THE WHITE HOUSE

WASHINGTON

March 1, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K.

FROM: Chris J. and Jeanne L.

RE: RESPONSE TO BREAUX PLAN BY ALTMAN AND TYSON

Today, Stuart Altman and Laura Tyson sent a list of suggested changes to Chairmen Breaux and Thomas on their reform plan. They have informed us that it is their belief that these changes are not negotiable but, rather, are what would be minimally acceptable for them to even consider voting to report out a Commission plan. Their recommendations are generally consistent with the principles for reform that the President outlined. For example, they suggest including the surplus or an analogous proposal, adding an optional prescription drug benefit accessible and affordable to all beneficiaries, ensuring guaranteed benefits, and allowing 62 to 64 year olds to buy into Medicare.

However, the list also includes controversial elements such as raising the age eligibility from 65 to 67 so long as there is a subsidized Medicare buy-in and adding an income-related premium beginning at $50,000 (which is twice as high as recommended by the Commission but much lower than most of the Democratic base would contemplate). Although consistent with their past statements, the document reiterates their openness to premium support that meets the goals that they outline (e.g., adequate government payment, defined benefits).

This paper was sent confidentially, but we would be surprised if it doesn't soon become public. If it does, Senator Daschle, Congressman Gephardt and others can be expected to be critical on both substantive and political grounds. They will be particularly upset that the President's appointees continue to negotiate with Senator Breaux and Congressman Thomas at a time when they feel they have disregarded Democratic concerns. Having said this, it is unlikely that Senator Breaux will be able to obtain Republican support for all of Stuart and Laura's recommendations. If this is the case, then the Commission will likely report out with 9 or 10 votes, not the supermajority (11 votes) needed. We will keep you posted on any news.

~~CONFIDENTIAL~~--NOT TO BE QUOTED

DRAFT 3/1/99

Recommended Changes to the Breaux Medicare Reform Plan

Stuart H. Altman
Laura Tyson

The Medicare program which began in 1965 has been among the most successful programs developed by the Federal government. It has allowed millions of Americans, mostly over age 65, to have access to the best health care our nation offers, and provided critically needed funding to enable the health care system to support its ever changing structure and the use of increasingly expensive technology. But, Medicare has problems, problems which will grow much worse in the years ahead. To greatly simplify these problems can be put into three categories:

A. Inadequate Benefits

Medicare currently covers about 53 percent of the health care spending of Americans 65 years of age and over. Among the benefits not covered the most important are outpatient prescription drugs and long-term care.

B. Future High Cost

The combination of Medicare spending on a per capita basis growing faster than the growth in GNP and the number of Medicare beneficiaries doubling over the next 30 years, every projection indicates that spending under the current Medicare program will consume an ever larger proportion of our national income. With that said, it should also be emphasized that Medicare will be required to cover a much larger proportion of the US population and that Medicare spending per capita must be related to the medical cost growth in the general economy or the program will cease to provide adequate coverage for "mainstream" medical care.

C. Inflexible Program

Medicare is a major federal program which is governed by the laws of Congress and administered by an agency of the federal government. As a result it is often restricted in its operation and the creation of new programs by political infighting within the Congress and between the Congress and the Administration. These political problems are compounded by the bureaucratic inertia of a large governmental program.

PROPOSED CHANGES TO BREAUX REFORM PLAN

To address the problems listed above and still maintain the integrity and valu... this vital program requires that we not replace three of Medicare's critical underlyin... principles:

1. A government guarantee that a specified set of benefits will be covered b... any approved and financed Medicare plan.

2. A sufficient government contribution such that adequate coverage will b... available and affordable to all beneficiaries regardless of their income o... geographic location.

3. A premium and cost sharing structure that does not invalidate the social insurance aspects of Medicare such that it no longer is a preferred plan f... all income groups.

A premium support plan with defined benefits and expanded coverage for outpatient prescription drug expenses that has limited income related premiums and/or co-payments can meet these requirements if it is designed correctly and is adequately financed.

The specifics outlined by Senator Breaux could be the foundation for such a plan but, fails to include a number of important factors and includes other components which could undermine the basic integrity of Medicare as a social insurance program. We have summarized these issues below along with proposed changes we believe are necessary to make the reform plan adequate for the 21st century and meet the high goals originally established for the Medicare program.

1. **Lacks a specified and adequate set of benefits.**

In order for adequate benefits to be available and affordable to all Medicare beneficiaries they must be specified in law and available in all approved Medicare plans including the one administered by the federal government. They also must include sufficient payments to providers that they will in fact be available and sufficient funds from the Medicare program that they will be affordable to all beneficiaries. To that end, we would propose the following additions to the Breaux plan.

A. All health insurers approved by Medicare including the program operated by the federal government must provide for beneficiaries to select as an option to basic coverage a plan which includes at least the following coverage for outpatient prescription drug expenses.

-- Following a special drug benefit deductible of $500, the plan will pay 75 per cent of all outpatient drugs prescribed by an approved Medicare provider. After an individual reaches an out-of-pocket payment including the deductible of $2500 per year, the plan would pay all additional drug expenses. For a couple living together the spending limit would be $4000. For the basic Medicare plan, the federal government will contract with a limited number of private prescription drug benefit managers to administer the program. It is expected that such PBMs will use the same techniques developed by private health plans to help control spending including volume discounting, mail order dispensing and approved pharmacy formularies. The prescription drug option would require a special premium which would equal 50 percent of its expected costs. Beneficiaries would pay more or less than this average premium based on an income related schedule consistent with the design established for the basic Medicare plan. For low income beneficiaries, the deductible would vary from $0 up to 135% of poverty to the full $500 at 300% of poverty.

B. A detailed set of benefits covered under all Medicare plans must be specified in law. At a minimum, benefits would include all services covered under the existing Medicare program plus an option for outpatient prescription drugs. All plans, including the one administered by the federal government, can establish their own rules as to how these benefits will be provided. Also permitted will be small variations requested by plans from the exact magnitude of the benefits subscribed in law. The Board which will oversee the operation of the premium support plan must approve all benefit designs and develop sufficient oversight competence that it can assure the Congress and the President that all plans do in fact provide the approved benefits and comply with all other aspects of the relevant statutes.

2. **Income related payments could jeopardize social insurance aspects of Medicare**

A. Any income related aspects of the reform plan will not consider family income below $75,000 ($50,000 for an individual) to be subject to a higher than average payment amount. The income related schedule should also recognize that some government payment amount is appropriate even for the highest income groups as they are also the groups which pay the largest tax amounts. Furthermore, any individual whose annual income is equal to or less than 135% of the poverty level will not be required to pay any premium or co-payment amounts.

3. **Raising age could increase uninsured**

A. The age when an individual becomes eligible for the full Medicare program will gradually be raised from age 65 to age 67. In tandem with this change all otherwise eligible individuals could buy into the Medicare program at age 62. For those aged 65-67, the premium charged would be income related for the lowest income groups using the same schedule as discussed above.

