

Harvard Law School  
Briefing Papers on Federal Budget Policy

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*Briefing Paper No. 45*

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**Bending the Health Care  
Cost Curve**

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May 12, 2014

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## TABLE OF CONTENTS

INTRODUCTION .....	5
I. SCOPE, STRUCTURE AND CONSTRAINTS OF THE MAJOR HEALTH CARE PROGRAMS .....	6
A. The federal government increases public access to health care services through Medicare, Medicaid, CHIP and ACA subsidies. Each of these programs has a unique legal and budgetary structure. ....	7
1. Medicare is an open-ended mandatory spending program funded solely by the federal government. ....	7
2. Medicaid is an open-ended, appropriated mandatory spending program funded by the federal government and the states. ....	8
3. CHIP is a closed-ended, appropriated mandatory spending program funded by the federal government and the states. ....	10
4. The ACA authorizes new spending under Medicare, Medicaid and CHIP, and also creates new subsidies for health insurance purchases made on federal exchanges. ...	10
B. Mandatory spending growth is restrained by the Byrd Rule and PAYGO financing. However, these procedural rules are limited in their potential to improve the long-term viability of the major health care programs. ....	11
1. The Byrd Rule prevents mandatory spending bills that increase baseline deficits from passing through reconciliation. ....	11
2. PAYGO financing prevents mandatory spending bills that increase short-term baseline deficits from passing through traditional legislative action. ....	12
C. CASE STUDY: The legislative enactment of the ACA in 2010 exemplifies the manner in which modern mandatory spending reforms interact with the Byrd Rule and PAYGO financing. ....	13
1. Congress may use “sidecar” reconciliation bills to make amendments to substantive legislation affecting mandatory spending programs. These amendments, but not the substantive legislation itself, are susceptible to points of order under the Byrd Rule's mandates of deficit neutrality. ....	13
2. Substantive legislation affecting mandatory spending programs must utilize PAYGO financing. However, CBO scoring of PAYGO legislation often discounts long-term spending levels. ....	15
II. ASSUMPTIONS AFFECTING LONG-TERM HEALTH CARE COST PROJECTIONS.....	17
A. Health care cost growth rates have been gradually decreasing, but federal health care spending continues to increase. It remains unclear what factors are currently driving health care cost growth downward, and how health care costs will behave in the out years following the traditional 10-year budget window. ....	17
1. The CBO uses a variety of legal, economic and actuarial assumptions to develop comprehensive long-term baseline figures. ....	18

<b>B. Future health care cost growth rates substantially alter extended federal baseline spending projections. ....</b>	<b>19</b>
<b>C. There are three primary drivers of long-term federal health care spending: aging insurance populations, excess cost growth and program eligibility expansion. ....</b>	<b>20</b>
1. <i>Aging Insurance Populations</i> .....	20
2. <i>Excess Cost Growth</i> .....	21
3. <i>Program Eligibility Expansion</i> .....	22
4. <i>Observing how these cost drivers vary over time provides policymakers with important targets for legislative intervention. ....</i>	<i>24</i>
<b>D. CASE STUDY: Several of the substantive provisions of the ACA reduce long-term spending associated with aging insurance population, excess cost growth and program eligibility expansion. The effectiveness of these provisions is limited by the ability of agencies and Congress to implement the ACA as-written. ....</b>	<b>24</b>
1. <i>Increased Medicaid Eligibility Criteria</i> .....	25
2. <i>Reductions to the Medicare Sustainable Growth Rate Mechanism</i> .....	25
3. <i>Implementation of the Independent Payment Advisory Board</i> .....	26
4. <i>Closing the Prescription Drug Benefit “Donut Hole”</i> .....	26
5. <i>Cumulative Budgetary Effects</i> .....	27
<b>III. ANALYSIS OF FUTURE PROPOSALS TO BEND THE HEALTH CARE COST CURVE.....</b>	<b>28</b>
<b>A. Three proposals for reducing federal health care spending - increasing the Medicare eligibility age, switching federal insurance from a system of “defined benefits” to a system of “defined contributions,” and restructuring Medicare Part B premiums - are explained below. While these approaches have the potential to improve long-term deficits, it is unlikely that any individual approach, if implemented in isolation, would substantially alter the long-term fiscal trajectory of the major health care programs. ....</b>	<b>28</b>
1. <i>Increasing the Medicare Eligibility Age</i> .....	28
2. <i>Providing Medicare Premium Support</i> .....	31
3. <i>Restructuring Medicare Part B Premiums</i> .....	33
<b>IV. ACCRUAL ACCOUNTING AND LONG-TERM BUDGET SCORING .....</b>	<b>37</b>
<b>A. Accrual accounting more accurately reflects the long-term liabilities of the major health care programs than cash accounting. As a result, accrual accounting methods provide political incentives for reforming the structure of the major health care programs that cash accounting methods do not. ....</b>	<b>37</b>
<b>B. The Long-Term SCORE Act is a recent proposal that aims to portray the long-term costs of new legislation, particularly legislation related to health care, with greater accuracy. ....</b>	<b>39</b>
<b>C. CASE STUDY: The Financial Report of the United States provides Statements of Social Insurance that use modified accrual accounting methods to incorporate</b>	

<b>additional information into budget projections and consolidate the long-term budgetary effects of mandatory spending reforms. ....</b>	<b>41</b>
<b>CONCLUSION .....</b>	<b>42</b>
<b>ILLUSTRATIVE FIGURES .....</b>	<b>43</b>
<b>WORKS CITED .....</b>	<b>50</b>

## BENDING THE HEALTH CARE COST CURVE

### INTRODUCTION

In early March 2014, Congressional Budget Office (“CBO”) Director Douglas Elmendorf addressed an audience gathered in Washington, DC to discuss the budgetary hurdles facing federally-funded social insurance programs.<sup>1</sup> “Fundamental fiscal challenges [face]... the major health care programs,” Elmendorf stated.<sup>2</sup> “We have a choice as a society to either scale back those programs relative to what is promised under current law; to raise tax revenue above its historical average to pay for the expansion of those programs; or to cut back on all other spending even more sharply than we already are. We haven't actually decided as a society what we're going to do, but some combination of those three choices will be needed.”<sup>3</sup>

Health care spending is indeed a large and growing portion of the federal budget.<sup>4</sup> By 2015, the CBO estimates that federal health insurance outlays will overtake Social Security payments as the single largest budgetary expenditure.<sup>5</sup> Over the next ten years, the CBO estimates that gross federal spending for Medicare, Medicaid and other national health care programs will more than double, commanding nearly one quarter of the federal budget.<sup>6</sup> Over the next twenty-five years, the CBO estimates that net federal spending (spending in excess of tax and premium receipts) for those same programs will constitute 8.0% of the entire American

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<sup>1</sup> Interview by Nancy Cook with Douglas Elmendorf, Director, Cong. Budget Office, “Federal Budget and The Economy,” *The Atlantic 2014 Economy Summit*, in Washington, DC (Mar. 18, 2014), *available at* <http://www.c-span.org/video/?318350-2/2014-economy-summit-douglas-elmendorf>.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> See CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: 2014-2024 (2014), *available at* [http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014\\_Feb.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf) [hereinafter BUDGET AND ECONOMIC OUTLOOK].

<sup>5</sup> *Id.* at 16.

<sup>6</sup> *Id.* at 56.

economy.<sup>7</sup> Aging beneficiary populations, rising health care costs and the recent legislative expansion of federal health care coverage all contribute to this increasingly troublesome fiscal trajectory.<sup>8</sup>

While most federal budget experts agree that significant measures need to be taken to “bend the health care cost curve,” they often disagree over how to assess the budgetary impact of such measures. This paper analyzes how competing health policy cost assumptions affect long-term federal budget projections. Part I briefly outlines the scope and structure of the major federal health care programs, Medicare, Medicaid, the Children’s Health Insurance Program (“CHIP”) and the Affordable Care Act (“ACA”), as well as current procedural restrictions on mandatory spending growth. Part II examines the rising share of federal spending devoted to health care and describes how various legal and economic assumptions alter long-term fiscal imbalances. Part III explains how three reform proposals – increasing the Medicare eligibility age, switching federal health insurance coverage from a system of “defined-benefits” to a system of “defined-contributions,” and adjusting Medicare Part B premiums – differ in their approaches to reducing federal health care spending and considers how the budgetary effects of these reform proposals fluctuate beyond the traditional 10-year baseline. Finally, Part IV discusses how accrual accounting and long-term scoring have the potential to provide more accurate estimates of long-term health care liabilities, and how these enhanced estimates may change the nature of political discourse related to the federal budget.

## **I. SCOPE, STRUCTURE AND CONSTRAINTS OF THE MAJOR HEALTH CARE PROGRAMS**

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<sup>7</sup> CONG. BUDGET OFFICE, THE 2013 LONG-TERM BUDGET OUTLOOK 30 (2013), *available at* [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO2013\\_0.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44521-LTBO2013_0.pdf) [hereinafter LONG-TERM BUDGET OUTLOOK].

<sup>8</sup> BUDGET AND ECONOMIC OUTLOOK, *supra* note 4, at 7-8.

**A. The federal government increases public access to health care services through Medicare, Medicaid, CHIP and ACA subsidies. Each of these programs has a unique legal and budgetary structure.**

*1. Medicare is an open-ended mandatory spending program funded solely by the federal government.*

Medicare guarantees a minimum level of health insurance coverage for people over the age of 65, people with long-term disabilities and people with end-stage renal disease.<sup>9</sup> It was enacted in 1965 under Title XVIII of the Social Security Act.<sup>10</sup> Currently, Medicare provides insurance for 52 million Americans.<sup>11</sup> The CBO values gross Medicare spending at \$603 billion, or approximately 3.5% of GDP.<sup>12</sup>

Medicare provides two forms of benefits to enrollees. Hospital Insurance (“HI”), alternatively referred to as Medicare Part A, covers hospital visits, home health, skilled nursing and hospice care for the aged and disabled.<sup>13</sup> Supplemental Medical Insurance (“SMI”), which consists of Medicare Part B and Medicare Part D, covers physician visits, outpatient health care and prescription drugs for the same set of beneficiaries.<sup>14</sup> Medicare Part C allows enrollees to receive Part A and Part B services from private “Medicare Advantage” health plans.<sup>15</sup> Part A expenditures represent approximately 45% of total Medicare costs, while Part B and Part D expenditures represent approximately 41% and 14% of total Medicare costs, respectively.<sup>16</sup>

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<sup>9</sup> Tom Bradley & Julie Topoleski, *An Overview of the Medicare Program*, CONG. BUDGET OFFICE (Sept. 18, 2013), <http://www.cbo.gov/publication/44587> [hereinafter Bradley & Topoleski, *Medicare Overview*].

<sup>10</sup> 42 U.S.C. § 1395.

<sup>11</sup> Bradley & Topoleski, *Medicare Overview*, *supra* note 9.

<sup>12</sup> BUDGET AND ECONOMIC OUTLOOK, *supra* note 4, at 50.

<sup>13</sup> Bradley & Topoleski, *Medicare Overview*, *supra* note 9.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> Patricia Davis, *Medicare: Part B Premiums*, CONG. RESEARCH SERV. 1 (Mar. 12, 2014), <http://www.fas.org/sgp/crs/misc/R40082.pdf> [hereinafter Davis, *Medicare Part B*].

Medicare benefits are financed in various ways. Medicare Part A benefits are financed principally by a payroll tax.<sup>17</sup> The revenues from this tax (2.9% of all taxable earnings, with an additional 0.9% on individual earnings over \$200,000.00) are credited to the HI trust fund.<sup>18</sup> Medicare Part B benefits are financed by a combination of premiums paid by beneficiaries (credited to the SMI trust fund) and revenues from the Treasury's general fund.<sup>19</sup> Premiums cover approximately 25% of total Part B outlays.<sup>20</sup> Medicare Part C benefits are financed proportionately using a "blend of funds from Parts A and B."<sup>21</sup> Finally, Medicare Part D benefits are financed through a combination of premiums paid by beneficiaries and revenues from the Treasury's general fund.<sup>22</sup> Premiums cover approximately 25% of total Part D outlays.<sup>23</sup>

*2. Medicaid is an open-ended, appropriated mandatory spending program funded by the federal government and the states.*

Medicaid is a joint federal-state program that guarantees certain health care services for low-income individuals.<sup>24</sup> It was enacted in 1966 under Title XIX of the Social Security Act.<sup>25</sup> Currently, Medicaid provides health care services for 73 million Americans.<sup>26</sup> The CBO values gross federal Medicaid spending at \$298 billion, or approximately 1.7% of GDP.<sup>27</sup>

States administer their Medicaid programs according to administrative guidelines that specify which health services must be provided to certain categories of enrollees.<sup>28</sup> Required services include inpatient and outpatient hospital visits, physician visits, nursing home care and

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<sup>17</sup> Bradley & Topoleski, *Medicare Overview*, *supra* note 9.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> Jean Hearne & Julie Topoleski, *An Overview of the Medicaid Program*, CONG. BUDGET OFFICE (Sept. 18, 2013), <http://www.cbo.gov/publication/44588> [hereinafter Hearne & Topoleski, *Medicaid Overview*].

<sup>25</sup> 42 U.S.C. § 1396.

<sup>26</sup> Hearne & Topoleski, *Medicaid Overview*, *supra* note 24.

