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Medicare [Folder 1]

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RESTRICTION CODES

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MEDICARE:

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

June, 1999

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. President's Plan for Modernizing and Strengthening Medicare

- Making Medicare More Competitive and Efficient
- Modernizing Medicare's Benefits, Including Adding a Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21st Century

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans:** About 34 million elderly and 5 million people with disabilities receive Medicare.

- **Helps those who would otherwise be uninsured:** Before Medicare, almost half (44 percent) of the elderly were uninsured and millions more had substandard coverage. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty:** Since 1965:

  - Life expectancy of people at age 65 has increased by 20 percent (79 to 82 years)

  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)

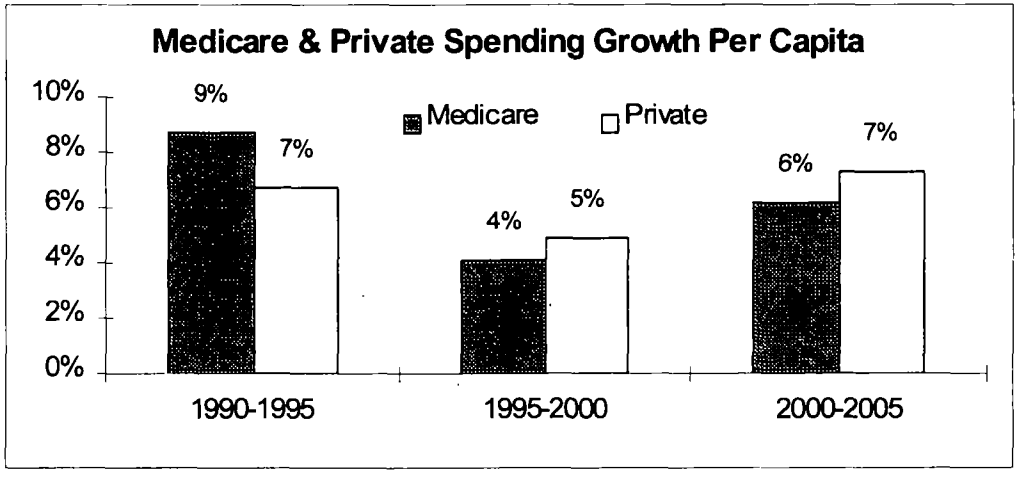
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. When President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999.

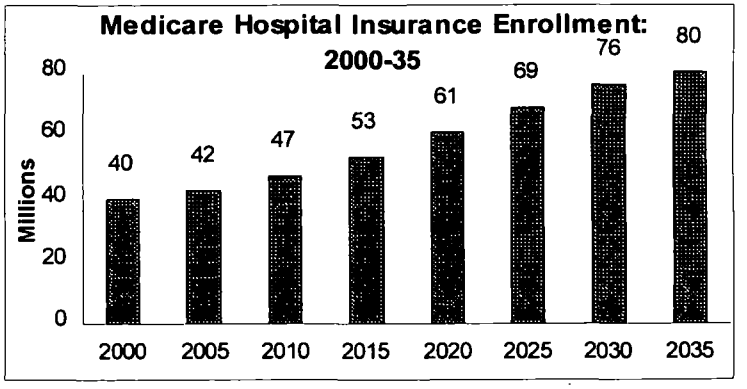
- In response, the President advocated for Medicare reforms in 1993 and 1997, and instituted an unprecedented crack-down on fraud and abuse. These actions, in combination with a strong economy, constrained cost growth and extended the life of the trust fund until 2015.

- The slow Medicare spending growth is expected to continue through 2002 -- when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.



- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

- **Millions have no coverage for prescription drugs.** Prescription drugs have become central to modern medicine, yet nearly 15 million Medicare beneficiaries have no coverage.
  - About 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $16,000 for a single, $22,000 for a couple).
- **Current prescription drug coverage is unstable and declining.**
  - Employer-sponsored retiree health insurance is declining. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1997.
  - Medigap, the individually purchased supplemental policies, have grown very expensive and less common. Medigap premiums have been rising at double-digit inflation.
  - Medicare managed care plans usually cover drugs, but 11 million beneficiaries do not have access to managed care plans. Drug coverage is typically limited (e.g., $1,000 cap).
- **Today's drug coverage resembles general insurance coverage when Medicare was created in 1965.** Although 56 percent of the elderly had insurance before Medicare, this coverage was expensive, inadequate and unreliable – much like the drug coverage today. Medicare would not have been created if this "coverage" was considered acceptable.

OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

- **Insufficient flexibility in traditional Medicare to adopt best private sector practices to reduce costs and increase quality.** Medicare is governed by statutory constraints that limit its ability to adopt innovative payment and management strategies.

- **Medicare pays managed care plans a flat rate, set by a complex statutory formula, that has nothing to do with plan prices.**

  ° Overpaid. A June 1999 report from the General Accounting Office found that the Balanced Budget Act has not eliminated managed care plan overpayments. For example, managed care plans in Los Angeles can provide the traditional Medicare benefits package for 79 percent of what they are currently paid.

  ° Only compete by providing extra benefits. Managed care plans offer extra benefits with the overpayment – they cannot compete on price.

    - *Unfairly subsidizes benefits in high-cost / high-payment areas*: 75 percent of rural beneficiaries do not even have the option of joining managed care.

    - *Hard for beneficiaries to comparison shop on benefits*

    - *Easy to attract healthy or avoid sick beneficiaries by custom-designing benefits*

II. PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21st Century

- **Reduces Medicare spending by $72 billion /10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years, fully financed by the offsets in the proposal. This cost is only about 5 percent of total Medicare spending in 2009.

- **Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027.** This would be the best prognosis ever for the Part A Trust Fund.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	*-5*	*-64.5*
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	*+27*	*+110*
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	*-22*	*-45.5*
Surplus Allocation	*-50*	*-374*

* Includes $5.7 billion in interactions/premium offset
** Does not count toward package

I. MAKING MEDICARE MORE EFFICIENT
Private Sector Purchasing & Quality Improvement Tools for Traditional Medicare

- **Allowing Traditional Medicare to Adopt Best Private Practices.** This proposal would build on the President's commitment to give traditional Medicare the ability to adopt payment and quality improvement tools that are frequently used in the private sector.

  - Promoting the use of high-quality, cost-effective providers. Give beneficiaries a financial incentive (e.g., lower cost sharing) to choose selected providers; pay facilities that meet quality and cost standards a single price.

  - Primary care case management and disease management. Structure payments to promote coordination of services for certain diseases of beneficiaries who have high health costs to reduce hospitalizations.

  - Coordinating care for dual eligibles. The 17 percent of beneficiaries who are Medicare-Medicaid dual eligibles account for 28 percent of spending. Provide information to help coordinate benefits; test models in traditional Medicare to coordinate services.

  - Innovative purchasing tools and contracting reform. Provide authority for competitive pricing, selective contracting, negotiated discounts; and flexible contracting.

Competitive Defined Benefit Proposal

- **Competitive defined benefit proposal.** This proposal would inject competition into Medicare managed care by paying plans based on their prices, not a fixed rate.

  - Beneficiaries' premiums would be based on their plan choices. Beneficiaries choosing higher-cost managed care plans would pay more, those choosing lower-cost plans would pay less. Those choosing traditional Medicare would pay the usual Part B premium.

- **Promotes fair competition.** Beneficiaries can more easily identify and choose plans based on price and quality. The system would also promote fair competition between managed care and traditional Medicare by assuring that beneficiaries choosing a similarly priced private plan pay the same premiums.

- **Saves through competition, not rate reductions.** Unlike the current system, Medicare would save money when beneficiaries choose lower cost plans. This contrasts with the way that Medicare saves under the current system, which is to simply reduce payment rates.

