Appendices

Table of Medicare Options and Budget Effects 197

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Table of Medicare Options and Budget Effects

The following table provides information about potential budget effects for the options included in this report. In general, the estimates in the table and text are from official and publicly available government sources, including publications from the Congressional Budget Office (CBO), the Medicare Payment Advisory Commission (MedPAC), the Office of Management and Budget (OMB), and the Department of Health and Human Services Office of Inspector General (HHS OIG). In a few cases, estimates from other sources are presented and noted accordingly. Estimates may differ in terms of the budget window and the year of implementation because they were drawn from different sources and published in different years. Some of these options have potential to achieve savings but do not have estimates from the official and publicly available government sources we relied on; in such cases, we note that estimates are "not available." Some estimates were produced before subsequent changes in law, including provisions in the 2010 Affordable Care Act (ACA) and the American Taxpayer Relief Act of 2012.

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION ONE: Medicare Eligibility, Beneficiary Costs, and Program Financing			
Age of Eligibility			
1.1: Raise the Medicare eligibility age from 65 to 67	$113 billion over 10 years (2012–2021)	Estimate for raising the eligibility age gradually to 67, by two months per year beginning in 2014; takes into account new Federal costs for health insurance exchange subsidies and the Medicaid expansion and reduced Medicare Part B premium revenues. *SOURCE: CBO 2012g*	4
1.2: Raise the Medicare eligibility age to 67 for people with higher lifetime earnings	Not available		6
Beneficiary Cost Sharing			
1.3a: Increase the deductible incrementally by $75 for new beneficiaries only	$2.3 billion over 10 years (2013–2022)	Estimate for increasing the deductible for new enrollees by $25 in each of 2017, 2019, and 2021. *SOURCE: CBO 2012b*	11
1.3b: Increase the deductible by $75 for all beneficiaries	Not available	Option could produce savings of $32 billion over 10 years (2014–2023), according to analysis by Actuarial Research Corporation (ARC) for the Kaiser Family Foundation; higher than the estimate for Option 1.3a because the increase would apply to all beneficiaries and be implemented sooner and fully at the outset.	11
1.4a: Impose a 10 percent coinsurance on all home health episodes	$40 billion over 10 years (2012–2021)	Estimate assumes implementation in 2013. *SOURCE: CBO 2011d*	12
1.4b: Impose a $150 copayment per full episode, that is, episodes encompassing five or more visits	Not available	Option could save $19 billion over 10 years (2014–2023), according to analysis by ARC for the Kaiser Family Foundation.	12
1.4c: Impose a $150 copayment per full episode, restricted to episodes that do not follow a hospitalization or post-acute care	$1 billion to $5 billion over five years	Estimate from MedPAC; CBO has estimated that a $100 copayment for this subset of episodes applied to new beneficiaries beginning in 2017 would save about $0.3 billion over 10 years (2013–2022); savings would increase as more people became eligible for Medicare. *SOURCES: MedPAC 2011b; CBO 2012b*	12

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION ONE: Medicare Eligibility, Beneficiary Costs, and Program Financing (continued)			
Age of Eligibility (continued)			
1.5: Introduce cost sharing for the first 20 days of a skilled nursing facility stay	$21.3 billion over 10 years (2012–2021)	Estimate for a daily copayment set at 5% of the Part A deductible if implemented in 2013. *SOURCE: CBO 2011d*	14
1.6: Introduce cost sharing for clinical lab services	$24 billion over 10 years (2010–2019)	Estimate for applying the Part B deductible and 20% coinsurance to clinical lab services beginning in 2011. *SOURCE: CBO 2008*	15
1.7: Modify current cost-sharing requirements to reflect “value-based insurance design”	Not available		16
1.8a: Restrict first-dollar Medigap coverage	$53 billion over 10 years (2012–2021)	Estimate for prohibiting coverage of the first $550 of beneficiary cost-sharing and limiting coverage to 50% of the next $4,950, beginning in 2011. *SOURCE: CBO 2011d*	17
1.8b: Impose a 20 percent premium surcharge on all supplemental policies (both Medigap and employer plans)	Not available	CBO estimated that an excise tax on Medigap policies set at 5% of the premium would save $12 billion over 10 years (2009–2018). *SOURCE: CBO 2008*	17
1.8c: Impose a 30 percent Part B premium surcharge for new enrollees who have “near first-dollar” Medigap coverage beginning in 2017	$2.6 billion over 10 years (2013–2022)	Savings would increase over time as new people join Medicare. *SOURCE: CBO 2012b*	17
Beneficiary Premiums			
1.9: Increase the Part B or Part D premium	$241 billion over 10 years (2012–2021)	Estimate for gradually increasing the standard Part B premium only (not Part D) by 2 percentage points each year to eventually cover 35% of Part B expenditures; because the average Part D premium is less than the Part B premium and fewer people are enrolled in Part D, increasing the Part D premium in a similar way would generate fewer savings. *SOURCE: CBO 2011d*	22
1.10: Increase the income-related Part B and Part D premiums or expand to more beneficiaries	$30 billion over 10 years (2013–2022)	Estimate for raising the Part B income-related premiums by 15%, increasing the Part D income-related premium in a similar manner, and freezing current income thresholds until 25% of beneficiaries pay an income-related premium, beginning in 2017; savings would increase as more beneficiaries paid the income-related premium. *SOURCES: OMB 2012a; CBO 2012b*	23
Revenues			
1.11: Increase the Medicare payroll tax	$651 billion over 10 years (2012–2021)	Estimate for replacing the 0.9 percentage point increase in the Medicare payroll tax for high-earners with a 1 percentage point increase in the Medicare payroll tax for all workers. *SOURCE: CBO 2011d*	28
1.12a: Increase the Federal tax on alcohol products and dedicate all or a portion of the revenue to Medicare	$60 billion over 10 years (2012–2021)	Estimate for increasing taxes on alcohol to a uniform $16 per proof gallon. *SOURCE: CBO 2011d*	30
1.12b: Increase the Federal tax on tobacco products and dedicate all or a portion of the revenue to Medicare	$42 billion over nine years (2013–2021)	Estimate for a 50-cent per pack increase in the tax on cigarettes and small cigars indexed to inflation; estimated $41 billion to come from new revenue; $730 million in net spending reductions including $251 million in Medicare savings. *SOURCE: CBO 2012h*	30
1.12c: Impose a new Federal excise tax on sugar-sweetened beverages and dedicate all or a portion of the revenue to Medicare	$50 billion over 10 years (2009–2018)	Estimate for an excise tax on sugar-sweetened beverages of three cents per 12 ounces. *SOURCE: CBO 2008*	31

