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OFFICE OF THE ACTUARY

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FROM: Paul Spitalnic
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SUBJECT: Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)

On March 26, 2015, the House passed the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2). This bill includes a provision to replace the Sustainable Growth Rate (SGR) formula used by Medicare to pay physicians with new systems for establishing annual payment rate updates for physicians' services. In addition, it would temporarily extend the Children's Health Insurance Program (CHIP) and increase premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels. H.R. 2 would also make numerous other changes to Medicare and Medicaid.

This memorandum summarizes the Office of the Actuary's estimates of the short-range and long-range financial effects of H.R.2, describes the bill's major provisions, and discusses the implications and limitations of the estimates.

Projections of health care spending are necessarily uncertain. Reasonable estimates can vary significantly from each other, particularly when applied over many years. While the estimates included in this memorandum are based on reasonable actuarial assumptions and methods, actual experience will likely be different than expected.

Summary

From fiscal year 2015 through 2025, we estimate that H.R. 2 would increase combined Federal spending for Medicare, Medicaid, and the health insurance marketplace by $102.8 billion. The year-by-year summary of the impact is shown in the table below.

Estimated Federal Fiscal Year Costs (+) or Savings (–) under H.R. 2
(in billions)

Provisions	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015-25
Total	6.9	13.1	15.7	9.9	6.1	8.4	8.8	10.0	10.1	8.2	5.5	102.8
Physician payment update	5.4	9.1	6.1	8.2	10.9	15.7	17.2	18.7	19.2	19.3	20.7	150.5
Other Medicare	0.9	2.7	3.4	−5.2	−7.4	−9.2	−9.5	−9.2	−8.8	−9.4	−10.5	−62.2
Medicaid/CHIP	0.5	1.4	10.1	10.3	2.9	2.2	1.5	1.0	0.2	−1.1	−4.1	25.0
Marketplace	0.0	−0.1	−3.8	−3.4	−0.2	−0.4	−0.5	−0.5	−0.5	−0.6	−0.6	−10.5

The physician payment updates included in H.R.2 would eliminate the significant and immediate problems with the current SGR formula approach. Avoiding these implausible payment reductions (including the 21.2-percent decrease that was scheduled for April 1, 2015) results in a

budget cost of $150.5 billion for fiscal years 2015 through 2025 compared to the current-law baseline. This cost is partially offset by other provisions in H.R. 2 that are estimated to have a net reduction in Federal expenditures of $47.7 billion. Accordingly, the net cost of the legislation is $102.8 billion.

While H.R.2 avoids the significant short-range physician payment issues resulting from the current SGR system approach, it nevertheless raises important long-range concerns that would almost certainly need to be addressed by future legislation. In particular, additional updates totaling $500 million per year and a 5 percent annual bonus are scheduled to expire in 2025, resulting in a payment reduction for most physicians. In addition, this bill specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates would be inadequate in years when levels of inflation are higher or when the cumulative effect of price updates not keeping up with physician costs becomes too large. We anticipate that physician payment rates under H.R.2 would be lower than scheduled under the current SGR formula by 2048 and would continue to worsen thereafter. Absent a change in the method or level of update by subsequent legislation, we expect access to Medicare-participating physicians to become a significant issue in the long term under H.R. 2.

Major Provisions of H.R. 2

This section describes the provisions that would have a measurable impact on Medicare, Medicaid, and health insurance marketplace spending and are important from a policy perspective.

Title I—SGR Repeal and Medicare Provider Payment Modernization. Under current law, Medicare's payment rates for services furnished by physicians were to be reduced by 21.2 percent on April 1, 2015. H.R. 2 would freeze those payment rates at current levels for 3 months and then increase them by 0.5 percent for services furnished during the last 6 months of calendar year 2015. Over the next several years, the bill would replace the SGR formula with new payment systems.

The major specifications of the new payment systems described in H.R. 2 are as follows:

- For services paid under the physician fee schedule and furnished during calendar years 2016 through 2019, Medicare's payment rates would increase by 0.5 percent a year.

  Payment rates for services on the physician fee schedule would remain at the 2019 level through 2025, but, starting in 2019, the amounts paid to individual providers would be subject to adjustment through one of two mechanisms, depending on whether the physician chose to participate in an Alternative Payment Model (APM) program or the Merit-Based Incentive Payment System (MIPS).

  For 2026 and subsequent years, there would be two payment rates for services on the physician fee schedule. For providers paid through an APM program, payment rates would be increased each year by 0.75 percent. Payment rates for other providers would be increased each year by 0.25 percent.

- Providers who opted to participate in MIPS would receive payments that would be subject to positive or negative performance adjustments. The basic adjustments would be

designed to be offsetting in aggregate, so that they would have no net effect on overall payments. The performance adjustment for an individual provider would depend on that provider's performance compared to a threshold. In addition, H.R. 2 would provide $500 million each year from 2019 to 2024 as an additional performance adjustment for providers in this program who achieved exceptional performance.

