Medicare Primer

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NATIONAL ACADEMY OF SOCIAL INSURANCE

Medicare Primer

Eligibility

Medicare currently provides coverage for 60 million beneficiaries: 51.2 million ages 65 and older and 8.8 million persons with disabilities (Centers for Medicare & Medicaid Services 2019a). Persons under the age of 65 who have received Social Security Disability Insurance (SSDI) benefits for at least 24 months are automatically enrolled in Medicare and are entitled to premium-free Part A benefits. The waiting period is waived for individuals who have qualified for SSDI due to amyotrophic lateral sclerosis. Individuals diagnosed with end-stage renal disease (ESRD) are eligible for Medicare without first having to receive SSDI benefits. In addition, individuals who were diagnosed with a specific lung disease or type of cancer and lived in an area subject to a public health emergency declaration by the Environmental Protection Agency for a specified period before diagnosis are entitled to Part A benefits and eligible to enroll in Part B.

Benefit Design

The Medicare program organizes benefits into four separate components, each with its own cost-sharing and premium requirements. Part A covers inpatient hospital services, including room and board, hospital facility use, inpatient drugs/biologics and supplies, and diagnostic and therapeutic items. Part A also covers limited periods of patient stays in post-hospital skilled nursing facilities and covers hospice care and home health care following a stay in a hospital/skilled nursing facility.

Part B covers physician services, outpatient hospital services, and inpatient prescription drugs/biologics, durable medical equipment, clinical laboratory and diagnostic tests, and other medical services, including preventive care, physical and occupational therapy, speech–language pathology therapy, and ambulance care. Part B covers home health care when such care does not follow a stay in a hospital or skilled nursing facility. However, Part A covers all home health care for Medicare beneficiaries who lack Part B coverage.

Parts A and B together are referred to as traditional fee-for-service (FFS) Medicare, in which the federal government directly pays for covered health services. In 2018, 59.6 million people were enrolled in Medicare Part A, which represented 99 percent of individuals eligible to enroll (Centers for Medicare & Medicaid Services 2019a). Part B had enrollment of 54.6 million (91 percent of individuals eligible to enroll), the vast majority of whom were also enrolled in Part A. The current traditional Medicare benefit package does not cover long-term services and supports (LTSS) or dental, vision, or hearing services, and it has no limit on beneficiary out-of-pocket (OOP) expenses.

Medicare beneficiaries may elect to receive Part A and Part B benefits through a private Part C Medicare Advantage (MA) plan, which offers coverage with an integrated benefit package similar to private insurance coverage. Unlike traditional Medicare, MA plans include networks that limit enrollees to a set of providers in a specific geographic area in order to offer enrollees lower premiums, and they can include managed care mechanisms. MA plans may offer benefits to Medicare enrollees beyond traditional Medicare coverage, such as dental or vision coverage, and/or lower cost-sharing requirements (Congressional Research Service 2019b). Employers and unions may sponsor MA plans for current and retired employees or members. These plans can operate under somewhat different rules, such as being permitted to restrict eligibility to employees and members and to provide customized benefits. Additionally, MA offers Medicare special needs plans, which provide coordinated care plans for individuals with specific needs, including institutionalized individuals, individuals dually eligible for Medicare and Medicaid, and individuals with specific chronic conditions (Congressional Research Service 2019b). The share of beneficiaries enrolled in MA has grown over time, with 21.3 million (35.6 percent) of Medicare beneficiaries receiving benefits through an MA plan in 2018 (Centers for Medicare & Medicaid Services 2019a).

Beneficiaries in Part A and/or Part B or in an MA plan without drug coverage are eligible to enroll voluntarily in prescription drug plans (PDPs) under Part D. Medicare heavily regulates the PDP formularies, specifying what drugs must be covered within therapeutic classes. All PDPs must follow a standard coverage benefit structure or offer an actuarially equivalent plan. Plan sponsors may also offer enhanced benefit plans in addition to a standard PDP. Part D plan sponsors can negotiate with drug manufacturers to set prices sponsors can include step therapy requirements and placement of drugs in preferred formulary tiers and they can determine beneficiary cost-sharing amounts (Congressional Research Service 2019b). Part D enrollment was 45.8 million in 2018 (Centers for Medicare & Medicaid Services 2019a).