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION ONE: Medicare Eligibility, Beneficiary Costs, and Program Financing (continued)			
Revenues (continued)			
1.12d: Increase taxes on employer-funded health insurance	$310 billion over 10 years (2012–2021)	Estimate for modifying the tax on high cost plans beginning in 2014 (rather than 2018) and lowering the threshold to initially include the top 20% of plans, and then indexing it to inflation. *SOURCE: CBO 2011d*	31
SECTION TWO: Medicare Payments to Plans and Providers			
Medicare Advantage			
2.1: Implement the Affordable Care Act benchmarks for the Medicare Advantage program over a shorter time period	Not available	Implementing the new benchmarks by 2015 rather than 2017 would reduce spending between 2014 and 2017 for counties with the longest transition period.	39
2.2: Set benchmarks for the Medicare Advantage program equal to local costs of traditional Medicare	Not available	Since the new ACA benchmarks are projected to be equal to the costs of traditional Medicare, on average, the actual savings from this option would be small, if any; CBO estimated relatively large savings from this option in 2008, prior to the enactment of the ACA. *SOURCE: CBO 2008*	40
2.3: Set benchmarks equal to local costs of traditional Medicare in counties in which benchmarks for Medicare Advantage plans are higher than local costs of traditional Medicare	Not available	Medicare spending would have been between $2 billion and $4 billion lower in 2012 if this option had been implemented that year.	40
2.4: Establish benchmarks for the Medicare Advantage program through competitive bidding	Not available	In 2008 CBO estimated that this option would reduce spending by $158 billion over 10 years (2010–2019), if implemented in 2012 and assuming benchmarks would be subject to a ceiling no greater than the benchmarks under current law; however, the ACA has since reduced benchmarks, thus, actual savings would be smaller. *SOURCE: CBO 2008*	41
2.5: Improve the risk adjustment system for Medicare Advantage plans	Not available	This option would increase payments for some Medicare Advantage plan enrollees and decrease payments for others; it could reduce spending if there were a net reduction in payments to plans.	43
2.6: Terminate the Quality Bonus Demonstration in 2013	Not available	Aggregate bonuses for Medicare Advantage plans are expected to be lower in 2014 than they were in 2012 ($3 billion); the CMS Office of the Actuary has estimated that the total cost of the demonstration will be about $8 billion over three years.	43
2.7: Restructure quality bonuses to Medicare Advantage plans to be budget neutral	Not available	This option would result in moderate savings by continuing to provide bonuses to half of the plans and reducing payments to the other half; in 2012, Medicare Advantage plans received about $4 billion in bonus payments, all of which will be savings if this option is implemented prior to 2015; however, bonus payments will be smaller in 2015 and future years if the CMS demonstration program ends as scheduled at the end of 2014.	44
2.8: Prohibit Medicare Advantage plans from receiving double bonuses in specified counties	Not available	In 2012, Medicare Advantage plans in 210 counties qualified for double bonus payments, and the double bonuses accounted for approximately 21 percent of all bonus payments.	45

