# Healthcare Policy Options to Reduce the Deficit

## Background

In December 2024, US House of Representatives Republicans informally proposed that in exchange for raising the debt limit by $1.5 trillion, they would cut $2.5 trillion in net mandatory spending. Likewise, President Trump's Department of Government Efficiency (DOGE) will be targeting trillions of dollars in savings. While the size and scope of spending reductions are not yet clear, stakeholders can expect Congress to consider cuts in federal spending this year. Healthcare makes up a significant portion of mandatory spending and therefore likely will be a large part of any cost-reduction effort. At the top of the list is Medicaid. Proposals could run the gamut, from changes in Medicaid provider tax rules to changes in eligibility requirements, per capita caps, and work requirements. Medicare cuts are also likely. While President Trump has taken cuts to Medicare benefits off the table, payment policies under consideration including Medicare site neutral payment reforms, 340B reform, and changes in Medicare Advantage (MA) payments.

To provide Congress with ideas for potential policies, the Congressional Budget Office (CBO) recently released a report titled "Options for Reducing the Deficit: 2025 to 2034." CBO releases this report periodically, and the inclusion of an option does not mean that it is politically feasible or that it will be pursued. Scoring polices does create a starting point, however, and provides a menu to Congress as members seek savings for the budget reconciliation bill.

Below is a compilation of possible healthcare options that could contribute to the cuts Republicans aim to make, including a sampling of the key healthcare policy options CBO identified in its report. Relevant information from another CBO report, "Expired and Expiring Authorizations of Appropriations for Fiscal Year (FY) 2024," is also included. Savings are described over a 10-year period unless otherwise specified.

## Key CBO Options

### Medicare

- **Implement Medicare Site Neutral Payment Reform.** Medicare payments for services received in hospital outpatient departments (HOPDs) are generally higher than payments for identical services received in physicians' offices. To address this, CBO included three options, although they are just a sampling of the wide variety of Medicare site neutral payment reform proposals under discussion. The first and most drastic policy would pay site-neutral rates for most services to all on- and off-campus HOPDs, saving $157 billion. The others would apply site-neutral rates to all off-campus HOPD drug administration services (saving $5.6 billion) and imaging services (saving $7.6 billion). CBO's first option aligns with the Medicare Payment Advisory Commission's (MedPAC's) June 2023 recommendation to adjust Medicare payments for services furnished in physician offices paid through the Physician Fee Schedule, HOPDs paid through the Outpatient Prospective Payment System, and ambulatory surgical centers (ASCs) paid through the ASC Prospective Payment System based on the setting in which the service is most often furnished. In May 2023, the House Energy and Commerce Health Subcommittee considered, but ultimately did not advance, legislation based on MedPAC's recommendation. CBO's first option also aligns with Policy Option two of the site neutral policy framework released by Senate Health, Education, Labor, & Pensions Committee Chair Cassidy (R-LA) and Sen. Hassan (D-NH). CBO's second option aligns with Section 203 of the Lower Costs, More Transparency Act, which passed the House in the 118th Congress and would

have reduced Medicare Part B payment rates for drug administration services provided at certain off-campus HOPDs to the rate paid in physician offices.

- **Reduce Payments for Drugs Delivered by 340B Entities.** Currently, Medicare reimburses 340B entities (including certain hospitals, federally qualified health centers, and certain clinics) for drugs at a rate equal to the drug's average sales price (ASP) plus 6%. The CBO policy options report includes an option to reduce payment rates to the ASP (saving $15.4 billion) and an option to reduce payment rates to the ASP minus 22.5% (saving $73.5 billion). The Centers for Medicare & Medicaid (CMS) previously implemented the ASP minus 22.5% policy in the Medicare Outpatient Prospective Payment System, but the Supreme Court of the United States subsequently overturned that policy, ruling that CMS did not have adequate statutory authority. Congress passing legislation to require such a change would eliminate that obstacle. Implementing either option would reduce 340B entities' savings and could impact programs funded by 340B savings and reduce access to services for patients.
- **Modify Payments to MA Plans for Health Risk.** Unlike Medicare fee for service (FFS), MA plans receive payment based on the risk scores of a plan's enrollees, which some commenters say creates a financial incentive to code more diagnoses for their enrollees so that risk scores are inflated. To account for the differences in coding, and therefore payment, CMS already applies an across-the-board reduction of at least 5.9% to MA payments. To further address these misaligned incentives, the CBO identifies three options:
    - Increase the MA payment reduction from 5.9% to 8% (saving $159 billion).
    - Increase the MA payment reduction from 5.9% to 20% (saving $1.049 trillion).
    - Use two years of data rather than one, and exclude diagnoses captured from health risk assessments to calculate risk scores (saving $124 billion).

