DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21207-0512

April 25, 2013

The Honorable Tom A. Coburn, M.D.
U.S. Senate
Committee on Finance
172 Russell Senate Office Building
Washington, DC 20510

Dear Senator Coburn,

The attached memorandum from John Shatto, Suzanne Codespote, and other members of my staff responds to the request made by Josh Trent on your behalf for an updated confidential analysis of "A Bipartisan Plan To Save Medicare & Reduce Debt," as developed by you and Senator Joseph Lieberman. Their analysis includes the estimated net Medicare savings by provision, the estimated numbers of beneficiaries affected by category of health insurance, and related effects such as Federal Medicaid outlays and Health Insurance Exchange subsidy expenditures.

These estimates reflect different specifications than those included in our December 6, 2012 memorandum. Specifically, the unified deductible and maximum out-of-pocket limits for Medicare are now indexed each year to grow with program costs. Also, several of the provisions are now assumed to take effect on January, 1 2014 instead of January 1, 2013. They include the proposals on; (i) the 3-year physician payment freeze, (ii) home health payments, (iii) payments for bad debts, (iv) the unified Medicare deductible and out-of-pocket limit, and (v) the restrictions on Medigap coverage. In addition, the provision requiring higher income Americans to pay more out of pocket for Medicare has been removed.

Please let us know if you or your staff members have any questions about these estimates or if we can be of further assistance.

Sincerely,

Paul Spitalnic

Paul Spitalnic, ASA
Acting Chief Actuary

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
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Date: April 25, 2013

From: John Shatto, Suzanne Codespote, Clare McFarland, Chris Truffer, Rich Coyle, Makhmud Sagandykov, John Wandishin, Elliott Weinstein, Dish-Lang Liu, Kent Clemens, John Klemm, Yaminee Thaker, David Vance

Subject: Estimated Financial Impacts of the Lieberman/Coburn Proposal

This memorandum provides an analysis of "A Bipartisan Plan to Save Medicare & Reduce Debt: The Lieberman/Coburn Proposal" including additional specifications as described below. It summarizes the Office of the Actuary's (OACT's) estimates of the financial and coverage effects of that proposal through fiscal year 2022. Detailed estimates for each of the provisions are included in the attached table. Since, in addition to Medicare, the proposal affects the Medicaid program and Federal subsidies provided for under the Health Benefits Exchanges, those impacts are shown separately.

Summary

The Lieberman/Coburn proposal comprises several major changes to the Medicare program, including (i) the creation of a new benefit structure with a unified deductible and maximum out-of-pocket limit; (ii) an increase in the eligibility age; (iii) limits on the scope of Medigap coverage; and (iv) increases in premium amounts. These revisions are estimated to save $536 billion in net Federal costs over the next 10 years and are summarized in the table below. The spending provisions are assumed to take effect January 1, 2014, while the premium provisions are assumed to begin on January 1, 2015.

Estimated Federal Costs (+) or Savings (−) for the Lieberman/Coburn Proposal
(in billions)

	Fiscal year										Total,
Provisions	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-22
Total	—	$10.8	$0.9	−$13.4	−$46.5	−$69.9	−$83.4	−$98.2	−$111.4	−$124.8	−$535.9
Medicare Benefits	—	9.7	3.0	−5.7	−32.3	−48.0	−52.8	−60.7	−69.3	−78.4	−334.6
Medicare Premiums	—	—	−4.6	−11.4	−19.4	−28.7	−39.2	−47.2	−53.0	−58.9	−262.4
Medicaid	—	0.7	1.6	2.3	3.2	4.1	5.2	5.5	5.9	6.3	34.9
Exchanges	—	0.4	0.9	1.5	2.1	2.7	3.4	4.1	5.0	6.2	26.2

These estimates reflect additional specifications for the Lieberman/Coburn proposal. They include; (i) indexing the parameters of the new Medicare benefits structure to the growth in

program costs, (ii) beginning many of the Medicare benefit provisions on January 1, 2014, and (iii) removing the provision to increase the out-of-pocket maximum for higher income Americans.