Example: Competitive Defined Benefit Proposal

Option	Plan Price (monthly)	Split of Plan Payments	
		Beneficiary	*Government*
Low-Price Plan	$433.33	$0.00 0%	$433.33 100%
Medium-Price Plan	$490.00	$42.50 9%	$447.50 91%
Price Equals 96% Of Traditional Costs	**$500.00**	**$50.00 10%**	**$450.00 90%**
High-Price Plan	$520.00	$70.00 13%	$450.00 87%

Smoothing Out Balanced Budget Act Policies: Short- and Long-Term

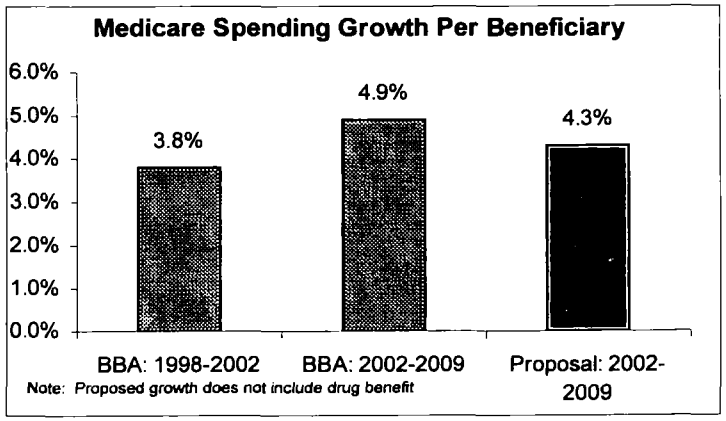
- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this concern, this plan:

  - Sets aside $7.5 billion over 10 years. The Administration would work with Congress and outside groups and experts to determine appropriate, targeted policy solutions.

  - Administrative actions. The plan also includes more gradual transitions to policies that may cause problems if implemented aggressively.

  - Targeting disproportionate share hospital payments. These payments would be removed from managed care payments, similar to graduate medical education, and paid directly to hospitals as subsidies for managed care admissions.

- **Constraining out-year program growth, but more moderately than BBA 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to un-sustainable growth rates. They are more modest than those included in the BBA of 1997.



Improving Medicare Management

- **Modernizing Medicare management**. The President's plan includes a major modernization reform of the management of Medicare. It would:

  - **Increase accountability through public/private advisory boards.** These include:

    - Management Advisory Council. Panel of public and private sector management experts to identify and recommend best management practices for Medicare.

    - Medicare Coverage Advisory Committee. Experts in medicine and science, consumer and industry representatives would help determine coverage policy.

    - Citizens' Advisory Panel on Medicare Education. Experts in consumer education and health policy and health care providers would monitor and evaluate Medicare's consumer education initiatives.

- **Outside review of personnel policy**. Medicare has contracted with an outside evaluator to determine how best it can prepare its staff for the challenges of the next century.

MODERNIZING MEDICARE BENEFITS
Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002.

  - Meaningful coverage. Medicare would cover half of drug costs from the first prescription up to $5,000 in spending per year ($2,500 in Medicare payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers.

  - Affordable premiums. Beneficiaries would pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded.

  - Private management. Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities to manage the benefit. Through competitive bidding, it would award one contract per area. No price controls would be imposed.

  - Medicare support for retiree coverage. Medicare would pay a reduced premium subsidy for beneficiaries who remain in their employers' health plan.

Improving Preventive Benefits and Eliminating Cost Sharing

- **Promoting prevention for Medicare beneficiaries.** This proposal would take a number of steps to make preventive services more affordable, as well as to raise awareness of services

  - Eliminating all existing preventive services cost sharing. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. For the rest of the preventive services covered by Medicare, cost sharing is already waived. Cost: $3 billion over 10 years.

  - Smoking cessation demonstration. It would initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.

  - Education campaign. It would also launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

  - U.S. Preventive Services Task Force study. This study would evaluate the range of preventive services that are appropriate for the elderly, providing guidance for the future.

Rationalizing Cost Sharing and Medigap

- **Rationalizing Medicare cost sharing.** The plan would change Medicare cost sharing by:

  - Adding a 20 percent clinical laboratory coinsurance. Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform. It also could cut down on fraud and help reduce over-use.

  - Indexing the Part B deductible to inflation. Medicare's Part B deductible of $100 would be indexed annually to inflation. This helps maintain the value of the deductible over time.

- **Reforming Medigap.** The plan would update the private insurance policies called Medigap:

  - Add a new plan option, with nominal cost sharing. This would better track the coverage for the nonelderly, and could reduce premium costs for Medigap.

  - Updating existing plan options. In light of the new prescription drug policy and other changes proposed in the plan, all of the Medigap plan options would be updated.

  - Report to Congress on policy alternatives to Medigap, since access problems are rising.

  - Access to Medigap for beneficiaries whose private plans withdraw from Medicare.

Medicare Buy-In for Certain People Ages 55-65

- **Important insurance option for those nearing Medicare eligibility.** The plan includes the President's proposal to expand health options for people ages 55 to 65. Its costs are offset in the context of the FY 2000 President's Budget submission.

  - People ages 62 to 65 would have the choice to buy into the Medicare program for approximately $300 a month if they agreed to pay a small risk adjustment payment once they become eligible for Medicare at age 65.

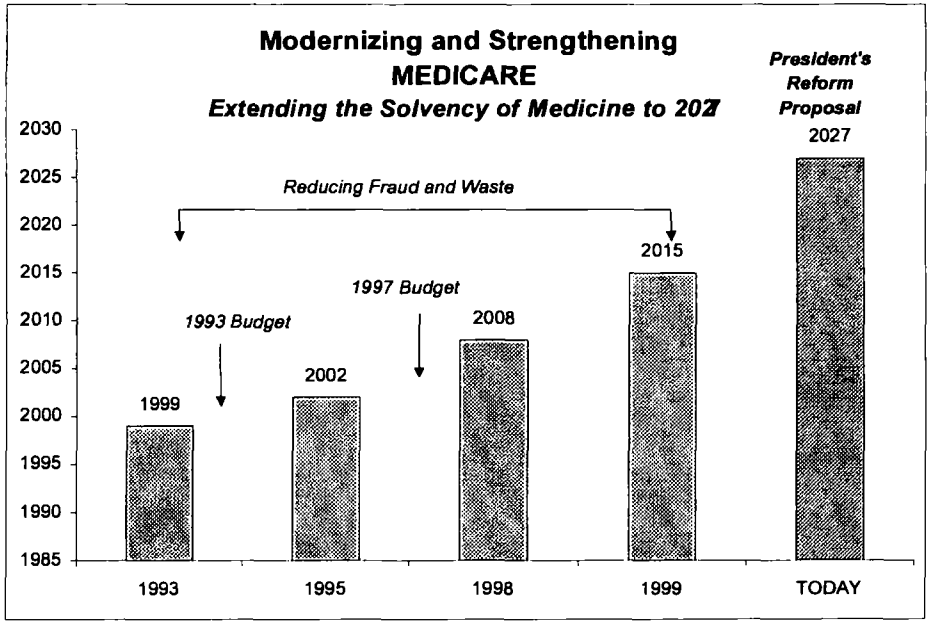
  - Displaced workers between 55-62 who involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400).

  - Retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

- All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever. The initiative should help 300,000 to 400,000 people.

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY
Surplus for Medicare Solvency

- **The President has renewed the commitment he made in the State of the Union Address to dedicate 15 percept of the surplus to Medicare.** Over the 15-year window covered by the President's Framework, $794 billion would be dedicated to strengthening and extending the solvency of Medicare – more than the $686 billion from the budget since the surplus has increased.
    - Under the latest projections, this would push the forecasted date of insolvency back to past 2027.
- **Unprecedented improvement to the trust fund.** In the almost 30 years that the Trustees have projected solvency, there has never been prognosis for the Medicare Trust Fund as good as this one.



Financing for the Prescription Drug Benefit

- **Prescription drug benefit designed to be fiscally responsible.** To ensure that it does not result in unsustainable spending growth in the out-years, this proposal's drug benefit's limit is indexed to general inflation. Thus, Medicare offsets are able to keep pace with its growth.

- **Medicare savings are the primary source of funding for the new prescription drug benefit.** About 60 percent of the costs of the prescription drug benefit would come from reducing Medicare cost growth, improving its efficiency, and beneficiary contributions.