- From 2019 through 2024, providers receiving a substantial portion of their revenue from alternative payment models would receive a lump-sum payment after each year equal to 5 percent of their Medicare payments for services reimbursed according to the physician fee schedule in that year. Providers with smaller amounts of revenue from APMs would receive either no adjustment to their payments or the MIPS performance adjustment if they reported measures and activities under that program.

Title II—Medicare and Other Health Extenders. Several Medicare provisions, including some that increase payments for certain low-volume and small rural hospitals, physicians, therapy services, and ambulance providers, were to expire on April 1, 2015. H.R. 2 would extend those increased payment amounts through the end of either fiscal year 2017 or calendar year 2017, depending on whether Medicare's payment system for that type of provider operates on a fiscal-year or calendar-year basis. The bill would also extend for 2 years the eligibility of Medicare Advantage plans for special needs individuals to participate in the Medicare program.

The bill would permanently extend two programs: (i) the Qualifying Individuals Program, which subsidizes Medicare Part B premiums for certain low-income Medicare beneficiaries, and (ii) Transitional Medical Assistance (TMA) under Medicaid, which requires states to provide continued medical coverage for certain families who become ineligible for medical assistance because of increased earnings.

Title III—CHIP. The Children's Health Insurance Program is currently funded only through 2015, although there are sufficient funds to cover most projected expenditures in 2016 as well. H.R. 2 would extend the funding through 2017 but would likely provide enough funds to cover some amount of projected expenditures in 2018. These additional CHIP costs would be offset somewhat by reductions in Medicaid costs and by premium tax credits and cost-sharing subsidies, as many CHIP enrollees would be expected to receive coverage in Medicaid or subsidized coverage in the health insurance marketplace if CHIP funding were to expire.

Title IV—Offsets. H.R. 2 includes a number of provisions that would result in savings to the Medicare and Medicaid programs. The more significant provisions are listed below.

- Beginning in 2018, the income thresholds for determining the premium subsidy for the Medicare Part B and Part D premiums paid by the beneficiary would be changed, resulting in more beneficiaries paying the higher premium amounts. In addition, beginning in 2020, more beneficiaries would be subject to the income-related premiums due to a change in the indexing of the income thresholds.

- Payment rate updates in 2018 for skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices, and long-term care hospitals would be limited to 1 percent.

- Under current law, state allotments for Medicaid disproportionate share hospital (DSH) payments are increased each year by the percent change in the consumer price index and

then adjusted by scheduled reductions. H.R. 2 would increase net allotments in 2017 through 2020 and decrease net allotments in 2021 through 2025.

- Currently, a 3.2-percent increase in payment rates for inpatient hospital services is scheduled for 2018. H.R. 2 would replace this single-year update with an increase of 0.5 percent each year from 2018 through 2023.

Short-Range Impacts

The short-range estimates are based on the President's Fiscal Year 2016 Budget baseline. These estimates include Medicare projections under current law and under an adjusted baseline that assumes that the reduction in physician payments scheduled under the SGR formula is replaced with 0-percent updates in all years. The provisions of H.R.2 were estimated relative to the current-law baseline.

The bill would replace the SGR formula with a new method for updating physician payment rates. For purposes of modeling the short-range impacts of this new method, a key assumption is the percentage of physician payments in the APM and MIPS programs. These estimates reflect that APMs are defined to include Accountable Care Organizations (ACOs) and demonstrations, including payment models being tested by the Center for Medicare and Medicaid Innovation.

Of the total physician spending in fee-for-service Medicare in 2015, roughly 25 percent is attributable to beneficiaries assigned to an ACO. For 2019 through 2025, APM physicians would receive a 5-percent bonus each year. Given the favorable financial incentives for APMs, we assume that the share of Medicare physician spending in ACOs or other qualifying payment models would grow. As a result, payments to physicians in APMs are assumed to constitute 60 percent of Medicare physician spending in 2019 and to continue to increase thereafter. The new physician system specified in H.R 2 is estimated to increase physician spending by $150.5 billion over fiscal years 2015 through 2025 compared to current law.

H.R. 2 would also provide allotments for CHIP for 2016 and 2017. Under current law, Federal CHIP allotments are provided only through 2015; however, as some amount of unspent CHIP funding is available to be disbursed in subsequent years, our current-law projection is that there would be enough CHIP funds to cover most of the 2016 costs. Similarly, the CHIP allotments provided under this bill are expected to furnish enough funding to cover all of the expected costs in 2017 and some portion of the costs in 2018. Although the funding is scheduled to expire in 2015, our estimate for this provision reflects the President's 2016 Budget baseline assumption of an annual $5.7-billion allotment beginning in 2016, as well as the statutory increase in the Federal matching rate for CHIP from 70 percent in 2015 to 93 percent in 2016. In addition, the estimate reflects that, in the absence of additional CHIP allotments, many children would likely have enrolled in Medicaid or in the health insurance marketplace to receive subsidized coverage; as a result, the increased CHIP costs are offset by reductions in Medicaid and marketplace expenditures. These changes result in additional Medicaid/CHIP spending of $25.0 billion for fiscal years 2015 through 2025, partially offset by health insurance marketplace savings of $10.5 billion compared to current law.