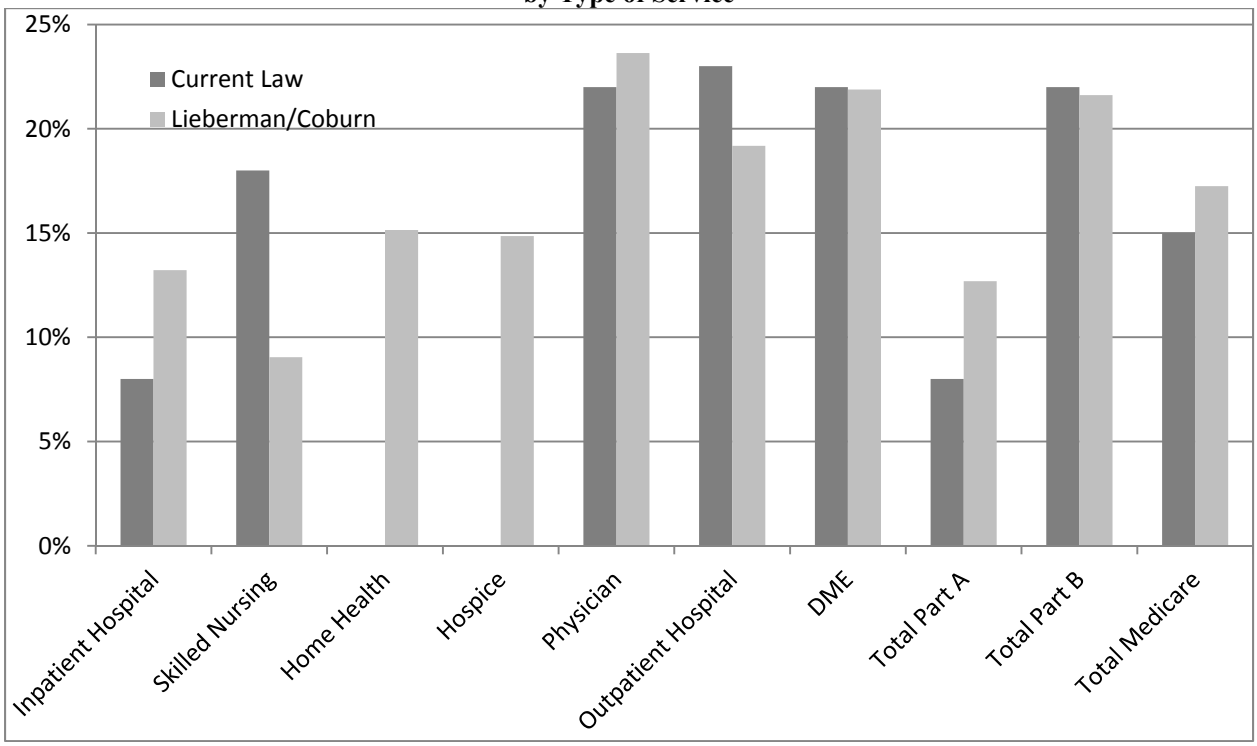
The estimated impacts were based on the FY 2013 Budget Mid-Session Review baseline updated to include the physician payment freeze for 2013. Many of the individual provisions interact significantly with one another. To account for these interactions, the estimates described in this memorandum generally build upon the prior provisions. In particular, the estimates were derived in 4 steps. The estimates for the increase in the Medicare eligibility age, the physician payment update, the reduction in bad debt payments, and the reduced home health rates were determined as stand-alone impacts. The unified deductible and maximum out-of-pocket provision is then estimated off a baseline that includes those first four provisions. After that, we determined the impact of the Medigap limits. Once the benefit provisions were completed, the impact of the increased basic and income-related premiums were calculated.

Unified Annual Deductible and Maximum Out-of-Pocket Limit

For this provision, the current Medicare cost-sharing requirements would be replaced by a new benefit structure that would be applied to Medicare Parts A and B combined. There would be a $550 deductible followed by 20-percent coinsurance for spending between $550 and $25,300. For spending between $25,300 and $65,300, beneficiaries would be subject to 5-percent coinsurance. Since the maximum out-of-pocket limit would be $7,500, spending over $65,300 would have no coinsurance. For purposes of determining the financing for Part A and Part B separately, when services occurred on the same day, Part A services would count towards the deductible first. As noted earlier, the financial effects of the unified benefit parameters were modeled after applying the effects of the provisions on (i) the physician payment update, (ii) home heath payments, and (iii) payments for bad debts.