- **Small fraction of the surplus used as financing.** The remaining $45 billion would be financed by using a fraction of the 15 percent of the surplus dedicated to Medicare. To put this amount in context, it is:

  - Less than one-eighth of the amount for Medicare -- 2 percent of the entire surplus.
  - Less than the drop in Medicare baseline spending between January and June, 1999.

- **Medicare baseline has dropped, in part because of administrative actions.** Policy experts advising the Congress (MedPAC, CBO, and Medicare Trustees) have credited our success in combating fraud, waste, and abuse as a major reason for the $241 billion, 10-year drop in Medicare spending from 1998 to 1999. Reinvesting savings that can be reasonably attributed to our anti-fraud and waste activities in a new prescription drug benefit is completely consistent with our precedent of using savings for programmatic improvements.

June 19, 1999

TO: Gene
FROM: Jeanne and Chris
RE: **PAPER FOR MEDICARE ROLL-OUT**

On this page, we have outlined the full list of document that we are intending on produce (with luck and little sleep) by mid-week. We are thinking that we probably need to give principals paper / begin briefing them by the end of the week, so we have a lot of work to do.

The rest of this document is what we are calling the master document. It is a detailed description of all the policies in the plan. We are still working on the hard ones – competition, drugs, provider savings policies – but will have drafts by Sunday night. We also are hoping to get to you the press paper sooner than later, since it frames the other documents.

PAPER

- Press paper
- Walk-through document
- Master document/Detailed policy descriptions
- Improvements for beneficiaries
- Competition paper
- Trust Fund / surplus paper
- Drug benefit paper
- Comparison to Breaux-Thomas (one-page table)
- Rural paper
- Women
- Provider group paper (internal)

CJ + LB

I have read entire document. I have many questions and need lots of briefing -- but one generic point is that we will need good logic on Traditional fee-for-service reforms with billing format.

1) Good health policy + savings
2) Private sector does it & saves ____ and helps Beneficiaries
3) Medicare can't + Now it can"

6/20/99

- Q and a (internal)

MASTER DOCUMENT: TABLE OF CONTENTS

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   c. Carving disproportionate share hospital (DSH) payments out of managed care
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4. **Improving Medicare Management**
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   b. Increasing accountability through Management Advisory Committee, Medicare Coverage Advisory Committee & Citizens' Advisory Panel on Medicare Education
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II. MODERNIZING MEDICARE BENEFITS

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   b. Launching information campaign on prevention
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for older Americans

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   b. Indexing the Part B deductible??
   c. Add a new Medigap plan option that allows for nominal (rather than no) cost sharing
   d. Allow access to Medigap for beneficiaries whose plan withdraws from Medicare
   e. Direct the Secretary of Health and Human Services and the National Association of Insurance Commissioners to update benefits in all Medigap plans
   f. Direct the Secretary of Health and Human Services to report to Congress on the feasibility and advisability of adding catastrophic coverage to Medicare

3. **Medicare Buy-In for Certain People Ages 55-56**
   a. Medicare buy-in for people ages 62-64
   b. Medicare buy-in for displaced workers ages 55-62
   c. Access to health insurance for retirees whose employers renege on coverage

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   j. Medigap

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2. **Income-Related Premium (Beginning at $100/120,000)**

16
16
/2

I. MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

1. Managed Care Reform: Competitive Defined Benefit [in progress]

2. Private Sector Purchasing Tools for Traditional Medicare

[note: disease management, quality section being added]

Overview. As a result of aggressive policies to make Medicare more efficient and reduce fraud, Medicare spending growth per beneficiary is now at or below that of the private sector. In the past decade, however, private health care purchasers have developed a variety of techniques that appear to be successful at maximizing value by controlling costs and increasing quality of care. These newer *tools* include competitive pricing, negotiation, selective contracting, and utilization management. Additionally, private payers have developed new *applications* of existing practices, such as preferred provider arrangements, targeted prior authorization, disease management, and various forms of bundled payments. Flexibility to customize an approach and choose among these tools and applications would maximize Medicare's ability to achieve high value under the traditional program.

In contrast to other public and private purchasers of health care, Medicare lacks the necessary flexibility to adopt these practices. External groups, including the National Academy for Social Insurance, have called for HCFA to be given greater flexibility to use these tools and applications in Medicare. Similarly, the Bipartisan Commission on the Future of Medicare considered various strategies for modernizing traditional Medicare. In addition, HCFA, through demonstrations and in some legislative proposals, has been exploring for several years the possibility of greater flexibility in how Medicare might pay providers and health plans.

A common theme in the policies included in this plan is "targeting" both beneficiaries and providers who can benefit from these new tools and applications. Targeting high-cost beneficiaries with appropriate interventions will lead to better quality of care, as well as yield savings. Targeting efficient, high-quality providers to encourage and reward preferred behaviors can have similar effects. Some of the proposals also involve targeting specific areas of the country where certain approaches are most appropriate (e.g., choosing one aspect of the modernization program but not another), or where there is the greatest likelihood of an immediate impact in terms of potential savings and improved quality of care. Implementation of these proposals is also likely to be staged by geographic area, with implementation beginning in areas in which there have historically been unexplained higher health care costs than other areas.

All of the policies listed below would be effective on January 1, 2001, and would save a combined total of $XX billion over 10 years.

a. Competitive and negotiated pricing authority [note: check w/ HCFA – not best price, right?]

Policy: This proposal would authorize use of either competitive bidding or price negotiations to set payment rates for Part B items and services (except for physicians' services). DHHS would have the authority to select both the items and services and the geographic areas to be included in a bidding or

negotiation process based on the availability of providers and the potential for achieving savings. Bids would be accepted only if the providers met specified quality standards. DHHS also would have the authority to selectively contract only with providers who accept negotiated or bid prices and other contract terms.

Under this proposal, DHHS also would be given the authority to negotiate alternative flexible purchasing administrative arrangements with providers and suppliers who either: (1) agree to provide price discounts to Medicare, or (2) should be recognized for better performance. The administrative arrangements could include such incentives as alternative claims processing, administrative and related procedures. The use of the special administrative arrangements could be targeted to those areas where market competition in the area makes other arrangements common. In general, before an alternative arrangement went into place, DHHS would have to certify that the arrangement would achieve program savings either as a result of the discounts, or as a result of encouraging beneficiaries to utilize provider and suppliers that have been identified as meriting special administrative treatment because of their demonstrated appropriate utilization practices.

Background/rationale: Under current law, payment for items and services is based on statutorily prescribed payment amounts or fee schedules. Any provider or practitioner that meets Medicare's conditions of participation is eligible to receive payment for items and services provided to Medicare beneficiaries. Other purchasers of health care have successfully used competitive processes and negotiation to establish payment rates and assure high quality of items and services. HCFA, under provisions of the Balanced Budget Act, is currently in the process of testing competitive bidding processes for durable medical equipment and is planning to also test a competitive process for procuring laboratory services.

In addition, DHHS currently has no authority to modify administrative procedures for selected individual providers or suppliers. Private sector payers can negotiate various discount arrangements with specific entities in exchange for providing administrative incentives or can use administrative incentive to reward for better performance.

b. Innovative pricing for certain procedures, conditions, services or sites

Policy: This proposal would authorize DHHS to provide a single, global payment to combinations of selected practitioners, providers and suppliers for all care delivered at:

- Specific site of service (e.g., all physicians' and hospital services delivered in the hospital setting, or all professional and facility services delivered in partial hospitalization programs; or for
- Specific conditions or needs of an individual (e.g., diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME).

Practitioners, providers, and suppliers would be selected based on their ability to provide services more efficiently, to improve coordination of care (e.g., disease management, case management), or to offer additional benefits to beneficiaries (e.g., respite care, nutritional counseling, adaptive and assistive equipment, transportation). In any area where suppliers or providers are selected to be paid on a global basis, Medicare could limit the number of entities paid through the global payment arrangement, even if

other entities would otherwise be eligible for the global payment arrangement. Within the global payment, providers would have flexibility both in how services are provided and in financing additional, non-covered benefits through the global payment. Global payment arrangements would be entered into only if overall program savings are anticipated, when compared to what program payments would have been in the circumstances (e.g., for the episode of care, for the beneficiaries in question) in the absence of global payments.