Coverage in the traditional Medicare program can be described as comprehensive—inclusive of services deemed medically necessary by a physician and, in the case

of medicines or devices, deemed safe and effective by the U.S. Food and Drug Administration. Prior authorization is not required for services covered under Parts A and B, and the utilization management techniques employed by private plans are not used. MA and Part D plans have more scope to restrict coverage of services and medicines for their enrollees on the grounds of appropriateness or relative cost-effectiveness, within defined parameters such as mandatory coverage of medicines in certain protected classes.

Premiums

A vast majority of enrollees are eligible for premium-free Part A benefits if they or their spouse are eligible for Social Security payments and have paid Medicare-eligible payroll taxes for 40 quarters (10 years). Individuals ages 65 and older without 40 quarters of coverage may choose to enroll and pay the full Part A monthly premium; however, 99 percent of Medicare beneficiaries do not pay a Part A premium (Centers for Medicare & Medicaid Services 2019b). The monthly premium is $458 in 2020, up from $437 in 2019. The premium is calculated from the expected average per capita cost of Part A for individuals ages 65 and older who are entitled to Part A coverage (Centers for Medicare & Medicaid Services 2018). Enrollees who do not qualify for premium-free Part A may qualify for a reduced premium if they have between 30 and 39 quarters of covered employment (Centers for Medicare & Medicaid Services 2018).

The standard monthly premium for Part B coverage increased from $135.50 in 2019 to $144.60 in 2019, which reflects an estimated 25 percent of program costs (Centers for Medicare & Medicaid Services 2019b). Since 2007, individuals with modified adjusted gross incomes that exceed a specific threshold are subject to a higher income-related premium that reflects a greater percentage of estimated program costs. Depending on income level, high-income beneficiaries' premiums are set to cover 35 percent to 85 percent of the expected per capita Part B costs for the year. The highest income-adjusted monthly premium is $491.60 in 2020 (Centers for Medicare & Medicaid Services 2019b). Additionally, beneficiaries who enroll in Part B after their initial enrollment period pay a premium surcharge unless they are employed and receive employer-sponsored health insurance benefits. In 2018, 1.4 percent of Medicare Part B enrollees were subject to this penalty (Congressional Research Service 2019a). The penalty is waived for beneficiaries eligible for a special enrollment period, such as when an individual has previously had employer coverage. For individuals whose premium is automatically deducted from their Social Security payment, the Part B premium is also subject to a "hold-harmless provision" that limits the dollar increase in Part B premiums each year to no more than the yearly increase in an individual's Social Security benefit (Congressional Research Service 2019a).

MA plans receive a per person monthly payment adjusted to reflect the demographics and health history of enrollees. The amount paid to MA plans is not adjusted by the volume of services that an enrollee uses, but MA may pay providers on an FFS basis. The monthly payment made to an MA plan is based on a comparison of that plan's estimated costs of providing all Part A and Part B benefits (the plan's bid) with the maximum amount that traditional FFS Medicare will pay for the benefits in the plan's service area (the benchmark). If the plan bid is lower than the benchmark, plans receive a portion of that difference in a rebate that must be passed on to beneficiaries, either through additional benefits, lower cost-sharing requirements, or a lower monthly premium. If the plan bid is greater than the benchmark, enrollees in that plan must pay an additional premium amount equal to the difference between the bid and the benchmark (Congressional Research Service 2019b). The MA benchmark is set between 95 percent and 115 percent of FFS Medicare costs, depending on whether the plan is located in a high-cost or low-cost FFS area (Kaiser Family Foundation 2019). Payments to MA plans are adjusted through star ratings (1–5, with 5 being the highest) to reflect a plan's performance on quality measures. Plans receiving a star rating of 4.0 or above receive a quality bonus payment.

Medicare Part D pays private prescription drug plans through a competitive bidding process in which the standard enrollee premium is based on the national average bid, and actual plan premiums reflect differences between the bid and the national average. Medicare pays PDPs a risk-adjusted monthly per capita amount reflecting that plan's bid during a given year. Part D plan sponsors negotiate payments with drug manufacturers, set their own formularies, and determine cost-sharing amounts (Congressional Research Service 2019b). The standard enrollee monthly premium is estimated to be $42.05 in 2020, up from $33.19 in 2019 (Cubanski and Damico 2019). Similar to Part B, beneficiaries above a specific income threshold are subject to a higher income-related premium that reflects a greater percentage of estimated per capita program costs. This adjustment ranges from 35 percent to 85 percent of the national average cost of providing Part D benefits.

