections, which underlie the Congressional budget resolution for fiscal year 2006, except in cases when subsequent legislation has changed the program in question. As specified by statute, certain programs that are reauthorized in this act were assumed to continue in the baseline projections; consequently, this estimate shows no cost for such reauthorizations. The programs affected include:

- Temporary Assistance for Needy Families, reauthorized for the period from April 1, 2006, to September 30, 2010; baseline budget authority over that period totals \$74.3 billion;
- The child care entitlement to states, reauthorized for the period from April 1, 2006, to September 30, 2010; baseline budget authority over that period totals \$11.7 billion;
- The authority for lenders in the guaranteed student loan program to make subsidized loans to new borrowers; extended through 2012--or through 2016, when necessary for students to complete their education;
- The Environmental Quality Incentives Program (EQIP) and the Conservation Security Program (CSP) of the Department of Agriculture, extended through 2010 and 2011, respectively; baseline budget

authority over those periods totals \$6.7 billion.

For this estimate, CBO assumes that the legislation will be enacted in early February 2006. The effects of this legislation fall within budget functions 350 (agriculture), 370 (commerce and housing credit), 400 (transportation), 500 (education, training, employment, and social services), 550 (health), 570 (Medicare), 600 (income security), 750 (administration of justice), and 950 (undistributed offsetting receipts).

## MAJOR PROVISIONS

The conference agreement<sup>1</sup> for S. 1932 contains 10 titles that are listed below.

**Title I** would amend laws governing federal assistance related to agriculture commodities, land conservation, and other agriculture-related programs. For the government's commodity program, the legislation would reduce spending in 2007 for advance direct payments for feed grains, oilseeds, wheat, cotton, rice, and peanuts. This change would not eliminate any such payments, but would shift payments from 2007 to 2008, followed by similar shifts in payments for future years--effectively shifting some outlays beyond 2015 (the last year of the 10-year window considered under the current budget resolution). Other commodity program changes would increase assistance to dairy producers but would decrease assistance to cotton producers.

The agriculture title would make several changes to land conservation programs, reducing their federal costs over the next 10 years. It also would reduce spending related to farm energy-efficiency systems, rural development, and grants that support research and education activities for U.S. agriculture.

**Title II** would make spending for certain activities associated with the sale of multifamily housing properties (obtained through defaults on federal loan guarantees) subject to appropriation. That change would reduce direct spending relative to current law because the Federal Housing Administration (FHA) can currently carry out such activities (primarily grants for property rehabilitation) without annual appropriation action. This title also would end some below-market sales of properties, leading to a net increase in annual sales receipts to FHA.

This title also would amend the deposit insurance system for banks and credit unions. It would restructure the federal insurance funds for that system and ultimately reduce net direct spending, primarily by giving the Federal Deposit Insurance Corporation more flexibility in determining the size of a new, combined insurance fund and in setting the premiums to be paid by deposit institutions. As a result, the government's receipts from such premiums would likely increase.

**Title III** would amend existing law regarding the Federal Communications Commission's (FCC's) authority to auction licenses to use the electromagnetic spectrum, resulting in additional auction proceeds. The title would allocate a portion of such proceeds for a variety of programs, mostly in the form of assistance to consumers for the switch from analog to digital television and to public safety agencies for interoperable communications systems.

**Title IV** would increase vessel tonnage charges on ships entering the United States. These charges are collected by the U.S. Customs Service.

**Title V** would make numerous changes to the Medicare program, including changes in the process for determining payments to managed care plans, to certain hospitals, and for certain medical procedures and services. The title also would restore payment rates for physicians' services back to the 2005 level--those rates were reduced by 4.4 percent on January 1, 2006; thus, this change would increase spending relative to current law. Finally, title V would shift some Medicare payments from the end of September 2006 into October.

**Title VI** would make several changes to the Medicaid program and the State Children's Health Insurance

Program (SCHIP). It also would provide funding to cover some health care costs in areas affected by Hurricane Katrina. The changes with the largest budget savings include new limits on the reimbursement of pharmacies for prescription drugs covered by Medicaid, revisions to the rules relating to individuals' asset transfers prior to gaining eligibility for long-term care services under Medicaid, and increased cost-sharing and premiums for certain Medicaid enrollees. This title also would increase some forms of Medicaid spending--including enhanced coverage of certain disabled children and home-and community-based services.

**Title VII** would:

- Reauthorize the Temporary Assistance for Needy Families (TANF) program, and change funding levels for the program;
- Increase funding for certain child care programs;
- Reduce funding for the child support enforcement program;
- Make several changes in child welfare programs, including some increases in funding and some reductions in expected spending from new limits on federal matching funds and eligibility;
- Require additional reviews before benefits can be awarded to certain disabled adults; and
- End distributions of antidumping and countervailing duties collected by the federal government.