In the case of global payments made for services delivered in a specific site, the payment would cover the episode of care at the site of service. For global payments made on the basis of beneficiary conditions, beneficiaries would voluntarily elect to participate in such arrangements for a defined period.

This proposal would also provide the authority to conduct demonstration projects to evaluate disease management for high-cost, chronic diseases. The Secretary would have the authority to determine appropriate accreditation standards for disease management vendors, who would provide (or subcontract to provide) services including patient screening and assessment, review of medications, patient education, telephone consultations, physician interaction, home nursing visits, and surveillance and reporting. To minimize fragmentation of care, HCFA would have the authority to require single vendors to provide disease management for related comorbidities (e.g., congestive heart failure, hypertension, coronary artery disease, and diabetes). Prospective vendors would bid competitively for contracts. Patients would enroll voluntarily and would have the right to disenroll at any time. HCFA would have the authority to require vendors to be at risk for savings of 5 to 10 percent in total medical spending (after correcting for risk selection and accounting for management fees) for the given diagnoses and to structure the payment provisions accordingly. HCFA would also have the authority to require vendors to guarantee certain patient satisfaction and quality of care outcomes. The demonstration projects would serve to evaluate the impact of disease management on quality, patient satisfaction, and costs, as well as to establish payment benchmarks for future projects.

Background/rationale: DHHS currently has no authority to modify FFS payment arrangements to reflect the combinations of services that are provided to beneficiaries in certain care settings or for certain conditions. This lack of flexibility is in sharp contrast to the ability that other payers have to negotiate various arrangements with specific entities, and the recent developments in the private sector to target certain high cost health conditions for special coordinated care delivery and structure payment accordingly. Private-sector disease management vendors indicate they are achieving savings of 20 to 50 percent (before fees) for selected high-cost, chronic diseases, and have begun to guarantee improvement in patient satisfaction and clinical outcomes, as well as cost savings.

c. Single payment for procedures or medical conditions

Policy: This proposal would create a Centers of Excellence program as a permanent part of Medicare. It would authorize the Secretary to pay competitively selected facilities a single bundled rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition. Beginning in 2001, the Secretary would establish Centers of Excellence throughout the Nation for coronary artery bypass grafts (CABG) and other heart procedures, knee replacement surgery and hip replacement surgery. The Secretary would also specify other appropriate procedures and conditions in which Centers of Excellence would be sought. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be

required to implement a quality improvement plan. The single rate paid to a Center for a particular procedure or admission can not exceed the aggregate amount that would otherwise be made in order to produce overall savings to the Medicare program.

Medicare would not be required to contract with an entity, even if it otherwise met program standards, if there were already enough Centers of Excellence in that geographic area to meet projected demand. Facilities would retain the Center of Excellence designation for a three-year period as long as they continued to meet quality standards. Experience with the demonstration indicates that the designation as a Center has a "spill-over" benefit for the participant's non-Medicare business. Beneficiaries would not be required to receive services at Centers, but Centers would be allowed to provide additional services (such as a private room) or reduce/waive cost sharing to attract beneficiaries. Any beneficiary incentives would have to be approved by the Secretary. It is estimated that about 20 percent of beneficiaries would use Centers of Excellence under this plan.

Background/rationale: From 1991-1998, HCFA conducted a demonstration through which certain facilities, referred to as Centers of Excellence, were paid a single fee to provide all of the facility, diagnostic and physicians' services associated with coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12 percent savings for CABG procedures performed through the demonstration. This technique is widely used by private sector health benefits managers [check].

d. Medicare preferred provider option (PPO)

Policy: This plan would establish a PPO for Medicare. From the beneficiary point of view, the Medicare PPO would resemble a preferred provider arrangement or point-of-service (POS) plan operated by an insurer in the private market. Beneficiaries would be guaranteed a lower level of cost sharing by using preferred providers. This level of cost sharing would be equal to that offered in the new Medigap Plan K or, if a beneficiary is enrolled in Plan K, waive cost sharing. The quality standards of the PPO would provide beneficiaries with a straightforward way of determining that they are using higher-quality health care providers.

Physicians, other practitioners, suppliers, and institutional providers could be PPO participants. Only "participating" physicians/suppliers already enrolled in the current Medicare "par program" would be eligible. The Secretary would pre-screen, or "credential," practitioners and providers applying to be preferred provider participants based on their claims history and any quality information to determine whether they are cost-conscious, high-quality health care providers. Only those applicants with a demonstrated history of cost-effective medical practice patterns would be selected as preferred providers. PPO participants would agree to meet quality standards and utilization management requirements as established by the Secretary. The Secretary would "profile" practitioners and providers on a continual basis and would provide feedback on performance. The preferred provider designation could be removed if the participant falls below quality and utilization standards expected of PPO providers.

The program would pay PPO practitioners and providers at discounted fees. However, PPO participants would be given administrative advantages, such as faster claims payment and alternative administrative and related procedures. If expenditure targets are met, or program savings are otherwise documented,

they could be eligible for bonus payments for achieving specified performance outcomes (e.g., more health-conscious behavior by patients, improved accessibility, or demonstrated higher quality care). PPO participants may also see a "spillover" benefit in their non-Medicare business by having the quality designation of being a Medicare PPO participant.

Background/rationale: In the private sector, preferred provider organizations (PPOs) and point-of-service (POS) plans have become the predominant form of managed care. These plans make distinctions between participating and non-participating providers (physicians as well as other providers). Enrollees of these kinds of plans face differential cost sharing, and may have other advantages in using participating physicians or other providers, such as freedom from prior authorization requirements (e.g., hospital care in the Federal Employees' Blue Cross PPO), or coverage of otherwise non-covered services if preferred providers are used. Providers that agree to the contract terms of the sponsoring plan can often expect an increase in volume of patients, resulting in greater total revenue despite the discounted payment rate. Sponsoring organizations typically use certain criteria to pre-screen providers wishing to participate as preferred providers (a process generally referred to as "credentialing"), and/or continually monitor the performance of a provider in relation to its peers or expected levels of quality standards and levels of expenditures and utilization. Providers can be "de-selected" from networks (i.e., the contract is terminated) if the norms are not met.

The Medicare program also makes a distinction between participating physicians and suppliers (excluding institutional providers), and non-participating physicians and suppliers, but for a different purpose. In exchange for an agreement to abide by certain payment rules that are advantageous to beneficiaries, the participating physicians and suppliers have been given payment and administrative advantages (such as electronic media claims submission). Nonparticipating physicians/suppliers that do not submit a claim on an assigned basis are permitted to "balance bill" a beneficiary beyond Medicare-allowed amounts, up to a limit. As part of the participation agreement, a "par" physician/supplier agrees to submit all claims on an assigned basis, accepting the Medicare payment (plus any beneficiary allowed cost sharing) as payment in full for covered services. Medicare, through its carriers, publicizes the availability of participating physicians/suppliers. In the sense that participating physicians/suppliers agree to always accept Medicare rates, Medicare beneficiaries choosing between participating and non-participating physicians/suppliers can face differential cost sharing if a non-participating physician/supplier chooses to submit a bill on other than an assigned basis.

c. Incentive payments for qualified integrated delivery arrangements (group practices)

Policy: This proposal would create a demonstration -- which would become nationwide if proven successful -- to give qualified integrated delivery arrangements bonus payments if they can reduce total volume and intensity of all types of Medicare covered services provided to beneficiaries during the year.

A "qualified integrated delivery arrangement" is a large physician group practice that would be required to: meet or exceed certain size and scope criteria, submit acceptable clinical and administrative management plans, participate in acceptable quality improvement plans, distribute at least a portion of the bonus payments based on quality performance, and submit required performance data. HCFA would provide performance profiles to support the organization's strategic planning for successful clinical management. The Secretary would have the authority to determine the terms of the selective contract, such as its duration, the financing arrangement, and conditions for renewal.