Cost Sharing

PParts A and B of Medicare have cost-sharing requirements for beneficiaries. Part A includes a deductible and coinsurance for hospital inpatient stays and daily coinsurance payments for skilled nursing facility care, shown in **Table A-1**. Part B enrollees are subject to a deductible of $198 in 2020 and a standard coinsurance of 20 percent for most covered services, except for clinical laboratory tests, home health agency services, and preventive care services (Centers for Medicare & Medicaid Services 2019b). Unlike traditional Medicare, MA plans are required to have

an OOP spending limit of $6,700 for services covered by Parts A and B. Table A-1 provides the cost-sharing requirements for hospital inpatient and skilled nursing facility stays.

Table A-1. Medicare Part A Deductibles and Coinsurance, 2020

Hospital inpatient			Skilled nursing facility		
Days 0–60	Deductible	$1,408	**Days 0–20**	No charge	N/A
Days 61–90	Daily coinsurance	$352/day	**Days 21–100**	Daily coinsurance	$176/day
Days 91–150 (lifetime reserve days)	Daily coinsurance	$704/day	**Days 101 and over**	Beneficiary responsible for all costs	Unlimited
Days 151 and over	Beneficiary responsible for all costs	Unlimited			

Note: *N/A (not applicable).*
Source: *Centers for Medicare & Medicaid Services 2019c.*

All private drug plans, including Part D PDPs and MA–PDs, must follow a standard coverage benefit structure or offer an actuarially equivalent plan, although plan sponsors may also offer enhanced benefit plans in addition to a standard PDP. Of the PDP enrollees in 2018, almost none were in a standard plan, 60 percent of PDP enrollees were in an actuarially equivalent plan, and 40 percent were in an enhanced plan (Medicare Payment Advisory Commission 2019). In 2020, all PDPs are offering an alternative benefit design (Cubanski and Damico 2019). The standard Part D plan cost-sharing is shown in **Table A-2**. Previously, beneficiaries were exposed to a coverage gap called the "doughnut hole," but in 2020 that has closed and beneficiaries are responsible for a 25% coinsurance during the former coverage gap phase (Cubanski and Damico 2019).

Table A-2. Medicare Part D Standard Benefit, 2020

Benefit phase	Total drug costs	Cost-sharing requirements		Total beneficiary out-of-pocket spending
Deductible period	$0–435	Enrollees: 100%		$435
Initial coverage period	$435–4,020	Enrollees: 25% Plans: 75%		$435–1,005*
Former coverage gap	$4,020.00–9,719.38	**Brand Name** Manufacturer discount: 70% Enrollees: 25% Plans: 5%	**Generic** Enrollees: 25% Plans: 75%	$1,005–6,350
Catastrophic coverage	$9,719.38+	Enrollees: 5% Plans: 15% Medicare: 80%		$6,350+

Notes: **Maximum an individual would pay in a plan with no deductible.*
Source: *Centers for Medicare & Medicaid Services 2019d.*

Supplemental Coverage

Traditional Medicare has gaps in covered benefits, including long-term services and supports and dental, vision, and hearing services. Beneficiaries are at risk of incurring significant OOP costs for covered services as well. Approximately 81 percent of traditional Medicare enrollees have some form of supplemental coverage (Cubanski et al. 2018). Approximately one in five beneficiaries is fully "dually eligible," qualifying for Medicaid coverage in their state, which covers cost sharing, the premium for Part B, and provides benefits not covered under Medicare. Many people with low incomes who do not qualify for Medicaid in their states may still qualify for cost-sharing assistance that reduces or eliminates their OOP costs, thereby reducing potential cost-related barriers to accessing services.

Many beneficiaries have private supplemental coverage either through a former employer or private Medigap policies that may fully or partially cover Part A and Part B cost-sharing requirements. Employer-sponsored insurance (ESI) coverage provides supplemental coverage to approximately 30 percent of Medicare beneficiaries (Cubanski et al. 2018). In 2019, only 28 percent of all large firms (200 or more workers) that offered ESI coverage to current employees also offered retiree health benefits (Claxton et al. 2019). The availability of retiree coverage differs by firms' characteristics: Firms offering ESI benefits are more likely to offer

retiree health benefits if they have at least some union workers, a larger share of high-income workers, or a larger share of older workers (Claxton et al. 2019). Of these firms, 91 percent offered health benefits for early retirees (individuals retiring before the age of 65), and 61 percent offered health benefits to individuals ages 65 and older in 2019 (Claxton et al. 2019).