Moreover, H.R. 2 would change the income-related premium provision that requires more beneficiaries to pay a higher premium under both Part B and Part D of Medicare. The additional premium income reduces the Federal transfers required from the general fund of the Treasury. We estimate that approximately 6.7 million Part B and 4.7 million Part D beneficiaries would be

affected by this provision in 2025. For fiscal years 2015 through 2025, the impact of this provision is a savings of roughly $35.8 billion.

The other major changes required by H.R. 2 are revisions to the payment updates for several Medicare providers, including inpatient hospitals, skilled nursing facilities, and home health agencies. The impact of these payment update changes is to reduce spending by an estimated $35.4 billion. The remaining provisions would increase spending by about $9.0 billion. Detailed estimates for all of the provisions of H.R.2 are shown in Attachment 1.

Long-Range Impacts

The long-range estimates are based on the 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Medicare Trustees Report). [1] This section of the memorandum examines the impacts of H.R.2 in the long term separately for Part A and Part B of Medicare.

The provisions of the bill that would have the largest impact on the Part A projections are those that would reduce payment updates to most Part A providers in 2018 and one that would adjust inpatient hospital updates in 2018 through 2023. These smaller provider updates would have the cumulative effect of lowering the long-range projections slightly. Based on the assumptions of the 2014 Medicare Trustees Report, the Hospital Insurance (HI) trust fund would be depleted in 2030. Under the provisions of H.R. 2, the fund would be depleted one year later, in 2031. Over the 75-year period, the actuarial deficit would be reduced from the current-law estimate of 0.87 percent of taxable payroll to 0.78 percent under H.R. 2. Similarly, the present value of future Part A benefits would decrease by $387 billion—from $20.365 trillion to $19.978 trillion.

For Part B, the Medicare Trustees Report presents costs under both current law and a projected baseline approach. In the short-range period, the projected baseline assumes that the SGR system used to update physician payments would be overridden and replaced with an annual increase equal to the average update over the past 10 years. For the long-range projections, per capita physician payments would ultimately increase at the rate of per capita national health expenditures. The Trustees chose to emphasize the projected baseline throughout the report to reflect a more useful projection of physician spending than would have been attainable under the current-law baseline, which included the unreasonable physician payment reduction that was expected to be overridden by lawmakers.

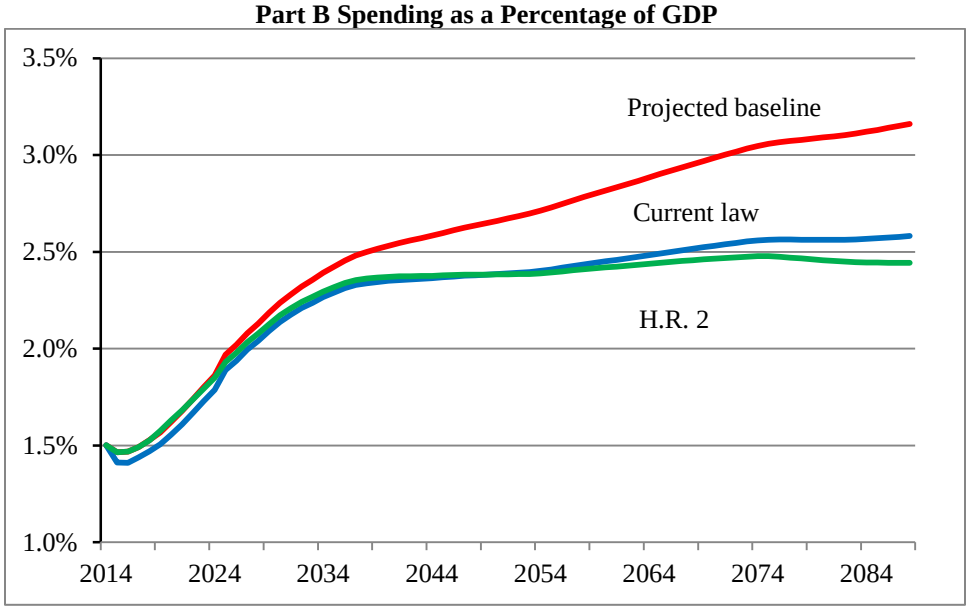
Under current law, Medicare payments to physicians are increased each year by the growth in the Medicare Economic Index (MEI) adjusted for performance under the SGR system, which intends to limit growth in physician spending to the rate of overall economic growth as measured by GDP. Because Medicare physician expenditures are projected to grow 1 percentage point faster than GDP, on average, in the long run, the current-law baseline assumes that the performance adjustment will be –1 percent over this period. As a result, physician payments are assumed to increase by an average of MEI less 1 percent under current law, or 1.3 percent (2.3 percent less 1 percent). In contrast, the average physician payment update is estimated to equal the MEI growth rate of roughly 2.3 percent under the projected baseline scenario.