Qualifying organizations would be given an annual per capita target based on the organization's own historic experience: average total Part A and Part B expenditures for the Medicare FFS beneficiaries seen by the organization in a base year. After each performance year, the target would be adjusted for actual age, reason for entitlement and other relevant factors. The target would need to be updated annually and possibly rebased every 3 to 5 years. A bonus could be paid to the organization when actual total per capita expenditures in the performance year are lower than the target. The bonus amount could be limited to a portion of the Medicare savings generated, and also adjusted for the portion of total Part A and Part B services that were actually provided by the qualified organization's physicians and other providers. To further encourage quality improvement, a portion of Medicare savings – separate from the bonus payment -- could be set aside each year and paid to qualifying organizations based on process and outcome improvements.

Beneficiaries would not enroll in these organizations. They would be notified of their physician's participation, but could obtain care from any provider as they currently do. Participating organizations would monitor patient satisfaction.

Background/rationale: The physician community is largely responsible for directing health care -- providing services and making referrals. Beneficiaries and the Medicare program could benefit if the physician community, through integrated delivery arrangements, better coordinated care across sites of service, and invested in administrative structures and processes to assure efficient service delivery. Currently, the Standard Growth Rate (SGR) is the incentive under which physicians operate in FFS. It is designed to control annual growth in expenditures, and pertains only to services covered under the Medicare Physician Fee Schedule. Under SGR, individual physicians are subject to blanket penalties or rewards regardless of their relative efficiency, and SGR has no effect on the behavior of physicians as it concerns referrals for most non-physician services.

While the majority of physicians are not organized in large groups, the majority of Medicare's physician services are provided by doctors who are organized in large groups. These large groups are often associated with integrated delivery arrangements. Extrapolating this finding to the other types of Medicare services that these doctors direct (e.g., hospitalizations, SNF admissions, durable medical equipment), a target budget derived for qualified organizations in local markets that volunteer to participate could result in lower costs and better outcomes for a large segment of the traditional Medicare program.

f. Primary care case management

Policy: This proposal would allow HCFA to provide incentives to both beneficiaries and providers to voluntarily participate in care coordination arrangements for high cost / high risk beneficiaries. To encourage these beneficiaries to voluntarily enroll with a primary care case manager (PCCM), Medicare would educate targeted beneficiaries about the option and could offer additional benefits or lower cost-sharing. The average additional costs of lower cost sharing or extra benefits would be offset by an average reduction in costly services such as avoidable hospitalizations. Beneficiaries who meet the criteria for a PCCM would volunteer to remain with a PCCM for a period of time, and would receive all their needed health care either directly from or through referral by their primary care case manager.

PCCM

The Secretary would have authority to selectively contract with physicians for PCCM services. Primary care physicians would have an incentive to become a PCCM, since the designation as a PCCM would be exclusively for physicians who meet certain performance standards and other criteria. Further, the PCCMs would be marketed so that beneficiary enrollment would guarantee patient volume. Physicians would be paid fee-for-service. They would receive case management fees that could incorporate physician education and training.

Background/rationale: Today, a small fraction of beneficiaries (5%) account for 45 percent of Medicare spending. These high-cost Medicare beneficiaries could benefit from assistance with coordinating their health care. Primary care case managers (PCCMs) have been used by Medicaid and private health plans to achieve savings and improve health care outcomes. For example, a study of Medicaid in Kentucky and Maryland found that PCCMs can reduce use of ancillary services and increase use of preventive services and primary care. This care management can be especially important for older and sicker beneficiaries, who have diminished capacity to navigate the health care system.

g. Stronger prior authorization and utilization review

Policy: This proposal would give the Secretary clear authority to: (1) use prior authorization review for specific targeted services and procedures of any supplier or provider in any setting of care; and (2) also contract with other entities (e.g., carriers, fiscal intermediaries) to make prior-authorization determinations.

Outlier practice patterns of providers and practitioners (particularly for high-cost, high-volume services and procedures) would be identified using profiles that measure performance against clinical benchmarks established from evidence-based guidelines. Outlier providers and practitioners would be required to seek prior authorization for the targeted services and procedures (e.g., certain admissions, invasive procedures and radiology services).

This proposal broadens the existing prior-authorization authority of the statute to include a wider range of Medicare covered services and it gives DHHS increased flexibility to use a variety of contractors to assure that Medicare pays for services that are reasonable and necessary. Given the role of the carriers and fiscal intermediaries in making payment decisions and preventing program abuse, it is appropriate to also have the flexibility to use these contractors for utilization management activities, including prior authorization. This flexibility allows for Medicare to operate an efficient prior-authorization program through a number of organizations. The Medicare contractors have experience with utilization management activities with their private lines of business.

Background/rationale: Prior-authorization that targets specific physicians or practitioners, types of service, or geographic areas with evidence of outlier patterns or utilization problems is now a common strategy that is used by private sector purchasers. Current law gives the Secretary authority to contract with Peer Review Organizations to perform various functions, including reviewing some or all of the professional activities of physicians, other health care practitioners and institutional and noninstitutional providers. The purpose of this function is, in part, to determine whether services and items are reasonable and medically necessary and whether services and items proposed to be provided on an inpatient basis can be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. However, this prior authorization authority is limited to proposed inpatient

services and items. The current authority applies only to contracts with PROs.

h. Contracting reform

Policy: This proposal would permit the Secretary to enter into a contract with any entity qualified to perform Medicare functions notwithstanding the fiscal intermediary and carrier provisions in the Social Security Act. The Secretary could contract for the performance of Medicare fiscal intermediary functions without regard to the provider nomination provisions in Section 1816. The Secretary could award Medicare contracts on a competitive basis under the Federal Acquisition Regulation (FAR), but would also retain her current flexibility to retain current contractors who are performing well and supplement the existing pool of contractors with new entrants as she deems in the best interests of the Medicare program. Further, the Secretary could award any type of contract permitted by the FAR. The Secretary could execute combined Medicare Part A and Part B contracts. The Secretary could terminate a contract without regard to procedural requirements that are unique to the Medicare program, and the conditions under which a fiscal intermediary or carrier contract could be terminated would be subject to the FAR. Finally, the Secretary could consult with providers, health plans, and contractors regarding performance evaluation standards.

Background/rationale: This proposal is a necessary first step in updating the tools HCFA needs to engage in effective oversight of the Medicare contractors. It brings the Medicare contracting authority into closer alignment with the general government contracting rules contained in the Federal Acquisition Regulation (FAR), while preserving certain essential flexibility in the awarding and renewal of contracts currently available to the Secretary under Medicare law. These changes will improve the cost effectiveness of Medicare contractor operations. Further, it may be a necessary pre-condition for HCFA being able to successfully pursue other proposals to modernize Medicare.

3. Provider Payment Policies

Overview. This plan builds on the fiscal discipline that the Balanced Budget Act (BBA) of 1997 brought to Medicare for 1998 through 2002 by including moderated policies beginning in 2003 through 2009 (the end of the budget window). These policies will help preserve and protect Medicare for the future and extend the life of the Part A Trust Fund. The plan also, however, recognizes that there may be a need to adjust and gradually phase-in of some of the BBA policies. As such, it includes set-aside funding for this purpose, and takes administrative actions to smooth out the transition.

a. Set-aside for Balanced Budget Act (BBA) adjustment

Policy: The Medicare reform plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion for FY 2000-09, is funded in the context of the reform plan, but its uses are not specified. The Administration wants to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would be most focused to address problems in a fiscally responsible way.

Background/rationale: The Balanced Budget Act implemented some of the most important changes to

Medicare in its history. It contributed to the unprecedented reduction in Medicare growth and extension of the life of the Trust Fund. More than x Medicare policies were added or changed, and Medicare spending reductions that resulted accounted for 40 percent of the BBA's contribution toward balancing the budget. Given the large number and magnitude of the changes, however, some issues have inevitably arisen. This appears especially to be the case for therapy caps, payments for acute cases in nursing homes, the new outpatient prospective payment system and rural and academic hospitals.