<sup>27</sup> BUDGET AND ECONOMIC OUTLOOK, *supra* note 4, at 50.

<sup>28</sup> Hearne & Topoleski, *Medicaid Overview*, *supra* note 23.



home health care.<sup>29</sup> States may expand eligibility criteria, provide additional benefits or acquire federal waivers<sup>30</sup> to augment their Medicaid programs.<sup>31</sup> By one estimate, expenditures on optional populations and benefits account for approximately 60 percent of total Medicaid spending.<sup>32</sup> Currently, nearly half of Medicaid enrollees are children, nearly one-third are adults and nearly one-quarter are elderly or disabled.<sup>33</sup> Notably, the elderly and disabled account for almost two-thirds of Medicaid outlays.<sup>34</sup>

The share of federal Medicaid spending relative to state Medicaid spending, known as the Federal Medicare Assistance Percentage (“FMAP”), averages approximately 57%.<sup>35</sup> This percentage is adjusted annually and varies with the per capita income of individual states.<sup>36</sup> Beginning in 2014, the federal government will pay 100% of all costs for newly eligible enrollees under the ACA’s Medicaid coverage expansion.<sup>37</sup> Over time, the federal share of expanded ACA Medicaid coverage will decline to 90 percent, where it will remain thereafter.<sup>38</sup> The CBO estimates this will result in an average FMAP of 60% by 2020.<sup>39</sup>

Medicaid, generally, is an open-ended entitlement.<sup>40</sup> There is no upper limit on the amount of absolute dollars states can receive through the program. Still, Medicaid is distinct from Medicare (and other traditional mandatory spending programs) because it is funded through annual appropriations and payments are made directly from the Treasury’s general fund.<sup>41</sup>

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<sup>29</sup> *Id.*

<sup>30</sup> *See, e.g.*, experimental and freedom-of-choice waivers under §§ 1115 and 1915(b) of the Social Security Act.

<sup>31</sup> Medicaid Overview, *supra* note 23.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*

<sup>40</sup> Alison Mitchell, *Medicaid Financing and Expenditures*, CONG. RESEARCH SERV. 2 (July 30, 2012), <http://www.fas.org/sgp/crs/misc/R42640.pdf>.

<sup>41</sup> *Id.* at 4.

Benefit and eligibility criteria account for the majority of Medicaid spending authorization, but Congress retains the ability to place funding restrictions on certain Medicaid services year-to-year.<sup>42</sup> Nevertheless, Congress may not appropriate fewer funds than it has previously obligated itself to pay.<sup>43</sup>

3. *CHIP is a closed-ended, appropriated mandatory spending program funded by the federal government and the states.*

CHIP provides health insurance coverage for children in families with income levels that fall outside Medicaid eligibility requirements.<sup>44</sup> It was passed as part of the Balanced Budget Act of 1997 and is authorized under Title XXI of the Social Security Act. Like Medicaid, CHIP is jointly financed by the federal government and the states.<sup>45</sup> It is administered by the states within broad federal guidelines. Currently, CHIP provides health insurance for more than 8 million children.<sup>46</sup> The CBO values gross federal CHIP spending at \$14 billion.<sup>47</sup>

The CHIP federal matching rate is 70%; a rate considerably higher than the Medicaid FMAP.<sup>48</sup> However, unlike Medicaid, CHIP allotments are capped, meaning that states can exhaust CHIP funds.<sup>49</sup> CHIP payments are made out of the Treasury's general fund.<sup>50</sup>

4. *The ACA authorizes new spending under Medicare, Medicaid and CHIP, and also creates new subsidies for health insurance purchases made on federal exchanges.*

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<sup>42</sup> *Id.*

<sup>43</sup> ALLEN SCHICK, THE FEDERAL BUDGET: POLITICS, POLICY, PROCESS 58 (3d ed. 2007).

<sup>44</sup> BUDGET AND ECONOMIC OUTLOOK, *supra* note 4, at 59.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 60.

<sup>47</sup> *Id.* at 59.

<sup>48</sup> *MACBasics: Federal CHIP Financing*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N 1(2011), <http://www.gpo.gov/fdsys/pkg/GPO-MACPAC-MACBasics-CHIP-2011-09/pdf/GPO-MACPAC-MACBasics-CHIP-2011-09.pdf>.

<sup>49</sup> *Id.*

<sup>50</sup> CTRS. FOR MEDICARE AND MEDICAID SERVICES, CMS ANNUAL FINANCIAL REPORT FISCAL 2013 IV (2013), available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2013\\_CMS\\_Financial\\_Report.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2013_CMS_Financial_Report.pdf) [hereinafter CMS REPORT].

The ACA provides subsidies for individuals and families purchasing health insurance through public exchanges.<sup>51</sup> The CBO estimates that 5 million Americans will receive ACA health insurance subsidies in 2014.<sup>52</sup> The CBO values gross federal ACA spending at \$18 billion.<sup>53</sup>

The ACA also contains a multitude of provisions affecting Medicare, Medicaid and CHIP. These provisions, several of which are discussed *infra*, impact the federal budget by reducing outlays, increasing revenues, refining health care delivery systems and altering benefits.<sup>54</sup> Although it is assumed that these provisions will ultimately improve the fiscal position of the United States, the ACA creates considerable uncertainty for federal health care cost projections.

**B. Mandatory spending growth is constrained by the Byrd Rule and PAYGO financing. However, these procedural rules are limited in their potential to improve the long-term viability of the major health care programs.**

*1. The Byrd Rule prevents mandatory spending bills that increase baseline deficits from passing through reconciliation.*

Mandatory spending obligations are created when Congress passes entitlement legislation that generates open-ended spending authority or authorizes permanent appropriations for specific social programs.<sup>55</sup> Most changes in mandatory spending levels are authorized through reconciliation, a process by which Congress implements budget resolution policies that bring existing revenue, spending and debt-ceiling levels into conformity with legislative targets.<sup>56</sup>

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<sup>51</sup> BUDGET AND ECONOMIC OUTLOOK, *supra* note 4, at 58.

<sup>52</sup> *Id.* at 59.

<sup>53</sup> *Id.*

<sup>54</sup> *See generally*, CMS REPORT, *supra* note 50.

<sup>55</sup> SCHICK, THE FEDERAL BUDGET, *supra* note 43, at 209-11.

<sup>56</sup> *Id.* at 61; *see also* Derek Lindblom, *The Budget Reconciliation Process* (May 11, 2008) (Harvard Law School Federal Budget Policy Briefing Paper No. 35).

The reconciliation process is governed by the Byrd Rule, a procedural safeguard that prohibits the use of reconciliation to increase budget deficits within and beyond the 10-year budget window.<sup>57</sup> The Byrd Rule allows members of Congress to strike individual reconciliation provisions that increase budget deficits “over the six-year or 11-year periods beginning with the current fiscal year” or “for a fiscal year beyond those covered by the reconciliation measure.”<sup>58</sup>

While the Byrd Rule is effective at preventing new legislation from increasing budget deficits, its ability to bend the health care cost curve is limited in two ways. First, it only applies to mandatory spending increases passed through reconciliation. Second, it only applies to new legislative proposals, not existing programs such as Medicare and Medicaid.

*2. PAYGO financing prevents mandatory spending bills that increase short-term baseline deficits from passing through traditional legislative action.*

Underlying all Pay-As-You-Go (“PAYGO”) legislation is the principle of budget neutrality. The Statutory PAYGO of 2010 “requires that all new legislation changing taxes, fees, or mandatory expenditures, taken together, must not increase projected deficits.”<sup>59</sup> This requirement is enforced by the threat of sequestration – automatic, across-the-board cuts to specific mandatory spending programs that occur in the event any new legislation, when taken as a whole, increases the federal deficit.<sup>60</sup>

While statutory PAYGO rules stem spending increases from new legislation, they do not stem increases generated by existing law.<sup>61</sup> PAYGO is analyzed using 5-year and 10-year Office

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<sup>57</sup> See Robert Keith, *The Budget Reconciliation Process: The Senate’s ‘Byrd Rule’*, CONG. RESEARCH SERVICE (Jul. 2, 2010), [http://assets.opencrs.com/rpts/RL30862\\_20100702.pdf](http://assets.opencrs.com/rpts/RL30862_20100702.pdf) [hereinafter *Byrd Rule*].

<sup>58</sup> *Id.* at 5.

<sup>59</sup> *The Statutory Pay-As-You-Go-Act of 2010: A Description*, OFFICE OF MGMT. & BUDGET, [http://www.whitehouse.gov/omb/paygo\\_description](http://www.whitehouse.gov/omb/paygo_description).

<sup>60</sup> *Id.*

<sup>61</sup> SCHICK, *THE FEDERAL BUDGET*, *supra* note 43, at 212.

of Management and Budget (“OMB”) scorecards.<sup>62</sup> Accordingly, PAYGO is only effective at controlling the growth of new mandatory spending costs five to ten years into the future. It is not very effective at controlling mandatory spending growth that occurs over the long-term. This is particularly problematic for health care programs like Medicare, Medicaid and the ACA, all of which contain structural liabilities that increase sharply in budgetary out years.<sup>63</sup>

**C. CASE STUDY: The legislative enactment of the ACA in 2010 exemplifies the manner in which modern mandatory spending reforms interact with the Byrd Rule and PAYGO financing.**

1. *Congress may use “sidecar” reconciliation bills to make amendments to substantive legislation affecting mandatory spending programs. These amendments, but not the substantive legislation itself, are susceptible to points of order under the Byrd Rule’s mandates of deficit neutrality.*

In 2009, at the inception of the 111th Congress, President Barack Obama brought forth a legislative agenda focused on enacting comprehensive health care reform. Congressional leaders debated whether the President’s reform proposals should be pursued through traditional legislative means, or whether the expedited procedures available through reconciliation would provide a more direct path to enactment.<sup>64</sup> In particular, Senate Majority Leader Harry Reid was concerned that Senate reforms were susceptible to a Republican filibuster. Reconciliation would protect against a filibuster, but would also expose new legislation to challenge under the Byrd

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<sup>62</sup> *Id.* at 58.

<sup>63</sup> See LONG-TERM BUDGET OUTLOOK, *supra* note 7.

<sup>64</sup> For additional discussion on the role of Congressional leadership in budget discussions, see David W. Cassaza & Greg Schmidt, *The History of the Congressional Appropriations Process* (May 12, 2014) (Harvard Law School Briefing Paper).

Rule.<sup>65</sup> Reid knew comprehensive health care reform could instead become piecemeal if parliamentary challenges proved successful.

The House and Senate passed separate versions of health care reform later that year, but did not resolve their difference before the end of the legislative session. The House passed H.R. 3962 while the Senate passed H.R. 3590 (another House-passed bill, previously unrelated to health care), both by razor-thin margins.<sup>66</sup>

When Congress reconvened in early 2010, Congressional leaders found an altered political landscape.<sup>67</sup> The Democratic Party no longer had a 60-vote, filibuster-proof majority in the Senate. Thus, the Senate could no longer pass H.R. 3962 and the House could not pass the Senate-amended H.R. 3590 without making significant changes. Democratic leaders resolved this dilemma by passing H.R. 3590 through the House, concurrently passing a “sidecar” reconciliation measure that would amend the bill to the satisfaction of majorities in both Congressional chambers.<sup>68</sup> Only the sidecar measure would be susceptible to the deficit-reduction mandates of the Byrd Rule, and the substance of H.R. 3590 would remain untouched.

To execute this strategy, the House adopted a special rule, H.Res. 1203.<sup>69</sup> Using this rule, the House agreed to the Senate’s amendments to H.R. 3590, clearing the initial health care reform bill for presidential approval.<sup>70</sup> Afterward, the House passed the reconciliation bill. Following its passage through the House, the Senate considered the reconciliation bill, made slight amendments, and returned it to the House for final approval.<sup>71</sup> Again, the House adopted a special rule, H.Res. 1225, “providing for the consideration of a motion for the House to concur in

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<sup>65</sup> See *Byrd Rule*, *supra* note 57, at 20.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.* at 21.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

the Senate’s reconciliation amendments.”<sup>72</sup> The House agreed to the motion, clearing the comprehensive health care reform package for President Obama to sign into law.<sup>73</sup>

*2. Substantive legislation affecting mandatory spending programs must utilize PAYGO financing. However, CBO scoring of PAYGO legislation often discounts long-term spending levels.*

In a series of letters dated from November 6 to December 20, 2009, CBO Director Douglas Elmendorf transmitted his agency’s official valuation of H.R. 3590, inclusive of amendments, to Senate Majority Leader Harry Reid.<sup>74</sup> The valuation, which had been undergone various revisions and adjustments in the weeks leading up to the passage of the ACA, encapsulates many of the major policy assumptions underlying statutory PAYGO scoring.

Overall, the CBO projected \$132 billion in deficit reductions over the traditional 10-year window.<sup>75</sup> These reductions focused strictly on the mandatory spending impact of the ACA, not the impact of the ACA on spending subject to appropriations.<sup>76</sup> The CBO’s score hinged on several important assumptions, including heightened excise and payroll taxes, substantial receipts from employer and individual mandate penalties, 30 million health care exchange enrollees, permanent reductions to annual updates of Medicare and Medicare Advantage payment rates, and reductions in federal health care services recommended by an Independent Payment Advisory Board (“IPAB”) in 2015.<sup>77</sup> While some of these assumptions proved correct,

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<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 22.