**Title VIII** would make numerous changes to federal higher education programs, including the student and parent loan programs. Some provisions would reduce direct spending for higher education programs, while others would increase costs. On balance, however, those provisions would lead to significant savings in direct spending for such programs. This title also would make changes to the premiums charged by the Pension Benefit Guaranty Corporation (PBGC). Those changes would reduce direct spending in the near term by bringing in more offsetting receipts to the federal government.

**Title IX** would provide \$1 billion in additional funding for the Low-Income Home Energy Assistance Program (LIHEAP) for fiscal year 2007. A portion of those funds (\$750 million) would be available on a contingency basis--that is, their availability would be subject to a determination that the funds are necessary to meet emergency assistance needs.

**Title X** would increase certain civil filing fees for parties appearing before U.S. federal courts and would increase filing fees for individuals seeking bankruptcy relief.

## **TITLE V - MEDICARE**

The act would make numerous changes to the Medicare program. The largest savings would result from provisions that would lower spending by:

- Revising how the Centers for Medicare and Medicaid Services (CMS) accounts for the health status of individuals enrolled in Medicare Advantage (MA) when determining payment rates for MA plans;
- Clarifying CMS's policy regarding the formula used to calculate Medicare disproportionate share hospital (DSH) payments; and
- Reducing payments for multiple imaging procedures and home health services.

The act would increase payment rates for physicians' services to the 2005 level (those payment rates were reduced by 4.4 percent on January 1, 2006). That provision would increase outlays during the 2006-2009 period, and would reduce Medicare's payments to physicians below current-law levels in subsequent years.

In addition, the act would shift \$5.2 billion in outlays from 2006 to 2007 by temporarily halting payments to providers during the last six business days of September 2006.

On net, CBO estimates that the provisions of title V would reduce Medicare spending by \$3.1 billion in 2006, \$6.4 billion over the 2006-2010 period, and \$22.4 billion over the 2006-2015 period.

#### **Subtitle A-Provisions Relating to Medicare Part A**

CBO estimates that the provisions relating to Part A would reduce spending by \$1.4 billion over the 2006-2010 period and \$4.0 billion over the 2006-2015 period.

##### **Hospital Quality Improvement.**

Under current law, Medicare's payment rates for hospital inpatient services are reduced by 0.4 percent if the hospital does not report certain quality-related data. That reduction for nonreporting will expire at the end of fiscal year 2007. Section 5001 would increase the reduction to 2 percent, beginning in fiscal year 2007, and would make it permanent.

In addition, this section would reduce payments to hospitals in some cases when the patient acquires an infection during a hospital stay. In particular, the Secretary of Health and Human Services would be required to select at least two sets of two or more diagnosis-related groups (DRGs) in which it is common for patients who otherwise would be assigned to a lower-paying DRG to be assigned to the higher-paying DRG when there is a secondary diagnosis that results from infections acquired during the hospital stay. For discharges occurring on or after October 1, 2008, Medicare would set the payment rate for cases involving those DRGs at the level of the lower-paying DRG if the secondary diagnoses that resulted in assignment to the higher-paying DRG were not present at the time of admission.

CBO estimates those provisions would reduce spending by \$0.3 billion over the 2006-2010 period and by \$0.8 billion over the 2006-2015 period.

**Disproportionate Share Hospital Payments: Eligible Medicaid Days.** Medicare makes additional payments, the so-called disproportionate share adjustment, to certain hospitals that serve a large number of low-income patients. The payment formula takes into account inpatient days for patients enrolled in Medicaid. Section 5002 would clarify that inpatient days for patients who are covered by Medicaid for other services, but not for hospital inpatient services, do not count as Medicaid days for the purposes of the disproportionate share adjustment. Based on information provided by CMS, CBO estimates that this provision would reduce spending by \$1.2 billion over the 2006-2010 period and by \$3.0 billion over the 2006-2015 period.

**Other Provisions.** This subtitle also contains provisions that would increase payment rates for certain small hospitals; delay the phase-in of rules that will reduce the number of hospitals that qualify for special payment rates as rehabilitation hospitals; and reduce payments to skilled nursing facilities for bad debt (from uncollected cost-sharing owed by Medicare patients). In combination, CBO estimates the net effect of those provisions would be to reduce spending by \$0.1 billion over 10 years.

#### **Subtitle B-Provisions Relating to Medicare Part B**

CBO estimates that the provisions related to Part B would increase spending by \$2.0 billion in 2006 and by \$3.2 billion over the 2006-2010 period. Over the 2006-2015 period, CBO estimates those provisions would reduce Medicare spending by \$9.4 billion. Six provisions account for the bulk of the estimated budgetary effect.

**Ownership of Durable Medical Equipment (DME).** Section 5101 would modify Medicare's payment

rules for oxygen equipment and for most other types of durable medical equipment.

Under current law, Medicare will make rental payments for oxygen equipment for an indefinite period. The act would require beneficiaries to receive ownership of oxygen equipment after 36 months of continuous rental (or 36 months after January 1, 2006, for individuals already renting oxygen equipment).

