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OPTIONS EXIST FOR OFFSETTING THE COST OF EXTENDING HEALTH COVERAGE TO MORE LOW-INCOME CHILDREN

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There is growing consensus that SCHIP reauthorization should make substantial progress toward covering all uninsured low-income children. SCHIP reauthorization legislation thus will require significant increases in federal funding, so states have sufficient federal SCHIP funds both to maintain their existing SCHIP programs and to enroll as many as possible of the roughly six million low-income children who are eligible for Medicaid or SCHIP but are uninsured.

The cost of such legislation will be substantial. The Congressional Budget Office estimates that the net federal cost of providing the federal funding needed just to sustain existing state SCHIP programs is $7.9 billion over five years. Based on CBO estimates of the cost per child of covering uninsured children as well as other factors, the additional federal cost of immediately enrolling the roughly six million eligible uninsured children easily exceeds $50 billion over five years.

Legislation reauthorizing SCHIP will be subject to the Pay-As-You-Go rules in the House and, most likely, in the Senate as well. (The Senate is expected to reinstate a Pay-As-You-Go rule in the budget resolution it will soon develop.) These rules require that the cost of increases in "mandatory" programs such as SCHIP and Medicaid (as well as tax cuts) be fully offset through entitlement reductions and/or revenue increases.

The reinstatement of Pay-As-You-Go budgeting has led some to argue that the goal of reaching many of the eligible uninsured children should be shelved because the costs cannot be "paid for," or that Congress should ignore Pay-As-You-Go, throw up its hands, and not try to find "offsets" to cover the legislation's costs because the task is too difficult. (The latter approach also could ultimately lead to the result of little progress being made in reducing the large number of uninsured low-income children, since legislation without offsets would have to overcome substantial obstacles, such as the need to get 60 votes in the Senate to waive Pay-As-You-Go.)

Such conclusions are unwarranted. On the merits, there are ample offsets on both the spending and revenue sides of the budget to cover the costs of SCHIP reauthorization a number of times over. Some of the spending offsets discussed below were approved by the Senate in 2005.

The issue is *not* that potential offsets are lacking, but that each potential offset is opposed by powerful special interests. Crafting an SCHIP reauthorization bill that substantially reduces the number of uninsured low-income children without swelling the deficit will require policymakers to

make tough choices, and to stand up to special interests in order to serve the broader national interest.

What follows is a representative list of potential offsets that would reduce entitlement expenditures or increase revenues and could be used to pay for SCHIP reauthorization (see Table 1). These include:

- reducing excessive overpayments to private health care plans in the Medicare program as recommended by the Medicare Payment Advisory Commission (MedPAC), Congress' own expert advisory body on Medicare payments;
- increasing the rebates that drug manufacturers pay under the Medicaid program;
- allowing the Food and Drug Administration to approve generic versions of biological drugs;
- canceling the parts of two tax cuts enacted in 2001 that exclusively benefit high-income Americans and have not yet taken effect (no taxpayer would lose a dollar in tax cuts he or she is currently receiving);
- closing a modest part of the capital gains "tax gap", as proposed by the Administration and some members of Congress, by requiring financial institutions to report the price for which assets are purchased, so that capital gains taxes can be computed more accurately; and
- raising federal tobacco and/or alcohol taxes.

This list is by no means exhaustive. Numerous other potential offsets also could be considered, including MedPAC recommendations to modify the payment rates for certain other Medicare providers, proposals to prevent drug manufacturers from impeding or delaying the entry of generic drugs into the market, and options developed by Congress' Joint Committee on Taxation to close unintended or unproductive tax breaks.

I. SPENDING REDUCTIONS

A. Adopt MedPAC Recommendations to Curb Medicare Advantage Overpayments

1. Curb excessive Medicare payments to private plans by paying the plans the same amounts — rather than more — that would be paid for treating the same patients under Medicare "fee-for-service."

According to the Medicare Payment Advisory Commission (MedPAC), Medicare payment rates to private plans now are *12 percent higher*, on average, than the cost of providing fee-for-service Medicare to comparable beneficiaries. Private plans were brought into Medicare a decade ago on the theory that they would introduce competition and save the program money. Instead, MedPAC has documented that the private plans are costing the Treasury tens of billions of dollars because they are significantly overpaid.