[1] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf

The long-range modeling of H.R. 2 reflects the physician update amounts specified in the bill of 0.75 percent for physicians participating in an APM program and 0.25 percent for physicians participating in MIPS. For 2026 and later, APMs would be paid increasingly more each year relative to non-APMs. Because of these growing financial incentives, we assume that the share of Medicare physician dollars in APMs would increase from 60 percent in 2019 to 100 percent by 2038. For purposes of these estimates, potential secondary effects, such as the possible significant reduction in beneficiary access to physicians that is described in the next section of this memorandum, are not included.

The long-range effects of Part B spending as a share of GDP under the proposed legislation are shown in the chart below and are compared to both current law and the projected baseline included in the 2014 Trustees Report.[2] Because H.R. 2 would eliminate the large physician payment reduction that was scheduled for April 1, 2015, spending under the proposal generally follows the projected baseline estimates for the next 10 years. The relatively low payment updates specified in the bill cause the spending projections to grow more slowly than under the projected baseline for the remainder of the 75-year projection period. Expenditures are expected to be lower than under current law after 2049. Overall, the 75-year present value of Part B spending under H.R. 2 is $0.04 trillion less than the Trustees' current-law projection of $21.847 trillion and $2.5 trillion less than the projected baseline projection of $24.311 trillion.

Part B Spending as a Percentage of GDP



Long-Range Implications

As noted previously, the physician update amounts specified in H.R. 2 are considerably lower than the projection of the MEI, a measure that has been used to update Medicare physician payments since the mid-1970s. This index reflects both the price change associated with the various inputs needed to furnish physicians' services and an adjustment for productivity to

[2] There are only minor difference between the projected baseline scenario and current law for Part A and Part D services.

capture efficiencies in the provision of these services.[3] Economy-wide prices and productivity measures are used in the MEI in order to meet the original legislative intent that it approximate a broad price index. The MEI is considered an appropriate measure to use as the basis for physician price increases under competitive, market-based conditions over the long-range projection period because it reflects underlying price pressures associated with physician care, both for labor and non-labor inputs.

Over the past 25 years, as shown in the table below, the published MEI update has increased at a rate similar to that for the GDP deflator, slightly less than the Consumer Price Index (CPI), and significantly less than the hospital market basket.[4] The historical relationship between the MEI and the GDP deflator is assumed to continue throughout the projection period; accordingly, the long-range MEI is assumed to increase 2.3 percent per year—the same long-range increase as exhibited by the GDP deflator in the 2014 Medicare Trustees Report.[5] Based on this assumption, physician prices would increase similarly to price increases for other services and goods in the economy, and, all else being equal, physician compensation in real terms would increase at rates similar to real compensation increases for the average worker in the economy.

Percent Change in Physician, Hospital, and Economy-wide Price Measures

Period	MEI update	GDP deflator	CPI	Hospital market basket
1990-2014	2.1%	2.1%	2.6%	3.3%
2005-2014	1.5%	2.0%	2.3%	2.8%

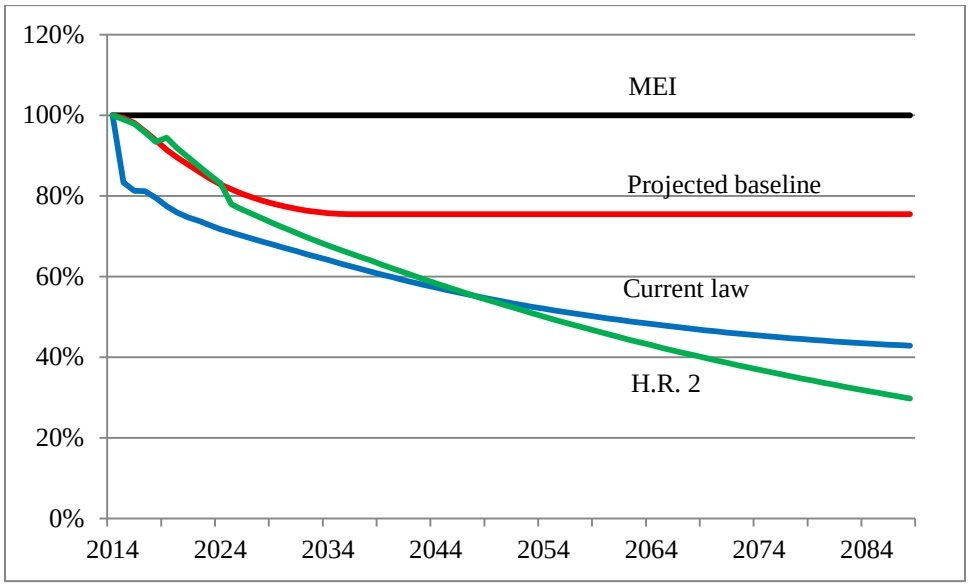
The Medicare physician updates would be 0.75 percent per year for those participating in an APM or 0.25 percent per year for those participating in MIPS, each amount less than the 2.3-percent increase assumed for the MEI. This difference raises significant long-range implications for physician payment rates under Medicare. While such implications currently exist with regard to the SGR system, under H.R. 2 these concerns are ultimately greater in the long range, as shown in the illustration below.