These new benefit parameters are applied in 2014 and are increased by the growth in Medicare costs for all subsequent years. This new structure would decrease the actuarial value of the Medicare program from roughly 85 percent to about 83 percent, generating significant savings to the program. However, the impact of this provision on the cost-sharing percentages varies by type of service. The chart below compares the cost-sharing percentages under current law to those estimated for the Lieberman/Coburn proposal for selected Medicare types of service. For home health and hospice services, there is currently no cost-sharing requirement. This proposal would require cost-sharing amounts that are expected to average about 15 percent. For inpatient hospital services, the average cost-sharing amount is expected to rise from roughly 8 percent to about 13 percent, reflecting a lower initial deductible but higher coinsurance. Part B services, such as physician payments, durable medical equipment, and outpatient hospital services, would be relatively unchanged from current law.

Estimated Effect of the Lieberman/Coburn Proposal on Medicare Cost-Sharing Percentages, by Type of Service



Over the next 10 years this proposal is estimated to reduce Medicare spending by roughly $169 billion (reflecting a reduction of $293 billion for Part A and an increase of $124 billion in Part B). Since the benefits for Part B are increasing, income from the current Part B premium payments is expected to rise by about $31 billion (before consideration of other provisions). For beneficiaries that are dually eligible for both Medicare and Medicaid, a share of their Medicare out-of-pocket costs will be covered by Medicaid. As a result, Federal Medicaid costs are estimated to increase by $11 billion.[1] Therefore, the net Federal impact of the unified proposed Medicare benefit structure is estimated to be a savings of $189 billion for fiscal years 2013 through 2022.[2]

Limit Medigap Coverage

The most popular Medigap policies generally provide first dollar coverage for beneficiaries as well as payments to cover most Medicare out-of-pocket costs. The Lieberman/Coburn proposal would prohibit Medigap policies from paying any of the $550 deductible and would limit coverage to half of the remaining cost-sharing amounts.

Given the reduction in benefits that would be available through Medigap policies, we are assuming that the number of such policies purchased would decline. Many of the individuals

[1] These impacts are based on the percentage of Medicare enrollees who are full benefit dual eligible and a percentage that Medicaid pays of cost-sharing charged to duals. This implicitly assumes that the cost-sharing changes to Medicare are proportional to Medicaid payments for cost-sharing under current law. It is possible that states could adjust their Medicaid program in response to the Medicare revisions; however, no state behavioral responses are assumed in these estimates.

[2] The impacts shown here do not include any associated changes to the utilization of Medicare services. Such utilization effects are included in the estimates for the provision to limit Medigap coverage.

who no longer purchase Medigap are expected to switch to a Medicare Advantage plan for more comprehensive coverage, while some are assumed to forego supplemental coverage altogether. Since payments to MA plans are currently about 15 percent higher than for traditional fee-for-service Medicare, Medicare costs would increase for beneficiaries who are assumed to switch to an MA plan. As a result of the Affordable Care Act, payments to MA plans will be reduced over the next several years; accordingly, by 2017 the payment differential relative to fee-for-service Medicare is estimated to fall to roughly 5 percent.[3]

Reductions in the utilization of Medicare services resulting from the limits to Medigap coverage are expected to more than offset the increased costs for those switching to MA plans. In general, since they have to pay only a small portion of the cost, individuals with health insurance tend to use more services than those without. Moreover, as the level of cost-sharing requirements for those with health insurance decreases, the demand for services increases. Therefore, to estimate the impact on health care expenditures resulting from the changes to the copayment requirements, we must quantify the impact of the induced demand for services. These effects were developed based on the assumptions used in the OACT Health Reform Model (OHRM).

Overall, the Medigap limits are estimated to save roughly $73 billion for fiscal years 2013 through 2022. This amount reflects the reduction in costs of $86 billion resulting from the assumed decrease in utilization, partially offset by the increase in costs of $13 billion for individuals who are expected to switch to MA plans.