<sup>74</sup> *See, e.g.*, Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Nov. 6, 2009); Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Nov. 18, 2009); Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Dec. 19, 2009); Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Dec. 20, 2009).

<sup>75</sup> Of this \$132 billion figure, \$81 billion was classified as “on-budget.” The ACA’s collateral impact on other programs, such as Social Security, was labeled “off-budget.” *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> *See id.*

many others did not.<sup>78</sup> Physician reimbursement reductions scheduled for 2010 have not yet entered into effect,<sup>79</sup> several aspects of Medicaid expansion were struck down by the Supreme Court,<sup>80</sup> employer mandates for certain businesses have been delayed<sup>81</sup> and it remains unclear whether insurance exchange enrollment rates will keep pace with CBO estimates.

The CBO's analysis also reviewed the effects of the legislation beyond the traditional 10-year budget window and tracked the legislation's overall effect on health insurance premiums. The CBO expressed very little confidence in the accuracy of these estimates, evincing a clear flaw in PAYGO's ability to restrain long-term health care costs. In his final letter to Reid, Elmendorf noted, with particularity:

“A detailed year-by-year projection for years beyond 2019, like those that CBO prepares for the 10-year budget window, would not be meaningful because the uncertainties involved are simply too great (...) These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation (...) The legislation would maintain and put into effect a number of procedures that might be difficult to sustain over a long period of time (...)”<sup>82</sup> It is unclear whether [a sustainable reduction in long-term health care cost] growth rate[s] could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or would reduce access to care or diminish the quality of care. *The long-term*

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<sup>78</sup> See *CBO Revises Projections Related to ACA and Health Care Spending*, CAL. HEALTHLINE (May 15, 2013), <http://www.californiahealthline.org/articles/2013/5/15/cbo-revises-projections-related-to-aca-and-health-care-spending>.

<sup>79</sup> See Stephanie Condon, *Senate Passes Medicare 'Doc Fix' at Last Minute*, CBS NEWS (Mar. 31, 2014), <http://www.cbsnews.com/news/senate-passes-medicare-doc-fix-at-last-minute/?elq=12cca39c6d074c579216ae220d02afbd&elqCampaignId=>.

<sup>80</sup> See CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION (2012), *available at* <http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

<sup>81</sup> See *Obamacare Employer Mandate is Delayed for Some Companies*, ASSOCIATED PRESS (Feb. 10, 2014), [http://www.huffingtonpost.com/2014/02/10/obamacare-mandate-delay\\_n\\_4762460.html](http://www.huffingtonpost.com/2014/02/10/obamacare-mandate-delay_n_4762460.html).

<sup>82</sup> Elmendorf specifically notes Medicare reimbursement rates being reduced by 21% in 2010 and the Independent Payment Advisory Board contributing to a 50% reduction in Medicare spending growth per beneficiary. Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Dec. 20, 2009).



*budgetary impact could be quite different if key provisions of the legislation were ultimately changed or not fully implemented.”<sup>83</sup>*

It is worth noting, too, that the CBO also discovered several intergovernmental and private-sector mandates as defined under the Unfunded Mandates Reform Act (UMRA). Although undisclosed, the total costs of those mandates were said to “greatly exceed the thresholds established in [the] UMRA.”<sup>84</sup> Thus, the CBO’s initial score suggests not only a reduction in health care costs, but also a shift in obligations from the federal government to state governments and the private sector.

## **II. ASSUMPTIONS AFFECTING LONG-TERM HEALTH CARE COST PROJECTIONS**

### **A. Health care cost growth rates have been gradually decreasing, but federal health care spending continues to increase. It remains unclear what factors are currently driving health care cost growth downward, and how health care costs will behave in the out years following the traditional 10-year budget window.**

With health care price inflation at its lowest rate in 50 years, per capita health care spending growth is the lowest on record.<sup>85</sup> This slow growth has dramatically improved federal health care cost projections within the traditional 10-year budget window.<sup>86</sup> And yet, federal spending for Medicare, Medicaid, CHIP and ACA subsidies continues to consume a larger and larger share of the economy. These health care programs are responsible for nearly three quarters of mandatory spending increases projected over the next 25 years and beyond.<sup>87</sup> The CBO

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<sup>83</sup> As of March 26, 2014, the ACA had experienced 38 delays. *See Obamacare Delay Number 38*, WALL ST. J. (Mar. 26, 2014), <http://online.wsj.com/news/articles/SB10001424052702303325204579463493933733888>.

<sup>84</sup> Letter from Douglas Elmendorf, Director, Cong. Budget Office, to Sen. Harry Reid (Dec. 19, 2009).

<sup>85</sup> *See* OFFICE OF MGMT. & BUDGET, TRENDS IN HEALTH CARE COST GROWTH AND THE ROLE OF THE AFFORDABLE CARE ACT 1 (2013), *available at* [http://www.whitehouse.gov/sites/default/files/docs/healthcostreport\\_final\\_noembargo\\_v2.pdf](http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf).

<sup>86</sup> *Id.*

<sup>87</sup> *See* LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 24.

projects that net federal spending for the major health care programs will constitute approximately 8% of GDP in 2038, 10% of GDP in 2050 and 14% of GDP in 2088.<sup>88</sup>

*1. The CBO uses a variety of legal, economic and actuarial assumptions to develop comprehensive long-term baseline figures.*

Health care cost projections rely on a variety of legal, economic and actuarial assumptions. Legal assumptions include legislative enactments and judicial opinions that expand or contract the scope of federal health care coverage. Economic assumptions include population, price, inflation, and interest rate changes that affect the cost of individual health care services. Actuarial assumptions include demographic shifts and mortality and fertility rate changes that alter the size and duration of current mandatory spending commitments. Naturally, as projections extend outward into the future, they become less certain. Large-scale fluctuations in the business cycle, disruptive technological advancements and unforeseeable changes to current law have the potential to radically alter even the most carefully constructed budget estimates.

The CBO compensates for long-term budgetary uncertainty by publishing a variety of baseline cost figures.<sup>89</sup> The first figure is the traditional 10-year baseline. This figure tends to dominate most budget discussions because of its high degree of political salience. The 10-year baseline is used not only for PAYGO and Byrd Rule assessments, but also for measuring the budgetary effects of most mandatory spending reforms. The second figure is the extended baseline. This figure examines health care cost growth 25, 50 and 75 years into the future. The extended baseline incorporates large structural shifts in Medicare, Medicaid, CHIP and ACA enrollments into its cost projections. Both the 10-year and extended baseline projections rely on the assumption that federal laws will remain essentially unchanged. Additionally, these

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<sup>88</sup> *Id.* at 114.

<sup>89</sup> *Id.* at 2.

projections are static – that is, they do not incorporate any “feedback” from fiscal policy to the economy. Instead, they rely on pre-determined economic benchmarks to project constant rates of interest, inflation, debt and GDP growth.<sup>90</sup>

If future tax and spending laws were to differ substantially from their present form, budget outcomes would differ substantially as well. For this reason, the CBO publishes an alternative set of fiscal projections that use routine policy amendments and dynamic scoring to help lawmakers understand the possible scope of disagreement between present and future budgetary trends.<sup>91</sup> Under one set of alternative projections, the extended alternative fiscal scenario, the CBO holds constant certain policies that are scheduled to change under current law, but unlikely to actually do so. One example of a policy held constant under the extended alternative fiscal scenario is the so-called “doc fix,” which prevents Medicare reimbursement rates from being reduced over time. Under another set of alternative projections, the 10-year deficit-reduction scenario, the CBO inserts hypothetical deficit reductions to current law. Perhaps not surprisingly, the growth trajectory of the extended alternative fiscal scenario is often much higher than the 10-year, extended baseline and deficit-reduction figures.

**B. Future health care cost growth rates substantially alter extended federal baseline spending projections.**

The CBO does not provide disaggregated health care program cost projections under each of its various baseline figures. However, the CBO does explain how various rates of health care cost growth affect long-term federal spending. Between 2013 and 2038, Medicare spending per beneficiary is projected to grow at an average annual rate of 4.3 percent, and Medicaid spending

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<sup>90</sup> See CONG. BUDGET OFFICE, THE 2013 LONG-TERM BUDGET OUTLOOK: DATA UNDERLYING THE FIGURES (2013), available at [www.cbo.gov/sites/default/files/cbofiles/attachments/DataUnderlyingFigures\\_1\\_REV0227.xls](http://www.cbo.gov/sites/default/files/cbofiles/attachments/DataUnderlyingFigures_1_REV0227.xls).

<sup>91</sup> See LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 75-77.

per beneficiary is projected to grow at an average annual rate of 4.7 percent.<sup>92</sup> Because spending for these programs is so large, even small changes in growth rates can yield large changes in budget deficits. If Medicare and Medicaid spending per beneficiary grew 0.5 percentage points per year more slowly, federal health care spending in 2038 would be 10 percent lower and federal debt held by the public would be 14 percent lower than the extended baseline.<sup>93</sup> Conversely, if Medicare and Medicaid spending per beneficiary grew 0.5 percentage points per year more rapidly, federal health care spending in 2038 would be 11 percent higher and federal debt held by the public would be 15 percent higher than the extended baseline.<sup>94</sup>

**C. There are three primary drivers of long-term federal health care spending: aging insurance populations, excess cost growth and program eligibility expansion.**

*1. Aging Insurance Populations*

As the baby boom generation becomes eligible to receive federal health insurance, Medicare will pay considerably more in benefits than it receives through taxes and premiums. The total number of Medicare beneficiaries is expected to increase by one-third over the next ten years and double over the next fifty.<sup>95</sup> While the average age of Medicare beneficiaries will temporarily decrease over the next ten years due to a large influx of 65-year-olds, it will increase significantly after 2025.<sup>96</sup> Older beneficiaries naturally require more physician visits, specialist services and prescription medications than their younger counterparts, placing upward pressure on health care expenditures in the out years.<sup>97</sup> This pressure is compounded by the fact that current beneficiaries have significantly longer life expectancies than the beneficiaries Medicare

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<sup>92</sup> *Id.* at 98.

<sup>93</sup> 96% of GDP, as opposed to 108% of GDP. *Id.*

<sup>94</sup> 123% of GDP, as opposed to 108% of GDP. *Id.* at 99.

<sup>95</sup> CMS REPORT, *supra* note 50, at 209.

<sup>96</sup> *Id.* at 137.

<sup>97</sup> LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 99.

was initially designed to assist.<sup>98</sup> Furthermore, health care spending is severely back-loaded, with approximately 50% of individual Medicare outlays occurring post-retirement<sup>99</sup> and 25% occurring in the last year of life.<sup>100</sup>

## 2. *Excess Cost Growth*

Excess cost growth refers to the growth in health care spending per person relative to the growth of GDP per person after controlling for demographic changes.<sup>101</sup> It is measured by calculating an annual underlying rate, as well as a multi-year weighted average. Since 1985, per capita health care spending growth has outpaced per capita GDP growth by a weighted average of 1.5% per year.<sup>102</sup> This differential is generally attributed to changes in medical technology, consumer demand and insurance reimbursement percentages.<sup>103</sup>

Excess cost growth has the capacity to dramatically increase long-term health care costs. In 2007, it was estimated that excess cost growth could be responsible for up to 90% of long-term Medicare and Medicaid spending inflation.<sup>104</sup> Although excess cost growth has slowed in recent years (a phenomenon budget analysts have struggled to explain<sup>105</sup>), it is unclear how long

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<sup>98</sup> S. Jay Olshansky, Dana P. Goldman, Yuhui Zheng & John W. Rowe, *Aging in America in the Twenty-first Century: Demographic Forecasts from the MacArthur Foundation Research Network on an Aging Society*, 87 THE MILBANK Q. 842, 842-62 (2009), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2009.00581.x/full>.

<sup>99</sup> Berhanu Alemayehu & Kenneth E. Warner, *The Lifetime Distribution of Health Care Costs*, 39 HEALTH SERV. RES. 627, 627-42 (2004), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361028>.

<sup>100</sup> Christopher Hogan, June Lunney, Jon Gabel & Joanne Lynn, *Medicare Beneficiaries' Costs Of Care In The Last Year Of Life*, 20 HEALTH AFFAIRS 188, 188-95 (2001), available at <http://content.healthaffairs.org/content/20/4/188.full>.

<sup>101</sup> LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 37.

<sup>102</sup> *Id.* at 38.

<sup>103</sup> *Id.*

<sup>104</sup> See CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 14 (2007), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8758/11-13-lt-health.pdf> [hereinafter CBO 2007].

<sup>105</sup> See, e.g., Jason Furman, *New Report from the Council of Economic Advisers: The Recent Slowdown in Health Care Cost Growth and the Role of the Affordable Care Act*, WHITE HOUSE COUNCIL OF ECON. ADVISORS (Nov. 20, 2013), <http://www.whitehouse.gov/blog/2013/11/20/new-report-council-economic-advisers-recent-slowdown-health-care-cost-growth-and-rol>; David M. Cutler and Nikhil R. Sahni, *If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off by \$770 Billion*, 32 HEALTH AFFAIRS 841, 841-50 (2013), available at <http://dx.doi.org/10.1377/hlthaff.2012.0289>; Alexander J. Ryu et.al., *The Slowdown in Health Care Spending in*

this trend will continue. A significant spike in excess cost growth could dramatically alter long-term CBO baseline projections, which currently assume a steady decline.