For certain other items of durable medical equipment, Medicare pays on a so-called “capped rental” basis under current law. That means that the program will make rental payments for a maximum of 15 months. The beneficiary has the option of receiving ownership, without further expense, after 13 months of rental. If the beneficiary exercises that option, the program will pay for repairs as they are needed.

If the beneficiary does not exercise that option to assume ownership after 13 months of rental, Medicare will make rental payments for two additional months (that is, for a total of 15 months) and then will make semi-annual maintenance payments of 10 percent of the original purchase price. (In aggregate, rental payments over 13-month and 15-month periods amount to 105 percent and 120 percent of the original purchase price, respectively.)

The act would require that ownership of the item be transferred to the beneficiary after the 13th month (or 13 months after January 1, 2006, for individuals already renting specified items). The policy would eliminate the option of continuing to pay rent for the 14th and 15th months and the associated semiannual maintenance payments. Medicare would be responsible for paying for maintenance services on a cost-reimbursement basis.

CBO estimates those changes to Medicare’s payment rules for oxygen and other durable medical equipment would reduce Medicare spending by \$0.7 billion over the 2006-2010 period and by \$1.9 billion over the 2006-2015 period.

**Payment for Imaging Services.** Section 5102 would reduce spending on imaging services (such as X-rays and magnetic resonance imaging) by \$2.8 billion over the 2007-2010 period and by \$8.1 billion over the 2007-2015 period, CBO estimates. Those savings would be realized, in part, by capping the “technical” component of payments (as distinguished from the “professional” --or interpretation--component) for imaging services that are performed in a doctor’s office. Those payment rates would be capped at the rates paid to hospital outpatient departments.

In addition, the act would exempt from Medicare’s budget-neutrality rules scheduled reductions in payments for certain imaging services that are performed on contiguous body parts. Exempting these reductions (which were put in place through administrative action) from the budget neutrality rules would allow savings resulting from the new payment rates to decrease overall spending rather than being used to increase payment rates for other services.

**Payment for Physician Services.** Effective January 1, 2006, Medicare’s payment rates for physicians’ services were reduced 4.4 percent. Section 5104 would eliminate that reduction and increase payment rates to the 2005 level. The Administration has announced that, if this provision is enacted, the Medicare program intends to make retroactive adjustments to payments for services that were paid at the lower rate.

Under the formula used for determining physician payments, increasing payment rates in 2006 to the 2005 level would also result in higher rates from 2007 through 2009. That change would increase Medicare spending by \$1.5 billion in 2006 and by \$7.3 billion over the 2006-2010 period. However, the act also would require that the cost of increasing payment rates for physician’s services be offset by future reductions in those rates. Consequently, Medicare’s payments for physicians’ services would be below current-law levels from 2010 through 2015. Assuming that occurs, CBO estimates that Medicare spending would be reduced by about \$0.4 billion over the 2006-2015 period.

**Payment for Dialysis Services.** Section 5106 would increase payment rates for dialysis services by 1.6

percent, beginning January 1, 2006. CBO assumes that Medicare would make retroactive adjustments to payments for services furnished before enactment, and estimates that provision would increase spending by \$0.5 billion over the 2006-2010 period and by \$1.3 billion over the 2006-2015 period.

**Income-related Part B Premium.** Section 5111 would accelerate the phase-in of the scheduled increase in Part B premiums for beneficiaries with incomes above specified thresholds. CBO estimates that this provision would increase premium collections (which are considered offsetting receipts) and, therefore, reduce net Medicare spending by \$1.6 billion over the 2007-2010 period.

**Other Provisions.** This subtitle also contains provisions that would: cap payment rates for services furnished in ambulatory surgical centers at the rates paid for such services when they are furnished by a hospital outpatient department; increase payment rates for certain small hospitals; expand coverage for therapy services; provide coverage of screening for colorectal cancer; expand services that are eligible for Medicare payments when provided in federally qualified health centers; and waive the penalty for late enrollment in Part B for certain volunteers serving in foreign countries. In combination, those provisions would reduce Medicare spending by less than \$100 million over the 2006-2015 period, CBO estimates.

#### **Subtitle C-Provisions Relating to Parts A and B**

CBO estimates that the provisions in subtitle C would reduce Medicare spending by \$5.3 billion in 2006, \$2.0 billion over the 2006-2015 period, and \$5.7 billion over the 2006-2015 period. A provision reducing payment rates for home health services and a provision that would shift certain payments from fiscal year 2006 to fiscal year 2007 account for the bulk of those estimated budgetary effects.

**Payment for Home Health Services.** On January 1, 2006, Medicare's payment rates for home health services were increased by 2.8 percent. Section 5201 would reduce payment rates for home health services to the 2005 level. However, it would establish a 5 percent add-on payment for home health services furnished in rural areas during 2006. Beginning in 2007, the act also would reduce the rates paid to home health agencies that do not report certain quality-related data by 2 percent.

CBO estimates those provision would decrease spending by \$2.0 billion over the 2006-2010 period and by \$5.7 billion over the 2006-2015 period. CBO's estimate assumes that the reductions in payment rates for home health services in 2006 would not be imposed retroactively.