Increase the Eligibility Age from 65 to 67

The Lieberman/Coburn proposal would increase the Medicare eligibility age by 2 months every year, beginning with people who will turn 65 in 2014, until the eligibility age reached 67. It would also include corresponding increases in the maximum age for eligibility for the Medicaid expansion and for subsidies available for lower-income individuals purchasing coverage through the State-based Health Benefits Exchanges.

Currently, there are over 6 million people aged 65 or 66 on Medicare. Once the proposed increase in the eligibility age were fully phased in to 67, a comparable number of individuals would no longer have access to the Medicare program based on their age. However, about 17 percent of those individuals would still receive coverage through Medicare based on their disability status or because they have end-stage renal disease (ESRD). Based on an analysis of people aged 63 and 64, we estimate that 51 percent would continue to receive employer-sponsored health insurance (ESI) coverage. For the remaining individuals, about 10 percent are estimated to have incomes below 138 percent of the Federal poverty level, making them eligible for the Medicaid expansion.[4] The remaining group (22 percent) would be eligible for the Exchanges. Since not all of those eligible for the Medicaid expansion or the Exchanges are expected to participate in these programs, we expect a slight increase in the number of uninsured individuals. A summary of the estimated population changes is shown in the table below.

[3] The estimates prepared here are based on the Mid-Session Review of the fiscal year 2013 Budget. New MA payment policies will increase the ultimate differential in future baselines.

[4] The estimates prepared here are based on the Mid-Session Review of the fiscal year 2013 Budget. These estimates were prepared before the Supreme Court ruling on the Affordable Care Act was announced. At that time, it was assumed that every State would participate in the Medicaid expansion. The upcoming Fiscal Year 2014 Budget will include the impact of the Supreme Court decision, which will likely result in an expectation that some States will not expand their Medicaid programs.

Estimated Effect of Increasing the Medicare Eligibility Age from 65 to 67 on 2022 Enrollment by Insurance Coverage
(in millions)

Calendar year	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Medicare	—	−0.5	−0.9	−1.4	−2.0	−2.5	−3.0	−3.6	−4.1	−4.8
Medicaid	—	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.5
ESI	—	0.3	0.6	0.9	1.2	1.5	1.9	2.2	2.6	2.9
Exchanges	—	0.1	0.2	0.3	0.5	0.6	0.7	0.8	1.0	1.1
Uninsured	—	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2

The individuals who are expected to lose their Medicare coverage as a result of the change in the eligibility age have costs that are far below average because they are relatively younger than the average Medicare enrollee and because the higher-cost disabled and ESRD beneficiaries would remain in the program.

As noted earlier, some of the individuals aged 65 and 66 who would be losing Medicare are expected to purchase coverage through the Exchanges. Because costs tend to increase with age, this shift would cause Exchange premiums to rise. The effect is likely to be more pronounced for younger people due to the requirement that Exchange premiums vary by no more than 3 to 1 for age.

Raising the eligibility age is estimated to reduce Medicare expenditures by $138 billion for fiscal years 2013 through 2022. These reduced costs would lead to a reduction in Part B and Part D premium revenues of $20 billion and to a net Medicare 10-year savings of $118 billion. Individuals gaining coverage through Medicaid are estimated to cost the Federal government $15 billion for 2013 through 2022, and Federal premium and cost-sharing subsidies are expected to rise by $26 billion for that period as some of these individuals gain coverage through the Exchanges. As a result, the net Federal impact of this provision is estimated to be a savings of $76 billion for fiscal years 2013 through 2022.

Increases in Medicare Premiums

The Lieberman/Coburn proposal includes three provisions aimed at increasing income to the Medicare program. The first provision would increase the standard Part B premium rate from 25 percent to 35 percent of program costs by raising the rate in 2-percentage-point increments for 2015 through 2019. To estimate the impact of raising the Part B premium rate, we first calculated the premium rates reflecting all of the other provisions in the Lieberman/Coburn proposal and then modeled the savings from the higher premiums. The following table shows the projected premium rates under current law compared to (i) those that reflect all of the non-premium provisions of the Lieberman/Coburn proposal and (ii) those that further include the increase to 35 percent of costs.

