4/4/97

MEDICARE OPTIONS

1. MOVE TO $100 BILLION IN CBO-SCORED SAVINGS

- CBO scored the Administration's $100 billion package as achieving only $82 billion in savings over 5 years. Because of differences in baselines and assumptions, CBO said that our savings policies would save less than the HCFA actuaries project, and our new benefits and program improvements would cost more.

- To close the $18 billion gap with CBO, we would need to consider adding additional provider savings policies, and dropping at least one of the new benefits, but we could achieve most of the additional savings through policy changes that are analytically defensible. Note, however, that providers are looking for beneficiary savings in the Administration's next savings package and will react negatively if we fill the gap exclusively through provider cuts.

  For example, we could increase our CBO-scored savings by:

  - **Convincing CBO to modify its scoring--$1 billion**. We believe we may be able to recapture as much as $1 billion in savings that CBO failed to credit because of misunderstandings about the Administration's proposals.

  - **Dropping premium surcharge policy--$3 billion**. Our budget included a policy to replace the premium surcharge assessed against Part B beneficiaries who enroll in the program after the deadline with a surcharge that reflects the actual cost to the Medicare program of late enrollment at a cost of $1 billion. CBO scored this new policy as costing $3 billion; HHS agrees that if we need more savings, this policy should be dropped.

  - **Adopting PROPAC's recommendation for no hospital increase in 1998--$4 billion**. PROPAC's recommendation, which was based on data showing high hospital profits from Medicare payments, would give PPS hospitals no increase in 1998. Our policy, which was determined before PROPAC made its recommendation, gives hospitals a 1.8% increase in 1998. If we were to adopt the PROPAC recommendation for 1998 and then return to our policy for 1999-2002, we could save about $3 billion more, including an additional $1 billion from its indirect effect on managed care.

  - **Additional hospital reductions --$4 to 5 billion.** We could include policies such as freezing the non-prospective payment system (PPS) hospital update ($0.8 billion); reducing PPS capital payments by an additional 5% ($2.0 billion); eliminating the depreciation adjustment for hospital sales ($0.3 billion); and reducing the indirect medical education (IME) adjustment to 5.5% in FY 1999 rather than 2000 ($2.0 billion).

- **Additional physician, skilled nursing facility (SNF), and oxygen reductions -- $6 billion.** Savings could be increased by speeding up the implementation of the incentives for high volume physicians to reduce utilization and tightening the payment limits ($1.2 million); further reductions in skilled nursing facility payments ($3.4 billion); and changing a regulation that reduces oxygen payments into a legislative proposal ($1.3 billion).

- Achieving more than $100 billion in CBO-scored policies would require us to make more significant, and more controversial, changes in our original package, such as increasing savings from hospitals and other providers; modifying or dropping some of the other new benefits; and/or adopting other beneficiary savings proposals.

2. MOVE TO PLAN X -- $113 BILLION IN CBO-SCORED SAVINGS

- Plan X achieves $113 billion in savings over 5 years. Savings from managed care are lower than the Administration's plan ($20 billion as opposed to $30 billion), and hospital savings are higher ($33 billion as opposed to $25 billion). Savings from other providers are comparable, and Plan X includes the reallocation of some home health spending from Part A to Part B to extend the solvency of the Trust Fund.

- Relative to the Administration's plan, the major issues with Plan X are that it:

  - **does not include any new preventive benefits**, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;

  - **has a higher Part B premium** because it includes the home health spending transferred from Part A in the calculation of the premium;

  - **proposes to income-relate the Part B premium**;

  - **includes a Medicare MSA**; and

  - **cuts medical education funding more deeply** than the Administration and does not include the IME/GME/DSH carve-out policy.

- If the Administration decides to achieve $113 billion in savings, we would have to add $33 billion in savings to our original package (scored by CBO as saving $82 billion). Possible options to meet this target (in addition to those outlined to meet the $100 billion target above) are:

  - **include home health reallocation in the Part B premium--$6 billion** (with low-income beneficiary protections). This policy would result in approximately an $11 per month increase in the Part B premium in 2002, but only for individuals with incomes over $30,000 (less than one-third of beneficiaries) -- same proposal as Blue Dogs -- or other approaches to assure that low-income beneficiaries are

not disproportionately affected.