The major health care programs experience various levels of excess cost growth. For example, because state governments and private sector insurance providers have more flexibility to respond to rising health care cost pressures than does the federal government, the CBO expects excess cost growth to slow more in Medicaid than Medicare. Overall, the CBO expects excess cost growth for Medicare to hover around 0.3% during the 10-year window and increase to 1.4% at the end of the decade.<sup>106</sup> Meanwhile, the CBO expects excess cost growth for Medicaid to remain steady at 1.5%.<sup>107</sup> Ultimately, the CBO expects the current excess cost growth rate weighted average of 1.5% will decline to a 0% underlying rate for Medicaid and a 1% underlying rate for Medicare in 2088.<sup>108</sup>

### 3. *Program Eligibility Expansion*

The Affordable Care Act made significant changes to the nature and scope of federal health care coverage. In April 2014, after the resolution of several key issues related to the law's implementation, the CBO released updated estimates on the budgetary impact of the ACA.<sup>109</sup> These estimates took into consideration all judicial and administrative actions taken before March 2014. Although the CBO's ability to analyze these elements has significantly improved over time, ACA cost projections continue to hinge on several major legal and economic assumptions. These assumptions – which range in substance from the law's enrollment figures to its ability to withstand full legislative repeal – remain difficult to forecast.

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2009–11 Reflected Factors Other Than the Weak Economy and Thus May Persist, 32 HEALTH AFFAIRS 835, 835–40 (2013), available at <http://dx.doi.org/10.1377/hlthaff.2012.1297>.

<sup>106</sup> LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 40.

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* at 41.

<sup>109</sup> See CONG. BUDGET OFFICE, UPDATED ESTIMATES OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT (2014), available at [http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA\\_Estimates.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

The elements of the ACA that most significantly affect federal health care spending are the new subsidized insurance exchanges and state Medicaid and CHIP expansion. The CBO estimates that these provisions will have a net cost to the federal government of more than \$1.38 trillion during ten-year budget window – the result of \$1.84 trillion in added costs and \$456 billion in added revenues.<sup>110</sup> This estimate reflects a \$104 billion dollar downward revision from estimates provided in March 2014.<sup>111</sup> Annual net costs are projected to rise sharply until 2018, and rise by more modest amounts thereafter.

During the period from 2017 through 2024, the CBO forecasts dramatic shifts in the composition of major health care programs. Approximately 24 million people are expected to purchase insurance through state and federal exchanges, more than 13 million people are expected to be added to Medicaid and CHIP and more than 7 million fewer people will obtain insurance through their employer.<sup>112</sup> In total, it is expected that more than 25 million people will gain some form of health insurance.

The CBO forecasts that the ACA will become more expensive in the years following the current 10-year budget window. “As time passes,” the CBO writes, “projected costs over the subsequent 10 years have risen, because (...) each time a year goes by, a less expensive early year is replaced by a more expensive later year in the 10-year period covered by the estimates.”<sup>113</sup> While the highest rates of growth occur in the first five years of the CBO’s 10-year estimate, the highest absolute levels of spending occur in the succeeding five years.<sup>114</sup>

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<sup>110</sup> *Id.*

<sup>111</sup> See Jessica Banthin & Sarah Masi, *Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act*, CONG. BUDGET OFFICE (Mar. 4, 2014), <http://www.cbo.gov/publication/45159>.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> See *id.*; see also CONG. BUDGET OFFICE, *UPDATED ESTIMATES*, *supra* note 108, at 2.

4. *Observing how these cost drivers vary over time provides policymakers with important targets for legislative intervention.*

The CBO provides an estimate of the percent of growth in federal spending as a share of GDP for which each driver – aging, excess cost growth and eligibility expansion – is independently responsible. Observing how these estimates differ between the traditional 10-year budget window and the extended baseline reveals important information about future health care cost trends. By 2023, aging will account for 21% of the growth in federal spending related to health care as a share of GDP, excess cost growth will account for 26%, and Medicaid expansion and exchange subsidies will account for 53%.<sup>115</sup> By 2038, however, aging will account for 35% of the growth in federal spending related to health care as a share of GDP, excess cost growth will account for 40%, and Medicaid expansion and exchange subsidies will account for 26%.<sup>116</sup> These numbers suggest that expanding access to health care services through Medicaid and exchange subsidies greatly increases federal health care spending in the near-term, but bends them downward over time. Meanwhile, the true impact of baby boom retirement populations is not fully accounted for in the 10-year budget window. Excess cost growth, because of its historical size and volatility, is anticipated to account for a much greater percentage of health care cost growth than it currently does. It can be assumed that the most effective proposals for bending the health care cost curve will prioritize and address these cost drivers in accordance with their long-term significance.

**D. CASE STUDY: Several of the substantive provisions of the ACA reduce long-term spending associated with aging federal insurance population, excess cost growth and**

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<sup>115</sup> LONG-TERM BUDGET OUTLOOK, *supra* note 7, at 25.

<sup>116</sup> *Id.*



**program eligibility expansion. The effectiveness of these provisions is limited by the ability of administrative agencies and Congress to implement the ACA as-written.**

### *1. Increased Medicaid Eligibility Criteria*

The ACA extends Medicaid eligibility to most individuals earning between 100% and 138% of the Federal Poverty Level (“FPL”).<sup>117</sup> Increasing the amount of people receiving Medicaid increases the share of health care costs assumed by the government, but potentially bends the health care cost curve downward in two ways. First, increasing Medicaid eligibility allows low-income individuals to receive relatively inexpensive preventative health care services that forestall costly pharmaceutical and surgical treatments for diseases that would otherwise go unaddressed.<sup>118</sup> Second, increasing Medicaid eligibility creates even larger economies of scale for the most common health services.<sup>119</sup>

### *2. Reductions to the Medicare Sustainable Growth Rate Mechanism*

Reducing payments for physicians’ services by curtailing the Sustainable Growth Rate (“SGR”) mechanism is among the most obvious (yet, politically difficult) ways to reduce federal health care costs. The SGR was enacted under the Balanced Budget Act in 1997 to update yearly Medicare physician reimbursements. Under the SGR, physician spending in excess of GDP growth in any given year results in a proportional and automatic cut to Medicare physician reimbursements the following year. Under the ACA, these payment rates were scheduled to be reduced by 25% in January 2014 and by smaller amounts in subsequent years. When scoring the ACA, the CBO noted, “In recent years, legislation has been enacted to block similar reductions

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<sup>117</sup> *Medicare Eligibility*, CTR. FOR MEDICAID AND CHIP SERVICES, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (last visited May 11, 2014).

<sup>118</sup> See Alex Wayne, *Health Care Economies of Scale*, BLOOMBERG BUSINESSWEEK (Mar. 22, 2012), <http://www.businessweek.com/articles/2012-03-22/health-care-economies-of-scale#p1>.

<sup>119</sup> *Id.*

that were scheduled to occur.” And indeed, the famed “doc fix,” which prevents statutorily-mandated cuts to Medicare physician reimbursements adjustments from taking effect, was passed with bipartisan support once again in 2014.<sup>120</sup>

### 3. *Implementation of the Independent Payment Advisory Board*

The ACA’s Independent Payment Advisory Board (“IPAB”) is aimed squarely at the problem of excess cost growth. The IPAB is authorized to recommend Medicare spending cuts when spending per beneficiary substantially exceeds the growth of other consumer goods and services, measured using the Consumer Price Index.<sup>121</sup> Like SGR reductions, IPAB recommendations will be difficult to implement politically, and it remains to be seen whether and how they will ultimately take effect. The ACA itself places a number of limitations on the actions available to the IPAB, including a prohibition against modifying Medicare’s eligibility rules or reducing benefits.

### 4. *Closing the Prescription Drug Benefit “Donut Hole”*

The ACA sets a target of completely closing the Medicare Part D “donut hole” by 2020.<sup>122</sup> The donut hole is a gap in prescription drug coverage wherein Medicare recipients become responsible for paying the full cost of their medicine. This coverage gap, which currently exists somewhere between \$2,930 and \$4,700, affects an estimated 3.8 million seniors annually.<sup>123</sup> Closing the donut hole increases the amount overall the government spends on prescription drugs, but gradually bends the health care cost curve downward by ensuring that

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<sup>120</sup> See Condon, *Last Minute*, *supra* note 78.

<sup>121</sup> See Sarah Kliff, *As Health-Care Costs Slow, IPAB’s Launch is Delayed*, WASH. POST WONKBLOG (May 13, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/03/as-health-care-costs-slow-ipabs-launch-is-delayed/>.

<sup>122</sup> Jonathan Blum, *What is the Donut Hole?*, THE MEDICARE BLOG (Aug. 9, 2010), <http://blog.medicare.gov/2010/08/09/what-is-the-donut%C2%A0hole>.

<sup>123</sup> *Id.*

aging Medicare beneficiaries continue to take their necessary medications, reducing the incidence and progression of costly diseases.

### 5. *Cumulative Budgetary Effects*

Taken together, the ACA provisions described have the potential to significantly improve the long-term fiscal trajectory of the major federal health care programs.<sup>124</sup> In 2010, the Centers for Medicare & Medicaid Services (“CMS”) Annual Trustees Report (“Report”) provided an in-depth analysis of the effects of the ACA on long-term health care costs. Comparing the estimated 75-year open-group unfunded obligations for HI and SMI before the passage of the ACA (using figures provided in the 2009 Report) and after (using figures provided in the 2010 Report) reveals more than \$15 trillion in current-dollar savings. In 2009, the 75-year unfunded liability of HI was \$13.8 trillion and the 75-year unfunded liability of SMI was \$24.3 trillion (a combined \$38.1 trillion deficit).<sup>125</sup> In 2010, after incorporating increases in Medicaid eligibility, reductions in the Medicare SGR, the implementation of IPAB spending cuts, amendments to the Medicare Part D prescription drug benefit and many other ACA provisions into CMS projections, the 75-year unfunded liability of HI fell to \$2.7 trillion and the 75-year unfunded liability of SMI fell to \$20.1 trillion (a combined \$22.8 trillion deficit).<sup>126</sup>

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<sup>124</sup> Additional ACA provisions not analyzed in this briefing paper, but relevant to the long-term effects of federal health care costs include: new research into payment and service delivery models, such as Accountable Care Organizations (“ACOs”), new funds devoted to medical research and development, patient-centered “medical homes,” improvements in care coordination for individuals with multiple chronic health conditions, payment bundling, “pay for performance” initiatives, and programs providing preventative care and assistance for individuals looking to make more informed health choices.

<sup>125</sup> CTS. FOR MEDICARE & MEDICAID SERVICES, 2009 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 201 (2009), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2009.pdf>.

<sup>126</sup> CTS. FOR MEDICARE & MEDICAID SERVICES, 2010 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 210-43 (2010), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2010.pdf> [hereinafter TRUSTEES REPORT 2010].

The estimated cost savings of the ACA have endured in more recent CMS Reports, although they have been gradually reduced as various delays and alterations have taken effect. The 2013 Report estimates the 75-year unfunded liability of HI at \$4.8 trillion and the 75-year unfunded liability of SMI at \$22.5 trillion (a combined \$27.3 trillion deficit), reflecting more than \$10 trillion in long-term spending reductions when compared with the 2009 Report.<sup>127</sup> The reduction of ACA cost savings over time reflects not only the uncertainty inherent in all prospective accounting models, but also the importance (and difficulty) of implementing mandatory spending reforms as-written. The CMS accrual accounting of HI and SMI obligations allows budget analysts and policymakers to visualize how deviations from enacted law affect the current fiscal health of the United States. If lawmakers continue to override statutory decreases in Medicare, Medicaid and CHIP spending, actuarial deficits could worsen significantly.

### **III. ANALYSIS OF FUTURE PROPOSALS TO BEND THE HEALTH CARE COST CURVE**

**A. Three proposals for reducing federal health care spending – increasing the Medicare eligibility age, switching federal insurance from a system of “defined benefits” to a system of “defined contributions,” and restructuring Medicare Part B premiums – are explained below. While these approaches have the potential to improve long-term deficits, it is unlikely that any individual approach, if implemented in isolation, would substantially alter the long-term fiscal trajectory of the major health care programs.**

#### *1. Increasing the Medicare Eligibility Age*

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<sup>127</sup> CTS. FOR MEDICARE & MEDICAID SERVICES, 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 227 (2013), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/tr2013.pdf> [hereinafter TRUSTEES REPORT 2013].

One of the most common proposals for reducing federal health care spending is increasing the Medicare eligibility age. The budgetary effects of this proposal are straightforward and intuitive. Increasing the Medicare eligibility age lowers health care spending by reducing the amount of years the federal government is responsible for providing health insurance to each enrollee. This is one approach to counter the budget growth stemming from the increased life expectancy of Medicare beneficiaries.