Although some adjustments are inevitably needed, the Administration wants to carefully evaluate evidence of problems and proposed policy solutions with the Congress, advisory groups like the Medicare Payment Advisory Commission, the General Accounting Office and the Congressional Budget Office, and provider and beneficiary groups. It also intends to proceed with caution – the BBA represents an important, sound piece of legislation that should only be moderated slightly, not re-visited or repealed. The Administration will only support targeted, justifiable changes and will oppose legislation that significantly opens up the BBA.

b. *Administrative actions to smooth implementation of the BBA*

Policy: The Administration will take a number of time-limited actions to smooth the implementation of the more radical provisions of the Balanced Budget Act. These changes will help ensure beneficiary access to care in hospitals, home health agencies, skilled nursing facilities, and other settings while maintaining BBA discipline that is essential for protecting Medicare's future. These changes have no to small costs that will be offset by other administrative changes in Medicare [check].
Background/rationale: The Balanced Budget Act implemented many of its changes on a rapid schedule, without fully taking into account Y2K and other implementation issues. Because of the magnitude of some of the changes, certain providers may need additional time to prepare or adjust to them. These administrative actions are taken to ensure that the implementation of the BBA changes is done in a way that simultaneously assures savings and accessible, high-quality health care.

[note: the rest of this section is BBA extender-type policies. We know the policies but are still working on the rationale].

4. Improving Medicare Management: Private Advisory Boards

[done/being edited]

II. MODERNIZING MEDICARE BENEFITS

1. Improving Preventive Benefits and Eliminating Cost Sharing

Overview. Older Americans are the fastest growing age group in the United States, with an increasing number of older Americans surviving to age 85 and older. They carry the greatest proportion of chronic disease burden and disability, much of it preventable. For example, 88 percent of those over the age of 65 have at least one chronic health condition, and large numbers of older adults suffer from impaired functioning and well-being. Early detection and health screening programs and appropriate follow-up care can result in a significant reduction in morbidity and possibly prevent or postpone functional

disability.

a. Eliminating all preventive services cost sharing

Policy: This proposal would waive the Part B deductible and 20 percent coinsurance rate for all preventive services not already waived under current law. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.

Background/rationale: Cost sharing can decrease use for preventive services. According to recent studies, Medicare preventive services, many of which were added in the Balanced Budget Act of 1997, are underutilized. For example, the 1999 Dartmouth Atlas of Health Care found that only one out of eight elderly people get recommended tests for colon cancer, one in four women in their sixties are tested as recommended for breast cancer, and fewer than half the older Americans with diabetes receive regular exams that can avert serious complications of the disease. In the first two years that Medicare covered screening mammographics, only 14 percent of eligible women without supplemental insurance received a mammogram. [do we have any other data on utilization of new benefits?]

b. Launching information campaign on prevention

Policy: HHS would launch a two year, $10 million nationwide education campaign beginning in 2001 to promote the use of preventive health services by older Americans and people with disabilities. The campaign would have three parts:

- **Educating all Americans over age 50 and people with disability about the importance of preventive health care.** The Department of Health and Human Services, the Social Security Administration, and private sector partners would combine PSAs and a print media campaign to raise awareness of the value of prevention. HHS would distribute brochures and other information on health promotion and disease prevention activities through the State Health Insurance Associations and the Area Agencies on Aging. HHS would also place brochures in the Social Security Administration's 1,300 field offices. SSA would include information on the importance of preventive health care on the Cost Of Living Adjustment notice, which is sent to the approximately 6 million people with disabilities who receive SSA or SSI benefits. Information on the importance of preventive health care will also be included on the Personal Earnings and Benefit Estimate Statement and in currently produced brochures on retirement and survivors benefits. Finally, SSA would expand the section in its Medicare brochure to include a fuller discussion of the importance of health promotion activities and the benefits offered under the Medicare program.

- **Encouraging Medicare beneficiaries to use its preventive benefits.** This campaign would provide Medicare beneficiaries about the importance of regularly receiving preventive health care benefits, such as vaccinations and mammograms, and would encourage individuals to access these benefits under Medicare. This would be done is several ways:

- *Distribute comprehensive information on preventive benefits to all 39 million Medicare beneficiaries.* HHS would (1) expand the section on preventive benefits in the *Medicare and You* handbook to include information on the importance of receiving mammograms, diabetes monitoring, colorectal cancer screening, bone mass measurements, and regular vaccinations; (2) instruct insurance carriers to include preventive benefits messages on the Medicare Summary Notice statement and the Explanation of Medicare Benefits; (3) include prevention messages regularly on the Medicare Part B benefits statement; and (4) work with the private sector, including senior centers, the Cooperative State Research Education and Extension Service, the Meals on Wheels programs, and religious organizations, to deliver information to Medicare beneficiaries about the importance of preventive benefits and which ones are covered under the Medicare program.

- *Development of health status assessment tool for Medicare beneficiaries.* HCFA, together with CDC and AHCPR, will develop a health status assessment tool for beneficiaries. This self assessment tool will help the beneficiary identify important health information or significant symptoms that should be discussed with their health care provider. HHS will train the State Health Insurance Assistance Program staff to assist Medicare beneficiaries with the completion of the self assessment form so that they can raise the health issues identified by the form to their health care provider.

- **Launching an education and awareness campaign to prevent falls in the elderly.** DHHS would launch a nationwide campaign to educate older Americans about the best way to modify their home environment in order to avoid potentially harmful and debilitating falls. The campaign would utilize radio advertisements and print media, and would emphasize the following messages: use anchor rugs; minimize clutter on floors; use nonskid mats; install handrails in bathrooms, halls, and along stairways; light hallways, stairwells, and entrances; and wear sturdy shoes.

Tubs

Background/rationale: Loss of function can begin to become evident as early as the fifth decade of life, arguing for preventive approaches begun in the middle years, as well as earlier, as a means of promoting health and limiting disability in the later years of life.

Increasing the venues through which Medicare beneficiaries and older Americans will be educated about the importance of preventive benefits and how to access them under the Medicare program will increase the likelihood that beneficiaries will use these services. A recent study indicates that Medicare beneficiaries do not understand that Medicare covers preventive benefits; almost 70 percent of beneficiaries who stated that they knew about the range of Medicare services were unable to answer questions about Medicare's coverage of preventive benefits correctly. However, studies indicate that repeated short, simple, print media messages enhance the target population's recall and retention of health promotion messages. These messages have also been shown to have a greater impact on individuals at higher risk.

In addition to educating beneficiaries about the importance and availability of preventive services, this proposal would address one of the major public health problems faxing the elderly: the high incidence of falls. In 1995, more than 7,700 people over the age of 65 died as a result of a fall. For people aged 65 to 84, falls are the second leading cause of injury-related death; for those aged 85 or older, falls are the leading cause of injury-related death. Falls are the most common cause of injuries and hospital admissions for trauma among the elderly, accounting for 87 percent of all fractures among people aged

65 years or older and are the second leading cause of spinal cord and brain injury. For people aged 65 years or older, 60 percent of fatal falls occur in the home. This education campaign aims to reduce the risk of falls, aiming to improve the quality of life and reduce Medicare costs.

c. Charging the U.S. Preventive Services Task Force to identify new preventive services for older Americans

Policy: The Secretary would direct the U.S. Preventive Services Task Force to conduct a series of new studies to identify preventive interventions that can be delivered in the primary care setting that are most valuable to older Americans. In addition, promoting the health of older Americans would become part of the mission statement of the Task Force.

Background/rationale: Despite the potential for preventive services to improve the quality of life for older Americans, few clinical guidelines focus on preventive care for older Americans.

The U.S. Preventive Services Task Force, an independent panel of preventive health experts, together with the Centers for Disease Control, is charged with evaluating the scientific evidence for the effectiveness of a range of clinical preventive services, including common screening tests, immunizations, and counseling for health behavior change and to produce age-and risk-factor-specific recommendations for these services. The task force focuses primarily on preventive interventions that can be delivered in the primary care setting, are widely available, and for which scientific evidence exists to assess efficacy and effectiveness.

d. Conducting a demonstration of smoking cessation drugs and counseling

Policy: HCFA would launch a demonstration project to evaluate the most successful and cost-effective means of providing smoking cessation services to Medicare beneficiaries, including testing incentive systems for both providers and beneficiaries to optimize "quit" rates. The demonstration would be based on the latest scientific evidence regarding smoking cessation strategies and guidelines developed by the Agency for Health Care Policy and Research. These guidelines suggest that the most effective smoking cessation strategies include an initial patient assessment, counseling services, and nicotine replacement therapy. Non-Medicare providers could participate in the demonstration since part of its purpose will be to determine the most cost-effective providers for delivering smoking cessation services. Medicare rules would be waived to the extent necessary to allow such providers to bill for these services. Providers would be reimbursed for the lesser of 100 percent of the cost of the service or the amount determined by a fee schedule established by the Secretary. Acupuncture and hypnosis for the purposes of encouraging smoking cessation will not be reimbursable.