To address this problem, MedPAC has recommended that the benchmarks against which competitive bids by private plans are evaluated (the process that determines the Medicare payment

levels for the private plans) be set at 100 percent of the costs of fee-for-service Medicare. This would ensure equity between private plans and traditional Medicare fee-for-service.

Testifying before Congress on March 1, MedPAC chairman Glenn Hackbarth said these overpayments are driving up Medicare payments and thereby making the task of sustaining Medicare more difficult. Hackbarth said Medicare faces "a very clear and imminent risk from this overpayment that will put this country in an untenable position."[1]

This important reform would substantially reduce federal costs. The Congressional Budget Office estimates it would save $54 billion over five years (and $149.1 billion over ten years).

2. Stop Medicare from paying *twice* for indirect medical education costs.

Medicare reimburses teaching hospitals directly for the indirect medical education costs they incur when treating Medicare beneficiaries. Indirect medical education costs are the higher costs that teaching hospitals incur because they offer a wider array of health care services and because their patients have poorer than-average health status.

However, the benchmarks used to evaluate the bids that private plans submit to the Medicare program are based on the old private-plan payment system that assumes that the plans will reimburse teaching hospitals for their teaching costs, even though Medicare reimburses such hospitals directly.

MedPAC consequently has found that Medicare essentially *pays twice* for indirect medical education — once by reimbursing teaching hospitals directly for IME costs, and a second time by inflating payments to managed care plans to cover IME costs. To remove the double payments, MedPAC recommends eliminating IME from the calculation of the payment benchmarks used to set Medicare payment levels to private plans.

CBO estimates this reform would save $5.2 billion over five years (and $12.9 billion over ten years).

3. Eliminate the Medicare stabilization fund for preferred provider organizations.

The 2003 Medicare drug law developed a new type of private plan — the *regional* Preferred Provider Organization (PPO) — to provide care to Medicare beneficiaries. As an inducement for PPOs to enter and remain in regional markets, the drug law established a $10 billion "stabilization fund" to provide additional funds to PPOs, above and beyond the regular Medicare payments these PPOs would receive.

MedPAC recommended eliminating the stabilization fund, which many critics have referred to as a "slush fund", both to eliminate unnecessary costs and to ensure a "level playing field" for competing types of Medicare plans, whether traditional fee-for-service, HMOs, or the regional PPOs. Otherwise, due to the higher reimbursements available through the stabilization fund, the

[1] See BNA's Health Care Daily Report, "Growth of Managed Care Plans Threatens Program's Finances, MedPAC Chairman Says," March 2, 2007.

TABLE 1

List of Representative Spending Reduction and Revenue Raising Options

	5 Year Savings (2008-2012)	10 Year Savings (2008-2017)
	(in billions of dollars)	
Spending Reduction Options		
1. Pay Medicare private plans at same levels as Medicare fee-for service*	$54.0	$149.1
2. Remove indirect medical education costs from the benchmarks used to set Medicare payments for private plans.*	$5.2	$12.9
3. Eliminate the remaining Medicare stabilization fund for PPOs.*	$1.6	$3.5
4. Take into account upcoding in implementing risk adjustment for Medicare payments to private plans.**	$7.0	$31.0
5. Require in Medicare that regional PPO bids and benchmarks be determined in same manner as the bids and benchmarks for local plans.**	$2.0	$6.0
6. Increase the minimum Medicaid drug rebate paid by drug manufacturers.**	$2.4	$6.5
7. Provide an additional Medicaid drug rebate adjustment if generic drug prices rise faster than inflation.	n/a	n/a
8. Extend the Medicaid drug rebate to drugs dispensed through managed care plans.**	$1.8	$5.1
9. Establish an explicit pathway for FDA approval of generic versions of biological drugs.	n/a	n/a
Revenue Raising Measures		
1. Hold two tax cuts for high-income taxpayers that are now phasing in (related to use of itemized deductions and personal exemptions) at their current levels.***	$13.0	$13.0
2. Require financial institutions to report the "basis" of financial assets to IRS for purposes of determining capital gain taxes.*	$0.5	$3.3
3. Increase the federal excise tax on tobacco.*	$26.6	$53.2
4. Adjust the tobacco excise tax for inflation since 2002.****	$3.7	$7.4
5. Increase and make uniform the federal excise taxes on alcoholic beverages.*	$28.0	$59.5
6. Adjust alcohol excise taxes for inflation since 1991	n/a	n/a

* Current Congressional Budget Office or Joint Committee on Taxation estimates.