Estimated Monthly Part B Premium Rates

Calendar year	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Current Law	$106.90	$112.50	$117.20	$122.20	$128.50	$135.70	$143.70	$151.90	$160.50	$169.50
Lieberman/Coburn 25%*	106.90	115.00	118.50	122.60	128.90	136.00	143.60	150.70	158.80	167.00
Lieberman/Coburn 35%*	106.90	115.00	128.00	142.20	159.90	179.50	201.00	211.00	222.30	233.80

*Includes the impact of the non-premium proposals.

In addition to the increase in the standard Part B premium rate, higher-income Americans would be required to pay more for both Part B and Part D coverage. These higher premiums would apply for individuals earning more than $85,000 and for married couples with incomes over $170,000. The highest-income earners would pay a premium rate equal to 100 percent of the average cost for Part B and Part D. As a result of these higher premium rates, some beneficiaries with below-average expenditures are expected to drop their coverage; specifically, we assume that 8 percent of these individuals would drop Part B. Since Part D expenditures are far more predictable than are those for Part B, we assume that 50 percent of those in the highest-income category would forego Medicare's prescription drug coverage.

The increase in the standard Part B premium rate to 35 percent of costs is estimated to save the Medicare program in higher premium revenues of $218 billion over the next 10 years. Raising the amount that high-income earners pay for Part B and Part D increases premium revenues further by approximately $45 billion through 2022. In addition, Medicare expenditures will be reduced by an estimated $2 billion as a result of beneficiaries dropping out.

Additional Medicare and Medicaid Impacts

The Lieberman/Coburn proposal would make three additional changes to the Medicare program. First, the proposal would apply productivity adjustments to home health care payment rates beginning in 2014 instead of 2015 and would direct the Secretary of Health and Human Services to fully phase in the home health prospective payment system rebasing by 2015 instead of 2017. In estimating the impact of this proposal, we assumed the 14-percent rebasing reduction would be split evenly—that is, 7 percent in 2014 and 7 percent in 2015. The overall impact is estimated to be a savings of $7 billion from 2013-2022.

The proposal would also revise Medicare payments to physicians. Physician payments are currently updated based on the sustainable growth rate (SGR) system. As a result of the SGR formula, a reduction of nearly 25 percent is scheduled for 2014. This proposal would provide a 0-percent physician payment update for 2014 through 2016. For 2017 and later, the update would again be based on the SGR system and would be applied as if the 3-year payment freeze had not occurred. Therefore, a large payment reduction would then be scheduled to occur in 2017. The change in the physician payment update is estimated to cost roughly $89 billion for fiscal years 2013 through 2022.[5]

[5] The estimated impact of increasing the physician payment updates shown here does not include an offset for increased Part B premiums. This is the result of an assumption made for the Budget baseline which calculates the monthly Part B premium rates including a margin for the contingency that the physician payment reductions do not occur.

The final provision relates to payments for bad debts. Currently, for hospitals and non-dual-eligible beneficiaries using skilled nursing facilities, Medicare reimburses bad debt at 65 percent of the total amount. In addition, other providers who receive bad debt reimbursement from Medicare currently receive 88 percent of their total amount (which will drop to 65 percent in the next 3 years). The Lieberman/Coburn proposal stipulates that the current reimbursement rates be reduced to 25 percent of the total amount of bad debt over a 3-year period. This provision is estimated to save $23 billion in Medicare reimbursement over the next 10 years.

As noted throughout, the Lieberman/Coburn proposal has many provisions affecting the Medicare Part B premium rate either directly or indirectly. For individuals who are dually eligible for both Medicare and Medicaid, the Medicaid program generally pays their Part B premium; therefore, an increase in the Part B premium rate would increase revenue to the Medicare program, but there would be some offset to net Federal costs as Medicaid would pay a portion of those premiums. Accordingly, Federal Medicaid costs are expected to increase by $24 billion for fiscal years 2013 through 2022.