**Delay Payments to Providers.** Section 5203 would postpone payments for Medicare Part A and B benefits for six business days at the end of fiscal year 2006. The provision would postpone--until October 2, 2006--payments that otherwise would be made by Medicare carriers and fiscal intermediaries during the period from September 22 through September 30, 2006. This provision would shift an estimated \$5.2 billion in spending from fiscal year 2006 to 2007 but would not affect total spending over the two-year period (and would have no effect after fiscal year 2007).

**Other Provisions.** This subtitle also contains provisions that would delay payments for claims that are not submitted electronically and would provide an additional \$100 million in additional funding to the Medicare Integrity Program in 2006.

#### **Subtitle D-Provisions Relating to Part C**

Part C of Medicare encompasses plans in the Medicare Advantage program and certain other health care plans that are paid primarily on a capitated basis (in contrast to being paid on a fee-for-service basis). Those plans provide services covered in fee-for-service settings by Parts A and B of the Medicare program (and may provide drug benefits covered under Part D) and are paid with funds drawn from those Medicare trust funds.

The act would modify how payments to Medicare Advantage plans are adjusted to reflect differences in

expected costs that are associated with the health status of the beneficiaries enrolled in those plans. It also would establish a grant program to encourage certain plans to operate in rural areas. CBO estimates that the provisions of subtitle D would reduce spending by \$6.4 billion over the 2006-2010 period and by \$4.0 billion over the 2006-2015 period. Nearly all of the estimated budgetary effect is due to the provision that would modify payments to MA plans.

**Risk Adjustment of Payments to MA Plans.** Section 5301 would require the phased elimination of certain payments to Medicare Advantage health plans. Currently, Medicare makes a “budget neutrality” adjustment to payment rates that returns to MA plans all of the savings that would result from the application of risk adjustment based on health status. The act would require the Secretary to phase out that budget-neutrality adjustment.

This section also would require the Secretary to modify the risk adjustment process during the 2008-2010 period to take into account the effect on measures of health status of differences in data reported by providers in the fee-for-service and Medicare Advantage settings. The legislation would limit the ability of the Secretary to adjust for such differences after 2010. CBO estimates that the provisions of section 5301 would reduce spending by \$6.5 billion over the 2006-2010 period and by \$4.1 billion over the 2006-2015 period. The Secretary would have substantial latitude in carrying out this adjustment in payment rates to MA plans because the legislation would not specify the details of that process. There is therefore considerable uncertainty about how the Secretary would implement the requirement to modify the risk-adjustment process. As a result, the budgetary effect of enacting this provision could be larger or smaller than CBO has estimated.

**Grants for Rural PACE Providers.** Section 5302 would establish a grant program for qualified providers to establish and deliver services in rural areas under the “Program of All Inclusive Care for the Elderly” (PACE). CBO estimates that this provision would increase spending by less than \$50 million over the 2006-2010 period and by \$0.1 billion over the 2006-2015 period.

### **Interactions**

Changes in total Medicare spending affect the “benchmarks” that Medicare uses to determine how much the program pays for beneficiaries in the Medicare Advantage program. CBO estimates that the changes in Medicare spending discussed above would reduce MA payments by \$0.1 billion over the 2006-2010 period and by \$3.4 billion over the 2006-2015 period.

Beneficiaries enrolled in Part B of Medicare pay premiums for Part B that offset about 25 percent of the cost of those benefits. Therefore, about one-quarter of the changes in Part B spending would be offset by changes in those premium receipts. The Part B premium for 2006 has already been announced and will not be changed. Therefore, the act would have no effect on Part B premium receipts in 2006. CBO estimates that the legislation would reduce receipts of Part B premiums by \$0.3 billion over the 2006-2010 period, and would reduce receipts by about \$3.9 billion over the 2006-2015 period.

## **TITLE VI - MEDICAID AND SCHIP**

The provisions of this title would make a variety of changes to the Medicaid program, modify the State Children’s Health Insurance Program, and provide funding for health care costs in areas affected by Hurricane Katrina. CBO estimates that enacting the provisions of this title would increase direct spending by \$2.2 billion in 2006, but would reduce direct spending by \$4.7 billion over the 2006-2010 period and by \$26.4 billion over the 2006-2015 period.

Subtitle A would reduce Medicaid outlays by allowing states to reduce benefits and impose additional cost-sharing requirements and premiums on certain enrollees, reducing payments for prescription drugs, and tightening the rules relating to asset transfers prior to eligibility for Medicaid long-term care services. Those savings would be partly offset by increased Medicaid coverage for certain disabled children,

expanded home- and community-based services, and other benefit expansions. Subtitle B would provide additional SCHIP funding for states that will face funding shortfalls in 2006 and prohibit any additional states from using SCHIP funds to cover childless adults.