** Based on prior estimates by the Congressional Budget Office.

*** Tax Policy Center estimates.

**** Rough estimate based on CBO estimate of savings from a larger tobacco tax increase.

PPOs will have an unfair competitive advantage over Medicare fee-for-service and other private plans.

A partial version of this MedPAC recommendation was included in the "tax extenders" bill enacted in late 2006. That legislation eliminated about $6.5 billion of the $10 billion fund. The remainder of the stabilization fund could be eliminated now. Doing so would put Congress in full compliance with the MedPAC recommendation in this area.

The savings would be $1.6 billion over the next five years (and $3.5 billion over ten years), according to CBO.

4. Prevent private plans from obtaining excessive Medicare payments by appropriately taking into account any pattern of inaccurate reporting of the health conditions of the patients they serve.

Healthier Medicare beneficiaries are less costly to serve than sicker beneficiaries. Since the beneficiaries who enroll in private plans are, on average, healthier than beneficiaries in Medicare fee-for-service, the Medicare program needs to adjust the payments it makes to private plans to reflect this. The process of adjusting the payments to reflect the health status of Medicare beneficiaries who are enrolled in the private plans, which is known as "risk adjustment," is necessary to prevent Medicare from overpaying the private plans because the beneficiaries they enroll are healthier and less costly to treat.

The Center for Medicare and Medicaid Services at the Department of Health and Human Services has developed such a risk adjustment process. Prior to 2007, however, the process essentially had not been implemented. (Technically, CMS had instituted the risk adjustment system but had accompanied it with a "hold harmless" policy that *increased* payments to private plans to offset the downward payment adjustments that resulted from risk adjustment.) Following the recommendations of MedPAC, the budget reconciliation bill that the Senate passed in 2005 required the Secretary of Health and Human Services to phase out the hold-harmless policy, and thereby to implement risk adjustment fully, between 2006 and 2010.

This Senate provision also contained a key feature requiring the Secretary to take "upcoding" into account when he set the risk-adjusted payments for the private plans. To determine the health status of patients enrolled in private plans, the risk adjustment process uses the diagnostic codes that hospitals and physicians assign to their patients. The phenomenon of "upcoding," or "coding creep" — whereby Medicare beneficiaries may be unintentionally or intentionally assigned diagnostic codes over time that make them appear less healthy than they actually are — could enable private plans to continue being overpaid for healthier Medicare beneficiaries whom they serve, despite the phase-out of the hold harmless payments. Accordingly, the Senate provision contained safeguards to prevent this problem from occurring.

At the behest of the private plans, however, the Senate provision was rendered toothless in the House-Senate conference agreement on the budget reconciliation bill enacted in early 2006. In conference, the Senate provision was altered so that after 2010 — in the years when risk adjustment would take full effect — the Secretary would have no obligation to take any upcoding patterns into account. (The Secretary would be allowed but not required to do so.) In analyzing the conference agreement, CBO concluded that the Secretary would *not* act after 2010 to prevent upcoding from compromising the risk-adjustment system, because HHS would face intense industry opposition if it sought to take such action. CBO concluded that, as a result, Medicare payments to private plans would again become excessive after 2010.

CBO accordingly reduced its estimate of the savings from this provision from $26 billion over ten years under the original Senate-passed reconciliation bill to only $4 billion over ten years under the legislation that emerged from conference.

Requiring the Secretary to take into account any upcoding in years after 2010, as the original Senate bill would have done, would close this potential loophole and ensure that Medicare payments to private plans are properly risk-adjusted. Based on previous CBO estimates, this would save approximately $7 billion over five years (and $31 billion over ten years).