The CBO recently analyzed a plan to increase the Medicare eligibility age from 65 to 67.<sup>128</sup> The plan phases in gradually, increasing eligibility by two months every year until peaking at 67.<sup>129</sup> This sequential approach gives near-term recipients adequate notice of statutory changes and allows them to make individual coverage adjustments as necessary. Implementing such a plan in 2016 would reduce federal budget deficits by an estimated \$19 billion over the current 10-year budget window.<sup>130</sup> This reduction represents the net effect of a \$23 billion decrease in outlays and a \$4 billion decrease in revenues from 2016 to 2024.<sup>131</sup> Looking past the 10-year budget window through 2038, the CBO estimates that increasing the eligibility age by two years would decrease Medicare spending by 3% when compared with current law.<sup>132</sup>

Like most other projections, the exact budgetary effects of increasing the Medicare eligibility age are highly uncertain. In recent years, the CBO has dramatically reduced the amount of money it expects to save from increasing the Medicare eligibility age. In a report published in January 2012, the CBO estimated that such a change in policy would result in

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<sup>128</sup> See CONG. BUDGET OFFICE, RAISING THE AGE OF ELIGIBILITY FOR MEDICARE TO 67: AN UPDATED ESTIMATE OF THE BUDGETARY EFFECTS (2013), *available at* <http://www.cbo.gov/sites/default/files/cbofiles/attachments/44661-EligibilityAgeforMedicare.pdf>.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* at 2.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.* at 3.

budgetary savings of \$113 billion over the 10-year budget window.<sup>133</sup> The current, lower estimate reflects the latest economic insights related to new Medicare beneficiaries. The 55- to 65-year-old beneficiaries who would be most affected by an increase in the Medicare eligibility age are among the least expensive Medicare beneficiaries. As such, they do not contribute substantially to federal health care cost growth. New Medicare beneficiaries to be in much better health than beneficiaries already enrolled in Medicare upon turning 65, either due to disability or end-stage renal disease. Further, many 65- and 66-year-old beneficiaries are workers (or the spouses of workers) who receive employment-based health insurance. For most of these beneficiaries, employment-based health insurance is their primary source of coverage, and Medicare is a secondary payer. Thus, Medicare payments are limited to only the cost-sharing obligations that beneficiaries face under employment-based health plans. As a result of these insights, CBO's current estimate of the net costs to Medicare of 55- to 65-year-old beneficiaries under current law is approximately 60 percent lower than its previous estimates.<sup>134</sup>

One factor complicating current CBO projections is the effect increasing the Medicare eligibility age has on other federal programs. For example, many seniors already qualify for Medicare before the age of 65 due to disability and other conditions. Even seniors who do not qualify for Medicare might enroll in Medicaid or receive federal insurance subsidies through ACA exchanges. Although the federal share of Medicaid and ACA insurance costs is lower than the federal share of Medicare costs, temporarily redirecting Medicare recipients to alternate forms of federal health coverage is unlikely to result in significant cost savings. Overall, the CBO projects that roughly two-thirds of the long-term savings realized from eligibility age increases would be offset by increases in federal spending for Medicaid and exchange subsidies.

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<sup>133</sup> *Id.* at 4.

<sup>134</sup> *Id.* at 5.

The CBO’s analysis also found a related decrease in outlays for Social Security retirement benefits when the Medicare eligibility age was increased. The CBO theorized that many people apply for Social Security at the same time they apply for Medicare. These people might postpone their retirement to maintain their employer-based health insurance until they become eligible for Medicare.

## *2. Providing Medicare Premium Support*

“Premium support” is an oft-discussed proposal for controlling federal health care spending. In effect, premium support changes federal health insurance coverage from a system of “defined benefits” to a system of “defined contributions.” Under the current system of defined benefits, Medicare promises to provide beneficiaries with standard fee-for-service health insurance coverage. Under a system of defined contributions, Medicare would provide beneficiaries with credit towards a private health insurance plan. Premium support allows Medicare to cap future expenditures without eliminating coverage for any single category of beneficiaries. In fact, many premium support models include a traditional Medicare fee-for-service plan that competes locally with private insurers.

The CBO recently conducted an analysis of various premium support models and concluded that a system of defined contributions would reduce federal health care costs and improve the long-term viability of Medicare.<sup>135</sup> Furthermore, the CBO found that private health care plans supplemented with federal contributions could provide superior coverage at lower cost to individual beneficiaries.

In its analysis, the CBO modeled two illustrative premium support options and compared spending estimates to future Medicare cost projections under current law. Under both models,

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<sup>135</sup> See CONG. BUDGET OFFICE, A PREMIUM SUPPORT SYSTEM FOR MEDICARE: ANALYSIS OF ILLUSTRATIVE OPTIONS (2013), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-18-PremiumSupport.pdf> (hereinafter PREMIUM SUPPORT).

the CBO assumed a starting date for implementation of 2018. The first option, which based the federal contribution on the average bid of competing private health plans, reduced net Medicare spending by \$15 billion two years after implementation.<sup>136</sup> The second option, which based the federal contribution on the second-lowest bid of competing private health plans, reduced net Medicare spending by \$45 billion over the same timeframe.<sup>137</sup> Over the 10-year budget window, maintaining a starting date for implementation of 2018, the average bid option would reduce net federal health care spending by \$69 billion and the second-lowest bid option would reduce net federal health care by \$275 billion.<sup>138</sup> Although the CBO did not conduct a long-term analysis that tracked cost savings into the out years, its report states generally that “the percentage savings from either illustrative option would remain roughly constant for about a decade (...) At that point, heightened price competition would probably reduce the growth of Medicare spending over the long term relative to that under current law, and that effect would probably be larger under the second-lowest bid option than under the average-bid option.”<sup>139</sup> A long-term CBO analysis of a premium support proposal advanced by Budget Chairman Paul Ryan in 2011 suggests mandatory health care spending would fall from its current trajectory of 8% of GDP in 2038 to 6% through 2040 and 5% through 2050.<sup>140</sup>

Some commentators believe that cost savings under premium support plans will be even more pronounced than CBO estimates. These commentators draw attention to the fact that current Medicare fee-for-service estimates are artificially suppressed by Medicare

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<sup>136</sup> *Id.* at 2.

<sup>137</sup> *Id.*

<sup>138</sup> See Robert E. Moffit & Rea S. Hederman, Jr., *CBO Confirms: Medicare Premium Support Means Savings for Taxpayers and Seniors*, THE HERITAGE FOUND. (Feb. 3, 2014), [http://www.heritage.org/research/reports/2014/02/cbo-confirms-medicare-premium-support-means-savings-for-taxpayers-and-seniors#\\_ftn4](http://www.heritage.org/research/reports/2014/02/cbo-confirms-medicare-premium-support-means-savings-for-taxpayers-and-seniors#_ftn4).

<sup>139</sup> PREMIUM SUPPORT, *supra* note 134, at 19.

<sup>140</sup> CONG. BUDGET OFFICE, LONG-TERM ANALYSIS OF A BUDGET PROPOSAL BY CHAIRMAN RYAN 2 (2011), available at [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan\\_letter.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf).



reimbursement rate cuts that are unlikely to ever take effect due to the “doc fix.”<sup>141</sup> They also maintain that increasing market competition among private and public insurance plans will naturally drive prices lower in all sectors of the health care industry.<sup>142</sup>

One significant drawback of premium support plans is the fact that exempting baby boomers or “grandfathering” near-term retirees would substantially reduce federal cost savings. If baby boomers were exempted from the premium support plans described above, savings would be reduced by as much as 85%.<sup>143</sup> For example, under the second-lowest bid option, the federal government could expect to save only \$8 billion two years after implementation if current beneficiaries were not given the option to enroll in private plans.<sup>144</sup>

Another substantial drawback of premium support plans is the fear that they merely transfer high health care costs from the government to seniors.<sup>145</sup> Opponents note that Medicare Advantage, which is also based upon increasing competition between health plans, currently costs taxpayers more than traditional Medicare Parts A and B. Although this effect is somewhat mitigated by the proposed continuance of traditional Medicare fee-for-service coverage along with the introduction of private insurance plans, it is conceivable that many seniors might be forced to absorb the effects of higher premiums and fewer benefits if they opt out of Medicare coverage and private rates increase.

### 3. *Restructuring Medicare Part B Premiums*

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<sup>141</sup> See Moffit & Hederman, Jr., *CBO Confirms*, *supra* note 137.

<sup>142</sup> *Id.*

<sup>143</sup> *Id.*

<sup>144</sup> *Id.*

<sup>145</sup> Jed Lewison, *White House Rejects Ryan–Wyden: ‘This Plan Would End Medicare as We Know It’*, THE DAILY KOS (Dec. 15, 2011), <http://www.dailykos.com/story/2011/12/15/1045680/-whitehouse-rejects-wyden-ryan-this-plan-would-end-medicare-as-we-know-it>.

The growth of Medicare Part B premiums and general fund transfers is of great concern to federal budget analysts.<sup>146</sup> SMI revenue growth currently exceeds both GDP growth and HI payroll tax growth, a phenomenon expected to continue long into the future.<sup>147</sup> This phenomenon exists partly because current law adjusts SMI revenue to match expenditures on an annual basis, while HI revenue is determined independent of yearly costs.<sup>148</sup> Accordingly, as HI payroll taxes, Social Security taxes and interest income become inadequate to satisfy HI obligations, SMI premiums and general fund transfers will constitute an even larger share of total Medicare revenues.<sup>149</sup> As general revenue requirements continue to grow, so does the impact of Medicare on the federal budget. In 2010, SMI general revenues equaled 1.5% of GDP.<sup>150</sup> At that time, CMS estimated that SMI general revenues had the potential to grow to more than 5.2% of GDP over the 75-year budget window.<sup>151</sup> Restructuring Medicare Part B premiums is among the most direct methods of curbing long-term SMI inflation.

The statutory approach for determining Medicare Part B premiums has changed several times since the passage of Medicare in 1966. Changes to Part B premiums reflect not only changing views of how beneficiaries should contribute to their health care coverage, but also changing economic conditions. Initially, Part B premiums were set at a fixed dollar amount equal to 50% of total Part B expenditures.<sup>152</sup> These premiums were updated annually at a rate equal to the Social Security cost of living adjustment (“COLA”). Over time, these annual increases grew much slower than health care cost inflation, and annual Part B premiums fell to a rate of 25% of

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<sup>146</sup> It should be noted that much of the analysis regarding Medicare Part B premiums can also be applied to Medicare Part D premiums, which follow a similar funding structure.

<sup>147</sup> TRUSTEES REPORT 2010, *supra* note 126, at 22.

<sup>148</sup> For this reason, SMI revenues are insulated from fluctuations in the business cycle, whereas HI revenues are not. It is interesting to note that during the 2009 recession, HI payroll tax receipts declined so significantly that general revenue transfers became the single largest source of Medicare income for the first time in history. *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> Davis, *Medicare Part B*, *supra* note 16, at 27.

total Part B expenditures.<sup>153</sup> In 1984, Congress voted to override future Social Security COLA limitations and set the rate of premium contributions at 25% of total program costs.<sup>154</sup> In 1990, Congress returned to the practice of using fixed dollar amounts to set Medicare Part B premiums.<sup>155</sup> It was not until the Balanced Budget Act of 1997 that Congress permanently fixed premiums at 25% of total program costs, allowing premiums to rise and fall proportionately with federal health care costs.<sup>156</sup>

Part B premiums are set annually using monthly actuarial rates estimated by CMS. Contingency reserve adjustments are set to accommodate unforeseen increases in Part B costs throughout the year and added to monthly actuarial rates. In general, higher premiums are charged to high-income beneficiaries while premium subsidies are made available to low-income beneficiaries. This process has seen Medicare Part B premiums increase by approximately 5% per year, and grow 120% since the year 2000.<sup>157</sup>

There are a variety of ways to restructure Medicare Part B premiums. As deductibles, coinsurance percentages, coverage caps and supplemental cost-sharing plans all influence premium rates, each of these can be adjusted to increase or decrease the total dollar amount

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<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

<sup>155</sup> *Id.*

<sup>156</sup> *Id.*

<sup>157</sup> Part B premium determinations reveal a complex interplay of cost-transfers and cross-subsidies between Medicare, Medicaid, Social Security and various other mandatory spending programs. Since the year 2000, Medicare Part B premiums have grown 120% while Social Security payments grown only 37%. “Hold harmless” provisions protect Medicare beneficiaries on Social Security from realizing reductions in their Social Security benefits in the event Social Security COLAs are insufficient to cover Medicare Part B premium increases. However, even beneficiaries held harmless (i.e. beneficiaries whose Social Security benefits were held constant from one year to the next) see their purchasing power decline as they become unable to realize the full value of their Social Security COLA. Those who are not held harmless, either because they have been classified as high-income or because Medicaid pays their Part B premiums, subsidize those held harmless such that the total amount of premiums paid into the SMI trust fund in any given year remains 25%. This analysis becomes even more complicated when state contributions to Medicaid are considered. When Medicaid is used to fund Medicare Part B premium increases, a share of rising health care cost is transferred to the states. *Id.* at 23.

beneficiaries contribute to their health insurance.<sup>158</sup> However, the most straightforward way to restructure premiums is to raise or lower statutory rates directly. To improve federal budget deficits, Medicare premium rates could be increased for all beneficiaries,<sup>159</sup> or for only high-income beneficiaries.<sup>160</sup> Examples of proposals to increase Medicare Part B premium rates include the Tom Coburn and Joe Lieberman “Bipartisan Plan to Save Medicare and Reduce Debt,” which increases standard premium rates from 25% to 35% of total Part B costs for all current beneficiaries, and President Obama’s FY2015 budget proposal, which increases the percentage of Medicare expenditures paid by high-income beneficiaries from the current range of 35% to 80% to a new range of 45% to 90%, and freezes current income thresholds in an attempt to double the amount of beneficiaries who fall into high-income brackets.