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION TWO: Medicare Payments to Plans and Providers (continued)			
Prescription Drugs			
2.9: Require manufacturers to pay a minimum rebate on drugs covered under Medicare Part D for beneficiaries receiving low-income subsidies	$137 billion over 10 years (2013–2022)	Projected savings are $15 billion in the first year of full implementation. *SOURCE: CBO 2012b*	49
2.10: Authorize the Secretary of Health and Human Services (HHS) to negotiate lower prices for high-cost single-source drugs	Not available	CBO has suggested minimal savings from this option because the HHS Secretary would not have leverage for negotiation without a Federally-required formulary; the Secretary could consider requiring plans to use prior authorization for specified drugs for which no discount is provided as part of a negotiation strategy, even in the absence of a national formulary. *SOURCE: CBO 2008*	50
2.11: Authorize the HHS Secretary to administer a Medicare-sponsored Part D plan to compete with private Part D plans	Not available	Budget effects would depend on design decisions and on projected enrollment; savings could be achieved to the extent that the Medicare option provides coverage more efficiently than private plans or spurs greater competition.	51
2.12: Authorize the HHS Secretary to engage in a competitive bidding approach that excludes plans with relatively high bids or poor quality	Not available		51
2.13: Reduce reinsurance payments to Part D plans	Not available	Savings would be achieved if the reduction of reinsurance encourages plans to more effectively manage utilization by high-cost users	52
2.14a: Increase the differential between generic and brand drug copayments in drug classes where generics are broadly available	Not available	CBO projected savings of nearly $1 billion if all prescriptions for multiple-source brand-name drugs had been filled with generics and another $4 billion with increased therapeutic substitution in seven drug classes. *SOURCE: CBO 2010*	53
2.14b: Increase the differential between generic and brand drug copayments for Low-Income Subsidy Part D enrollees in drug classes where generics are broadly available	$17 billion over 10 years	Estimate for MedPAC recommendation on drug copays for LIS beneficiaries; if adherence to medications increases, there could be additional savings as a result of lower use of other medical services. *SOURCE: MedPAC 2011a*	53
2.15: Strengthen incentives for adherence	Not available	Increased adherence would likely increase spending for drugs in Part D, but could reduce spending on Part A or Part B services; CBO finds that a 1% increase in prescription drug use results in a reduction in spending for medical services of about one-fifth of 1%. *SOURCE: CBO 2012f*	54
2.16: Strengthen medication therapy management programs	Not available	The highest-cost Part D enrollees are projected to incur $30 billion in Part D spending in 2013; if these costs were reduced by 10%, it would represent $3 billion in annual savings; greater savings could be achieved if MTM programs result in lower medical spending. *SOURCE: Budnitz et al. 2011*	55
2.17: Repeal provisions in the Affordable Care Act that would close the Part D coverage gap by 2020	$51 billion over 10 years (2013–2022)	Estimate incorporates an anticipated reduction in Part D spending, offset in part by an expected increase in the use of other Medicare services; savings could be reduced if the Federal government had to repay discounts already provided by manufacturers. *SOURCE: CBO 2012f*	56
2.18: Lower the percentage paid by Medicare for Part B drugs from 106 percent to 103 percent of the average sales price	$3.2 billion over 10 years	*SOURCE: CBO*	56

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION TWO: Medicare Payments to Plans and Providers (continued)			
Prescription Drugs (continued)			
2.19: Change from the current average wholesale price (AWP) methodology for certain Part B drugs to the average sale price (ASP) methodology used for other Part B drugs	Not available	Total spending in 2010 for Part B drugs was $11.5 billion, of which no more than 5% was for drugs paid under the AWP methodology; 10% savings would save up to $500 million over 10 years.	57
2.20: Restore the legal authority for CMS to use a "least costly alternative" policy among competing Part B drugs	Not available	MedPAC has reported that restoring the Secretary's authority to apply a least costly alternative policy would lead to savings of $1 billion in Federal spending over 10 years. *SOURCE: MedPAC 2011a*	57
2.21: Require manufacturer discounts or rebates for Part B drugs or allow Medicare to negotiate drug prices for Part B drugs when Medicare purchases account for a large share of spending on a specific drug	$1.6 billion in 2010	Estimate for implementing rebates for the 13 costliest drugs where Medicare accounts for the majority of spending; savings would be greater if based on the full list of qualifying drugs. *SOURCE: OIG 2011*	58
2.22: Lower the reimbursement for Part B drugs for which the price based on the average manufacturer price (AMP) is lower than the current ASP-based price	$17 million in 2012	Estimate for substituting the AMP-based price for 14 of the 29 drugs for which the ASP exceeds the AMP by 5%; quarterly estimate multiplied by four to obtain the annual estimate. *SOURCE: OIG 2012a*	59
2.23: Shorten the exclusivity period for biologics from 12 years to 7 years	$3 billion over 10 years (2013–2022)	*SOURCE: CBO 2012b*	59
2.24: Prohibit pay-for-delay agreements associated with patent exclusivity periods	1) $4.8 billion over 10 years (2012–2021) 2) $5.0 billion over 10 years (2013–2022)	*SOURCES: 1) CBO 2011b; 2) CBO 2012b*	60
Provider Payments			
2.25: Repeal the sustainable growth rate (SGR) and establish a series of legislated updates	Spending increase: $200 billion over 10 years	Estimate for repealing the SGR coupled with a 10-year freeze in fees and a 5.9% cut in fees for non-primary care services each year for the first three years; estimate made prior to enactment of the American Taxpayer Relief Act of 2012. *SOURCE: MedPAC 2012b*	66
2.26: Retain the SGR and revise with a new a base period and other changes	Spending increase over 10 years (2013–2022): 1) $254 billion 2) $314 billion 3) $377 billion	Estimates for resetting the SGR target at the 2011 spending level and using 1) GDP+0%, 2) GDP+1%, or 3) GDP+2% in the target; estimate made prior to enactment of the American Taxpayer Relief Act. *SOURCE: CBO 2012e*	67
2.27a: Recalibrate the Resource-Based Relative Value Scale (RBRVS) to address "misvalued" services	Not available	Savings would depend on the specific codes involved and corresponding utilization.	68
2.27b: Expand the multiple procedure payment reduction (MPPR) policy	Not available	Savings would depend on the specific procedures involved; under current law, changes in the MPPR are made in a budget neutral manner; Congress could change that approach to achieve savings.	69
2.27c: Change the assumptions used for determining the equipment utilization for calculating practice expense relative value units	Not available	Savings would require implementation in a non-budget neutral manner, as in the ACA and American Taxpayer Relief Act.	70