5. Require that regional PPO bids and payment benchmarks reflect the average cost of serving the Medicare beneficiaries whom a PPO actually enrolls, rather than the average cost of the overall Medicare population in the region.

The bids and payment benchmarks of private plans that serve *local* areas are based on the average cost of serving a plan's enrollees. But while the bids that the new *regional* PPOs submit reflect the average cost of serving the Medicare beneficiaries in their service areas whom they expect to enroll, the payment benchmarks used to determine how much the regional PPOs actually are paid will be based on the average cost of *all* Medicare beneficiaries in a PPO's region. If a regional PPO targets counties within a region in which beneficiaries have lower average costs than the region as a whole, but the PPO is paid based on the higher average cost for the entire region, the regional PPO will receive higher payments from Medicare than local plans that serve similar beneficiaries. MedPAC has warned that these overpayments will both waste funds and create an unfair competitive advantage for regional PPOs over local plans.

MedPAC has recommended that both the bids *and* the benchmarks for regional PPOs be calculated in the same manner as the bids and benchmarks for local plans. Previous CBO estimates indicate that doing so would save at least $2 billion over five years (and $6 billion over ten years), although a new cost estimate might be lower since enrollment in regional PPOs has been lower than earlier projected.

B. Increasing the Medicaid Drug Rebate

1. Increase the minimum drug rebate that pharmaceutical companies pay to the Medicaid program.

Under current law, drug manufacturers must pay rebates to the federal government and the states for the prescription drugs that Medicaid dispenses. The rebate for *brand-name* drugs is currently equal to the higher of 15.1 percent of the Average Manufacturer Price (AMP, the price at which manufacturers sell to wholesalers) or the difference between that price and the lowest price at which the manufacturer sells the drug to private purchasers. The minimum rebate for *generic* drugs is 11 percent of the AMP.

Some state Medicaid programs have been able to negotiate additional rebates with some drug manufacturers. This suggests that the federal government is not making the most of the Medicaid program's large purchasing power to secure more favorable prices for the prescription drugs the program uses. Strengthening the rebate program would make the federal government a more cost-effective purchaser and reduce both federal and state Medicaid costs without harming beneficiaries. The National Governors Association has recommended increasing the Medicaid rebates on prescription drugs. The Senate-passed version of the reconciliation bill in 2005 included an increase in the minimum Medicaid drug rebate.

CBO has estimated that increasing the minimum rebate for brand-name drugs to 20 percent of the AMP would generate federal savings of $1.4 billion over five years (and $3.6 billion over ten years.). Increasing the minimum rebate for both brand-name drugs *and* generic drugs to 17.8 percent of AMP — the proposal included in the Senate-passed reconciliation bill in 2005 — would generate savings of $2.4 billion over five years (and $6.5 billion over ten years), based on prior CBO estimates.

2. Provide an additional rebate adjustment if generic drug prices rise faster than inflation.

Manufacturers of brand-name drugs must pay an additional rebate if the Average Manufacturer Price of their brand-name drug products climbs at a faster annual growth rate than the Consumer Price Index. This additional rebate creates incentives that limit annual brand-name drug price increases. Manufacturers of generic drugs, however, are not subject to this additional rebate adjustment. Requiring a similar rebate adjustment for generic drugs would reduce Medicaid costs for prescription drugs and also should limit generic drug price increases. No estimate of the savings is available.

3. Extend the Medicaid drug rebate to drugs dispensed through Medicaid managed care plans.

Drug manufacturers are not required to pay rebates on drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. This exception is in place because, when the rebate law was enacted in 1990, it was assumed that managed care plans could negotiate discounted drug prices as favorable as those available under the rebate system.

Analysts now believe, however, that managed care plans do *not* get discounted prices equivalent to those provided under the rebate system, with the result that Medicaid costs are pushed up. This exception could be eliminated and the rebate applied to drugs dispensed through managed care plans as well. Such a change would ensure that Medicaid managed care plans get the best drug prices available and would allow states to achieve corresponding savings in their managed care reimbursement rates.

This proposal, as well, has been endorsed by the National Governors Association. It also was included in the reconciliation bill that the Senate approved in 2005.