In 2013, the CBO scored the effects of increasing SMI premiums from 25% to 35% and freezing income thresholds for high-income premium brackets.<sup>161</sup> Over ten years, increasing basic premiums would reduce Medicare spending by \$274 billion and freezing income thresholds would reduce Medicare spending by \$20 billion.<sup>162</sup> If these two proposals were implemented at the same time, the CBO estimates that total cost savings would be \$287 billion by 2023.<sup>163</sup>

Plans for increasing Medicare Part B premiums are susceptible to criticism on the basis that they transfer health care costs without bending the overall health care cost curve. This reduces the disposable income of Medicare recipients and burdens states that pay Medicare premiums for low-income citizens through Medicaid. Proponents of plans for increasing SMI

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<sup>158</sup> CONG. BUDGET OFFICE, OPTIONS FOR REDUCING THE DEFICIT: 2014-2023 211(2013), *available at* [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-2\\_1.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-2_1.pdf).

<sup>159</sup> Sens. Tom Coburn & Joe Lieberman, *A Bipartisan Plan to Save Medicare and Reduce Debt*, *available at* [http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=36cddfe6-ec32-41b1-a0d2-b3ad7f6675bf](http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=36cddfe6-ec32-41b1-a0d2-b3ad7f6675bf).

<sup>160</sup> OFFICE OF MGMT. & BUDGET, FISCAL YEAR 2015 BUDGET OF THE U.S. GOVERNMENT 180 (2014), *available at* <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/budget.pdf>.

<sup>161</sup> CONG. BUDGET OFFICE, OPTIONS FOR REDUCING THE DEFICIT, *supra* note 157, at 222.

<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

premiums believe that if beneficiaries assume a greater share of their health insurance and prescription drug costs, they will have greater incentives to seek cost-effective treatments. Current CBO analysis of increased Medicare premiums is limited to a series of 10-year projections, making it difficult to understand how premium adjustments affect long-term federal health care spending imbalances and to set benchmarks that can be measured against future Medicare cost performance. This is an area where additional analysis could be greatly beneficial to lawmakers.

#### **IV. ACCRUAL ACCOUNTING AND LONG-TERM BUDGET SCORING**

##### **A. Accrual accounting more accurately reflects the long-term liabilities of the major health care programs than cash accounting. As a result, accrual accounting methods provide political incentives for reforming the structure of the major health care programs that cash accounting methods do not.**

Budget deficits related to the federal health care programs are currently accounted on a cash basis. Cash basis accounting tracks the difference between receipts and expenditures in a single budget year. An alternative method for assessing the fiscal health of these programs is accrual accounting. Accrual accounting recognizes future obligations at the time they are incurred. Generally, accrual accounting provides a more accurate representation of long-term liabilities.

The problem faced by federal health care programs such as Medicare is the structural imbalance between contributors and beneficiaries. Currently, there are approximately three contributors for every one Medicare beneficiary. By 2030, this ratio is expected to fall to approximately two-to-one, the product of falling birth rates and a growing number of baby boom retirees. This imbalance is worsened by the effects of aging insurance populations, excess cost

growth and increased coverage described in Part II of this paper. One recent study suggests that single beneficiaries and dual-earner couples can expect to receive three dollars of coverage for every one dollar they contributed in Medicare payroll taxes.<sup>164</sup> Consequently, the study suggests, single-earner couples can expect to receive six dollars of coverage for the same one dollar contribution.<sup>165</sup> These trends continue – and may, in fact, accelerate – long into the future.<sup>166</sup>

Over the 75-year open-group budget horizon, Medicare receipts fall short of obligations by \$27.3 trillion.<sup>167</sup> \$4.8 trillion stems from HI while \$22.5 trillion stems from SMI.<sup>168</sup> Because HI is primarily funded by tax receipts, and no provision under current law authorizes funding for HI shortfalls, the \$4.8 trillion figure represents the amount by which benefits will be curtailed once the HI trust fund has been exhausted.<sup>169</sup> Because SMI receives transfers from the Treasury's general fund, the \$22.5 trillion figure represents the amount of future tax increases or discretionary spending cuts that will need to be made in order to maintain SMI solvency.<sup>170</sup>

By ignoring these unfunded liabilities, cash basis accounting of the major federal health care programs creates perverse political incentives. Lawmakers proposing reductions in Medicare benefits receive immediate political pushback, but delayed gratification for cost savings. For example, most proposals for increasing the Medicare eligibility age, similar to the one outlined in Part III of this paper, do not reach their peak effect until current 55-year-olds (who have not been grandfathered into the new system) reach the age of 65. Thus, lawmakers receive a decade of harsh ridicule before their reforms yield any positive budgetary effects.

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<sup>164</sup> See C. Eugene Steuerle & Stephanie Rennane, *How Lifetime Benefits and Contributions Point the Way Toward Reforming Our Senior Entitlement Programs*, NAT'L INST. FOR HEALTH CARE MGMT. 1-2 (2011), available at <http://www.urban.org/uploadedpdf/1001553-Reforming-Our-Senior-Entitlement-Programs.pdf>.

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> TRUSTEES REPORT 2013, *supra* note 126, at 227.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.* at 228.

<sup>170</sup> *Id.*

Worse, it may never become apparent to voters that lawmakers made any significant changes to entitlement program solvency because the federal health care programs are currently solvent on a cash basis. For Medicare, reaching the end of the short term budget window without exhausting its trust funds might seem like business as usual, even though it likely would not have happened but for extraordinary political efforts.

These perverse political incentives are particularly problematic because most health industry experts agree that relatively minor adjustments to Medicare and Medicaid today can prevent major cutbacks in the future. Even though the unfunded liabilities of Medicare and Medicaid are frightening to contemplate, they are the most compelling evidence in favor of comprehensive reform. Unfortunately, without a system that gives politicians credit for long-term deficit reduction efforts, near-term adjustments may never occur.

**B. The Long-Term SCORE Act is a recent proposal that aims to portray the long-term costs of new legislation, particularly legislation related to health care, with greater accuracy.**

On April 9, 2014, Congressman Reid Ribble (R-WI) and Congressman Mark Pocan (D-WI) introduced the Long-Term Studies of Comprehensive Outcomes and Returns for the Economy Act (“Long-Term SCORE Act”).<sup>171</sup> The Long-Term SCORE Act was written with the explicit purpose of bending the health care cost curve.<sup>172</sup> The Act would allow any member of Congress “to request a long-term score covering at least 50 years for any legislation that already received a traditional ten-year CBO score.”<sup>173</sup> It allocates funds for the CBO to create a long-

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<sup>171</sup> THE COMM. FOR A RESPONSIBLE FED. BUDGET, ‘*Long-Term SCORE Act*’ Introduced Today (Apr. 9, 2014), <http://crfb.org/blogs/long-term-score-act-introduced-today>.

<sup>172</sup> Rep. Reid Ribble, *Ribble Introduces Legislation to Help Address Long-Term Health Care Costs* (Apr. 9, 2014), <http://ribble.house.gov/press-release/ribble-introduces-legislation-help-address-long-term-health-care-costs>.

<sup>173</sup> THE COMM. FOR A RESPONSIBLE FED. BUDGET, *Long-Term SCORE Act*, *supra* note 170.

term scoring division “dedicated to analyzing legislation and its impacts on federal programs, particularly ones that focus on medical research and disease prevention.”<sup>174</sup>

The authors believe the Long-Term SCORE Act will allow members of Congress to become more accurately informed about the budgetary impacts of health care legislation. It is intended to correct the distortions of the traditional ten-year window, which is often manipulated by offsets, revenue smoothing and backloaded spending.<sup>175</sup> Specifically, the Act frames health care spending as a capital investment with returns that need to be assessed and accounted for over time. For example, the premium support and Medicare eligibility age increases described above begin in the middle of the 10-year window, and are only given partial credit in the 10-year score. Although the Long-Term SCORE Act would not allow lawmakers to use the new method of CBO scoring to comply with PAYGO or the Byrd Rule, it would provide them with important information about how costs and savings accumulate in budgetary out years.<sup>176</sup>

Long-term scoring is subject to many of the same restrictions as current CBO, OMB and CMS attempts to forecast future health care costs. Legal, economic and actuarial uncertainties limit the accuracy of baseline figures that extend beyond the traditional 10-year budget window, and Congressional representatives find it difficult to act on long-term recommendations when voters are not presented with accrued figures that depict the net present value of structural reforms. Still, long-term scoring has the potential to improve budget discussions by isolating the fiscal effects of individual policy proposals, improving the ability of lawmakers to solicit expert testimony and generate new targets for deficit reduction. Understanding how complex initiatives such as patent reform, tort reform, FDA reform and Medicare premium rate increases affect

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<sup>174</sup> Rep. Ribble, *Long-Term Health Care Costs*, *supra* note 171.

<sup>175</sup> SCHICK, THE FEDERAL BUDGET, *supra* note 43, at 79-81.

<sup>176</sup> THE COMM. FOR A RESPONSIBLE FED. BUDGET, *Long-Term SCORE Act*, *supra* note 170.



long-term budget projections is helpful for refining health care legislation and generating public support on other important issues.

**C. CASE STUDY: The Financial Report of the United States provides Statements of Social Insurance that use modified accrual accounting methods to incorporate additional information into budget projections and consolidate the long-term budgetary effects of mandatory spending reforms.**

The Financial Report of the United States issued by the United States Treasury operates using many of the same legal, economic and actuarial assumptions as the Long-Term Budget Outlook issued by the CBO.<sup>177</sup> Like the CBO, the Treasury uses these assumptions to create a variety of comparable budget scenarios; some based on current law, others based on current policy. However, the Statements of Social Insurance (“SOSI”) provided by the Treasury in the Financial Report of the United States portray all future revenues and expenditures related to these budget scenarios in a consolidated form, netted to present value. This “accrual basis” methodology has the dual-effect of incorporating current financial conditions (such as trust fund performance) into future projections and making the estimated outcomes of long-term policy changes immediately apparent.<sup>178</sup>

The SOSI show the accrued liabilities of Medicare trending downward over time, reflective of the most recent economic and legislative conditions germane to the program. These figures overlap with the unfunded liabilities estimated in the CMS Report. After the passage of the ACA, long-term Medicare liabilities fell dramatically. These liabilities rise gradually as the uncertainties inherent in earlier projections – namely, those related to the implementation of the deficit-reduction features of the ACA – are made manifest. Overall, the Treasury estimates a

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<sup>177</sup> THE DEP’T OF THE TREASURY, A CITIZEN’S GUIDE TO THE FISCAL YEAR 2013 FIN. REPORT OF THE U.S. GOV’T 131-33 (2013), *available at* <http://www.fms.treas.gov/fr/13frusg/FR-Summary-2013.pdf>.

<sup>178</sup> *Id.* at 6.

current \$27.3 trillion 75-year, open-group unfunded liability for Medicare, down substantially from a \$38.1 trillion dollar 75-year, open-group unfunded liability prior to the passage of the ACA.<sup>179</sup>

The methods employed by Financial Report of the United States would be beneficial if applied to other federal health care programs, such as Medicaid, and other policy proposals, such as increasing the Medicare eligibility age, switching Medicare to a system of premium support and increasing Part B premiums. When combined with the 10-year, cash-basis accounting figures provided by the CBO, accrual accounting provides budget analysts with a more complete picture of how the health care cost curve bends in response to various legal, economic and actuarial stimuli.