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION TWO: Medicare Payments to Plans and Providers (continued)			
Provider Payments (continued)			
2.28: Freeze all Medicare payment rates for one year	Not available	Based on estimates from CBO, freezing payment rates for all Medicare services (except for those paid under the physician fee schedule) would save about $52 billion over 10 years (2013–2022); estimate based on CBO estimates made prior to enactment of the American Taxpayer Relief Act. *SOURCE: CBO 2012d*	71
2.29: Use a refined inflation measure to update Medicare payment rates currently adjusted by the CPI	Not available		71
2.30: Reduce payment rates for clinical laboratory services	Not available	MedPAC estimated in October 2011 that a 10 percent reduction in clinical lab rates would save $10 billion over 10 years; subsequent legislation imposed a 2% reduction and was scored by CBO as saving $2.7 billion over 10 years (2013–2022). *SOURCE: MedPAC 2011a*	72
2.31: Use value-based purchasing (VBP) programs to achieve savings (rather than being budget neutral), increase the percentage of Medicare payments subject to VBP, and place greater emphasis on patient outcomes and efficiency	Not available	Savings would depend on the proportion of payments subject to VBP and hospital performance on the quality measures; CMS estimated that the VBP incentive pool for FY 2013 will total $963 million; if 10% of the pool were not paid to hospitals, potential savings over 10 years would be roughly $3 billion.	73
2.32: Expand value-based purchasing to other Medicare services	Not available	Savings would depend on the amount of payments put at risk and the performance of providers on the quality measures; if extending VBP to other services resulted in savings of one-tenth of 1% of spending, additional savings could be $2.6 billion over seven years (2016–2022); additional savings would accrue to the extent VBP spurred quality improvements that reduce program spending.	73
2.33: Expand the readmissions reduction program to post-acute care providers such as skilled nursing facilities, long-term care and rehabilitation hospitals, and home health agencies	$1.4 billion over 10 years (2013–2022)	Estimate for SNF services only; no estimate is available for extending this program to other post-acute services. *SOURCE: CBO 2012b*	75
2.34: Reduce the indirect medical education adjustment	1) $3.5 billion over one year 2) $6 billion over 10 years (2013–2022)	1) Estimate for reducing the adjustment from 5.5% to 2%; extrapolating based on recent projections of IME spending suggests savings over 10 years of about $50 billion; 2) Estimate for phasing down the adjustment by a total of 10% beginning in 2014. *SOURCES: 1) MedPAC 2010; 2) CBO 2012b*	76
2.35: Reduce direct graduate medical education payments	Not available		77
2.36: Reduce and restructure graduate medical education payments to hospitals	$69.4 billion over 10 years (2012–2021)	Estimate for pooling the excess IME funds, direct GME funds, and Medicaid GME funds, and index that amount to CPI-1%; majority of savings would come from Medicare; budget effects of this approach would depend on the extent to which IME cuts are included and the indexing measure used. *SOURCE: CBO 2011d*	78