### **Subtitle A--Medicaid**

Enacting subtitle A would reduce direct spending by \$6.9 billion over the 2006-2010 period and by \$28.3 billion over the 2006-2015 period. Those savings would be achieved mostly by allowing states to trim benefits for certain enrollees, letting states impose higher cost-sharing requirements and premiums on certain enrollees, lowering payments for outpatient prescription drugs, and increasing penalties for individuals who transfer assets for less than fair market value in order to qualify for nursing home care.

**Chapter 1: Prescription Drugs.** The provisions of this chapter would limit payments for certain outpatient prescription drugs and increase the rebates that Medicaid receives from drug manufacturers. CBO estimates that those provisions would reduce Medicaid spending by \$3.9 billion over the 2006-2010 period and by \$12.6 billion over the 2006-2015 period.

*Limits on Pharmacy Reimbursement.* The act would change the maximum price Medicaid pays for multiple-source drugs from 150 percent of the lowest published price (usually the wholesale acquisition cost) for a drug to 250 percent of the lowest average manufacturer price (AMP). The AMP is the average price that manufacturers receive for sales to retail pharmacies. The revised limit would take effect on January 1, 2007. Like the current limit, it would apply only to a drug's ingredient costs and would not include dispensing fees, which would continue to be determined by the states.

The act also would require the Secretary of the Department of Health and Human Services (HHS) to disclose AMP data for all drugs (which are currently confidential) to the states on a monthly basis starting on July 1, 2006, and would appropriate \$5 million annually over the 2006-2010 period for the Secretary to survey retail prices for prescription drugs.

Based on administrative data on AMPs and prescription drug spending by Medicaid, CBO estimates that those provisions would reduce Medicaid spending by \$3.6 billion over the 2006-2010 period and \$11.8 billion over the 2006-2015 period. Those savings reflect CBO's expectation that states would raise dispensing fees to mitigate the effects of the revised payment limit on pharmacies and preserve the widespread participation of pharmacies in Medicaid. The estimate also accounts for lower rebates from drug manufacturers resulting from increased use of cheaper generic drugs.

*Other Provisions.* The chapter also contains provisions that would require states to collect rebates from drug manufacturers on certain drugs administered by physicians, expand the definition of the "best price" -- which HHS uses in calculating the rebate that manufacturers of brand-name drugs must pay to Medicaid--to include the prices of authorized generics, and allow certain children's hospitals to purchase prescription drugs at discounted prices (under section 340B of the Public Health Service Act). CBO estimates that those provisions would reduce net Medicaid spending by \$270 million over the 2006-2010 period and by \$870 million over the 2006-2015 period.

**Chapter 2: Asset Transfers.** The provisions of this chapter would reduce Medicaid spending by an estimated \$2.4 billion over the 2006-2010 period and by \$6.3 billion over the 2006-2015 period, primarily by increasing penalties on individuals who transfer assets for less than fair market value in order to qualify for nursing home care and by making individuals with substantial home equity ineligible for nursing home benefits.

*Revisions to Penalty Period.* Medicaid currently imposes a period of ineligibility for nursing home benefits on individuals who transfer assets for less than fair market value. The penalty period is based on the value of any assets transferred during the three years prior to application--known as the look-back period--and starts on the date the assets were transferred. Those rules have relatively little effect because any penalty period usually has expired by the time an individual applies for Medicaid.

Under this act, the penalty period would start when an individual becomes eligible for Medicaid and the look-back period would be extended from three years to five years. The act also would codify certain protections against undue hardship for individuals who transfer assets. Those changes would apply only to asset transfers that occur after enactment, so the effect of the longer look-back period would not be felt until January 1, 2009.

CBO expects that the provision would deter some individuals from transferring assets and thus delay or prevent them from receiving nursing home benefits; others would pay a penalty in the form of delayed eligibility for nursing home benefits. Those provisions would reduce Medicaid spending by \$1.5 billion over five years and \$4.0 billion over 10 years, CBO estimates.

*Treatment of Home Equity.* Under current law, the value of an individual's home is not included when determining eligibility for Medicaid. The act would make individuals with more than \$500,000 in home equity ineligible for nursing home benefits; states would be able to raise that limit to \$750,000. That figure would be adjusted annually for inflation starting in 2011. The prohibition would not apply if an individual's spouse, minor child, or disabled child (regardless of age) lives in the house and would allow exemptions in the case of hardship. This provision would apply to individuals who apply for Medicaid after January 1, 2006. CBO estimates that this change would reduce Medicaid spending by \$298 million over the 2006-2010 period and by \$878 million over the 2006-2015 period.

*Other Savings.* The act also would:

- Require Medicaid applicants with annuities to name the state as remainder beneficiary to the extent of Medicaid's expenditures for that individual,
- Change the rules under which income and assets are allocated from beneficiaries to their spouses who are living in the community,
- Clarify that deposits paid to continuing care retirement communities are counted when determining Medicaid eligibility and are available to pay for the costs of care,
- Make other revisions to asset-transfer rules that would further tighten the penalty period and restrict the use of certain financial instruments, and
- Repeal a moratorium on the number of states that may operate Long-Term Care Partnership Programs, which allow individuals who purchase certain kinds of long-term care insurance to protect more of their assets if they later need nursing home care under Medicaid.