4. **The core Medicare program must continue to be affordable to all**

A. The modernized Medicare plan operated by the federal government must continue to be primarily a fee-for-service plan open to all qualified and approved providers except for certain select high cost procedures and where clear quality differences are shown to exist. The basic Medicare plan should also be given the necessary authority to engage in the kinds of competitive bidding schemes used by private health plans for laboratory services, durable medical equipment and other similar services. Since this plan will retain much of its current character it should continue to have the power of federal government pricing and contracting authority.

B. The system used to allocate funds to different regions of the US and to price the national basic Medicare plan must not create a regional bias against particular regions or in favor of the non basic plan except where clear regional or plan inefficiencies exist. To this end, all extra legislated payments to providers beyond what the market for patient care requires should be calculated on a per patient basis (including both basic Medicare and private health plans) and paid by the government from the Medicare trust fund independent of the calculations used to determine beneficiary premiums and the regional payment to private health plans.]

Specifically, the extra payments for Indirect Teaching Costs and Disproportionate Share, or the special subsidies to rural providers should not be paid only by the Basic Medicare plan or required of patients of private plans who live in areas where such programs exist.

5. **Need an adequate financing plan**

A. The plan must include a detailed structure on how it will be financed. While the exact dollar amounts need not be included since predictions of future spending become increasing suspect beyond 10 years, the proportions required from the different sources of funds should be specified and in general how such funds will be generated. Specifically, while the Breaux plan includes a number of provisions which will increase beneficiary liabilities, it does not mention how the additional governmental funds will be raised. This is a serious omission since the legislation which established the Commission required that we develop plans to restore the solvency of the Federal Hospital

Insurance Trust Fund and maintain the financial integrity of the Supplemental Medical Insurance plan. In that connection, the plan should include either the proposal stated by the President to use a portion of the expected federal surplus to help fund Medicare in the future or indicate how the needed federal revenues will be generated. Most importantly, the plan should indicate what proportion of the expected costs of the program should come from beneficiaries and the federal government, and how much should come from reduced payment growth to providers.

6. **No discussion of Long-term care needs.**

A. No mention is made in the Breaux plan for how the aged will pay for the increasingly expensive costs of long-term care in the future. At a minium, recognizing the complex nature of this problem and its very high costs, the plan should contain some general statements about a preferred direction of future policy.

THE WHITE HOUSE

WASHINGTON

February 24, 1999

RECOMMENDED TELEPHONE CALL

TO: Senator John Breaux

DATE: February 24, 1999

RECOMMENDED BY: Steve Ricchetti, Gene Sperling, Larry Stein, Chris Jennings

PURPOSE: Return call to Senator Breaux to discuss the Medicare Commission

BACKGROUND:
Senator Breaux has requested that you call him to give your reaction to his Medicare reform proposal and, most likely, to seek your help in encouraging Laura Tyson and Stuart Altman to support the work of the Commission and help him achieve the 11 votes he needs to report out a recommendation. (The Senator is assuming he already has Senator Kerrey and, as such, has 10 votes -- 8 Republicans plus Senator Breaux and Senator Kerrey.)

Senator Breaux will no doubt continue to say he is very open to changes to appease Laura and Stuart. However, no proposal he has released to date comes close to reflecting the views of Laura, Stuart or -- for that matter -- meets the basic principles you outlined in your AARP speech. To the contrary, his proposal has so many serious shortcomings and major omissions that all of your base Democrats (the Vice President, Daschle, Gephardt, Dingell, Rockefeller) are urging us to avoid sending any positive signal about the Commission's work. Highlights of the problems include: no use of the surplus for Medicare, no acceptable prescription drug benefit, the inclusion of the age eligibility increase (without any policy to prevent the number of uninsured from rising OR any 55-65 buy in), and an income related premium that begins at $24,000 for single beneficiaries. (Attached is a more detailed summary of the current Breaux proposal.)

Although Senator Breaux's proposal contains some positive aspects (e.g., new market-oriented tools for the fee-for-service program, rationalizing its cost sharing, and at least the start of a potentially viable premium support program), we have concluded that the Commission's work product is both politically and substantively unsalvageable. Senator Breaux has not yet reached this conclusion and continues to court your appointees. In fact, as recently as this evening, he met with Laura and Stuart to solicit their ideas on what changes would be needed to obtain their votes. While Laura and Stuart do not believe that the Commission will be sufficiently responsive, they feel uncomfortable rejecting this request for assistance.

We believe the time has come to have an honest, direct conversation with Senator Breaux about why we do not believe we cannot support the Commission's proposal at this time. We believe it can be done in a way that illustrates why it would be beneficial to him and the prospects for reform to conclude the work of the Commission with the ten votes he has.

We believe you can have the most constructive conversation by telling him it would be completely counterproductive to the prospects for reform if you get in the middle of the debate and strong-arm the Democratic appointees. At this point, you can tell him, it would only divide the party and make it more difficult to pass legislation down the road. A better approach in which you can still show action and leadership is for the Senator to come forward with the best possible report and you can tell him you will: (1) praise the report for strongly advancing the issue and (2) assure him that you will commit to coming forward in the weeks that follow with your own constructive ideas for moving bipartisan legislation forward. Attached are some suggested talking points.

TALKING POINTS

- John, I believe your Commission is performing a constructive function. It is floating important ideas that have real potential and that may well lay the groundwork for the type of reforms we both want.

- Having said this, my Commission members -- even those who are supportive of the premium support concept (Laura Tyson and Stuart Altman) -- have raised a number of very legitimate concerns. I am sure you can tell from your conversations with them that their beliefs are their own. I also want to assure you that the only message the White House has given to Laura and Stuart is to be constructive and to help you produce the best possible package.

- More important, though, we are facing a real "melt-down" from the base Democrats. While you may want to still try, I am not at all confident that you can produce the changes that they want, let alone the alterations Laura and Stuart want, without losing all or most of your Republican support.

- And, because of the strong feelings the Democrats have against your package, I don't think it would be advisable or productive for me to jump in this debate at this time and try to jam it down their throats. Therefore, recognizing the situation you face, it may well be best for you to move your package out with 10 votes out of the Commission.

- Doing so would avoid giving Democrats more time to analyze, criticize and undermine your work, since the only way you could even hope to attract Laura or Stuart would be through a prolonged discussion about important details. If you do this, I will say very positive things about your work, underscoring my belief that it provides an important contribution toward addressing the complicated and numerous challenges facing the Medicare program.

- I will then work with you in trying to develop a proposal that takes your best ideas without totally driving away some of the key Democrats we will need to get the reform we both want.

SENATOR BREAUX'S MEDICARE COMMISSION PLAN, 2/23/99

OVERVIEW OF SENATOR BREAUX'S PACKAGE

- **Total Savings.** The Commission staff are distributing charts and press releases stating that the Actuaries projected that Senator Breaux's "premium support" plan would save $347 to 372 billion over 10 years. However, this is misleading because:

  - Premium support only achieves $75 to 102 billion -- a fraction of the total savings;

  - $100 billion in revenue from an extremely aggressive income-related premium that is supposed to be reinvested in low-income protections -- but is counted as savings in the Commission press paper; and

  - $50 billion in direct medical education that is transferred out of the Medicare Trust Fund but into a new mandatory grant program in a budget-neutral way.