- **income-relate the Part B premium --$3 billion**. This policy is modeled on the provision we included in the Health Security Act; it phases in a premium equal to 75 percent of Part B costs (triple the current premium) for high-income beneficiaries. Assuming that the premium would be $66.50 in 2002 (at 25%), this means that high-income beneficiaries would pay about triple that premium, or $199 a month (over $2000 more a year). Single beneficiaries with incomes over $90,000 (couples with incomes over $110,000) would be affected; this represents approximately 3% of Part B enrollees.

- **dropping OPD coinsurance reduction proposal--$7 billion.** This policy was designed to help beneficiaries by "buying down" the coinsurance they must pay for hospital outpatient department services (which is supposed to be 20% by law, but because of a statutory flaw, is at an effective rate of 46% and rising). The cost of this policy grows significantly in the years after 2002, which has resulted in some criticism.

- Relative to Plan X, we achieve the $113 billion in savings in this option without dropping the preventive benefits and the Alzheimer's respite benefit.

3. MOVE TO PLAN Y--$143 BILLION IN CBO-SCORED SAVINGS

- Plan Y achieves $143 billion in savings over 5 years. Savings from managed care are substantially lower than in the Administration's plan ($18 billion as opposed to $30 billion), while savings from hospitals are substantially higher ($54 billion as opposed to $25 billion). Savings from other providers are comparable, and Plan Y includes the reallocation of some home health spending from Part A to Part B to extend the solvency of the Trust Fund.

- Relative to the Administration's plan, the major issues with Plan Y are that it:

  - **does not include any new preventive benefits**, the Alzheimer's respite benefit, or the reduction in beneficiary coinsurance for hospital outpatient services;

  - **has a higher Part B premium** because it includes the home health spending transferred to Part B in the calculation of the premium;

  - **increases the Part B deductible** from $100 to $150 are indexes it to inflation;

  - **includes a Medicare MSA and private fee-for-service options** that appear to be similar to those in the vetoed balanced budget bill;

  - **includes much deeper hospital cuts**; and

- **cuts medical education funding more deeply** than the Administration and does not include the IME/GME/DSH carve-out policy.

- If the Administration decides to achieve $143 billion in savings, we would need to add $61 billion in savings to our original package (scored by CBO as saving $82 billion), and would be forced to adopt some of the policies in Plan Y. Possible options to meet this target (in addition to those outlined to meet the $113 billion target above) are:

  - **additional hospital reductions--$7 billion**. This policy assumes that we would provide no update to PPS hospitals for the next two years, after which they would receive an update of about 1% a year through 2002. Combined with the additional policies needed to achieve $100 billion in CBO-scored savings, this change pushes our total hospital savings from $25 billion up to $41 billion.

  - **additional SNF reductions--$1 billion**. This policy assumes that skilled nursing facilities would receive a lower annual update, rather than the full market basket increase they would have received under our original policy. Combined with the additional policies needed to achieve $100 billion in CBO-scored savings, this change pushes our total SNF savings from $8 billion up to $12 billion.

  - **additional physician reductions--$5 billion**. This policy assumes that physician reimbursements would grow at a rate of GDP-1%, as compared with our original policy, which grew physician reimbursements at GDP.

  - **additional HMO reductions--$3 billion**. Our original policy reduced HMO payments from 95% to 90% of fee-for-service reimbursements starting in 2000, in response to strong and growing evidence that Medicare significantly overpays managed care plans. If we made this reduction in the base payment now, rather than waiting until 2000, savings would be increased by around $3 billion.

  - **additional beneficiary savings--$22 billion**. This would include policies such as the income-related premium from the Blue Dog plan (starting at incomes of $50,000 for single beneficiaries, as opposed to the $90,000 income threshold level in the HSA income-related premium); a $5 nominal co-payment on home health services; and increasing the Part B deductible from $100 to $150 and indexing it to inflation. As an alternative to one or more of these policies, the remainder of the new benefits could be dropped, saving an additional $8 billion.

- Achieving $143 billion in savings over 5 years is substantially more difficult than achieving $100 billion or $113 billion in savings. This policy would be equivalent to about $260 billion in savings over 7 years.