[3] The structure, price proxies, and data sources used in the MEI have evolved over time (currently this measure reflects a 2006 base year). The MEI has been evaluated and validated by several technical panels, the most recent of which convened in 2012 (http://www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/MEI-Review-Report-to-HHS.pdf).

[4] Over the past decade, the MEI update has increased slightly less than the GDP deflator. This result is due in large part to low economy-wide wage growth (particularly apparent in the past 5 years because of the Great Recession) and the use of a 10-year moving average of economy-wide productivity in the MEI.

[5] An alternative method can be used to derive the MEI based on assumptions from the 2014 Medicare Trustees Report regarding the two major components of the index: input price changes and economy-wide productivity. The input price change is assumed to increase 3.4 percent per year based on a weighted-average of compensation price growth and non-compensation price growth. (Compensation price growth accounts for roughly 67 percent of the MEI and includes both physician and non-physician compensation; non-compensation price growth accounts for the remaining 33 percent of the MEI.) Compensation prices are assumed to increase at 4.0 percent per year, and non-compensation prices are assumed to increase at economy-wide rates, or 2.3 percent per year. Economy-wide productivity is assumed to grow at 1.1 percent per year. The resulting long-range MEI increase using this approach is 2.3 percent, derived by subtracting the 1.1-percent growth in productivity from the 3.4-percent growth in the input price index.

Illustrative Comparison of Medicare Prices for Physicians' Services under Current Law, the Projected Baseline, and H.R. 2 relative to the MEI



Over the next decade, physician prices under the projected baseline from the 2014 Trustees Report are assumed to grow at about 0.6 percent per year, or roughly the average payment update over the past 10 years. The payment rates under H.R. 2 are similar to those under the projected baseline by the end of the short-range period, although the year-to-year growth rates may differ. Because these updates are less than the increase in the MEI, by 2025 Medicare prices under H.R. 2 and the projected baseline would be roughly 80 percent of Medicare prices updated by the MEI. Under current law, which reflects the 21-percent price reduction that was scheduled for April 1, 2015 and anticipated fee reductions thereafter due to the SGR system, Medicare prices would be approximately 70 percent of those updated by the MEI.

The payments to physicians in APMs under H.R. 2 would include a lump-sum payment equal to 5 percent of their total Medicare reimbursement beginning in 2019. At the same time, bonuses totaling $500 million would be available for providers in MIPS who achieved exceptional performance. Both the lump-sum payment and the performance bonuses would end in 2024. As a result, payments to APM physicians in 2025 would decrease by 5 percent, and physicians in MIPS with exceptional performance would also see a significant reduction. It is important to note that payment reductions of roughly 5 percent were scheduled in 6 previous years and were legislatively overridden in 5 of them.

From 2025 until 2039, Medicare price updates under H.R. 2 would grow based on the assumed participation rates in APMs and MIPS. Thereafter, all physicians are assumed to be in APMs, and therefore prices are updated at 0.75 percent per year. These updates are less than the 2.3-percent assumption for the MEI and less than the updates underlying the projected baseline, which transition from the short-range updates of 0.6 percent to the MEI assumption by 2038 and then remain at the MEI growth rate for the rest of the 75-year projection period. As a result, Medicare prices under H.R. 2 would continue to diverge from the MEI and begin to deviate from the projected baseline. By 2048, Medicare prices under H.R. 2 would be less than under the current-law SGR system, and, by 2087, they would be just one-third of prices based on the MEI update and 30 percent lower than what they would have been under current law.

The implications of the long-range divergence of Medicare physician payment rates from the MEI are significant. While H.R. 2 addresses the near-term concerns of the SGR system, the issues of inadequate physician payment rates are ultimately greater. If Medicare payments were to fall to a fraction of payments based on cost drivers, there would be reason to expect that access to physicians' services for Medicare beneficiaries would be severely compromised, particularly considering that physicians are less dependent on Medicare revenue than are other providers, such as hospitals and skilled nursing facilities. Similarly, the quality of care provided to Medicare beneficiaries would likely not keep pace with the care furnished to other types of patients.