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION TWO: Medicare Payments to Plans and Providers (continued)			
Provider Payments (continued)			
2.37: Expand the use of competitive bidding	Not available	According to CMS, the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program saved Medicare about $202 million in its first year (2011); CMS projects the program will save $26 billion over 10 years (2013–2022), in part due to expansion to additional areas of the country; no estimates are available for other possible uses of competitive bidding. *SOURCE: CMS 2012*	79
2.38: Adopt selective contracting for provider or service categories	Not available		79
2.39: Equalize payments across settings	1) $1 billion to $5 billion over five years 2) $900 million in one year	1) Estimate for equalizing payments for visits to hospital outpatient departments (phased in over three years, with some safeguards); 2) Estimate for payment reductions for other hospital outpatient services, with the goal of a site-neutral payment policy; savings would depend on the services affected, their utilization trends, and the amount of the reductions. *SOURCES: 1) MedPAC 2012b; 2) MedPAC 2012c*	80
2.40: Use inherent reasonableness authority to reduce overpayments	Not available	CMS has characterized the savings potential for non-mail order diabetic testing supplies as significant.	81
2.41: Encourage care in lower-cost settings	Not available		82
2.42a: Rebase SNF and home health payment rates	1) $5 billion to $10 billion over five years 2) $5 billion to $10 billion over five years 3) $45 billion over 10 years (2013–2022)	1) Estimate for rebasing SNF rates with a 4% reduction in 2014 and applying subsequent reductions, as determined by the Secretary, over a transition period; 2) Estimate for accelerating the rebasing of home health payment rates from 2014 to 2013; 3) Estimate for reducing payment updates for post-acute care by 1.1 percentage points (or to zero if the result would have been a payment reduction) each year for eight years. *SOURCES: 1) MedPAC 2012b; 2) MedPAC 2012b; 3) CBO 2012b*	83
2.42b: Modify SNF and home health payment to combine prospective payment with shared savings and risk	Not available	This type of option could be budget neutral or could be designed to bring average margins in line with what a prudent purchaser may be willing to pay; a 10 percentage point reduction in the average margin would have resulted in savings of about $3 billion in SNF spending and $2 billion in home health spending in 2011.	84
2.42c: Refine SNF and home health prospective payments to fully incorporate therapies on a prospective basis	Not available	These modifications may be introduced in a budget-neutral manner. Their budgetary impact would then be related to the changes in inappropriate or excessive therapy amounts.	85
2.43: Modify payments to Inpatient Rehabilitation Facilities (IRFs) to apply a blended rate for specific diagnoses and raise minimum case-mix requirements	1) $1.4 billion over 10 years (2013–2022) 2) $0.8 billion over 10 years (2013–2022)	1) Estimate for blending SNF and IRF rates for three diagnoses; 2) Estimate for increasing the compliance threshold to 75%. *SOURCE: CBO 2012b*	85
2.44: Modify the hospital inpatient prospective payment system to include payment for long-term care hospitals	Not available		86

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION TWO: Medicare Payments to Plans and Providers (continued)			
Provider Payments (continued)			
2.45: Modify prospective per diem payments to hospices to reflect variation in service intensity over the course of an episode	Not available	Savings may occur if the entry of for-profit hospices is slowed by the prospect of less profit from extended stays.	86
2.46: Reduce or eliminate special payments to rural hospitals	1) $2 billion over 10 years (2013–2022) 2) $62 billion over 10 years (2012–2021)	1) Estimate for reducing critical access hospital (CAH) reimbursement to 100% of costs and, beginning in 2014, excluding facilities within 10 miles of another hospital from CAH reimbursement; 2) Estimate for entirely eliminating the CAH, Sole Community Hospital, and Medicare-Dependent Hospital programs. *SOURCES: 1) CBO 2012b; 2) CBO 2011d*	87
2.47: Reduce or eliminate payments for Medicare bad debt	$24 billion over 10 years (2013–2022)	Estimate for phasing down reimbursement of bad debt over three years to 25%, beginning in 2013. *SOURCE: CBO 2012b*	88
2.48: Limit Medicare disproportionate share hospital payments to large urban hospitals	Not available	In 2011, about 11% of DSH payments went to rural hospitals or hospitals in urban areas with fewer than 100 beds; applying this proportion to CBO projections of DSH payments suggests potential savings over 10 years of about $13 billion.	89
2.49a: Reduce physician payments in areas with unusually high spending	Not available	In 2008, CBO estimated savings of $5 billion over 10 years (2010–2019) from this option, which would be phased in over five years beginning in 2011. *SOURCE: CBO 2008*	89
2.49b: Reduce hospital payments in areas with a high volume of elective admissions	Not available	In 2008, CBO estimated savings of $3 billion over 10 years (2010–2019) from this option, which would be phased in over five years. *SOURCE: CBO 2008*	90
2.49c: Reduce all Medicare payment rates in high-spending areas	Not available	In 2008, CBO estimated savings of $51 billion over 10 years (2010–2019) from this option, which would be phased in over five years. *SOURCE: CBO 2008*	90
Medical Malpractice			
2.50: Adopt traditional tort reforms at the Federal level	$40 billion to $57 billion over 10 years (2012–2021)	Tort reform would lower costs for health care both by reducing medical malpractice costs and by reducing defensive medical practices; savings are expected to come from reduced spending under Medicare and other government health programs, as well increases in Federal revenues. *SOURCE: CBO 2011a*	96
2.51: Adopt more innovative tort reforms	Not available		98
SECTION THREE: Delivery System Reform and Care for High-Need Beneficiaries			
Delivery System Reform			
3.1: Accelerate implementation of payment reforms authorized under the Affordable Care Act	Not available		104
3.2: Provide real-time information to improve clinical decision-making by physicians and other health professionals under current and reformed payment systems	Not available	There would be administrative costs of performing the analytics and acting on the findings.	106