SAVINGS UNDER BREAUX'S PLAN
(Calendar Years, Dollars in Billions)

	00-04	00-09
Premium Support		
Limited Extra Benefits	-26	-75
No Extra Benefits	-37	-102
Income-Related Premium (Not counted as savings)		
Limited Extra Benefits	-36	-96
No Extra Benefits	-38	-95
Raising Age Eligibility	-2	-25
Cost Sharing / Medigap Changes	-14	-31
Medicare Fee-For-Service Reforms		
BBA Extenders	-7	-57
Modernizing Fee-For-Service	-9	-22
Removing DME from Medicare (Not counted as savings)	-20	-46
Interactions	1	6
FEDERAL SAVINGS		
Low Premium Support	**-58**	**-204**
High Premium Support	**-69**	**-231**

This means that the Federal savings are really $204 to 231 billion over 10 years ($58 to 69 billion over 5 years).

- **About one-fourth to one-half of savings from beneficiaries.** The package includes:

  - $31 billion from cost sharing increases (i.e., home health coinsurance) and Medigap reforms;

  - $25 billion from raising age eligibility with no options to prevent the uninsured from rising;

  - $96 billion from an aggressive income-related premium; and

  - Tens of billions from higher fee-for-service premiums under premium support.

- **Does not include**:

  - **Surplus:** The plan does not include your 15 percent surplus proposal nor any other revenue proposals.

  - **Prescription drug benefit**: Although Senator Breaux has indicated a willingness to work on a benefit, the current proposal has no prescription drug coverage.

SPECIFIC PROPOSALS IN SENATOR BREAUX'S PLAN

- **Premium support ($75 to 102 billion over 10).** The actuaries estimated savings from Senator Breaux's premium support because beneficiaries have a financial incentive to choose lower-cost plans, thus lowering the Medicare average spending over time. The higher savings estimate assumes that there is no ability for private plans to vary their benefits, encouraging competition on price. The lower savings estimate assumes that plans can offer some extra benefits, thus reducing savings. In both models, the actuaries estimate that the premium for fee-for-service will be 10 to 20 percent higher than current law since low-cost plans will make fee-for-service a higher cost -- and thus higher premium -- plan.

- **Income-related premium ($95 to 96 billion over 10).** Beneficiaries with income above $24,000 for singles, $30,000 for couples would pay an increasing higher premium. These income thresholds are half as high as the 1997 Chafee-Breaux proposal, and would affect more than twice as many people -- about 30 percent of beneficiaries (about 12 million beneficiaries). Assuming 1999 costs, this premium would be $125 a month a single beneficiary with $40,000 and a married beneficiary with $50,000 in income. All revenue from this income-related premium, according to the description, would be reinvested in a yet- to-be designed low-income protections and therefore would be budget neutral (no savings).

- **Raising the age eligibility ($25 billion over 10).** The real savings from this proposal are in the long-run -- a separate analysis indicated that this policy alone would produce as much savings as premium support over the 30-year period. The analysis does not include any proposal to help insure people losing Medicare eligibility OR a proposal to allow people under age 65 buy into Medicare.

- **Cost sharing and Medigap changes ($31 billion over 10).** This plan would make a number of changes to Medicare cost sharing which, in total, would increase the amount that beneficiaries pay out-of-pocket ($20 billion over 10). This primarily results from a new 10 percent home health copay. The plan would also prohibiting Medigap from covering Medicare's deductible ($11 billion over 10).

- **Fee-for-service reforms ($16 billion over 5, 79 billion over 10):** This includes extending most Balanced Budget Act proposals from 2003 to 2007 ($57 billion over 10). The plan would also modernize Medicare fee-for-service by giving it additional flexibility used by private health plans ($22 billion over 10). These savings are more than we expected, and probably are more than CBO would estimate.

- **Transferring direct medical education out of Medicare ($46 billion over 10).** This proposal does not actually save the Federal government any money -- it simply moves DME spending from Medicare to some other, unnamed place in the budget.

To: Bonnie

NEED FOR NEW REVENUE FOR THE MEDICARE TRUST FUND

DRAFT: February 28, 1998

NATURE OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND

- **Created to ensure that revenue from Hospital Insurance payroll tax is used to fund Medicare:** The Trust Fund is a separate account in the Treasury that is primarily funded through an automatic appropriation of revenues from the Hospital Insurance payroll tax. This tax is 1.45 percent of income for employees and employers (2.9 percent total). The second largest funding source for the Trust Fund is the interest income generated by the payroll tax and other revenue; it accounted for about 8 percent of assets in 1997.

- **Pays for certain Medicare services**: The Trust Fund pays for services in hospital (inpatient), skilled nursing facilities, hospices, and certain home health and managed care services. Funding for other Medicare services (e.g, services from physicians, labs) comes from beneficiary premiums (25%) and general revenues (75%).

- **Why the Trust Fund matters**: Although the Trust Fund does not finance all Medicare services, it has historically served a critical role catalyzing policies to strengthening Medicare's fiscal integrity. At several points in its history, the Medicare Trust Fund has been within several years of being insolvent. If all of its assets were used up, the Trustees would have to borrow money to pay for services. Impending insolvency has been a reason for the major changes to Medicare that occurred in the 1980s, OBRA 1993, the Republican efforts to reduce Medicare spending in 1995, and the Balanced Budget Act of 1997.

STATUS: IMPROVED BUT STILL FACES ENORMOUS CHALLENGES

- **Improved but still large Trust Fund problem**. In 1993 when President Clinton took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent through 2008, in large part because of the historic changes in the Balanced Budget Act of 1997. Medicare contributed a major share of the savings that went to balancing the budget and leading to the surplus that we have today.

  - If Medicare growth in 1999 remains low, Medicare will have had four consecutive years of single-digit spending growth for the first time in history.

  - Medicare spending growth per beneficiary (HI and supplemental medical insurance, Parts A and B) is projected to grow at 5.8 percent between 2000 and 2020. This compares to an average per beneficiary growth rate of 10.8 percent between 1970 and 1996.

- **Insolvency in 2008**: Since expenditures are currently exceeding income to the Trust Fund, its assets are being depleted. In 1999, the shortfall is expected to be $6.8 billion, resulting in assets at the end of the year of only $101 billion. These assets are projected to be used up by 2008. -- just as the baby boom generation begins to retire.

CONSEQUENCES OF NOT ADDING NEW REVENUE

- **Unsustainable, low growth rates.** Competition, efficiency and traditional savings alone cannot secure Medicare. If reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be constrained to 2.8 percent per year -- in every year -- to get to 2020. To put this rate into perspective:
  - Medicare growth would have to be over 60 percent below projected private health insurance spending per person (7.3 percent).

  - By 2020, a growth rate of 2.8 percent per beneficiary would result in Medicare spending that is over 40 percent below what is projected to be under current law. Since this growth rate is below inflation according to the Trustees, the value of Medicare spending per beneficiary would erode by 10 percent by 2020.