CBO estimates that those provisions would reduce Medicaid spending by \$598 million over five years and \$1.5 billion over 10 years.

**Chapter 3: Fraud, Waste, and Abuse.** This chapter includes several provisions intended to improve payment integrity in the Medicaid program. CBO estimates that those provisions would lower Medicaid outlays by \$822 million over five years and by \$2.8 billion over 10 years, largely by making it easier for states to avoid overpayments for Medicaid recipients who also have private health insurance. In addition, the chapter would add spending of \$528 million over five years and \$1.2 billion over 10 years for activities to promote program integrity.

*Third-Party Recovery.* The act would strengthen Medicaid's status as payer of last resort relative to private health insurance by specifying that pharmacy benefit managers and selfinsured plans are liable third parties, requiring insurers to submit eligibility and claims data for Medicaid recipients to states on a regular basis, and requiring insurers to pay claims for Medicaid recipients that are submitted within three years of the date of service. Those provisions would take effect on January 1, 2006. CBO estimates that the act would

improve states' abilities to identify liable third parties and would increase the amounts that Medicaid recovers from insurers for recipients who also have private health insurance, thereby reducing Medicaid spending by \$570 million over the 2006-2010 period and by \$1.7 billion over the 2006-2015 period.

*Other Savings.* The act also would encourage states to enact false claims acts, mandate that certain employers conduct education campaigns for employees about false claims acts, prohibit states from billing Medicaid twice for prescription drugs, and require recipients to document their U.S. citizenship. CBO estimates that those provisions would reduce Medicaid spending by a combined \$252 million over the 2006-2010 period and by \$1.1 billion over the 2006-2015 period.

*Medicaid Integrity Program.* The act would appropriate \$5 million in 2006, \$50 million in both 2007 and 2008, and \$75 million annually after that for the Secretary of HHS to improve the accuracy of payments in the Medicaid program. The act also would appropriate \$480 million over the 2006-2015 period for activities that support the Medicare-Medicaid data match program and \$25 million annually between 2006 and 2010 for Medicaid-related activities by the department's Office of the Inspector General (OIG). Based on historical spending patterns for the OIG and for program integrity activities in Medicare, CBO estimates that those appropriations would increase direct spending by \$528 million over the 2006-2010 period and by \$1.2 billion over the 2006-2015 period.

**Chapter 4: Cost Sharing and Benefits.** This chapter contains a number of provisions that would reduce direct spending, most notably by allowing states greater flexibility in imposing cost-sharing requirements and premiums than they have under current law, and by permitting states to restrict benefits for certain enrollees. In aggregate, we estimate that the provisions of this chapter would reduce Medicaid outlays by \$3.2 billion over the 2006-2010 period and by \$16.0 billion over the 2006-2015 period.

*Increase Cost Sharing and Premiums.* Current Medicaid law permits states to impose nominal cost-sharing requirements on services for certain beneficiaries other than children and pregnant women and narrowly limits states' ability to charge premiums. Since 1982, Medicaid regulations have limited nominal cost sharing to \$3 for most services and have prohibited providers from denying services to individuals who do not pay. Although some states have permission from the Centers for Medicare and Medicaid Services to impose premiums and cost-sharing requirements on higher-income enrollees through waivers of Medicaid law, the majority of Medicaid enrollees do not pay any cost sharing.

The act would permit states to subject a broader range of enrollees to premium and costsharing requirements beginning on March 31, 2006. (Changes to cost-sharing requirements for prescription drugs are discussed in the next section.) Those proposed increases in cost sharing would apply to all Medicaid beneficiaries with family income at or above the poverty level with some exceptions, mainly children that states are required to cover under Medicaid rules, pregnant women, and individuals living in institutions. Moreover, cost sharing would not apply to preventive services for all children, pregnancy-related services, and certain other services that are exempt from cost sharing under current law. Under the act, premiums could not apply to individuals with income between 100 and 150 percent of the poverty level.

The act would limit the amount of cost sharing that states could impose to 10 percent of the cost of an item or service for individuals with family income between 100 and 150 percent of the poverty level and to 20 percent for individuals with family income above 150 percent of the poverty level. However, regardless of family income, aggregate cost sharing and premiums for all Medicaid individuals in a family could not exceed 5 percent of family income (which the states would apply on a quarterly or monthly basis). Additionally, states could allow providers to deny services for lack of payment and condition benefits on prepayment of premiums. Under the act, states also would be permitted to increase nominal copays by medical inflation starting in 2006 for individuals with income below under the poverty level.

CBO based its estimate on an analysis of current state premium and cost-sharing policies, income data from the Current Population Survey, and Medicaid administrative data, and assumed that states would adopt new cost-sharing measures over a 10-year period. CBO estimates that the proposed changes in cost-sharing

policy would decrease Medicaid spending by \$960 million over the 2006-2010 period and by \$4.4 billion over the 2006-2015 period. Those savings reflect CBO's expectation of reduced utilization of services due to higher cost-sharing requirements and decreased participation in Medicaid by individuals who would be required to pay premiums.