Conclusion

The new systems for calculating physician rates under H.R. 2 would effectively avoid the need for annual (or more frequent) legislative overrides to the SGR formula under current law. These new physician payments would result in additional Federal Medicare spending of $150.5 billion for fiscal years 2015 through 2025. Other provisions included in H.R. 2 would partially offset these impacts, resulting in a net cost of $102.8 billion for the legislation. The long-range estimates in this memorandum include the following effects that would occur under H.R. 2: (i) the depletion date of the HI trust fund would be slightly delayed; (ii) the HI actuarial deficit would be slightly improved; and (iii) the present value of Part B spending would be slightly less than under current law and somewhat lower than under the projected baseline shown in the 2014 Medicare Trustees Report.

While physician payment updates would be adequate for many years, there are a number of concerns about the specified updates in the long range. In particular, the physician payment rates would be problematic under H.R. 2 in years with high inflation, in 2025 when the 5-percent APM bonus and the $500 million additional pool for MIPS are scheduled to expire, or at the point when the cumulative effects of payment updates not keeping up with physician costs become too large. If not addressed by subsequent legislation, we expect that access to, and quality of, physicians' services would deteriorate over time for beneficiaries.

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MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (H.R. 2)

(In millions)

Section	Provision	Fiscal Year 2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2015-19	2015-25
	Title I—SGR Repeal and Medicare Provider Payment Modernization													
101-106	Physician payment update													
	Part B	5,430	11,730	11,220	12,370	15,550	21,170	23,210	25,210	25,880	25,980	26,860	56,300	204,610
	Part B, net of premium offset	5,430	9,130	6,060	8,230	10,850	15,680	17,170	18,730	19,200	19,300	20,680	39,700	150,460
	Title II—Medicare and Other Health Extenders													
	Subtitle A—Medicare Extenders													
201	Extension of work GPCI floor													
	Part B	210	610	810	350	0	0	0	0	0	0	0	1,980	1,980
	Part B, net of premium offset	160	460	610	260	0	0	0	0	0	0	0	1,490	1,490
202	Extension of therapy cap exceptions process													
	Part B	590	1,690	2,250	960	0	0	0	0	0	0	0	5,490	5,490
	Part B, net of premium offset	440	1,270	1,690	720	0	0	0	0	0	0	0	4,120	4,120
203	Extension of ambulance add-ons													
	Part B	60	170	110	30	0	0	0	0	0	0	0	370	370
	Part B, net of premium offset	50	130	80	20	0	0	0	0	0	0	0	280	280
204	Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals													
	Part A	140	390	460	50	0	0	0	0	0	0	0	1,040	1,040
205	Extension of the Medicare-dependent hospital (MDH) program													
	Part A	60	180	220	20	0	0	0	0	0	0	0	480	480
206	Extension of specialized Medicare Advantage plans for special needs individuals													
	Part A	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part B, net of premium offset	0	0	0	0	0	0	0	0	0	0	0	0	0
207	Extension of funding for quality measure endorsement, input, and selection													
	Part A	15	15	15	0	0	0	0	0	0	0	0	45	45
	Part B	15	15	15	0	0	0	0	0	0	0	0	45	45
	Part B, net of premium offset	10	10	10	0	0	0	0	0	0	0	0	30	30
208	Extension of funding outreach and assistance for low-income programs													
	Part A	13	19	19	0	0	0	0	0	0	0	0	50	50
	Part B	13	19	19	0	0	0	0	0	0	0	0	50	50
	Part B, net of premium offset	10	10	10	0	0	0	0	0	0	0	0	30	30
209	Extension and transition of Medicare reasonable cost contracts													
	Part A	0	0	0	-10	0	0	0	0	0	0	0	-10	-10
	Part B	0	0	0	-10	0	0	0	0	0	0	0	-10	-10
	Part B, net of premium offset	0	0	0	0	0	0	0	0	0	0	0	0	0
210	Extension of home health rural add-on													
	Part A	0	50	70	30	0	0	0	0	0	0	0	150	150
	Part B	0	80	120	40	0	0	0	0	0	0	0	240	240
	Part B, net of premium offset	0	60	90	30	0	0	0	0	0	0	0	180	180

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (H.R. 2)

(In millions)