- **Removing critical services**. To give a sense of the size of the problem, even ending Trust Fund financing for all skilled nursing facility plus hospice spending, or Part A home health spending, or all graduate medical education and disproportionate share hospital spending alone would not be sufficient to extend the life of the Trust Fund through 2020.

NEW REVENUE OPTIONS

- **Dedicating 15 percent of the surplus to Medicare.** The President has proposed to dedicate an amount equal to 15 percent of the surplus over the next 15 years to Medicare. This amount is $689 billion over 15 years, $120 billion between 2000 and 2004 alone. This will have the effect of extending the life of the Trust Fund until 2020 with no other changes. The surplus is probably the most fair source of new revenue for Medicare. It was created largely by the people who will soon become Medicare beneficiaries -- the baby boom generation and those nearing retirement -- whose contributions to the economy have increased revenues.

- **Alternatives could hurt lower wage workers or vulnerable beneficiaries.** To get to 2020:
  - **Nearly a 20 percent increase in the payroll tax** for both employees and employers would be needed (from 2.9 to 3.4 percent combined).

  - **A 75 percent increase in beneficiary premiums.** A $37 per month on top of the current premium would be needed to equal the amount transferred from the surplus in 2000 under the President's proposal. This would be about $890 a year for an elderly couple.

- **Waiting exacerbates problem**. Immediately adding revenue to the Medicare Trust Fund would generate interest income, lessening the amount of new funding needed in the future. Without new revenue and program changes, it would take $1.5 trillion to fund the Medicare shortfall through 2020. (See attached table)

- **Merging Medicare's Trust Fund with Part B will not end its financial problems.** While Trust Fund solvency is not a measure of Medicare's overall health, it does impose fiscal discipline since Congressional action is required to increase financing. In contrast, proposals to merge the Trust Fund with Part B would likely result in unlimited general revenues being used for services previously funded only by the Trust Fund.

premiums are collected under current law.

The government-run fee-for-service plan would set its premium as a national plan based on its actual and projected claims costs. Other plans could choose national, regional, or local service areas, subject to the approval of the Board. The Board would ensure that plans did not manipulate their service areas or benefit packages for selection purposes, that plans met minimum benefit standards, and that plans' benefit offerings were within a limited range of variation. The Board could require that certain plans or types of plans set regional or national service areas to aid access in areas that otherwise would have limited plan availability.

Specifically, the Medicare Board would ensure that all plans covered at least those benefit items covered by the fee-for-service plan, and that plans covered those items to an extent comparable to the fee-for-service plan. To encourage innovations by plans and broad competition among various types of plans, plans would be given the flexibility to propose benefit design options. The Board would approve any proposed changes. The Board also would be required to exclude certain benefits for dental, vision, and hearing services from the computation of the national average premium, and the Board would be allowed to exclude other such peripheral benefits at its discretion. Furthermore, the Board would keep benefits within a certain range of value. This estimate assumes that the variation of benefit value would not exceed 10 percent.

Risk adjusters for plans would include

- age, sex, institutional status, Medicaid enrollment, employment, and eligibility based on disability as under current law,
- geographic location (the geographic adjuster would be based on the cost of doing the business of providing health care in an area, which is not necessarily the same as the cost of health care in an area), and
- health status. Adjusters for health status would be crafted to avoid unwanted incentives or unwarranted administrative burdens that could affect varying types of plans' ability or willingness to offer coverage. An adjustment for tenure (the length of time a beneficiary has been with a plan) could be combined with other adjusters as they were developed.

The geographic payment adjuster would include elements of historical Medicare costs and the cost of providing health services in areas. This estimate assumes that the areas would be defined as Metropolitan Statistical Areas with one additional area for non-metropolitan areas of each state. The geographic adjustment factors would be approximately budget-neutral; the magnitude of the geographic adjusters would be a policy decision. This estimate assumes that the geographic adjuster would have approximately 75 percent of the variation currently embedded in Medicare's AAPCC payment

March 6, 1999

NOTE TO: Stuart Altman

SUBJECT: Level of Government Subsidy for Voluntary Medicare Drug Benefit

As you know, beneficiaries will generally act in their best interest when given a choice of health insurance coverages. What is optimal for their financial interests is generally more expensive for the insurer. This same principle applies in the case of a voluntary drug benefit for Medicare, paid for in part by beneficiaries. An extreme example would be if the benefit could be selected month-by-month. Obviously, beneficiaries would only purchase the coverage in a given month if they anticipated drug expenditures exceeding the cost of the coverage.

The provision to offer voluntary coverage on a one-time-only basis at the time of initial enrollment was designed to help offset the selection problems that would otherwise occur. Assuming that all beneficiaries paid the same premium (that is, the premiums were not established by age), there would still be a problem since younger beneficiaries would have to pay premiums for many years that were considerably in excess of the value of the coverage. Not all would choose to do so, thereby setting off a potential selection spiral.

Provision of a government subsidy is intended to address this problem. We have estimated, on a largely judgmental basis, that a 50-percent subsidy would be sufficient to induce the vast majority of beneficiaries to enroll for the drug benefit. With a subsidy of this level, younger beneficiaries would receive coverage worth approximately their premiums and would generally opt for the coverage (especially given the one-time opportunity).

With lower subsidy levels, we believe that progressively larger numbers of beneficiaries would not select drug coverage, because of the progressively less favorable value comparison. These would generally not be beneficiaries who anticipate significant drug expenditures in the near term, naturally. Thus, we anticipate that the overall cost of the drug coverage would not be significantly reduced with lower subsidies but aggregate beneficiary premiums would be reduced somewhat as a result of fewer participants.

The cost to Medicare would decline overall with a lower subsidy rate but the risk pool would worsen somewhat and the coverage would become less efficient. There are other potential concerns with a voluntary program, including the administrative complexity of dealing with beneficiaries whose coverage varies and (undoubtedly) the issue of under what circumstances a beneficiary would be allowed to sign up for coverage despite his not having signed up at the one-time opportunity.

Good luck with your policy considerations and negotiations, and please let us know if you have any other questions about these issues.

Rick Foster

cc: Jeanne Lambrew

REVISED COMMISSION PROPOSAL: February 16, 1999

PREMIUM SUPPORT

- **Types of plans:** Under this plan, there would be private managed care plans and Medicare fee-for service, but HCFA would also be required to organize a privately-run fee-for-service plan. Medicare fee-for-service would not operate in areas where HCFA had provided for a privately-run fee-for-service plan.

- **Benefits:**
  - **Standard option.** All plans would offer "standard option": those benefit items currently covered "to an extent comparable to the government-run plan" (probably some amount, duration and scope flexibility).

  - **High option plan.** Private managed care and private fee-for-service plans would have to offer a "high option" plan that includes prescription drugs and any other benefit at the Board's approval. There would be no high-option plan in Medicare fee-for-service -- only in the private fee-for-service option.

  - **Cost sharing rationalization**: This would include:

    - Combined Part A and B deductible of $380 (indexed to inflation) and a 10 percent copayment for home health (not clear whether it reduces preventive cost sharing).