Based on previous CBO estimates, the savings should be approximately $1.8 billion over five years (and $5.1 billion over ten years).

C. Allowing Use of Generic Versions of Biological Drugs

1. Establish an explicit FDA regulatory mechanism for generic versions of biological drugs to enter the market.

Biologicals are innovative drugs derived from living cells that treat a variety of medical conditions including anemia, hepatitis, rheumatoid arthritis, some forms of cancer, and multiple sclerosis. Unlike for drugs generally, there is no existing FDA-approved process for bringing generic versions of biological drugs into the market. As a result, the firms that manufacture the biological drugs

usually have permanent monopolies on these drugs, with no competition. As a consequence, these drugs can remain very costly for long periods of time.

Allowing generic versions of biological drugs would bring prices down, make such drugs more affordable, and reduce federal and state costs for Medicare, Medicaid, and SCHIP, as well as for employers and people who purchase health care coverage individually. Legislation to establish an FDA process for approving generic versions of biological drugs has recently been introduced by Representative Henry Waxman (H.R. 1038) and Senator Charles Schumer (S. 623).

No estimate of the savings is currently available, but the savings should be significant. (Some consultants estimate savings in the vicinity of $7 billion over five years just in Medicare Part B. There would be additional savings in Medicare Part D, Medicaid, and other federal health programs.)

II. REVENUE RAISING MEASURES

1. Freeze two tax cuts exclusively benefiting high-income taxpayers that are still phasing in.

The 2001 tax-cut legislation included two tax cuts exclusively for high-income taxpayers that were to take effect in three stages — in 2006, 2008, and 2010. The two tax cuts would benefit high-income individuals by gradually eliminating the provision of the tax code that places limits on the value of itemized deductions that taxpayers with very high incomes may take, and by gradually eliminating the tax-code provision that phases out the value of personal exemptions for those taxpayers.

President Bush never requested these two tax cuts. Congress added them on top of the Bush tax-cut proposals in 2001, and phased them in extremely slowly so their full costs would show up in only one year (2010) of the ten years that the 2001 tax-cut legislation covered.

Congress could act now to cancel the parts of these two tax cuts that are not yet in effect (i.e., the portions slated to take effect in 2008 and 2010), while maintaining the portion of these two tax cuts that is already in effect. No individual would lose a dollar in tax cuts he or she now receives.

Based on estimates from the Urban Institute-Brookings Tax Policy Center, this would save approximately $13 billion over five years. (The ten-year savings are the same since the two tax cuts are scheduled to expire at the end of 2010, along with most of the other tax cuts enacted in 2001.) Only high-income taxpayers would be affected. The Tax Policy Center estimates that *98 percent* of the benefits of these two tax cuts will go to the four percent of households with incomes over $200,000 a year. Nearly two-thirds of the benefits will go to the 0.3 percent of households with incomes over $1 million a year.

The effect on taxpayers with incomes below $200,000 would be miniscule. The Tax Policy Center estimates that retaining the part of these tax cuts that is now in place, while canceling the parts not yet in effect, would cause taxpayers with incomes between $100,000 and $200,000 to forgo an average additional tax cut of just $7 in 2010. (The average loss for households below $100,000 would be zero; virtually none of them would be affected.)

While households with incomes over $1 million would forgo significant additional tax cuts, they still would fare handsomely from tax cuts that have already taken effect. The Tax Policy Center estimates that these households will receive an average tax reduction of $120,000 in 2007 as a result of the tax cuts enacted in 2001 and 2003. Moreover, these households' average tax cut will still climb to $146,000 in 2010 if the portions of the two above-mentioned tax cuts that are slated to take effect in 2008 and 2010 are canceled, according to the Tax Policy Center. If these two tax cuts are *not* reined in, the overall tax cut for people with incomes of more than $1 million will be climb by $12,000 more, to an average of $158,000 in 2010.

Policymakers who oppose freezing these two tax cuts, while advocating a small SCHIP bill on the grounds that a larger bill is not affordable, can be asked how the nation can afford an additional $12,000 annual tax cut for millionaires but not be able to afford to insure more low-income children.