Section	Provision	Fiscal Year 2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2015-19	2015-25
	Subtitle B—Other Health Extenders													
211	Permanent extension of the qualified individual (QI) program	370	840	920	1,005	1,125	1,255	1,390	1,535	1,690	1,860	2,045	4,260	14,035
212	Permanent extension of the transitional medical assistance (TMA)													
	Medicaid	-10	-40	45	100	135	220	260	280	300	320	340	230	1,950
	Health insurance marketplaces - premium tax credits and cost-sharing reduction subsidies	20	70	-80	-170	-235	-380	-450	-485	-520	-555	-590	-395	-3,375
213	Extension of special diabetes program for type I diabetes and for Indians	No Medicare/Medicaid impact												
214	Extension of abstinence education													
215	Extension of personal responsibility education program (PREP)													
216	Extension of funding for family-to-family health information centers													
217	Extension of health workforce demonstration project for low-income individuals													
218	Extension of maternal, infant, and early childhood home visiting programs													
219	Tennessee DSH allotment for fiscal years 2015 through 2025	53	53	53	53	53	53	53	53	53	53	53	266	584
220	Delay in effective date for Medicaid amendments relating to beneficiary liability settlements	115	150	165	45	20	15	10	5	5	5	5	495	540
221	Extension of funding for community health centers, the National Health Service Corps, and teaching health centers	No Medicare/Medicaid impact												
	Title III—CHIP													
301	2-year extension of the Children's Health Insurance Program													
	CHIP	0	500	9,900	8,600	0	0	0	0	0	0	0	19,000	19,000
	Medicaid	0	-100	-2,200	-1,900	0	0	0	0	0	0	0	-4,200	-4,200
	Health insurance marketplaces - premium tax credits and cost-sharing reduction subsidies	0	-200	-3,700	-3,200	0	0	0	0	0	0	0	-7,100	-7,100
302	Extension of express lane eligibility													
	Medicaid	0	20	35	25	25	20	15	15	10	10	5	105	180
	CHIP	0	15	25	20	0	0	0	0	0	0	0	60	60
303	Extension of outreach and enrollment program	No Medicare/Medicaid impact												
304	Extension of certain programs and demonstration projects													
305	Report of the Inspector General of HHS on use of express lange option under Medicaid and CHIP	0	0	0	0	0	0	0	0	0	0	0	0	0
	Title IV—Offsets													
	Subtitle A—Medicare Beneficiary Reforms													
401	Limitation on certain Medigap policies for newly eligible Medicare beneficiaries													
	Part B	0	0	0	0	0	-10	-40	-70	-110	-160	-210	0	-600
	Part B, net of premium offset	0	0	0	0	0	-10	-30	-50	-80	-120	-160	0	-450
402	Income-related premium adjustment for Parts B and D													
	Part B, premium income	0	0	0	-610	-920	-2,890	-3,810	-4,250	-4,750	-5,320	-5,920	-1,530	-28,470
	Part B	0	0	0	-40	-80	-130	-160	-180	-210	-230	-260	-120	-1,290
	Part B, net of premium offset	0	0	0	-30	-60	-100	-120	-140	-160	-170	-200	-90	-980
	Part D, premium income	0	0	0	-120	-190	-650	-860	-970	-1,070	-1,180	-1,300	-310	-6,340
	Part D	0	0	0	-40	-40	-140	-190	-210	-250	-270	-270	-80	-1,410
	Part D, net of premium offset	0	0	0	0	0	0	0	0	0	0	0	0	0
	Part D, net of premium offset and clawback	0	0	0	0	0	0	0	0	0	0	0	0	0

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (H.R. 2)

(In millions)

Section	Provision	Fiscal Year 2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2015-19	2015-25
	Subtitle B—Other Offsets													
411	Medicare payment updates for post-acute providers													
	Part A	0	0	0	-1,150	-1,380	-1,480	-1,610	-1,800	-1,910	-2,020	-2,240	-2,530	-13,590
	Part B	0	0	0	-160	-270	-290	-320	-360	-380	-400	-440	-430	-2,620
	Part B, net of premium offset	0	0	0	-120	-200	-220	-240	-270	-290	-300	-330	-320	-1,970
412	Delay in reduction to Medicaid DSH allotments	0	0	1,120	2,330	1,510	640	-180	-930	-1,840	-3,320	-6,520	4,960	-7,190
413	Levy on delinquent providers	0	0	0	0	0	0	0	0	0	0	0	0	0
414	Adjustments to inpatient hospital payment rates													
	Part A	0	0	0	-4,540	-4,750	-3,960	-2,990	-1,930	-670	-500	-530	-9,290	-19,870
	Title V—Miscellaneous													
	Subtitle A—Protecting the Integrity of Medicare													
501	Prohibition of inclusion of Social Security account numbers on Medicare cards													
	Part A	13	49	49	49	0	0	0	0	0	0	0	160	160
	Part B	13	49	49	49	0	0	0	0	0	0	0	160	160
	Part B, net of premium offset	10	40	40	40	0	0	0	0	0	0	0	130	130
502	Prevent wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
503	Consideration of measures regarding Medicare beneficiary smart cards	0	0	0	0	0	0	0	0	0	0	0	0	0
504	Modifying Medicare durable medical equipment face-to-face-encounter documentation requirement	0	0	0	0	0	0	0	0	0	0	0	0	0
505	Reducing improper Medicare payments	0	0	0	0	0	0	0	0	0	0	0	0	0
506	Improving senior Medicare patrol and fraud reporting rewards	0	0	0	0	0	0	0	0	0	0	0	0	0
507	Requiring valid prescriber National Provider Identifiers on pharmacy claims	0	0	0	0	0	0	0	0	0	0	0	0	0
508	Options to receive Medicare Summary Notice electronically	0	0	0	0	0	0	0	0	0	0	0	0	0
509	Renewal of MAC contracts	0	0	0	0	0	0	0	0	0	0	0	0	0
510	Study on pathway for incentives to States for State participation in Medicaid data match program	0	0	0	0	0	0	0	0	0	0	0	0	0
511	Guidance on application of Common Rule to clinical data registries	0	0	0	0	0	0	0	0	0	0	0	0	0
512	Eliminating certain civil monetary penalties; gainsharing study and report	0	0	0	0	0	0	0	0	0	0	0	0	0
513	Modification of Medicare home health surety bond condition of participation requirement	0	0	0	0	0	0	0	0	0	0	0	0	0
514	Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation	0	0	0	0	0	0	0	0	0	0	0	0	0
515	National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport	0	0	0	0	0	0	0	0	0	0	0	0	0
516	Repealing duplicative Medicare secondary payor provision	0	0	0	0	0	0	0	0	0	0	0	0	0
517	Plan for expanding data in annual CERT report	0	0	0	0	0	0	0	0	0	0	0	0	0
518	Removing funds for Medicare Improvement Fund added by IMPACT Act of 2014	0	0	0	0	0	0	0	0	0	0	0	0	0
519	Rule of consideration	0	0	0	0	0	0	0	0	0	0	0	0	0