    - Medigap reform: All plans would be required to offer prescription drugs, and a new drug-only plan would be approved. Medigap could not cover the deductible or coinsurance in private plans.

- **Government payments**: The government would pay a percent of the plan's premium up to a cap. This payment schedule is based on the "national weighted average" of the plan's standard option premiums only. Specifically, all plans, including Medicare fee-for-service, would submit their premiums for the standard option benefits, as well as their estimated enrollment. A national average would be calculated from this information. Using this national average, a government payment schedule would be set so that government pays:

  - 100 percent of the premium for plans below 85 percent of the national average;

  - A percent between 100 and 88 percent for plans with premiums between 85 percent and 100 percent of the national average; and

  - 88 percent of the national average for plans with premiums above the national average.

  While the schedule of government payments is based on premiums for the standard option, it appears that the government will pay for high option benefits if the premium for the high option plan is below the national average.

The government payment would be partially adjusted for geographic variation (75 percent of the variation). This partial geographic adjuster could have the effect of underpaying plans in high cost areas, and thus reducing the number of plans in those areas.

- **Beneficiary payments**: Beneficiaries would pay the difference between the plan's premiums and the government contribution.

  - **Low-income beneficiaries**: Current Medicaid protections would be expanded with a Federal matching rate of 100 percent. Beneficiaries with income below 135 percent of poverty would not have to pay premiums for plans available to them up to the cost of the Medicare fee-for-service plan, the standard option private fee-for-service plan, or the lowest-cost standard option plan available to them. Beneficiaries with income between 135 and 200 percent of poverty would receive premium assistance on a sliding scale.

    Prescription drug coverage: Beneficiaries with income below 135 percent of poverty would receive a subsidy for drug coverage in a high option private managed care or private fee-for-service plan.

  - **High-income beneficiaries**: Does not include a proposal for income-related premium.

MEDICARE FEE-FOR-SERVICE

- **Modernization**: This proposal would include a list of policies to give Medicare the same tools that the private sector uses to manage costs.

- **Balanced Budget Act Extenders**: The proposal includes a somewhat modified set of extenders, with the caveat that this does not "imply a literal extension of the listed provisions....serves only as a concrete example."

RAISING THE AGE ELIGIBILITY FOR MEDICARE

- **Conforms Medicare eligibility age to that of Social Security**

- **Allows certain beneficiaries with delayed eligibility to participate in Medicare.** For the purpose of the estimate, waives 2-year waiting period for people on disability insurance.

GRADUATE MEDICAL EDUCATION

- **Carves out direct medical education**: Removes from Medicare financing; funds those activities "elsewhere in the budget."

- **Reduces indirect medical education payments** by 20 percent

FINANCING

- **No proposals**

DRAFT: MEDICARE REFORM PLANS, February 18, 1999

COMPONENT	BREAUX'S PLAN	ALTERNATIVE (*changes in italics*)
Administration	Board that: Decides service areas Negotiates benefits, premiums Sets standards Provides information	Board that: Decides service areas Negotiates benefits, premiums Sets standards Provides information *Runs private fee-for-service plan*
Benefits	Basic: Includes core benefits Total package at least equal to FFS Drugs: Private plans: May design and offer a drug and other benefits and receive gov't subsidy if total premium is below national average FFS: No benefit [placeholder] Cost Sharing: Private plans: No Standards FFS: $350 combined deductible 10% for home health , no hosp limits	Basic: *Appears to be equal to current benefits, with limited flexibility* Drugs: *Private managed care and fee-for-service plans: Must offer an unspecified drug benefit* *Medigap: Must offer drugs* *Medicare FFS: No benefit* Cost Sharing: Private plans: No Standards FFS: $350 combined deductible 10% for home health , no hosp limits
Government Contribution	Fixed percent of the premium (including extra benefits) up to a dollar limit (fixed percent of the national average premium)	Fixed percent of the premium (excluding extra benefits) up to a dollar limit (fixed percent of the national average premium)
Beneficiary Contribution	In general: FFS: Difference between the national average Medicare spending and the gov't contribution Private plans: Difference plan premium and gov't contribution Low-income: Unspecified High-income: Phases from 12 to 27% of premium for benes with income b/w 300-500%	In general: FFS: Difference between the regional average Medicare spending and the gov't contribution Private plans: Difference between plan premium and gov't contribution Low-income: *No premium below 135% of poverty* *Sliding scale premium to 200%* *No premium for drug benefit in private plans below 135%* High-income: *None*
Fee-For-Service Reforms	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO *Some BBA extenders*
Age Eligibility Increase	Raise to conform with Social Security Allow some type of Medicare buy-in	Raise to conform with Social Security *Waive waiting period disability recipients*
Graduate Med. Education	Move direct medical education out of Medicare; Consider removing IME, DSH	Move direct medical education out of Medicare; *Cut IME by 20%*
Financing	No specific options	No specific options

March 6, 1999

NOTE TO: Rick Foster

SUBJECT: Illustrative Calculations of Beneficiary Premiums and Government Contributions under Senator Breaux's "Alternative" Premium Support Formula

The attached table presents the subject illustrations for three geographic cost areas ("low," "average," and "high" cost) and three levels of plan costs within each area (similarly, "low," "average," and "high"). Illustrations are also shown for the national Medicare fee-for-service (FFS) plan. The examples illustrate how the "alternative" premium support formula included in Senator Breaux's Medicare legislative package would operate under a variety of situations.

The table lists the determination of beneficiary premiums and corresponding government contributions for each of the illustrative plans, based on our understanding of the proposal.[1] The following statements summarize the calculations:

Weighted Average Premium (WAP) - Assumption used for this illustration; represents the average cost for all participating plans, weighted by the number of enrollees in each plan.

85% of WAP - For informational purposes; 85 percent of WAP is the first "bendpoint" in the "alternative" premium support formula used in this illustration.

Full geographic cost factor - Reflects local health care costs relative to the national average. (In practice, this factor has traditionally been based on Medicare fee-for-service costs.)

Partial geographic adjustment - Factor is a 75/25 blend of the local and national rates. Approximates the blend under current law which is a 50/50 blend of local rates and an input-price-adjusted national rate. Pending a more specific provision, we have assumed this geographic adjustment based on preliminary indications from the Medicare Commission staff.

Plan cost - Plan costs vary within geographic areas due to such factors as degree of efficiency within the plan, the plan's ability to negotiate discount rates from provider networks, and the plan's benefit package.

Partial geographic adjustor - Plans are assumed to submit bids that will allow them to recover their full costs. In practice, they would accomplish this result by adjusting their actual costs by the same geographic adjustment as would be used in the calculation of their plan payment.

Plan bid - Plan cost divided by the partial geographic adjustor.

---

[1] Our understanding of Senator Breaux's proposal is based on staff documents and explanations. If our understanding is incorrect for any reason, the examples shown in this memorandum would be subject to change.