Conclusions

The provisions of the Lieberman/Coburn proposal are expected to save the Federal government $536 billion over the next 10 years through a combination of reduced expenditures and increased revenues. We would also like to reiterate that the individual line-item estimates shown here in some cases include interactive effects with other provisions of the plan and cannot be assumed to represent the same effect if the specific proposal were implemented on its own.

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Estimated Costs (+) or Savings under "A BIPARTISAN PLAN TO SAVE MEDICARE & REDUCE DEBT" (The Lieberman/Coburn Proposal)

(In millions)

Proposal	Fiscal year										Total,	
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2013-17	2013-22
Replace current cost-sharing requirements with a unified A/B annual deductible and a maximum limit on out-of-pocket expenses for all enrollees												
Part A	$0	-$14,740	-$26,480	-$28,610	-$30,340	-$32,410	-$35,170	-$38,270	-$41,640	-$45,220	-$100,170	-$292,880
Part B	0	6,840	11,800	12,270	12,240	12,830	14,250	15,830	17,690	19,870	43,150	123,620
Part B, net of premium offset	0	5,130	8,850	9,200	9,180	9,620	10,680	11,870	13,270	14,900	32,360	92,700
Total net Medicare	0	-9,610	-17,630	-19,410	-21,160	-22,790	-24,490	-26,400	-28,370	-30,320	-67,810	-200,180
Medicaid (cost-sharing payments for dual-eligible beneficiaries)	0	510	950	1,060	1,170	1,270	1,360	1,450	1,550	1,640	3,690	10,960
Total net Federal	0	-9,100	-16,680	-18,350	-19,990	-21,520	-23,130	-24,950	-26,820	-28,680	-64,120	-189,220
Adjust eligibility age for Medicare to partially reflect gains in life expectancy												
Part A	0	-620	-1,690	-2,840	-3,450	-4,330	-5,740	-8,050	-10,400	-12,640	-8,600	-49,760
Part B	0	-790	-2,230	-3,840	-4,710	-5,990	-8,080	-11,520	-15,040	-18,520	-11,570	-70,720
Part B, net of premium offset	0	-590	-1,680	-2,880	-3,530	-4,490	-6,060	-8,640	-11,280	-13,890	-8,680	-53,040
Part D	0	-260	-640	-1,090	-1,250	-1,620	-2,080	-2,890	-3,510	-4,290	-3,240	-17,630
Part D, net of premium offset	0	-220	-540	-920	-1,060	-1,380	-1,770	-2,450	-2,990	-3,640	-2,740	-14,970
Total net Medicare	0	-1,430	-3,910	-6,640	-8,040	-10,200	-13,570	-19,140	-24,670	-30,170	-20,020	-117,770
Medicaid	0	270	570	900	1,220	1,590	1,970	2,350	2,850	3,510	2,960	15,230
Health Insurance Exchanges	0	440	920	1,460	2,060	2,700	3,380	4,130	5,000	6,150	4,880	26,240
Total net Federal	0	-720	-2,420	-4,280	-4,760	-5,910	-8,220	-12,660	-16,820	-20,510	-12,180	-76,300
Accelerate home health care payment adjustments												
Part A	0	-40	-360	-820	-730	-340	-200	-200	-220	-240	-1,950	-3,150
Part B	0	-70	-580	-1,310	-1,200	-560	-320	-330	-360	-390	-3,160	-5,120
Part B, net of premium offset	0	-50	-440	-980	-900	-420	-240	-250	-270	-290	-2,370	-3,840
Total net Medicare	0	-90	-800	-1,800	-1,630	-760	-440	-450	-490	-530	-4,320	-6,990
Limit Medigap coverage of Medicare's cost sharing												
Part A	0	-2,190	-4,010	-4,430	-4,560	-4,720	-5,040	-5,400	-5,900	-6,530	-15,190	-42,780
Part B	0	-2,040	-3,740	-4,140	-4,280	-4,430	-4,750	-5,100	-5,590	-6,200	-14,200	-40,270
Part B, net of premium offset	0	-1,530	-2,810	-3,110	-3,210	-3,330	-3,560	-3,830	-4,200	-4,650	-10,660	-30,230