Approximately 29 percent of traditional Medicare beneficiaries in 2016 were enrolled in Medicare supplemental insurance plans to pay health costs not covered by Medicare, popularly known as Medigap (Cubanski et al. 2018). The benefits offered by these plans are standardized by the Centers for Medicare & Medicaid Services, but significant variation occurs in the operation of Medigap marketplaces across states. Beneficiaries are eligible to enroll in a Medigap plan during their open enrollment period (the first six months of their enrollment in Part B). During this open enrollment period, Medigap coverage must be offered on a guaranteed-issue basis, meaning Medigap insurers cannot deny a policy to any applicant based on age, gender, or health status. In addition, for Medigap coverage purchased during the open enrollment period, premiums cannot vary by health status. Most states allow Medigap insurers to practice medical underwriting outside of this open enrollment period and deny coverage or charge higher premiums to beneficiaries with preexisting conditions. Federal law does not require Medigap insurers to sell policies to beneficiaries who qualify for Medicare based on long-term disability or to any beneficiaries switching from a Medicare Advantage plan to traditional Medicare during the annual open enrollment period. States have the flexibility to go beyond these minimum standards for Medigap policies (Boccuti et al. 2018).

Medicare coordinates benefit coverage with other coverage sources. While in some circumstances, Medicare is the secondary payer, in most instances, Medicare is the primary payer, with any supplemental coverage providing secondary, wraparound coverage. The Medicare Secondary Payer provisions specify that Medicare is the primary payer for beneficiaries with supplemental coverage through a group health insurance plan under the following conditions: for individuals 65 years or older enrolled in a group health plan through an employer with fewer than 20 employees; for persons with a disability who are younger than 65 enrolled in a plan through an employer with fewer than 100 employees; and for people 65 years or older with retiree coverage through a former employer. Medicare is the secondary payer for beneficiaries with supplemental coverage from a group health insurance plan for individuals ages 65 and older if the employer has more than 20 employees and for people under the age of 65 with a disability if the employer has 100 employees or more. Medicare is the primary payer for beneficiaries dually covered by Medicare and Medicaid and for individuals with a private Medigap plan (Medicare Learning Network 2019).

Cost Assistance Programs

Several cost assistance programs currently exist within Medicare. Medicare beneficiaries with low incomes and limited resources may qualify for one of three Medicare Savings Programs to assist with premiums and OOP expenses. The Qualified Medicare Beneficiaries (QMB) program is available to beneficiaries with incomes at or below the federal poverty level (FPL). QMB individuals are entitled to receive assistance for all Medicare Part A and Part B cost-sharing charges (including the Part B premium, all deductibles, and all coinsurance), paid by Medicaid. The Specified Low-Income Medicare Beneficiaries (SLMB) program is available to individuals with income greater than 100 percent but less than 120 percent of FPL. Beneficiaries who qualify for the SLMB program have their Medicare Part B premium paid by Medicaid. The Qualifying Individuals (QI) program is for individuals with income between 120 percent and 135 percent of FPL. As shown in **Table A-3**, Medicaid pays the Medicare Part B premium for these individuals; however, 100 percent of the payment comes from federal government allocations to states. Funds for the QI program come from the Medicare Supplementary Medical Insurance (SMI) Trust Fund (Congressional Research Service 2019a).