Background/rationale: The four leasing causes of death – heart disease, cancer, cerebrovascular disease, and chronic obstructive pulmonary disease – are strongly related to smoking. The risk of death due to coronary heart disease in smokers is two to four times greater than in non-smokers; the risk of stroke is 1.5 times greater in smokers than in non-smokers; and mortality and serious morbidity related to COPD occurs almost exclusively in smokers. Studies from the last three decades have shown that when people stop smoking, their risk of tobacco-related morbidity and mortality decreases significantly. For example, the risk of myocardial infarction diminishes by almost one third after the first year of smoking

cessation and reaches the level of people who have never smoked by the third or fourth year of quitting.

In addition to its health benefits, smoking cessation may reduce costs. A recent study by the Mayo Clinic indicates that the estimated cost of smoking cessation treatment is $6,828 per net year of life gained (this estimate takes into account relapse rates expected for patients not undergoing intervention). This is inexpensive relative to the cost-effectiveness of other medical services (e.g., breast cancer screening costs up to $26,800 per year of life gained). However, a demonstration is needed to evaluate what type of method and reimbursement structure is most cost effective.

2. Rationalizing Cost Sharing and Medigap

[add overview paragraph on importance]

a. Adding 20 percent coinsurance on clinical laboratory services

Policy: Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to beneficiaries. For most other Part B services, beneficiaries are subject to both a deductible and the 20 percent coinsurance rate. This policy would apply 20 percent cost-sharing requirements to all clinical laboratory services and count lab services toward the deductible. Note that this cost-sharing requirement would not apply to lab services which are also preventive services (e.g., pap smears and fecal occult blood lab tests for colorectal cancer screening).

Background/rationale: Clinical laboratory services is a fast-growing Medicare service (check – any stats on historical or projected annual growth?). About 24 million beneficiaries used diagnostic lab service in 1997, at a rate of about 14 services and an annual cost of $200 per user. Some of this cost growth may result from unnecessary utilization or fraudulent providers. In 1997 alone, several clinical lab companies settled suits alleging kickbacks, billing for tests not performed, and fabrication of diagnostic codes for a total of about half a billion dollars. The HHS Office of the Inspector General estimated that, in 1996, Medicare paid about $12 billion to independent labs that could not be located.

Making beneficiaries contribute towards their lab services would help reduce over-use and cut down on fraud. As such, it is recommended by the Medicare Payment Advisory Commission among other experts. It also contributes toward the goal of making cost-sharing requirements under Part B more uniform and easier to understand. Most private health insurance plans also have some cost sharing associated with lab services.

b. Indexing the Part B deductible [note: placeholder/likely dropped]

Policy: Medicare's Part B deductible of $100 would be indexed annually to inflation. Indexing at inflation would ensure that the deductible grew at roughly the same rate as beneficiaries' Social Security benefit cost of living adjustment (COLA) increases.

Background/rationale: The Part B deductible (i.e., the amount that enrollees must pay for services each year before the government shares financial liability) is set at $100 a year. It is less than most private

indemnity insurance plans. The deductible has been increased only three times since Medicare began in 1966, when it was set at $50. In relation to average annual per capita charges under the SMI program, the deductible has fallen from 45 percent in 1967 to about 3 percent (projected) for 1999, according to CBO.

This policy does not really increase the deductible, but instead links it to inflation, maintaining its current value of $100 in future years. As such, it would rise by about $3 per beneficiary per year. Relative to other cost sharing proposals, it is the most evenly spread change since virtually all Medicare beneficiaries meet their Part B deductible in a year. It has been supported by organizations like MedPAC/PPRC (check) and the Congressional Budget Office.

c. Add a new Medigap plan option that allows for nominal (rather than no) cost sharing

Policy: This policy would create a new Medigap plan option that has more rational cost sharing than the current standardized plans. The design of the cost sharing would be to protect beneficiaries against catastrophic costs while maintaining nominal cost sharing to discourage unnecessary use of health care services. The Secretary would work with NAIC to design this option. It would not cover the Part B deductible.

All Medigap carriers would offer this policy, which would likely be less expensive than other plan options because of its nominal cost sharing.

Background/rationale: Medigap plans typically eliminate all cost sharing for most Medicare services. As a consquence, beneficiaries have no immediate financial cost of using health care services. One study found that Medicare spending for beneficiaries with Medgiap coverage was 29 percent higher than that of beneficiaries with no coverage, and 11 percent higher than that of beneficiaries with retiree health coverage (which typically has some cost sharing). Additionally, the premiums for Medigap have been rising rapidly – over 10 percent per year according to some sources. A policy with limited cost sharing could be less expensive than the current plan options.

d. Allow access to Medigap for beneficiaries whose managed care plan withdraws from Medicare

Policy: The President's budget included several policies that would improve access to Medigap for beneficiaries whose private plans have withdrawn from Medicare. They include:

- **Initial Open Enrollment for Medigap for Disabled and ESRD.** Under current Federal law, only aged beneficiaries have an initial open enrollment period for Medigap. Eighteen States mandate an initial open enrollment period for beneficiaries under 65 (although one of these states does not include individuals with ESRD). This proposal would expand the initial 6-month open enrollment period to new disabled and ESRD beneficiaries. It would mandate that insurers who write policies for new aged beneficiaries offer these same policies to new disabled and ESRD beneficiaries. Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare and also in the case of Medicare+Choice plan termination. This proposal would be effective upon enactment.

- **Special Medigap Open Enrollment Period for Certain Beneficiaries.** The BBA provided that

beneficiaries in plans that terminated their Medicare contract or reduced their service area have a 63 day open enrollment period for Medigap. The provision was triggered for the first time by plan terminations and service area reductions effective January 1, 1999. Unfortunately, given the newness of this provision, some insurance carriers were not properly prepared to answer inquiries regarding this new right. This proposal would provide a one-time additional special Medigap open enrollment period for individuals who were enrolled in a plan and who had no Medicare+Choice option after the plan terminated its contract or reduced its service area effective January 1, 1999. The special enrollment period would begin upon enactment and would last for 90 days.

- **Expand Choice of Medigap Plans During Special Enrollment Periods.** The BBA provided special enrollment opportunities for Medigap under certain situations (e.g., for an enrollee of a Medicare+Choice plan whose plan terminates its contract or reduces its service area). Under current law, however, beneficiaries in these situations only have access to plans "A","B","C" and "F", none of which include coverage of prescription drugs. This proposal would expand the BBA special open enrollment opportunities to include access to all Medigap options offered to new enrollees. This proposal would be effective upon enactment.

- **Increase Civil Monetary Penalties for Violation of Medigap Open Enrollment Requirement.** Issuers who violate the open enrollment requirement are subject to a civil monetary penalty (CMP) of $5,000 for each violation. This proposal would increase the CMP for failure to $50,000 for each violation plus $5,000 per day per violation and would be effective upon enactment.

Background/rationale: [do we have some standard language about plan pull-outs / risks to beneficiaries?]

e. Direct the Secretary of Health and Human Services and the National Association of Insurance Commissioners to update benefits in all Medigap plans

Policy: This proposal would authorize the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), to review the standard Medigap packages on a periodic basis to determine whether any changes should be made to the content or number of the packages. It would also conform Medigap benefits to the changes in this reform plan.

Background/rationale: The 10 standard Medigap packages were created as a result of OBRA 90. There is no authority in the statute to periodically reexamine these packages.

f. Direct the Secretary of Health and Human Services to report to Congress on the feasibility and advisability of adding catastrophic coverage to Medicare.

3. Medicare Buy-In for Certain People Ages 55-65

Overview. Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. Some lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs due to

company downsizing or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly. As a result, this is the fastest growing group of uninsured.