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION THREE: Delivery System Reform and Care for High-Need Beneficiaries (continued)			
High-Need Beneficiaries			
3.3: Scale up and test care coordination and care management approaches that have demonstrated success in improving care and reducing costs for well-defined categories of high-need beneficiaries in traditional Medicare	Not available		110
3.4: Launch new Medicare pilot programs to test promising care management protocols for beneficiaries living in the community with physical or mental impairments and long-term care needs	Not available		112
3.5: Pay PACE plans like Medicare Advantage plans	Less than $1 billion over five years	Estimate for paying PACE plans using the current law benchmarks for MA plans and allowing PACE plans to qualify for quality-based bonus payments. *SOURCE: MedPAC 2012a*	114
3.6: Require beneficiaries who are dually eligible for Medicare and Medicaid to enroll in comprehensive Medicaid managed care plans	Not available	The Simpson-Bowles commission estimated that this option would save $1 billion in 2015 and $12 billion over six years (2015–2020); savings may be smaller if implemented in conjunction with State demonstrations to improve care coordination for dual eligibles.	117
3.7: Incorporate the capacity to provide high-quality palliative care into Medicare's hospital conditions of participation requirements, and develop and implement quality measures to assess the performance of palliative care for Medicare beneficiaries	Not available		118
3.8: Launch a large-scale pilot to test palliative care as a Medicare benefit	Not available		119
3.9: In conjunction with launching a large-scale pilot testing palliative care as a Medicare benefit, narrow the hospice benefit so that it serves only patients truly at the end-of-life with an identifiable short prognosis	Not available		120
Patient Engagement			
3.10: Increase provider payments for time spent interacting with patients in traditional Medicare and Medicare Advantage	Not available	The option could be designed to be budget neutral within the constraints of total physician fee schedule spending, and could produce savings for both Medicare and beneficiaries to the extent that it helps patients to manage their chronic conditions, avoid complications, and prevent new conditions from arising.	125
3.11: Emphasize patient access and use in Meaningful Use requirements for electronic medical records	Not available		125

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION THREE: Delivery System Reform and Care for High-Need Beneficiaries (continued)			
Patient Engagement (continued)			
3.12: Identify and incorporate measures of patient engagement in patient surveys and in provider and plan payment	Not available		126
3.13: Promote greater involvement of Quality Improvement Organizations (QIOs) in patient engagement strategies	Not available		126
3.14: Increase the use of comparative information within Medicare by improving the quality and promotion of public reports	Not available		127
3.15: Implement more effective and sustained education of the Medicare population about various aspects of the program, including coverage options, using multiple media	Not available		128
3.16: Create a Federal-level Medicare patient and family council; require all hospitals, rehabilitation facilities, hospice agencies, home health agencies, Accountable Care Organizations, medical homes, and Medicare Advantage plans to create such councils	Not available		129
SECTION FOUR: Medicare Program Structure			
Benefit Redesign			
4.1a: Establish a combined deductible, uniform coinsurance rate, and a limit on out-of-pocket spending	$32 billion over 10 years (2012–2021)	Estimate for a $550 deductible, uniform 20% coinsurance rate, and $5,500 spending limit, beginning in 2013. *SOURCE: CBO 2011d*	135
4.1b: Establish a combined deductible, uniform coinsurance rate, and a limit on out-of-pocket spending, along with Medigap reforms	$93 billion over 10 years (2012–2021)	Estimate for the option described under Option 4.1a, along with Medigap restrictions prohibiting coverage of the first $550 of beneficiary cost sharing and limiting coverage to 50% of the next $4,950, beginning in 2013; greater savings under this option relative to Option 4.1a due to expected reductions in use when Medigap enrollees face higher out-of-pocket spending. *SOURCE: CBO 2011d*	137
4.1c: Establish a combined deductible, varying copayments, and a limit on out-of-pocket spending in a way that will not change aggregate beneficiary liabilities, along with a surcharge on supplemental plans	$2.5 billion in 2009	Derived from a MedPAC estimate for an illustrative benefit design including a $500 combined deductible, varying copayments, and a $5,000 spending limit, along with a 20% surcharge on supplemental plan premiums. *SOURCE: MedPAC 2012a*	138
4.2: Provide a new government-administered plan with a comprehensive benefit package as an alternative to traditional Medicare and Medicare Advantage	Not available	This option could be designed to be budget neutral if the premium is set to cover additional costs.	139