Beneficiary premium - Under the "alternative" formula, the beneficiary pays nothing for plans with bids below 85 percent of WAP. For plans with bids between 85 percent and 100 percent of WAP, the beneficiary's marginal contribution is 82 percent (i.e., for every additional dollar, the beneficiary pays $0.82 and the government pays $0.18). For plans above 100 percent of WAP, the beneficiary pays an additional premium equal to 100 percent of the difference between the plan bid and the WAP.

Using a high-cost plan in a low-cost area as an example, the beneficiary premium would be calculated as follows:

$$\begin{aligned}\text{Beneficiary premium} &= 0.0*.85*\text{WAP} + .82*(\text{WAP} - .85*\text{WAP}) + 1.0*(\text{Plan bid} - \text{WAP}) \\ &= 0.0*.85*\$5{,}100 + .82*(\$6{,}000 - \$5{,}100) + 1.0*(\$8{,}471 - \$6{,}000) \\ &= \$0 + \$738 + \$2{,}471 \\ &= \$3{,}209\end{aligned}$$

Government contribution - Calculated as the plan bid times the partial geographic adjustor minus the beneficiary premium. Continuing the example from above:

$$\begin{aligned}\text{Government contribution} &= (\$8{,}471*.85) - \$3{,}209 \\ &= \$3{,}991\end{aligned}$$

Payment to plan - Calculated as the sum of the beneficiary premium and the government contribution. Note that the plan payments equal plan costs.

These examples illustrate the nature of the premium support formula but are not intended to portray every possibility or to suggest what proportion of actual premium/contribution determinations might fall into one or another of the illustrative categories. As indicated in the examples, beneficiary premiums could be zero, for plans with sufficiently low costs, or could represent a substantial portion of total costs in higher-cost plans. (In practice, the proposal by Senator Breaux would limit the actuarial value of a plan's benefit package; this limitation is not necessarily reflected in the attached examples, which do not distinguish between higher costs attributable to broader benefit coverage from those arising from inefficient delivery of care.)

Note that as the government contribution is only partially geographically adjusted, beneficiaries pay less in low-cost areas and more in high-cost areas than they would pay with a fully geographically adjusted plan bid. For example, beneficiaries in "average-cost" plans in the illustrative low-, average-, and high-cost areas would pay premiums representing 9.4 percent, 12.3 percent, and 14.2 percent, respectively, of total plan costs. With full geographic adjustment of the government contribution, beneficiaries in the illustrative average plans would all pay a $738 premium, equivalent to 15.4 percent, 12.3 percent, and 9.5 percent of plan costs, respectively. Conversely, in the absence of any geographic adjustment, the premium in the illustrative low-cost areas would be zero and the corresponding high-cost-area premium would be 33 percent of plan costs.

We have separately estimated that the average per-beneficiary cost for the national fee-for-service plan would be somewhat greater than the weighted average premium for all plans under Senator Breaux's proposal. As indicated in the examples, if this cost differential were $100 then the beneficiary premium under the FFS plan would be $100 greater than the premium associated with the weighted average cost level or, in the illustration, $838. This example illustrates the intentionally steep increase in beneficiary premiums for plans with above-average costs: in this instance, a 1.7-percent increase in plan cost, relative to the average, results in a 13.6-percent increase in the beneficiary premium. The intent is to provide a strong incentive for beneficiaries to select lower-cost plans.

The partial geographic adjustment, together with the "alternative" formula, causes a possible anomaly in government contribution rates. This effect can be seen in the comparison of the government contributions for average- and high-cost plans in a low-cost area. Because proportionately more of the cost is paid by the beneficiary as described above, the government contribution for the high-cost plan is lower than the government contribution for the average-cost plan. This may or may not be an intended consequence.

Please let me know if you have any questions about these illustrations.

Sally Burner

Sally Burner

Illustrative calculations of beneficiary premiums and government contributions under Senator Breaux's "alternative" premium support formula, by geographic area and plan cost

Weighted Average Premium (WAP)	$6,000
85% of WAP	$5,100

	Low Cost Areas			Average Cost Areas			High Cost Areas		
Full geographic cost factor	0.80	0.80	0.80	1.0	1.0	1.0	1.30	1.30	1.30
Partial geographic adjustment	0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23

		Plan Costs			Plan Costs			Plan Costs			National FFS plan
		Low	Average	High	Low	Average	High	Low	Average	High	
Plan cost		$ 3,600	$ 4,800	$ 7,200	$ 4,500	$ 6,000	$ 7,500	$ 5,850	$ 7,800	$ 9,750	$ 6,100
+ Partial geographic adjustor		0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23	1.0
= **Plan bid**		$ 4,235	$ 5,647	$ 8,471	$ 4,500	$ 6,000	$ 7,500	$ 4,776	$ 6,367	$ 7,959	$ 6,100
Bid amount below 85% of WAP	0%	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
+ Bid amount 85% to 100% of WAP	82%	0	449	738	0	738	738	0	738	738	738
+ Bid amount above 100% of WAP	100%	0	0	2,471	0	0	1,500	0	367	1,959	100
= **Beneficiary premium**		$ 0	$ 449	$ 3,209	$ 0	$ 738	$ 2,238	$ 0	$1,105	$2,697	$838
Plan bid		$ 4,235	$ 5,647	$ 8,471	$ 4,500	$ 6,000	$ 7,500	$ 4,776	$ 6,367	$ 7,959	$ 6,100
* Partial geographic adjustor		0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23	1.0
- Beneficiary premium		0	-449	-3,209	0	-738	-2,238	0	-1,105	-2,697	-838
= **Government contribution**		$ 3,600	$ 4,351	$ 3,991	$ 4,500	$ 5,262	$ 5,262	$ 5,850	$ 6,695	$ 7,053	$ 5,262
Beneficiary premium		$ 0	$ 449	$ 3,209	$ 0	$ 738	$ 2,238	$ 0	$ 1,105	$ 2,697	$ 838
+ Government contribution		3,600	4,351	3,991	4,500	5,262	5,262	5,850	6,695	7,053	5,262
= **Payment to plan**		$ 3,600	$ 4,800	$ 7,200	$ 4,500	$ 6,000	$ 7,500	$ 5,950	$ 7,800	$ 9,750	$ 6,100

Note: Plan payment = plan cost

Office of the Actuary
Health Care Financing Administration
2/26/99

March 8, 1999

NOTE TO: The File

SUBJECT: Marginal Rates of Government Contributions and Beneficiary Premiums under "Alternative" Premium Support Formula

Sally Burner's note of March 6 indicates a potential anomaly with the "alternative" premium support formula included in Senator Breaux's Medicare legislative proposals. As her examples demonstrate, in some instances the government contribution for plans in low-cost areas can decline with increasing plan cost.

As shown in the attached charts, this effect is not isolated and has a corresponding opposite impact in higher-cost areas. In particular, it affects the marginal government and beneficiary contribution rates whenever the geographic index is not exactly 1.00. Under the alternative formula, in areas with a geographic index of exactly 1.00, beneficiaries would pay a zero premium for plan costs at or below 85% of the weighted average premium, 12.3% for a plan cost equal to the weighted average, and all of any cost in excess of the weighted average. This "two-bendpoint" formula implies marginal beneficiary premium rates of 0, 82%, and 100% for costs below 85% of the weighted average, in between 85 and 100%, or above 100%, respectively.