  These options would result in higher cost sharing and premiums and fewer supplemental benefits for MA enrollees and could shift some beneficiaries back into Medicare FFS.
- **Reduce MA benchmarks.** The amount CMS pays MA plans per enrollee is partially based on MA benchmarks, which are currently tied to the projected spending for an average beneficiary in Medicare FFS in the same county. According to the CBO paper, reducing MA benchmarks by 10% would save $489 billion. Much like other MA options, this reduction would lead to higher cost sharing and premiums and fewer supplemental benefits for MA enrollees.
- **Increase Part B premiums.** Currently, Medicare Part B premiums are set to cover about 25% of expected costs for beneficiaries. According to CBO, incrementally increasing the premium cost to eventually cover 35% of expected costs would save $510 billion. In addition to increasing costs for beneficiaries, this option would increase Medicaid spending because the program pays for the Part B premiums of some enrollees. This would be a direct hit on beneficiaries by causing them to pay higher premiums.
- **Reduce Medicare's Coverage of Bad Debt.** Medicare currently reimburses eligible facilities for 65% of allowable bad debt, which is unpaid and uncollectible cost-sharing amounts for covered services provided to Medicare beneficiaries. CBO suggests either reducing the reimbursement amount to 45% (saving $16.7 billion) or 25% (saving $33.2 billion), or eliminating the reimbursement altogether (saving $54.1 billion).
- **Consolidate and Reduce Medicare Payments for Graduate Medical Education (GME) at Teaching Hospitals.** Hospitals with teaching programs can receive funds from Medicare for costs related to GME, which fall into two categories: direct and indirect medical education. CBO's options include consolidating these two GME costs into a grant program in which the funds for 2026 would be the sum of Medicare's 2024 payments for both direct and indirect medical costs. Funding for the program would grow either with the consumer price index for all urban consumers (CPI-U) (saving $94 billion) or with the CPI-U minus 1 percentage point (saving $103 billion). Because hospitals rely on Medicare payments to administer their GME programs, this option would likely reduce resident physician salaries and/or the amount of dedicated teaching activities provided by the hospital.

## Medicaid

- **Limit State Taxes on Providers.** State Medicaid programs use state provider taxes to generate the state share of Medicaid expenditures. Under current federal regulations, states may use healthcare-related taxes as a source of non-federal share of Medicaid if the taxes are:
    - Broad based;
    - Uniform; and
    - Do not hold taxpayers "harmless" – meaning taxpayers cannot be given a direct or indirect guarantee that they will be repaid for all or a portion of the amount of taxes that they contribute.

  Hold harmless arrangements can be permissible, as long as those taxes remain below 6% of net patient revenue. CBO's options include lowering the threshold to 5% (saving $48 billion), lowering the threshold to 2.5% (saving $241 billion), and eliminating the exception altogether (saving $612 billion). All options would lead to less tax revenue and less ability for states to raise non-federal share of Medicaid financing. This could cause states to lower Medicaid reimbursement rates or reduce optional services. There has historically been bipartisan interest in reforming provider taxes and enforcing the prohibition on "hold harmless" arrangements.
- **Place Caps on Federal Spending.** This policy includes two options:
    - Setting an annual maximum amount of funding that the federal government would provide to each state to operate Medicaid (saving $459 billion if using the CPI-U plus 1% or $742 billion if using the CPI-U).
    - Setting an upper limit on federal payments per Medicaid enrollee in each eligibility group (saving $588 billion if using the CPI-U plus 1% or $893 billion if using the CPI-U).

  Either option would limit state Medicaid budgets compared to current law, which allows for open-ended Medicaid funding. These options could cause states to cut optional services, restrict enrollment, or lower provider reimbursement rates. The options could also cause some Medicaid-eligible individuals to instead enroll in the Marketplace or employer insurance. Congressional Republicans have previously expressed interest in limiting or slowing federal Medicaid spending.
- **Reduce Federal Matching Rates.** This policy includes three options:
    - Standardize a 50% match for all administrative services, saving $69 billion.
    - Remove the 50% federal floor for non-Affordable Care Act (ACA) eligibility groups, saving $530 billion.
    - Reduce the federal match for the ACA eligibility group from 90% to the rate used for other enrollees, saving $561 billion.