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION FOUR: Medicare Program Structure (continued)			
Premium Support			
4.3: Set Federal contributions per beneficiary at the lesser of the second lowest plan bid in a given area or average spending per capita under traditional Medicare	Not available	Medicare savings would vary based on the structure of the premium support system.	146
4.4: Set Federal contributions per beneficiary at the average plan bid in a given area (including traditional Medicare as a plan), weighted by enrollment	$161 billion over 10 years (2010–2019)	Estimate assumes implementation in 2012; produced prior to the enactment of the ACA. *SOURCE: CBO 2008*	147
4.5: Set Federal base year payments equal to average traditional Medicare per capita costs and limit the growth per person to an economic index	Not available	Medicare savings would depend on the index used.	147
SECTION FIVE: Medicare Program Administration			
Spending Caps			
5.1: Reduce the long-term target growth rate for IPAB recommendations from GDP+1% to GDP+0.5%	Not available	CBO has projected that IPAB will not be required to make savings recommendations in the coming decade; lowering the target to GDP+0.5% could mean that IPAB would need to make Medicare savings recommendations sooner.	157
5.2: Introduce a hard cap on Medicare per capita spending growth tied to the GDP per capita growth rate	Not available	A hard budget cap could be calibrated to achieve whatever Federal savings were desired.	158
5.3: Introduce a hard cap on the total Federal health care spending per capita growth rate tied to the GDP per capita growth rate	Not available	A hard budget cap could be calibrated to achieve whatever Federal savings were desired.	159
Coverage Policy			
5.4: Increase the authority of the Centers for Medicare & Medicaid Services (CMS) to expand evidence-based decision-making	Not available		163
5.5: Mandate coverage with evidence development	Not available		163
5.6: Adopt least costly alternative (LCA) and reference pricing for certain covered services	$1 billion over 10 years	Estimate for providing specific statutory authority to adopt LCA for functionally equivalent services; no estimate is available for a more expansive approach. *SOURCE: MedPAC 2011a*	164
5.7: Implement prior authorization as a condition of coverage when appropriate	Not available		166
5.8: Allow CMS to use cost considerations in making coverage determinations	Not available		167

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION FIVE: Medicare Program Administration (continued)			
Governance and Management			
5.9a: Broaden IPAB's authority	Not available		170
5.9b: Change to multi-year targets and savings	Not available		171
5.9c: Repeal or revise the authority of IPAB	$3.1 billion in additional spending over 10 years (2013–2022)	Estimate for repeal of IPAB; CBO does not project that the IPAB process will be triggered over this timeframe, but attached a cost to repeal, based on the probability that its projection is incorrect. *SOURCE: CBO 2012a*	171
5.10: Revise or eliminate the Center for Medicare & Medicaid Innovation (CMMI)	Not available		172
5.11: Provide more independent administration of CMS	Not available		172
5.12: Establish oversight structure for premium support model	Not available		173
5.13: Enhance CMS administrative capacities through contractors	1) $1 billion over 10 years (2010–2019) 2) No budget impact	Estimates for implementing prior authorization for advanced imaging services; no cost estimate is available for contracting for care management. *SOURCES: 1) CBO 2008; 2) CBO 2012b*	174
5.14: Increase CMS resources	Not available	Budget effects could be calibrated to specific levels of increased spending; for example, if Medicare's spending for administration were increased from 1.5% to 2% of program spending, spending would increase by about $2.6 billion.	175
Program Integrity			
5.15a: Disclose additional information on enrollment application	Not available		180
5.15b: Disclose use of high-risk banking arrangements	No budget impact	*SOURCES: CBO 2012b; OMB 2012a*	180
5.16a: Impose civil monetary penalties for failure to update enrollment records	1) No budget impact 2) $90 million over 10 years (2013–2022)	*SOURCES: 1) CBO 2012b; 2) OMB 2012a*	180
5.16b: Require certain providers to re-enroll in Medicare more frequently than every three years	Not available		181
5.16c: Require certain providers to pay an additional enrollment fee	Not available		181
5.17a: Expand the types of providers subject to the surety bond requirement	Not available		181
5.17b: Follow through on surety bond collections	Not available	CMS could have recouped at least $39 million in overpayments from home health agencies over four years if it had implemented the rule requiring that home health providers have $50,000 surety bonds in order to participate in Medicare. *SOURCE: OIG 2012b*	182
5.18: Apply a moratorium on certification of new home health agencies	Not available		182

Option	Federal Savings/ Revenue Estimate	Notes	Page
SECTION FIVE: Medicare Program Administration (continued)			
Program Integrity (continued)			
5.19a: Institute pre-payment review for hospices with a high proportion of patients with long stays	Not available		183
5.19b: Institute pre-payment review on a broader selection of mobility device claims	1) No budget impact 2) $140 million over 10 years (2013–2022)	*SOURCES: 1) CBO 2012b; 2) OMB 2012a*	184
5.19c: Design an electronic medical ordering system	No budget impact	*SOURCES: CBO 2012b; OMB 2012a*	184
5.20a: Institute post-payment review on home health agencies with inordinately high outlier payments	Not available		185
5.20b: Increase post-payment review on payments for chiropractic services	Not available		185
5.21a: Institute intermediate sanctions for home health agencies	Not available		186
5.21b: Impose stronger penalties for theft and use of beneficiaries' Medicare identification numbers	No budget impact	*SOURCES: CBO 2012b; OMB 2012a*	186
5.21c: Exclude those affiliated with sanctioned entities	1) No budget impact 2) $60 million over 10 years (2013–2022)	*SOURCES: 1) CBO 2012b; 2) OMB 2012a*	186
5.22: Establish new quantitative measures for the evaluation of Medicare contractors	Not available		187
5.23a: Improve data sharing among various governmental entities	Not available		188
5.23b: Improve data sharing among public and private entities	Not available		188
5.24: Maximize return on investment by seeking full funding for program integrity activities	Not available		189
5.25: Increase efforts to monitor Medicare Advantage and Part D organizations' identification and reporting of fraud and abuse	Not available		189
5.26: Narrow the in-office ancillary services (IOAS) exception of the Stark self-referral regulation to group practices that assume financial risk	Not available		190