In low-cost areas, however, with a geographic index less than 1, these marginal rates increase somewhat. For plan bids above the weighted average premium, the beneficiary rate becomes greater than 1.00—that is, a $1 increase in plan costs raises the beneficiary premium by more than $1. (This is the mirror image of the negative marginal rate for the government contribution mentioned in Sally's note.) In between 85% and 100% of the weighted average, the marginal beneficiary premium rate is higher than the 82% applicable in average-cost areas. With a partial geographic index of 0.85, for example, the marginal rate would be about 96%.

Similarly, the marginal beneficiary rates in higher-cost areas differ from the 82% and 100% standard factors. They would be approximately 67% and 82% , respectively, for a partial geographic index of 1.225.

There is corresponding variation in the marginal government contribution rates, as shown in the attached charts. With the current partial geographic adjustment, the marginal contribution rates are as follows, where "pgi" is the partial geographic index:

	Marginal beneficiary premium rate	Marginal government contribution rate
Between 1st & 2nd bendpoints	0.82/pgi	1 – 0.82/pgi
Above 2nd bendpoint	1/pgi	1 – 1/pgi

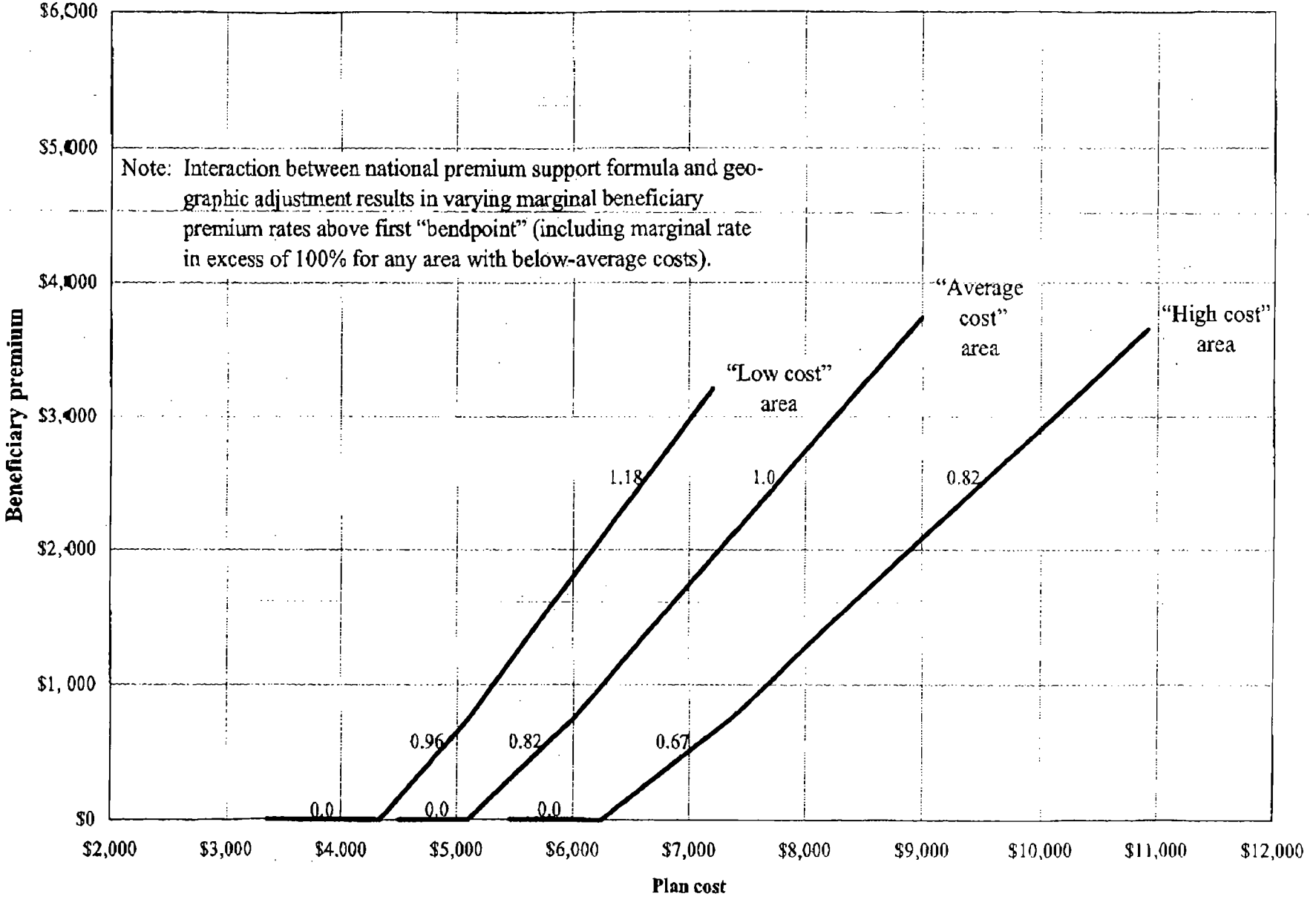
If we substitute full geographic adjustment for partial geographic adjustment, then the variation is greater: In the above formulas, replace "pgi" with "gi;" since gi is farther from 1.0 than pgi, the effect on the marginal rates is greater. This issue might go away if there is no geographic adjustment (but that scenario raises other important issues).

The geographic variation in marginal beneficiary premium and government contribution rates is apparently unintentional but may or may not represent a policy concern. If it does, there are probably ways to address it but we have not investigated them as yet. Our estimates for Senator Breaux's Medicare package only partially reflect this variation. Fully reflecting the geographic variations in the marginal rates would have only a minimal impact on our estimates for the alternative premium support formula but could have a much greater effect under other formulas.

Rick Foster

Beneficiary premium under "alternative" premium support formula, by plan cost and geographic cost area