## CONCLUSION

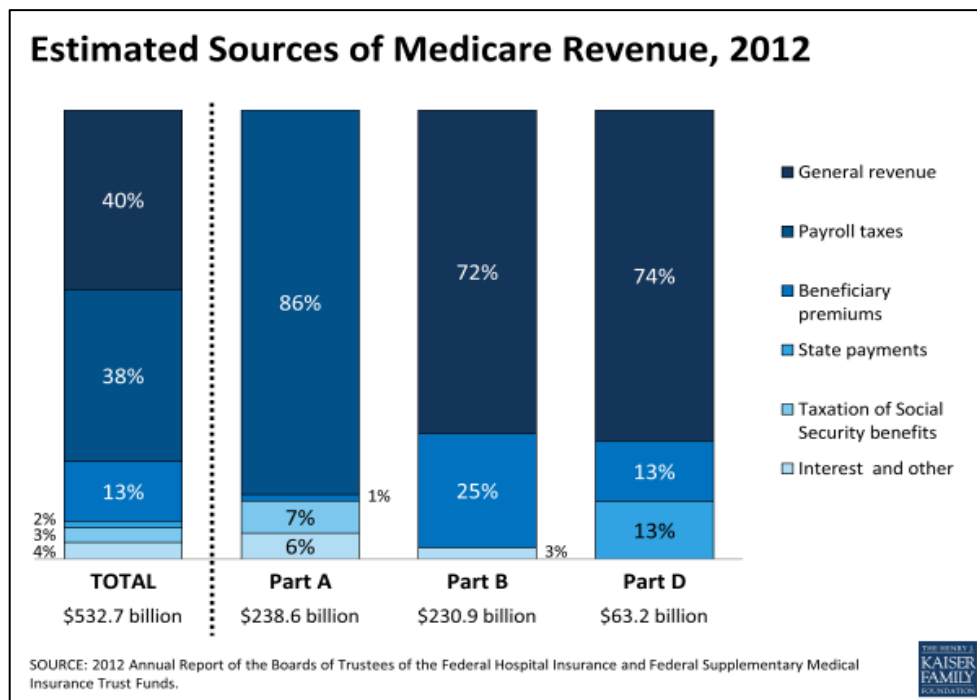
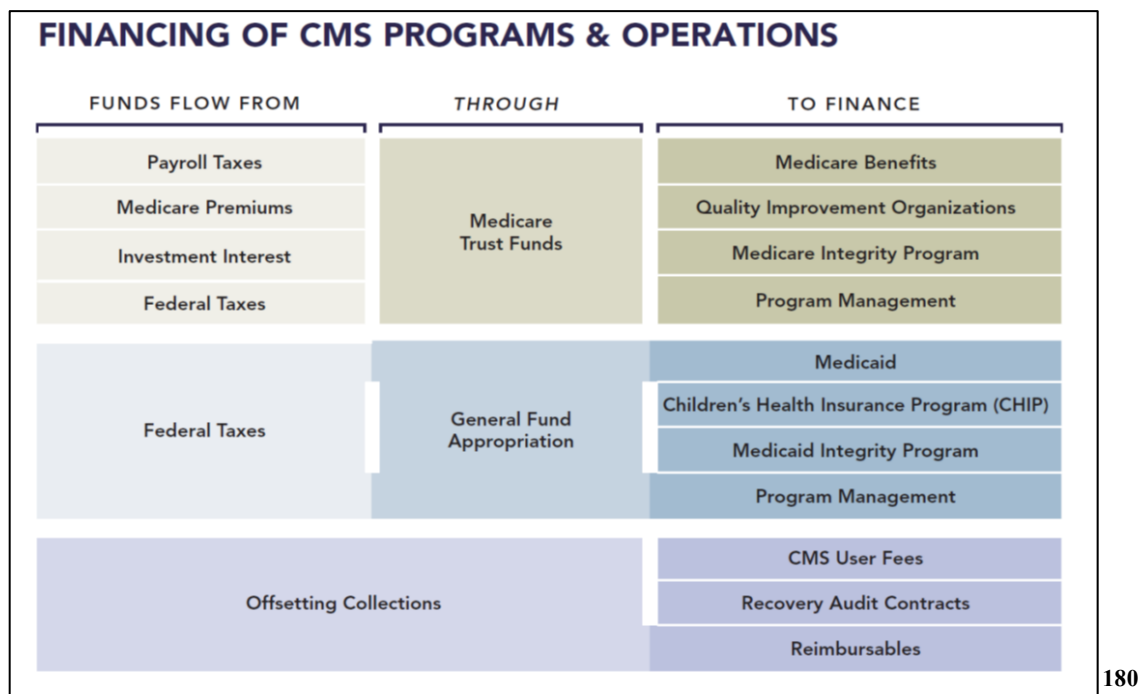
Federal health care programs provide critical services to millions of patients every year. The growth of these programs is anticipated to accelerate over time, worsening budget deficits and crowding out discretionary spending. It is likely that a combination of revenue increases and benefit reductions will be needed to preserve the viability of Medicare, Medicaid, CHIP and the Affordable Care Act. Unfortunately, it is difficult to gauge the effectiveness of legislative intervention in this area. Traditional mechanisms for enacting and scoring mandatory spending reforms are not conducive to long-term cost containment. New measures are likely needed to improve the ability of Congress to make decisions that increase access to affordable health care without generating fundamental fiscal imbalances.

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<sup>179</sup> *Id.* at 181.

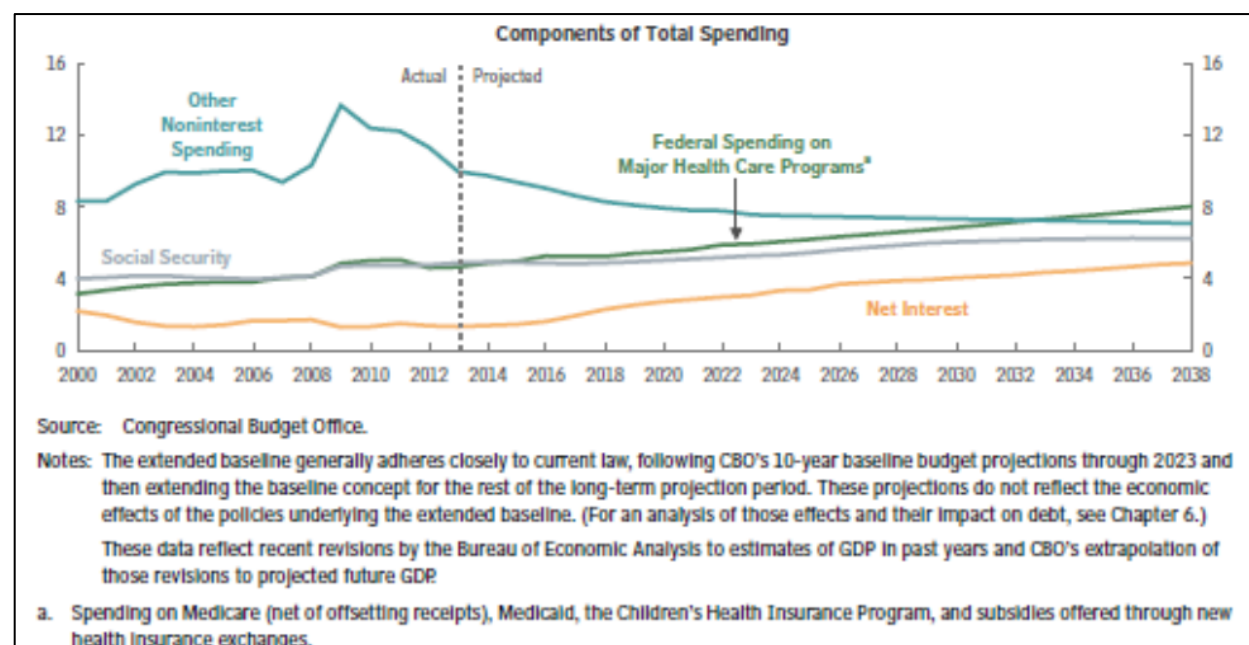
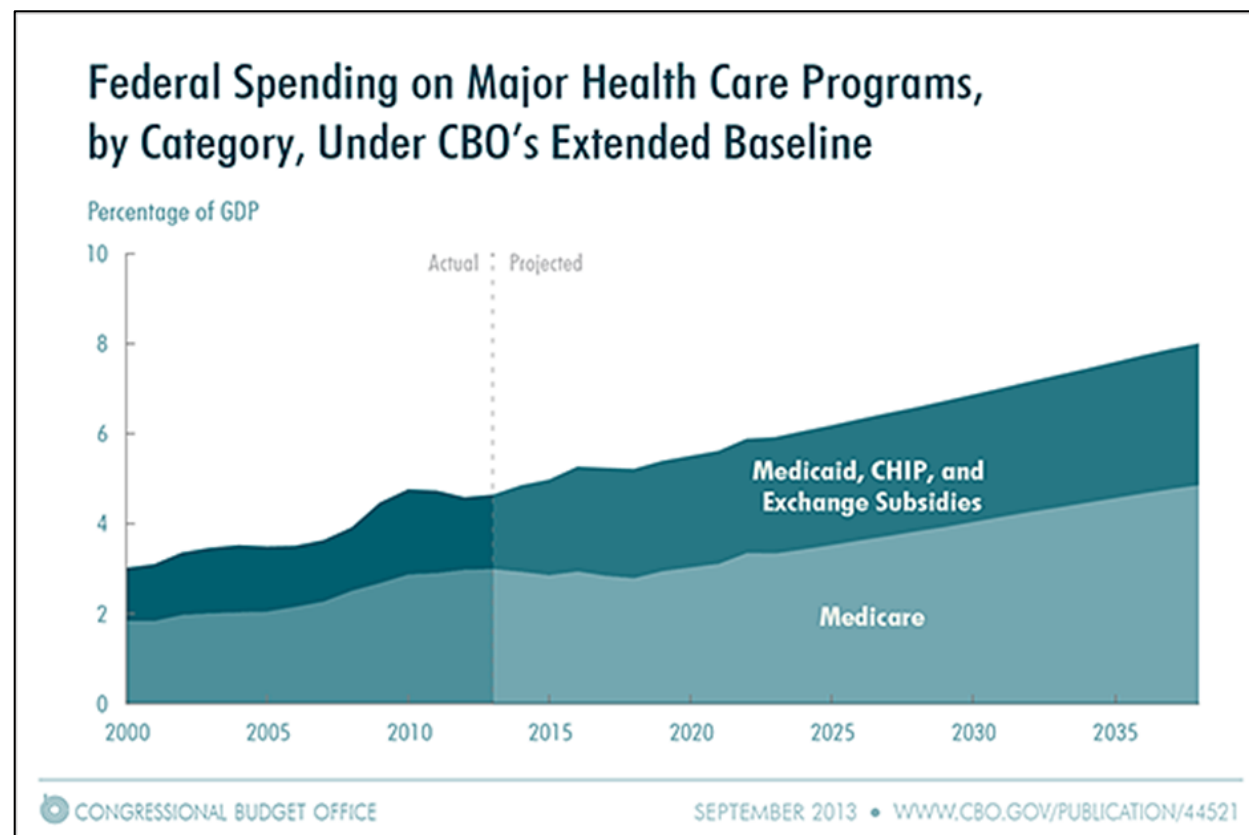
## ILLUSTRATIVE FIGURES

### I. SCOPE, STRUCTURE AND CONSTRAINTS OF THE MAJOR HEALTH CARE PROGRAMS



<sup>180</sup> CMS REPORT, *supra* note 50, at iv.

## II. ASSUMPTIONS AFFECTING LONG-TERM HEALTH CARE COST PROJECTIONS



**Table 1-2.****Projected Spending and Revenues in Selected Years Under CBO's Extended Baseline**

(Percentage of gross domestic product)

	2013	2023	2038
<b>Spending</b>			
Noninterest			
Medicare (Net of offsetting receipts) <sup>a</sup>	3.0	3.3	4.9
Medicaid, CHIP, and exchange subsidies	1.7	2.6	3.2
Social Security	4.9	5.3	6.2
Other	10.0	7.6	7.1
Subtotal	19.5	18.8	21.3
Net interest	1.3	3.1	4.9
Total Spending	20.8	21.8	26.2
<b>Revenues</b>	17.0	18.5	19.7
<b>Deficit (-)</b>			
Excluding net interest	-2.5	-0.3	-1.6
Total	-3.9	-3.3	-6.4
<b>Debt Held by the Public at the End of the Year</b>	73	71	100
<b>Memorandum:</b>			
Gross Medicare Spending <sup>a</sup>	3.5	4.0	5.8

Source: Congressional Budget Office.

Notes: The extended baseline generally adheres closely to current law, following CBO's 10-year baseline budget projections through 2023 and then extending the baseline concept for the rest of the long-term projection period.

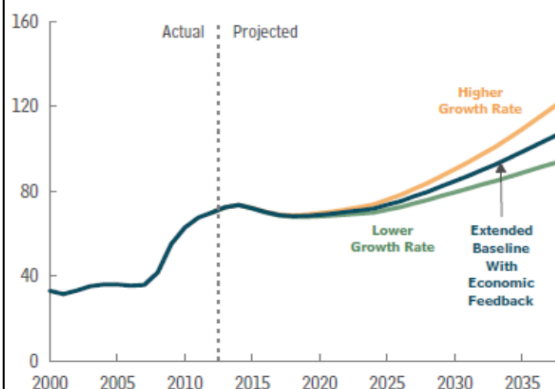
The numbers shown here for 2013 and 2023 differ from those published in Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2013 to 2023* (May 2013), [www.cbo.gov/publication/44172](http://www.cbo.gov/publication/44172), because of recent revisions by the Bureau of Economic Analysis to estimates of gross domestic product (GDP) in past years and CBO's extrapolation of those revisions to projected future GDP.

CHIP = Children's Health Insurance Program.

- a. Medicare spending net of offsetting receipts reflects premium payments by beneficiaries and certain other receipts used to offset a portion of spending for the Medicare program; gross Medicare spending does not include those offsetting receipts.

**Federal Debt Held by the Public Under Alternative Assumptions About the Growth of Federal Spending on Health Care**

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Notes: The extended baseline generally adheres closely to current law, following CBO's 10-year baseline budget projections through 2023 and then extending the baseline concept for the rest of the long-term projection period.

The higher growth rate of per-beneficiary federal spending on Medicare and Medicaid is 0.5 percentage points per year higher, and the lower growth rate is 0.5 percentage points per year lower, than in the extended baseline with economic feedback.