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015 (H.R. 2)

(In millions)

Section	Provision	Fiscal Year 2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2015-19	2015-25
	Subtitle B—Other Provisions													
521	Extension of two-midnight PAMA rules on certain medical review activities	0	0	0	0	0	0	0	0	0	0	0	0	0
522	Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program												0	0
523	Payment for global surgical packages													
	Part B	0	0	20	160	190	210	220	230	230	240	250	370	1,750
	Part B, net of premium offset	0	0	20	120	150	160	160	170	180	180	190	290	1,330
524	Extension of Secure Rural Schools and Community Self-Determination Act of 2000	0	0	0	0	0	0	0	0	0	0	0	0	0
525	Exclusion from PAYGO scorecards	0	0	0	0	0	0	0	0	0	0	0	0	0

A 0 in any line above means either no impact or negligible impact (< $5 million)
The Medicare provisions that affect fee-for-service benefits also reflect the resulting impact on payments to private health plans.
Interaction between the proposals is not fully reflected.

SUMMARY OF IMPACTS OF H.R. 2													
Part A	241	703	833	-5,551	-6,130	-5,440	-4,600	-3,730	-2,580	-2,520	-2,770	-9,905	-31,545
Part B	6,331	14,363	14,613	13,749	15,390	20,950	22,910	24,830	25,410	25,430	26,200	64,445	210,175
Part B net of premium	6,110	11,110	8,610	9,270	10,740	15,510	16,940	18,440	18,850	18,890	20,180	45,840	154,650
Part D	0	0	0	-40	-40	-140	-190	-210	-250	-270	-270	-80	-1,410
Part D net of premium	0	0	0	0	0	0	0	0	0	0	0	0	0
Part D net of premium and clawback	0	0	0	0	0	0	0	0	0	0	0	0	0
Part B income[1]	0	0	0	-610	-920	-2,890	-3,810	-4,250	-4,750	-5,320	-5,920	-1,530	-28,470
Part D income[1]	0	0	0	-120	-190	-650	-860	-970	-1,070	-1,180	-1,300	-310	-6,340
Medicaid/CHIP	528	1,438	10,063	10,278	2,868	2,203	1,548	958	218	-1,072	-4,072	25,176	24,959
Health insurance marketplaces	20	-130	-3,780	-3,370	-235	-380	-450	-485	-520	-555	-590	-7,495	-10,475
TOTAL IMPACT OF H.R. 2													
Net Medicare benefits	6,351	11,813	9,443	3,719	4,610	10,070	12,340	14,710	16,270	16,370	17,410	35,935	123,105
Total income	0	0	0	-730	-1,110	-3,540	-4,670	-5,220	-5,820	-6,500	-7,220	-1,840	-34,810
Net Medicare impact	6,351	11,813	9,443	2,989	3,500	6,530	7,670	9,490	10,450	9,870	10,190	34,095	88,295
Medicaid/CHIP	528	1,438	10,063	10,278	2,868	2,203	1,548	958	218	-1,072	-4,072	25,176	24,959
Health insurance marketplaces	20	-130	-3,780	-3,370	-235	-380	-450	-485	-520	-555	-590	-7,495	-10,475

[1]The income-related premium provision results in higher premium income for Part B and Part D, which is used to reduce transfers from the general fund of the Treasury.

Office of the Actuary
Centers for Medicare & Medicaid Services