2. Reduce a modest portion of the "tax gap" by requiring financial institutions to report data to the IRS on the purchase price (or "basis") of financial assets so that capital gains tax liability can be determined more accurately.

Currently, financial institutions are required to report dividends, interest payments, and sales prices of financial assets to taxpayers and the IRS. Capital gains taxes, however, are based on the sales price *minus the purchase price* (or "basis). And financial institutions are *not* required to report the purchase price of financial assets. Partly as a result, overstatement of the purchase price of assets (which leads to understatement of capital gains) is believed to be widespread and to contribute significantly to the capital gains "tax gap."

The Administration has included a proposal in its fiscal year 2008 budget to require financial institutions to begin reporting the purchase price of financial assets, starting with securities acquired in 2009. Similar legislation has been introduced by Senators Evan Bayh and Tom Coburn (S. 601) and by Representatives Rahm Emanuel and Walter Jones (H.R. 878). The Joint Committee on Taxation estimates that the Administration's proposal would produce savings of $465 million over five years (and $3.3 billion over ten years).

3. Increase the federal excise tax on cigarettes.

Senator Gordon Smith recently proposed raising the federal excise tax on cigarettes by 60 cents a pack to finance the SCHIP reauthorization legislation. The tax now stands at 39 cents a pack.

This measure would both raise revenues and reduce smoking and thereby improve health. According to CBO, researchers estimate that each 10 percent increase in the price of cigarettes would reduce use of cigarettes by 2.5 percent to 5 percent, and possibly by a greater amount among teenagers. A reduction in cigarette use would also reduce health care costs associated with tobacco use.

While CBO estimates of Senator Smith's proposal are not yet available, CBO estimates that an increase in the cigarette tax of *50* cents per pack would raise $26.6 billion in revenue over five years (and $53.2 billion over 10 years).

It also may be noted that the cigarette tax is fixed in nominal terms at 39 cents per pack and has not been changed since 2002. Simply adjusting for five years of inflation would justify an increase to 46 cents in 2008, which would raise close to $4 billion over five years.

4. Increase the federal excise taxes on alcoholic beverages.

Distilled spirits, beer and wine each have different federal excise taxes. As with tobacco use, alcohol use creates external costs, including higher health care costs, lower productivity, and the loss of lives and property due to alcohol-related accidents. Raising the federal excise taxes on alcoholic beverages would reduce alcohol use.

It also would make sense to tax different alcoholic beverages in a uniform manner so as to provide equal treatment for all alcoholic beverages, rather than favoring certain beverages over others. CBO estimates that increasing the federal excise tax on all alcoholic beverages to a uniform $16 per gallon option would raise $28 billion over five years (and $59.5 billion over ten years).

In a 2005 petition, 59 economists, including four Nobel Laureates, called for increasing taxes on alcoholic beverages.[2] They noted that, because alcohol taxes (like the cigarette tax) are fixed in nominal terms and have not been increased since 1991, "the effective rate of taxation on [alcohol] products has declined dramatically," and they commented, "we see no justification for expanding the economic availability of products that cause so much damage to society." Simply returning alcohol taxes to their 1991 levels, adjusted for inflation, would itself raise considerable revenue.

Conclusion

The measures described here are only a selection of the expenditure and revenue options that could be used to offset the costs of an SCHIP reauthorization bill. Many other appropriate money-saving measures also could be pursued. For example, MedPAC has recommended a number of additional measures to curb excess Medicare payments and increase Medicare's efficiency, while the President's budget includes a number of other proposals related to Medicare payments to providers that would produce further savings. In addition, the Joint Committee on Taxation issued a major report in 2005 setting forth a wide array of options to raise revenues by closing unintended or unproductive tax breaks and improving tax compliance.

The United States is the only western industrialized nation that lacks universal health care coverage, and thus is the only such nation with millions of uninsured low-income children. The SCHIP reauthorization legislation could provide the means to cover most of these children. Options are available to cover the cost. What is less clear is whether the political will is present to undertake this task.

2 "Economists' Declaration on Federal Alcohol Excise Taxes," May 2005, http://www.cspinet.org/new/pdf/petition-alcohol.pdf.