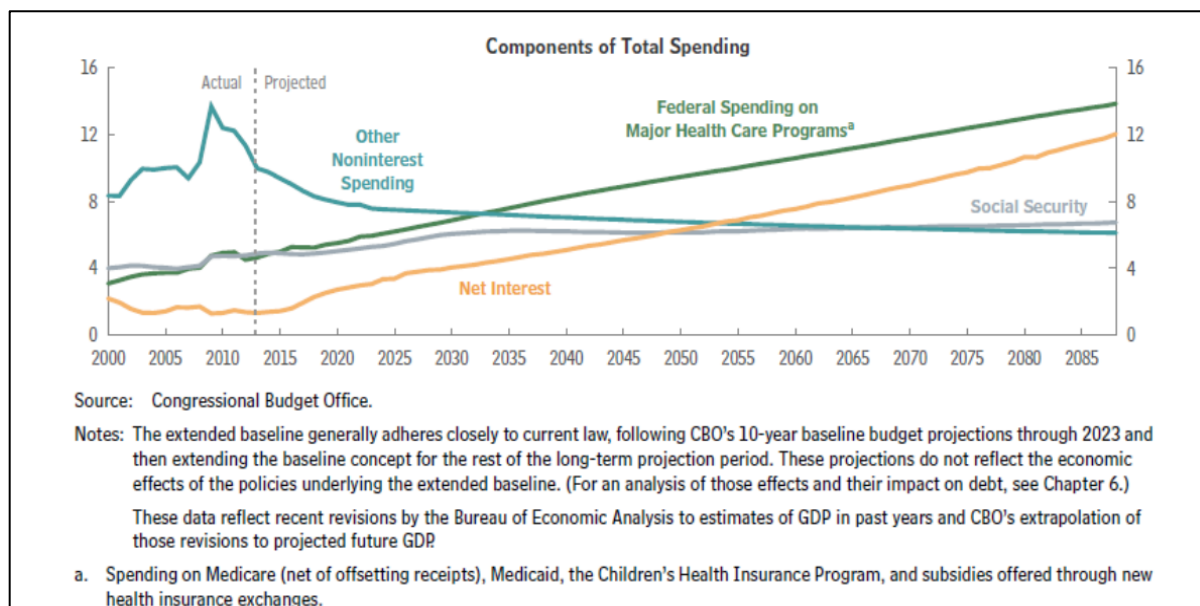
**Table 2-1.****Excess Cost Growth in Spending for Health Care**

(Percent)

	Medicare	Medicaid	Other	Overall
1975 to 2011	2.0	1.6	1.9	1.9
1980 to 2011	1.7	1.2	1.8	1.7
1985 to 2011	1.5	0.8	1.6	1.5
1990 to 2011	1.3	0.2	1.3	1.2

Source: Congressional Budget Office.

Note: Excess cost growth refers to the extent to which the annual growth rate of nominal Medicare or Medicaid spending per beneficiary, or of all other health care spending per capita or overall health care spending per capita—adjusted for demographic characteristics of the relevant populations—outpaced the annual growth rate of potential gross domestic product (GDP) per capita, on average. (Potential GDP is CBO's estimate of the maximum sustainable output of the economy.) The historical rates of excess cost growth are a weighted average of annual rates, placing twice as much weight on the latest year as on the earliest year.



**Table V.F2.—Present Values of Projected Revenue and Cost Components  
of 75-Year Open-Group Obligations for HI, SMI, and OASDI**  
(In trillions, as of January 1, 2012)

Revenue and expenditure categories	HI	SMI	OASDI	Combined
<b>Revenues from public:</b>				
Payroll and benefit taxes	\$15.6	—	\$45.1	\$60.7
Premiums	0.0	\$6.7	—	6.7
Other taxes and fees <sup>1</sup>	—	0.9	—	0.9
<b>Total</b>	<b>15.6</b>	<b>7.7</b>	<b>45.1</b>	<b>68.4</b>
<b>Total expenditures to public</b>	<b>21.2</b>	<b>29.3</b>	<b>56.5</b>	<b>106.9</b>
<b>Net Results for Budget Perspective</b>	<b>-5.6</b>	<b>-21.6</b>	<b>-11.4</b>	<b>-38.6</b>
<b>Revenues from other government accounts:</b>				
Transfers	0.0	21.5	0.1	21.6
Interest credits	n/a	n/a	n/a	n/a
<b>Total</b>	<b>0.0</b>	<b>21.5</b>	<b>0.1</b>	<b>21.6</b>
<b>Trust fund assets on January 1, 2012</b>	<b>0.2</b>	<b>0.1</b>	<b>2.7</b>	<b>3.0</b>
<b>Net Results for Trust Fund Perspective</b>	<b>-5.3</b>	<b>0.0</b>	<b>-8.6</b>	<b>-14.0</b>

<sup>1</sup>Includes Part B revenues from fees on manufacturers and importers of brand-name prescription drugs and Part D State transfers.

181

<sup>181</sup> TRUSTEES REPORT 2013, *supra* note 126, at 238.

### III. ANALYSIS OF FUTURE PROPOSALS TO BEND THE HEALTH CARE COST CURVE

Raise the Age of Eligibility for Medicare to 67												
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total	
											2014–2018	2014–2023
Change in Mandatory Outlays												
Medicare	0	0	-1.1	-2.6	-4.2	-6.1	-8.3	-10.6	-13.6	-17.1	-7.8	-63.5
Other	<u>0</u>	<u>0</u>	<u>0.8</u>	<u>1.9</u>	<u>3.1</u>	<u>4.4</u>	<u>5.7</u>	<u>7.2</u>	<u>8.0</u>	<u>9.5</u>	<u>5.7</u>	<u>40.5</u>
Total	0	0	-0.3	-0.7	-1.1	-1.6	-2.6	-3.4	-5.6	-7.6	-2.1	-23.0
Change in Revenues												
Net Effect on the Deficit	0	0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.7	-0.8	-0.9	-0.6	-3.9
	0	0	-0.2	-0.5	-0.8	-1.2	-2.1	-2.8	-4.8	-6.7	-1.5	-19.1

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

Note: This option would take effect in January 2016.

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

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

\* = between zero and \$500 million.

Increase Premiums for Parts B and D of Medicare												
(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total	
											2014–2018	2014–2023
Change in Mandatory Outlays												
Increase basic premiums	0	-4	-10	-16	-25	-35	-40	-44	-49	-52	-55	-274
Freeze income thresholds for income-related premiums	0	0	0	0	0	0	-3	-4	-6	-7	0	-20
Both of the above policies <sup>a</sup>	0	-4	-10	-16	-25	-35	-42	-46	-52	-56	-55	-287
Note: The first and third alternatives would take effect in January 2015; the second alternative would take effect in January 2020.												
a. If both policies were enacted together, the total effects would be less than the sum of the effects for each policy because of interactions between the approaches.												



# IV. ACCRUAL ACCOUNTING AND LONG-TERM BUDGET SCORING

<b>United States Government</b> <b>Statements of Social Insurance (Note 24)</b> <b>Present Value of Long-Range (75 Years, except Black Lung) Actuarial Projections</b>					
(In billions of dollars)	2013	2012	2011	2010	2009
<b>Federal Old-age, Survivors and Disability Insurance (Social Security):</b> <sup>14</sup>					
<i>Revenue (Contributions and Dedicated Taxes) from:</i>					
Participants who have attained eligibility age (age 62 and over).....	908	847	726	672	575
Participants who have not attained eligibility age .....	24,591	22,703	20,734	19,914	18,559
Future participants.....	23,419	21,649	20,144	19,532	18,082
All current and future participants.....	48,918	45,198	41,603	40,118	37,217
<i>Expenditures for Scheduled Future Benefits for:</i>					
Participants who have attained eligibility age (age 62 and over).....	(11,021)	(9,834)	(8,618)	(8,096)	(7,465)
Participants who have not attained eligibility age .....	(40,591)	(37,753)	(34,042)	(32,225)	(30,207)
Future participants.....	(9,600)	(8,890)	(8,100)	(7,744)	(7,223)
All current and future participants.....	(61,212)	(56,477)	(50,760)	(48,065)	(44,894)
<i>Present value of future expenditures in excess of future revenue .....</i>	<i>(12,294)<sup>1</sup></i>	<i>(11,278)<sup>2</sup></i>	<i>(9,157)<sup>3</sup></i>	<i>(7,947)<sup>4</sup></i>	<i>(7,677)<sup>5</sup></i>
<b>Federal Hospital Insurance (Medicare Part A):</b> <sup>14</sup>					
<i>Revenue (Contributions and Dedicated Taxes) from:</i>					
Participants who have attained eligibility age (age 65 and over).....	301	302	262	248	209
Participants who have not attained eligibility age .....	8,147	7,929	7,581	7,216	6,348
Future participants.....	7,744	7,367	7,260	6,944	5,451
All current and future participants.....	16,192	15,598	15,104	14,408	12,008
<i>Expenditures for Scheduled Future Benefits for:</i>					
Participants who have attained eligibility age (age 65 and over).....	(3,422)	(3,369)	(2,923)	(2,648)	(2,958)
Participants who have not attained eligibility age .....	(14,629)	(14,919)	(12,887)	(12,032)	(18,147)
Future participants.....	(2,913)	(2,891)	(2,546)	(2,411)	(4,673)
All current and future participants.....	(20,964)	(21,179)	(18,356)	(17,091)	(25,778)
<i>Present value of future expenditures in excess of future revenue .....</i>	<i>(4,772)<sup>1</sup></i>	<i>(5,581)<sup>2</sup></i>	<i>(3,252)<sup>3</sup></i>	<i>(2,683)<sup>4</sup></i>	<i>(13,770)<sup>5</sup></i>
<b>Federal Supplementary Medical Insurance (Medicare Part B):</b> <sup>14</sup>					
<i>Revenue (Premiums) from:</i>					
Participants who have attained eligibility age (age 65 and over).....	701	635	570	538	498
Participants who have not attained eligibility age .....	4,073	3,826	3,651	3,460	4,224
Future participants.....	944	884	865	839	1,270
All current and future participants.....	5,718	5,344	5,086	4,836	5,992
<i>Expenditures for Scheduled Future Benefits for:</i>					
Participants who have attained eligibility age (age 65 and over).....	(2,887)	(2,646)	(2,343)	(2,166)	(2,142)
Participants who have not attained eligibility age .....	(15,075)	(14,303)	(13,489)	(12,587)	(16,342)
Future participants.....	(3,415)	(3,211)	(3,108)	(2,984)	(4,672)
All current and future participants.....	(21,377)	(20,159)	(18,940)	(17,737)	(23,156)
<i>Present value of future expenditures in excess of future revenue</i> <sup>6</sup> .....	<i>(15,659)<sup>1</sup></i>	<i>(14,815)<sup>2</sup></i>	<i>(13,854)<sup>3</sup></i>	<i>(12,901)<sup>4</sup></i>	<i>(17,165)<sup>5</sup></i>
Totals may not equal the sum of components due to rounding.					
The accompanying notes are an integral part of these financial statements.					

182

<sup>182</sup> THE DEP'T OF THE TREASURY, 2013 FIN. REPORT, *supra* note 176, at 47.



**United States Government**  
**Statements of Social Insurance (Note 24), continued**  
**Present Value of Long-Range (75 Years, except Black Lung) Actuarial Projections**

(In billions of dollars)	2013	2012	2011	2010	2009
<b>Federal Supplementary Medical Insurance (Medicare Part D): <sup>14</sup></b>					
<i>Revenue (Premiums and State Transfers) from:</i>					
Participants who have attained eligibility age (age 65 and over).....	184	179	173	165	140
Participants who have not attained eligibility age .....	1,491	1,510	1,608	1,626	1,442
Future participants.....	665	661	703	694	618
All current and future participants.....	2,340	2,349	2,484	2,486	2,199
<i>Expenditures for Scheduled Future Benefits for:</i>					
Participants who have attained eligibility age (age 65 and over).....	(722)	(694)	(695)	(646)	(595)
Participants who have not attained eligibility age .....	(5,871)	(5,866)	(6,438)	(6,355)	(6,144)
Future participants.....	(2,617)	(2,568)	(2,817)	(2,714)	(2,632)
All current and future participants.....	(9,211)	(9,128)	(9,950)	(9,715)	(9,371)
<i>Present value of future expenditures in excess of future revenue <sup>6</sup></i> .....	<u>(6,871)<sup>1</sup></u>	<u>(6,778)<sup>2</sup></u>	<u>(7,466)<sup>3</sup></u>	<u>(7,229)<sup>4</sup></u>	<u>(7,172)<sup>5</sup></u>

183

**Medicare Present Values (in billions) (Unaudited)**

	2013 Consolidated SOSI	Illustrative Alternative Scenario <sup>1, 2</sup>
<b>Income</b>		
Part A.....	\$16,192	\$16,214
Part B <sup>3</sup> .....	5,718	7,364
Part D <sup>4</sup> .....	2,340	2,343
Total Income.....	<u>\$24,250</u>	<u>\$25,921</u>
<b>Expenditures</b>		
Part A.....	\$20,964	\$25,396
Part B.....	21,377	27,510
Part D.....	9,211	9,224
Total Expenditures.....	<u>\$51,552</u>	<u>\$62,130</u>
Part A.....	\$4,772	\$9,182
Part B.....	15,659	20,146
Part D.....	6,871	6,881
Excess of Expenditures over Income.....	<u>\$27,302</u>	<u>\$36,209</u>

<sup>1</sup> These amounts are not presented in the 2013 Trustees Report.

<sup>2</sup> At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare Trust Fund projections that differ from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

<sup>3</sup> Excludes \$15,659 billion and \$20,146 billion of General Revenue Contributions from the 2013 Consolidated SOSI projection and the Illustrative Alternative Scenario's projection, respectively; i.e., to reflect Part B income on a consolidated Governmentwide basis.

<sup>4</sup> Excludes \$6,871 billion and \$6,881 billion of General Revenue Contributions from both the 2013 Consolidated SOSI projection and the Illustrative Alternative Scenario's projection, respectively; i.e., to reflect Part D income on a consolidated Governmentwide basis.

Note: Amounts may not add due to rounding.

184

<sup>183</sup> *Id.* at 48.

<sup>184</sup> *Id.* at 130.

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