*Other Cost-Sharing Provisions.* Other provisions of this chapter would allow states to require cost sharing by enrollees--including those who otherwise are exempt from cost-sharing rules--for certain prescription drugs that are not preferred drugs within a class, and for non-emergency care provided in a hospital. The chapter also would appropriate \$50 million over the 2006-2010 period to assist states in developing alternative delivery networks. Those provisions would increase federal outlays by \$15 million in 2006, and would decrease spending by \$950 million over the 2006-2010 period and by \$5.5 billion over the 2006-2015 period, CBO estimates.

*Alternative Benefit Packages.* Under current law, state Medicaid programs generally must offer the same set of benefits to all enrollees, regardless of income or eligibility category. States also must provide benefits not otherwise covered by the state's Medicaid plan to children to treat medical conditions diagnosed under the program. Some states offer reduced benefit packages under current law to certain enrollees with family incomes above the federal poverty level under waivers granted by CMS.

Starting on March 31, 2006, the act would allow states to scale back Medicaid benefits provided to a limited group of enrollees, mainly adults who are not disabled or pregnant and have income that exceeds the eligibility standard for the old Aid to Families with Dependent Children program. States could offer reduced benefit packages only to enrollees who are in eligibility categories the state established before the date of enactment, not to new categories of enrollees. Additionally, states could not reduce benefits for children, pregnant women that the federal government requires state Medicaid programs to cover, certain poor parents, disabled individuals, individuals eligible for both Medicare and Medicaid, and certain other aged and disabled enrollees who receive long-term care services, or are medically frail or have special medical needs.

The provision would require that states choosing to restrict benefits offer packages of benefits that meet certain minimum standards. The package of benefits would have to include certain basic services, such as physician and hospital coverage, and with some exceptions, would be required to be actuarially equivalent to coverage provided under one of the specified "benchmark" benefit packages. The benchmark benefit packages would be the standard Blue Cross/Blue Shield preferred-provider option in the Federal Employees Health Benefit program, a health benefit plan that is offered and generally available to state employees, and the benefits offered by the health maintenance organization with the largest commercial enrollment in the state. The act would allow states to offer less than actuarially equivalent benefits for certain services, such as prescription drugs and mental health services, and would permit states to offer wrap-around coverage for other health insurance. States would be permitted to enroll children in a benchmark benefit plan but would be required to provide supplemental coverage for all other Medicaid benefits, including early and periodic screening, diagnostic, and treatment services.

CBO expects that some states would provide scaled-back coverage to certain categories of individuals and assumes that implementation would occur over a 10-year period. Based on Medicaid administrative data, and analysis of state experiences with providing limited benefit packages to poor families, CBO estimates that this provision would reduce federal spending by \$1.3 billion over five years and \$6.1 billion over 10 years.

**Chapter 5: State Financing.** The provisions of this chapter with the largest budgetary impact would (1) restrict states' ability to use revenues from taxes on health care providers to finance the state's share of Medicaid costs and (2) limit coverage of targeted case management services. Overall, we estimate that those provisions would reduce Medicaid spending by \$1.2 billion over five years and by \$5.0 billion over 10 years. In addition, other provisions in this chapter would increase spending by \$365 million over the 2006-2010 period and by \$657 million over the 2006-2015 period by providing additional Medicaid funding for Alaska, the District of Columbia, and U.S. territories.

*Restrictions on Provider Taxes.* Many states finance part of their share of Medicaid spending by imposing taxes on health care providers. States typically impose taxes on a particular type of provider and use the revenues to increase payment rates to those same providers. In the process, states collect federal Medicaid funds for those higher payments. Federal law generally requires states to tax all providers in a class, so states typically tax classes of providers (such as hospitals or nursing homes) of which a relatively large share receive significant Medicaid payments and stand to benefit from the higher payment rates that result from the provider tax. However, the law allows states to impose taxes only on those managed care organizations (MCOs) that serve Medicaid recipients. Because that exception makes it easier for states to impose provider taxes on MCOs, several states have already imposed such taxes, and more are planning to do so.

The act would require any taxes on MCOs to apply to all such organizations, including those that do not enroll Medicaid recipients. This provision would take effect upon enactment but would not apply fully to states with existing taxes on MCOs until 2009. CBO anticipates that states ultimately would eliminate their taxes on MCOs under the act and as a result, states would pay MCOs less and claim fewer federal Medicaid funds. Using CMS data on provider taxes, we estimate that federal Medicaid spending would be reduced by \$435 million over the 2006-2010 period and by \$2.9 billion over the 2006-2015 period.