Total net Medicare	0	-3,720	-6,820	-7,540	-7,770	-8,050	-8,600	-9,230	-10,100	-11,180	-25,850	-73,010
Reduce Medicare payments for bad hospital debts												
Part A	0	-580	-1,380	-1,740	-1,890	-2,020	-2,150	-2,300	-2,450	-2,620	-5,590	-17,130
Part B	0	-260	-640	-830	-910	-980	-1,050	-1,120	-1,200	-1,290	-2,640	-8,280
Part B, net of premium offset	0	-200	-480	-620	-680	-740	-790	-840	-900	-970	-1,980	-6,220
Total net Medicare	0	-780	-1,860	-2,360	-2,570	-2,760	-2,940	-3,140	-3,350	-3,590	-7,570	-23,350
Require higher income Americans to pay higher premium share for Medicare Part B coverage												
Part B, premium income	0	0	-310	-930	-1,880	-3,100	-4,400	-6,920	-9,150	-11,410	-3,120	-38,100
Part B, benefits	0	0	-50	-70	-90	-110	-150	-260	-360	-470	-210	-1,560
Part B, net of premium offset	0	0	-40	-50	-70	-90	-110	-190	-270	-350	-160	-1,170
Total net Medicare	0	0	-350	-980	-1,950	-3,190	-4,510	-7,110	-9,420	-11,760	-3,280	-39,270
Increase the standard Part B premium to 35% of the program's cost for enrollees												
Part B, premium income	0	0	-4,210	-10,230	-17,140	-25,030	-34,090	-39,090	-42,340	-45,650	-31,580	-217,780
Require higher income Americans to pay higher premium share for Medicare Part D coverage												
Part D, premium income	0	0	-70	-280	-370	-540	-740	-1,170	-1,510	-1,860	-720	-6,540
Part D, benefits	0	0	0	-10	-20	-30	-50	-140	-240	-330	-30	-820
Part D, net of premium offset	0	0	0	-10	-20	-30	-50	-130	-220	-300	-30	-760
Total net Medicare	0	0	-70	-290	-390	-570	-790	-1,300	-1,730	-2,160	-750	-7,300
Maintain physician payment rates at 2012 level in 2013-2015; revert to SGR in 2016 and later												
Part B	0	25,300	34,040	32,100	8,920	-3,340	-2,550	-2,010	-1,870	-1,920	100,360	88,670
Part B, net of premium offset	0	25,300	34,040	32,100	8,920	-3,340	-2,550	-2,010	-1,870	-1,920	100,360	88,670
Medicaid offset (additional premium payments for dual-eligible beneficiares)	0	150	670	1,260	2,020	2,870	3,840	4,060	4,360	4,660	4,100	23,890
TOTAL MEDICARE BENEFIT IMPACT (Part A + net Part B + net Part D)	0	9,670	2,980	-5,710	-32,340	-48,020	-52,750	-60,690	-69,340	-78,360	-25,400	-334,560
TOTAL MEDICARE PREMIUM INCOME IMPACT (Part B + Part D)	0	0	-4,590	-11,440	-19,390	-28,670	-39,230	-47,180	-53,000	-58,920	-35,420	-262,420
TOTAL MEDICAID IMPACT	0	660	1,620	2,320	3,190	4,140	5,200	5,510	5,910	6,300	7,790	34,850
TOTAL HEALTH INSURANCE EXCHANGE IMPACT	0	440	920	1,460	2,060	2,700	3,380	4,130	5,000	6,150	4,880	26,240
TOTAL NET FEDERAL IMPACT	0	10,770	930	-13,370	-46,480	-69,850	-83,400	-98,230	-111,430	-124,830	-48,150	-535,890

Notes:

1. Savings are shown as negative amounts and represent either reduced expenditures or increased revenues. Costs are shown as positive amounts and represent either higher expenditures or reduced revenues.
2. A 0 in any line above means either no impact or negligible impact (< $5 million)
3. The provisions that affect fee-for-service benefits also reflect the resulting impact on payments to managed care plans.
4. Interactive effects have been reflected, therefore, the impact of a particular provision may not have the same effect if the specific proposal were implemented on its own.

Office of the Actuary
Centers for Medicare & Medicaid Services