  All three options would decrease state Medicaid budgets and could cause states to lower reimbursement rates or reduce optional services. The second and third options could cause states to limit eligibility for the targeted groups, leading some individuals to enroll in the Marketplace or employer coverage. The third option could cause some states to reverse their expansion under the ACA.

## Putting the Options in Context

To illustrate how these policies could be combined or reworked to achieve significant federal savings from healthcare, the table below lists several versions of five policies ripe for inclusion and their CBO scores.

| Policy | 10 Year Savings |
|---|---|
| Medicaid Per Capita Caps | $893B – Using CPI-U |
| | $588B – Using CPI-U plus 1% |
| Reduced Payments for Drugs Delivered by 340B Entities | $73.5B – Reducing payment rates to the ASP minus 22.5% |
| | $15.4B – Reducing payments to be equal to ASP |
| Medicare Site Neutral Payment Reform | $157B – Paying site-neutral rates for most services to all on- and off-campus HOPDs |
| | $7.6B – Applying site-neutral rates to all off-campus HOPD imaging services |
| | $5.6B – Applying site-neutral rates to all off-campus HOPD drug administration services |
| Modified Payments to MA Plans for Health Risk | $1.049T – Increasing the MA payment reduction from 5.9% to 20% |
| | $159B – Increasing the MA payment reduction from 5.9% to 8% |
| | $124B – Using two years of data, rather than one, and excluding diagnoses captured from health risk assessments to calculate risk scores |
| Reduced Medicare Coverage of Bad Debt | $54.1B – Eliminating the reimbursement altogether |
| | $33.2B – Reducing the reimbursement amount to 25% |
| | $16.7B – Reducing the reimbursement amount to 45% |

If Republicans were to implement only these five policies (out of the many being discussed) using the versions that save the most money, they would save $2.226 trillion. Even if they used the more limited versions that save less, they would still achieve $803 billion in savings. This exercise reinforces that although the overall goal of $2.5 trillion in savings is substantial, there are ways that Republicans can get there, and healthcare is likely to feature prominently in that effort.

## Unauthorized Appropriations

Vivek Ramaswamy, who at the time was working as the prospective co-chair of DOGE, referred in a recent post on X to a CBO report that found that $516 billion each year goes toward unauthorized programs (meaning that the authorization to appropriate funds has expired), but Congress has chosen to appropriate the funds in a government spending bill anyway. Since Ramaswamy's post, unauthorized appropriations have been a subject of discussion in relation to cutting federal spending. Below are descriptions of some of the high-cost healthcare programs that have expired authorizations according to the CBO report, yet continue to receive yearly appropriations.

- **Veterans' Health Benefits.** The now-expired authorization in the Veterans' Health Care Eligibility Reform Act of 1996 was appropriated $119 billion for FY 2024. This provision created a medical benefits package that is available to all enrolled veterans and provides additional funding for veterans' hospital care and medical services.
- **National Institutes of Health (NIH).** Authorizing language for the NIH was last included in the 21st Century Cures Act and expired in 2020. Despite the expiration, the agency has continued to receive appropriations, including $47 billion in FY 2024. More information about NIH's reauthorization (or lack thereof) can be found here.
- **Advanced Research Projects Agency for Health (ARPA-H).** ARPA-H authorization expired at the end of FY 2023, but ARPA-H was appropriated $1.5 billion in FY 2024.
- **HIV/AIDS Care Grant Program.** The Ryan White HIV/AIDS Treatment Extension Act of 2009 authorized the third largest source of funding for HIV care in the United States, after Medicare and Medicaid. The authorization expired in 2013, but the program has continued to be funded, most recently being appropriated $1.3 billion in FY 2024.
- **Mental Health Grant Programs.** The Cures Act also included an authorization for Substance Abuse and Mental Health Services Administration grant programs to address mental health needs of "regional and national significance." The authorization expired in 2022, but Congress appropriated $1 billion to these programs in FY 2024.
- **Pandemic Preparedness.** The Pandemic and All-Hazards Preparedness Act (PAHPA) created programs for the advanced research, development, and procurement of countermeasures to address threats. PAHPA was last reauthorized in 2019, although it was included in the bipartisan, bicameral health package negotiated in December 2024. PAHPA provisions were appropriated $1 billion in FY 2024.

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