Table A-3. Medicare Savings Programs for Dual-Eligible Beneficiaries, 2019

Program	Monthly income limit	Asset resources limit	Costs paid by Medicaid
Qualified Medicare Beneficiaries	<100% of FPL Single: $1,061 Couple: $1,430	Single: $7,730 Couple: $11,600	All Part A and Part B premiums, deductibles, and coinsurance
Specified Low-Income Medicare Beneficiaries	100% to <120% of FPL Single: $1,061–$1,269 Couple: $1,430–$1,711	Single: $7,730 Couple: $11,600	Part B premium
Qualifying Individuals	120% to <135% of FBL Single: $1,269-$1,426 Couple: $1,711-$1,923	Single: $7,730 Couple: $11,600	Part B Premium

Note: *FPL (federal poverty level).*
Source: *Congressional Research Service 2019a.*

Medicare Part D also has cost-sharing and premium assistance programs. Medicare Part D provides low-income subsidies (LIS) to certain beneficiaries with limited incomes and resources to help them pay Part D premiums, cost-sharing amounts, and other OOP expenses. Individuals who receive assistance through an MSP, receive full Medicaid benefits, and/or receive Social Security income cash assistance are eligible for a full LIS. Eligible enrollees have their monthly premium paid up to a certain benchmark plan amount. Individuals with the full LIS also have no deductible, minimal cost sharing during the initial coverage period and during the coverage gap, and no cost sharing above the catastrophic threshold. Individuals with an income below 150 percent of FPL and limited assets may qualify for a partial low-income subsidy. Individuals may receive premium assistance equal to 25 percent to 75 percent of the cost of full LIS premium assistance, determined by an income-based sliding scale (Congressional Research Service 2018).

Provider Payments and Participation

The traditional Medicare program acts as a third-party payer, establishing fees for a variety of providers including hospitals, physicians, skilled nursing facilities, and home health care workers, through formulas prescribed in law and regulation.

Under Part A, Medicare pays acute care hospitals through the inpatient prospective payment system (IPPS). The IPPS determines a uniform, national prospective amount paid for every discharge based on the diagnosis associated with the inpatient stay. Components of this amount include a discharge payment weighted by the Medicare severity–diagnosis related group to reflect the relative costliness of the average patient in each group. This amount is adjusted (a) by a wage index based on the location and the classification of the hospital, (b) for graduate medical education, and (c) whether the provider is a disproportionate share hospital that provides a certain volume of services to low-income patients. IPPS payments may also be altered to reflect quality-related program measures (Congressional Research Service 2019b). Medicare Part B pays hospitals a predetermined amount per outpatient service through the outpatient prospective payment system (OPPS). Each outpatient service is assigned to an ambulatory payment classification group weighted by relative cost and converted to dollars. Virtually all hospitals accept Medicare payments for their services, and in 2017, the Medicare FFS program paid 4,700 hospitals $190 billion for covered services (Medicare Payment Advisory Commission 2019).

Physician, nonphysician practitioner, and therapist services in Part B receive payment under the Medicare physician fee schedule, which includes over 7,000 services codes. Payments to physicians are adjusted based on relative values that reflect physician work and practice expenses, as well as geographic variations in costs. These values are

converted to dollars using a national conversion factor updated annually. Payments are also adjusted if the provider is enrolled in the Merit-based Incentive Payment System or participates in an alternative payment model (APMs) under the Quality Payment Program. Payment reform efforts have driven the shift from traditional FFS payments to APMs and risk bearing by providers, including bundled payments, accountable care organizations, and medical home models (Congressional Research Service 2019b).

Physicians and some nonphysician practitioners have options for participating in the program and accepting Medicare payment methods and rates. Physicians and some practitioners who "accept Medicare assignment" agree to accept the Medicare rate as the full payment for services and may bill a patient only for the coinsurance amount and the amount of any unmet deductible. Physicians who accept all Medicare assignments in a given year are considered "participating physicians," and physicians who do not accept Medicare assignments on all claims for services are considered "nonparticipating physicians." Nonparticipating physicians receive a 5 percent lower payment for the specific claims for which they accept Medicare assignment and are able to charge beneficiaries the difference between that amount and up to 109.25 percent of the Medicare fee schedule amount for that service (Medicare Payment Advisory Commission 2019). Physicians and some nonphysician practitioners may also choose to completely "opt out" of Medicare and not accept Medicare assignment for any services and are free to enter into private contracts with patients; however, this is a very small percentage. Opt-out physicians and nonphysician practitioners are largely concentrated in the specialties of dentistry and behavioral health (including

psychiatry) (Medicare Payment Advisory Commission 2019). Assignment is mandatory for some types of providers, including physician assistants, nurse practitioners, and clinical social workers (Congressional Research Service 2019b). In 2018, 96 percent of the physicians and nonphysician practitioners billing Medicare were participating providers (Medicare Payment Advisory Commission 2019).