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List of Acronyms Used in This Report

ACA	Affordable Care Act (see also PPACA)
ACE	acute care episode
ACO	accountable care organization
AHRQ	Agency for Healthcare Research and Quality
ALS	amyotrophic lateral sclerosis
ARC	Actuarial Research Corporation
ASC	ambulatory surgical center
ASP	average sales price
AMP	average manufacturer price
ATRA	American Taxpayer Relief Act of 2012
AWP	average wholesale price
BBA	Balanced Budget Act of 1997
CAD	coronary artery disease
CAH	critical access hospitals
CAHPS	Consumer Assessment of Healthcare Providers and Systems (survey)
CBO	Congressional Budget Office
CCA	Commonwealth Care Alliance
C-CPI	chained consumer price index
CEA	cost effectiveness analysis
CED	coverage with evidence development
CHF	congestive heart failure
CHIP	Children’s Health Insurance Program
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COLA	cost of living adjustment
COPD	chronic obstructive pulmonary disease
CPI	consumer price index
CPI-U	consumer price index for urban consumers

CPS	Current Population Survey
CPT	Current Procedural Terminology
CRS	Congressional Research Service
CT	computed tomography
CTA	computed tomography angiography
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DRG	diagnosis related group
DSH	disproportionate share hospital
D-SNP	dual eligible special needs plan
EHR	electronic health record
ESRD	end stage renal disease
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FPL	federal poverty level
FTC	Federal Trade Commission
FY	Fiscal Year
GAO	Government Accountability Office
GDP	gross domestic product
GME	graduate medical education
GRACE	Geriatric Resources for Assessment and Care of Elders
HCFAC	Health Care Fraud and Abuse Control (program)
HEALTH Act	Help Efficient, Accessible, Low-Cost, Timely Healthcare Act
HHA	home health agency
HHS	(Department of) Health and Human Services
HI	Hospital Insurance (trust fund)
HIT	health information technology
HITECH	Health Information Technology for Economic and Clinical Health (Act)
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
HSA	hospital service area
ICU	intensive care unit
IME	indirect medical education

INTERACT	Interventions to Reduce Acute Care Transitions
IOAS	in-office ancillary services
IOM	Institute of Medicine
IPAB	Independent Payment Advisory Board
IRF	inpatient rehabilitation facility
LCA	least costly alternative
LCD	Local Coverage Decision
LIS	Low-Income Subsidy
LTCH	long-term care hospital
LTSS	long term services and supports
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCBS	Medicare Current Beneficiary Survey
MEDCAC	Medicare Evidence Development and Coverage Advisory Committee
MEDIC	Medicare drug integrity contractor
MedPAC	Medicare Payment Advisory Commission
MEI	Medicare Economic Index
MIP	Medicare Integrity Program
MMA	Medicare Modernization Act of 2003
MPRR	multiple procedure payment reduction
MRA	magnetic resonance angiography
MRI	magnetic resonance imaging
MTM	medication therapy management
NASI	National Academy of Social Insurance
NBI MEDIC	National Benefit Integrity Medicare Drug Integrity Contractor
NCD	National Coverage Decision
NCHC	National Coalition on Health Care
NCHS	National Center for Health Statistics
NIH	National Institutes of Health
NSC	National Supplier Clearinghouse
OACT	Office of the (Medicare) Actuary
OIG	(HHS) Office of Inspector General
OMB	Office of Management and Budget

ONC	Office of the National Coordinator (for Health Information Technology)
OPD	outpatient department
OPM	Office of Personnel Management
PACE	Program of All-inclusive Care for the Elderly
PCORI	Patient Centered Outcomes Research Institute
PDP	prescription drug plan
PE	practice expense
PEN	parenteral and enteral nutrition
PET	positron emission tomography
PL	Public Law
PPACA	Patient Protection and Affordable Care Act (see also ACA)
PPO	preferred provider organization
PPS	prospective payment system
QIO	Quality Improvement Organization
RAC	Recovery Audit Contractor
RBRVS	Resource-Based Relative Value Scale
RTI	Research Triangle Institute
RUC	Relative (Value) Update Committee
RVU	relative value unit
SDM	shared decision making
SGR	Sustainable Growth Rate
SMI	Supplementary Medicare Insurance (trust fund)
SNF	skilled nursing facility
SNP	special needs plan
SOW	scope of work
SSDI	Social Security Disability Insurance
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
VBID	value-based insurance design
VBP	value-based purchasing
ZPIC	Zone Program Integrity Contractor