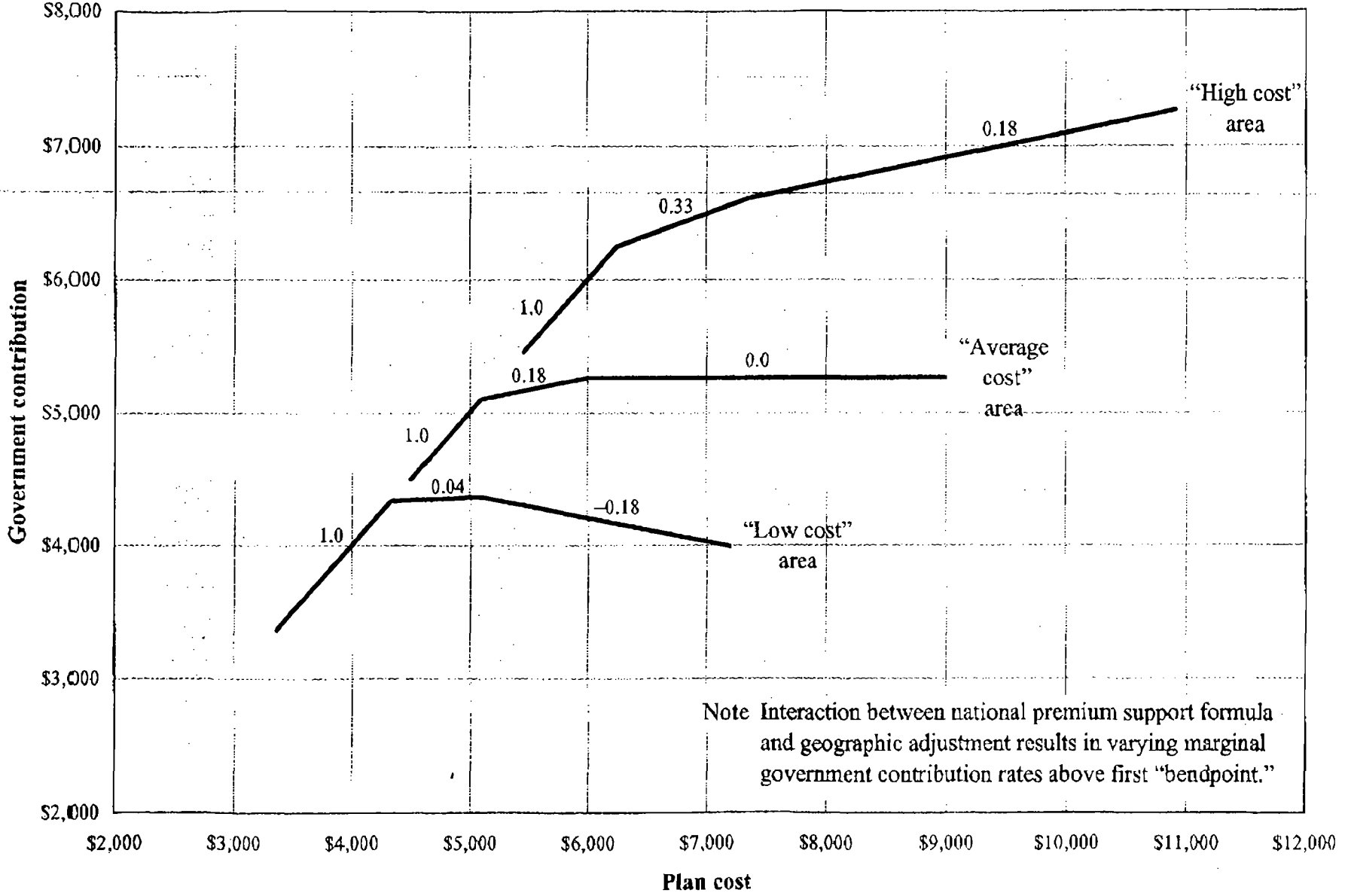
(marginal premium rates shown next to each curve segment)



Office of the Actuary
3/7/99

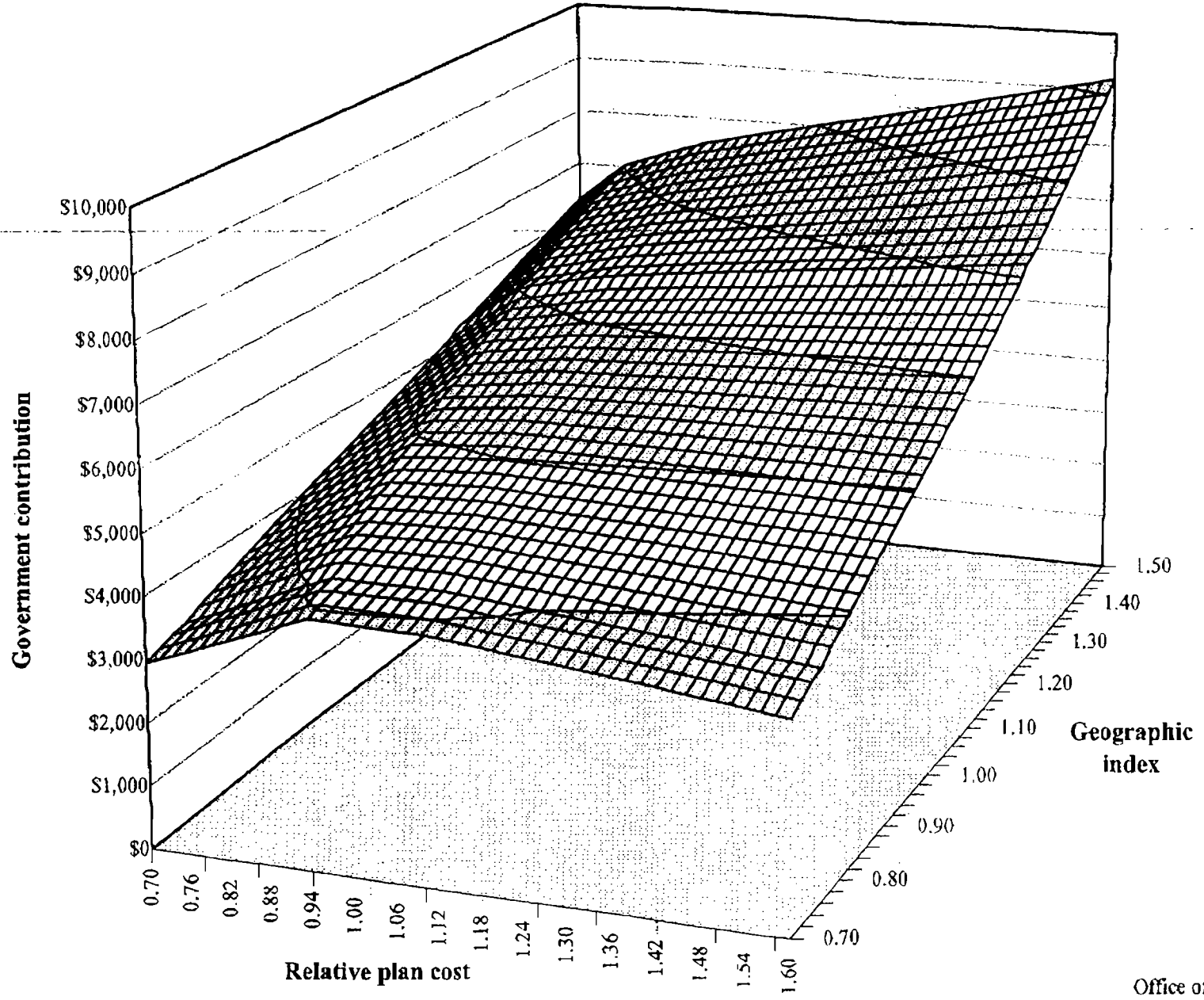
Government contribution under "alternative" premium support formula, by plan cost and geographic cost area

(marginal contribution rates shown next to each curve)



Office of the Actuary
3/7/99

Government contribution under "alternative" premium support formula, by plan cost and geographic cost area



Office of the Actuary
3/7/99