Private commercial insurance plans tend to pay physicians using an FFS system similar to traditional Medicare, but on average, traditional Medicare pays providers less than commercial insurance, although this difference varies significantly by service type, region, provider specialty, and level of provider consolidation (Pelech 2018). MA plans typically pay physicians rates similar to those of traditional Medicare, likely due to regulations that cap out-of-network MA prices at Medicare FFS prices (Pelech 2018). In 2017, Medicare's payment rates for physician and other health professional services were, on average, 75 percent of commercial rates paid by preferred provider organizations, with significant variation in payment by type of service (Medicare Payment Advisory Commission 2019).

Traditional Medicare also pays lower rates to hospitals than private commercial insurance does. The Congressional Budget Office (CBO) concluded that, on average, commercial rates for inpatient services were 89 percent greater than Medicare FFS rates and varied significantly across and within metropolitan areas (Maeda and Nelson 2017). Medicare FFS pays hospitals approximately 86.8 percent of their estimated average costs, while private payers pay hospitals 114.8 percent of their average costs (American Hospital Association 2018). The difference between Medicare FFS and commercial insurance payments to hospitals varies significantly based on geography, type of service, and level of hospital consolidation. Hospital consolidation and overall hospital market power are significant sources of this variation, where stronger market power allows hospitals to negotiate higher payment rates from private payers (Stensland, Gaumer, and Miller 2010).

Financing Structure

The primary source of funding for Part A is a payroll tax contribution of 1.45 percent on both employers and employees, with self-employed workers paying the full 2.9 percent. The tax revenues are added to the Hospital Insurance (HI) Trust Fund along with interest on federal securities held by the trust fund, federal income taxes paid on Social Security benefits, and premiums paid by enrollees not entitled to premium-free Part A. In 2018, total revenue accrued by the HI Trust Fund was $306.6 billion, total expenditures accounted for $308.2 billion, and the HI assets (compiled surpluses from previous years) were reduced by $1.6 billion. The assets were $200.4 billion at the beginning of 2019, which represents about 62 percent of expenditures.

The HI assets are expected to be depleted in 2026, at which point Medicare revenues will cover 89 percent of expenditures (in 2026), declining to 77 percent by 2046, and rising to 83 percent by 2093 (Centers for Medicare & Medicaid Services 2019a).

Part B benefits are financed through the SMI Trust Fund and are not at risk of insolvency because financing is derived through beneficiary premiums with general revenues filling the gap. Beneficiary premiums are set to finance 25 percent of expected program costs. Total revenue for the SMI Trust Fund in 2018 was $353.7 billion, and total expenditures were $337.2 billion, adding $16.5 billion to the SMI assets, which totaled $96.3 billion at the end of 2018. Payments and spending under MA (Part C) are set based on spending in traditional Medicare and are taken from the HI and SMI Trust Funds (Centers for Medicare & Medicaid Services 2019a).

Medicare Part D is also financed through federal general revenues and beneficiary premiums. Beneficiary premiums are set to cover, on average, 25.5 percent of the cost of a standard Part D plan. Additional revenue comes from state "clawback" payments, which reflect a portion of the amounts that state Medicaid programs would otherwise have had to pay for dual-eligible enrollees' drug coverage. Part D revenues are included in a separate account within the SMI Trust Fund. In 2018, total Part D expenditures were approximately $95.2 billion, and revenues were $95.4 billion (Centers for Medicare & Medicaid Services 2019a).

Governance and Administrative Structure

The Department of Health and Human Services' (HHS's) Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, with centralized decision-making, through a network of regional offices and private administrative contractors. Additionally, CMS contracts with private companies for administrative services, including claims adjudication, appeals from beneficiaries and providers, fraud detection, and a range of other services. Congress determines key features of the program, including changes in provider payment methodologies and levels. HHS promulgates detailed regulations to implement these congressional policies. In addition, Congress conducts oversight of the Medicare program through various committees including the Ways and Means Committee and the Energy and Commerce Committee in the House and the Finance Committee and the Health, Education, Labor and Pensions Committee in the Senate. Congress receives regular reports with recommendations regarding access to care and payment updates through the Medicare Payment Advisory Commission, as well as information and analysis from congressional bodies with a broader focus, including the Congressional Budget Office.

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