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

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

*Other Provisions.* The remaining provisions in this chapter would increase the federal match rate for Alaska in 2006 and 2007, allow the District of Columbia to make additional payments to disproportionate share hospitals, and increase funding for Medicaid programs in the United States' territories. On net, CBO estimates that those provisions would increase Medicaid outlays by \$365 million over the 2006-2010 period and by \$657 million over the 2006-2015 period.

**Chapter 6: Other Provisions.** This chapter contains a number of provisions that would increase direct spending, primarily by permitting states to offer Medicaid coverage to certain disabled children and providing additional funding for long-term care services that are provided in the community. In aggregate, CBO estimates that those provisions would increase Medicaid spending by \$3.6 billion over the 2006-2010 period and by \$12.6 billion over the 2006-2015 period.

*Coverage of Certain Disabled Children.* The act would allow state Medicaid programs to cover children who meet the disability standard used in the Supplemental Security Income (SSI) program but are ineligible for SSI because they do not meet that program's income or asset requirements. Eligibility would be limited to children whose family incomes do not exceed 300 percent of the federal poverty level. This provision would take effect on January 1, 2007, and would be phased in over a three-year period.

CBO anticipates that about two-thirds of states would ultimately provide Medicaid coverage under this provision. Based on information from the Survey of Income and Program Participation and Medicaid administrative data, we estimate that this provision would increase Medicaid outlays by \$1.4 billion over the 2007-2010 period and by \$6.4 billion over the 2007-2015 period.

*Home- and Community-Based Services.* States currently use waivers of Medicaid law approved by CMS to provide long-term care services in the home or community to limited numbers of individuals who otherwise would require the level of care provided in a nursing home. The act would allow states to provide certain community-based services, such as respite care and adult day health care, to beneficiaries with income below 150 percent of the poverty level without first getting a waiver. States also would be able to provide benefits to individuals who would not otherwise need to be in a nursing home. Those changes would take effect on January 1, 2007. Based on administrative data and information from the Survey of Income and Program Participation on health insurance and disability, CBO estimates this provision would increase Medicaid spending by \$766 million over the 2006-2010 period and by \$2.6 billion over the 2006-2015 period.

*Money-Follows-the-Person Demonstration.* The act would authorize a demonstration project under which the federal government would pay a higher share of costs than under current law (78 percent versus 57 percent, on average) for the first 12 months of long-term care services provided in the home or community for Medicaid recipients who used to be in nursing homes. The act would provide a total of \$1.8 billion in funding over five years for the demonstration and would take effect on January 1, 2007. After accounting for reduced spending on nursing home care and the additional cost of home- and community-based services beyond the initial 12 months, CBO estimates that this provision would increase Medicaid spending by \$340 million over the 2007-2010 period and \$2.0 billion over the 2007-2015 period.

*Other Provisions.* The remaining provisions in this chapter would:

- Authorize a demonstration project to provide home- and community-based services to disabled children who otherwise would require psychiatric residential treatment;
- Appropriate funds to develop health information centers;
- Change the date on which Medicaid eligibility starts for certain recipients of Supplemental Security Income (SSI) benefits;
- Provide \$150 million in funding to reward states that improve the management of their Medicaid programs;
- Establish a demonstration program--called health opportunity accounts--to allow certain beneficiaries to pay directly for some of their Medicaid costs with funds provided by their state;
- Amend the rules governing the provision of non-emergency transportation services;
- Extend the requirement that states provide transitional medical assistance and funding for abstinence education programs through December 31, 2006;
- Limit payment for emergency services that out-of-network hospitals provide to individuals enrolled in Medicaid managed care; and
- Allow certain enrollees who receive long-term care services in the community to contract directly with providers using a preset budget provided by the Medicaid program.

Taken together, CBO estimates those provisions would increase Medicaid spending by \$1.1 billion over five years and \$1.6 billion over 10 years.

## **TITLE VII - HUMAN RESOURCES AND OTHER PROVISIONS**

Title VII would:

- Reauthorize the Temporary Assistance for Needy Families program; it would increase funding for some grants and establish a new grant program, but it also would eliminate funding for other related grants;
- Increase funding for child care programs;
- Make several changes to the child support enforcement program, including reducing the federal share of funding, assessing fees on some families receiving services, and allowing the distribution to families of more collections from child support payments;
- Clarify eligibility for foster care and adoption assistance, place limits on federal matching funds for certain administrative costs for foster care, establish a new grant program, and increase funding for another;
- Require the Social Security Administration (SSA) to change its system of reviewing awards to certain disabled adults in the Supplemental Security Income (SSI) program and use installment payments for more retroactive SSI benefits; and
- End distributions of antidumping and countervailing duties under the Continued Dumping and Subsidy Offset Act (CDSOA).

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<sup>1</sup> The conference agreement for spending reconciliation legislation was reported in House Report 109-276 (under the House bill number H.R. 4241) and was passed by the House of Representatives on December 19, 2005. The Senate approved the conference agreement on December 21, 2005, after amending the legislation to remove a few provisions that were subject to a point of order. That amended legislation (contained in Senate Amendment 2691) is now pending before the House.