To address this problem, the President included in his 1998 and 1999 budget submissions a targeted, paid-for proposal to give Americans nearing age 65 new options to obtain health care coverage. There are three parts to this proposal: The centerpiece of this proposal is a Medicare "buy-in", which allows eligible people to purchase Medicare coverage at a fair price. This is comparable to the Social Security option to allow people to begin to receive benefits at the age of 62, paid for by reducing the amount that they receive over the course of their retirement. It also assists displaced workers ages 55 and older by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option. Thirdly, it providers Americans ages 55 and older whose companies regeged on their commitment to provide retiree health benefits a new health option by extending "COBRA" continuation coverage until age 65.

All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever. The short-term Medicare "loan" to buy-in participants, plus the costs of the displaced workers' buy-in, will cost approximately $1.4 billion over 5 years. These costs will be financed by a series of offsets in the President's budget; as such, its costs are not included in the summary table for this plan. The initiative should help 300,000 to 400,000 people.

[adding details from budget proposal]
a. Medicare buy-in for people ages 62-64

b. Medicare buy-in for displaced workers ages 55 to 62

c. Access to health insurance for retirees whose employers renege on coverage

4. Coordinating Care for Dual Medicare-Medicaid Eligibiles

Overview. Dual eligibles are a special category of beneficiaries for both the Medicare and Medicaid programs. They represent 17 percent of the Medicare beneficiary population in 1997 (19% of the Medicaid population), and account for 28% of total Medicare expenditures (35% of Medicaid expenditures.). The diversity of the dual eligible population -- frail elderly, physically disabled non-elderly, cognitively impaired SSI recipients, etc. -- leads to service delivery and financing challenges for both Medicare and the States. The result is a complex arrangement of services provided by two different programs that is difficult for dually entitled beneficiaries to understand and navigate.

a. Information to all new Medicare-Medicaid beneficiaries on coverage

Policy: This plan would provide beneficiaries who become dually eligible (full Medicaid, QMB, or SLMB) with an orientation package, AWelcome to Medicare and Medicaid,≡ containing information on unique dual eligible benefits, the programs that serve them, and how coordination of services across both programs works. The purpose of the orientation package would be to inform all dual eligibles about their special status, the Medicare and Medicaid programs, and how to obtain further information from HCFA,

the States and other relevant offices. This pamphlet would educate beneficiaries on the benefits, rights and responsibilities that accompany dual eligible status. Specific pamphlet information would include:

X Basic information on benefits available to each category of dual eligibles – i.e., additional services beyond the Medicare benefit package, premium assistance, cost-sharing assistance, etc.

X Where to get additional information about Medicare and Medicaid and the services available to dual eligibles;

X Information on beneficiaries= rights under each program regarding grievances, appeals, choice of provider (i.e., FFS, managed care, etc.), etc..

X Key phone numbers: Medicare contacts; Medicaid Office; State Health Insurance Program; Office on Aging; SSA

HCFA would work with States on the design and distribution of this universal AWelcome to Medicare and Medicaid≡ orientation package. This orientation package will complement efforts underway by HCFA, States and local governments to expand enrollment through outreach campaigns.

Background/rationale: Dually eligible beneficiaries are a particularly vulnerable population. By definition these beneficiaries are low-income and more likely than Medicare-only beneficiaries to report significant and chronic health problems such as diabetes and heart disease. In addition, the dual eligible population is more likely to suffer from cognitive impairment, mental disorders, and limitation in their ability to perform daily activities (Murray and Shatto, 1998). The health frailities of the dual eligible require comprehensive acute and long-term services. However, this population is often faced with problems of access, lack of continuity of care, and limited administrative coordination between the two health care programs serving them. Confusion regarding Medicare and Medicaid benefits is common, and many low-income beneficiaries who are dually eligible are not aware of thebenefits and programs that exist under Medicare and Medicaid to assist them.

Outreach and education is needed to identify, enroll and inform dual eligible beneficiaries of the unique benefits and programs available to them. The AWelcome to Medicare and Medicaid≡ orientation package will complement efforts underway by HCFA and States to expand outreach. HCFA is already addressing outreach challenges under the Government Performance Result Act (GPRA) goal to improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance. Under this GPRA goal HCFA is creating a resource guide for States, local and Tribal governments to use to design outreach and enrollment campaigns for dual eligibles. The AWelcome to Medicare and Medicaid≡ orientation package will complement these outreach efforts by providing education materials to dually eligible beneficiaries newly enrolled in State Medicaid programs. The AWelcome to Medicare and Medicaid≡ orientation package will provide dual eligible beneficiaries with the information they need to better access the complex arrangement of health care services available to them and to take full advantage of the benefits they are entitled to as dual eligibles.

b. Demonstration of financing / management options for coordinating care
Dual Eligibles: Care Coordination Demonstration

Policy: This proposal would authorize a demonstration program to test care coordination models for Medicare beneficiaries who are also eligible for Medicaid and who remain in fee-for-service Medicare. Dual eligible beneficiaries who participate would receive a one-time special clinical assessment, developed by geriatricians, of their acute and long-term care needs. Those with significant health care needs would qualify for a care coordination benefit that would include primary care services and advice from a team of providers. Care coordination services for the treatment group would be delivered by a team that includes a geriatrician, a social worker and nurse who would provide general primary care services and would advise the beneficiary about Medicare and Medicaid care options. For example, the team would suggest the best type of specialty acute care, (paid for by Medicare) review prescription drug use (paid for by Medicaid and Medicare) and make suggestions about when nursing home care and home health are necessary (paid for by Medicare and Medicaid). Other models of care coordination could also be tested. Up to 25,000 beneficiaries would be eligible for this demonstration.

Provider groups would apply for the demonstration. Providers under the demonstration could include grass-roots organizations as well as larger health care organizations. However, HCFA would be carefully screening provider applicants and monitoring the demonstration to ensure that the providers were not using the demonstration as a way to maximize Medicare payments. The demonstration would require that providers have an agreement with their state for full cooperation. Providers should have a good understanding of their state's Medicaid system.

Background/Rationale. About six million Medicare beneficiaries also receive some benefits from Medicaid. About 2/3 of these beneficiaries are eligible to receive full Medicaid coverage which includes long-term care and prescription drug benefits. On average, dual eligibles are sicker, older and poorer (by definition) than other Medicare beneficiaries and may have difficulty negotiating two separate public insurance programs for acute and long-term care coverage. In addition, providers for one program may be unaware of the actions of providers for another program --- unintentionally duplicating or contradicting each other. Some demonstration programs have tested using managed care to improve care coordination for this vulnerable population. Yet, the majority of dually eligible beneficiaries choose to remain in fee-for-service. This new demonstration effort will test models for improving care coordination for beneficiaries who choose to remain in fee-for-service.

III. MEDICARE PRESCRIPTION DRUG BENEFIT

1. Base Benefit
[draft of policy completed/being edited Saturday night; still working on rationale]

2. Catastrophic Benefit Financed by Tobacco Lawsuit.

IV. DEDICATED FINANCING FOR MEDICARE

1. Dedicating Part of the Surplus to Medicare

Policy: [draft/placeholder] The President's framework would reserve 15 percent of the projected surpluses -- $650-$700 billion -- over the next 15 years for the Medicare Trust Fund. These funds would

be prohibited from being used for any other purpose, ensuring that the money will go to help the health care needs of older and disabled Americans. Even in the absence of broader reforms, the President's framework would guarantee that Medicare can continue to provide its critical health services until 20xx -- doubling the life of the Medicare Trust Fund and providing the strongest outlook in the last 25 years.

Background/rationale: Like Social Security, Medicare enrollment will double between 1999 (39 million) and 2032 (78 million) as the baby boom generation retires. Not only will there be more elderly in the future, but the elderly will live up to 6 years longer on average by the middle of the next century. Compounding the demographic challenges are the unique factors that affect health spending -- changing disease patterns, technological advances, and a high value placed on health. For example, the improved ability to prevent and cure diseases, while making tremendous improvements in the nation's health, has also driven up costs. As a result, health spending growth has historically exceeded that of general inflation. These trends are expected to continue into the next century. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.

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 for the next ten years. This is due to the historic changes in the Balanced Budget Act of 1997, aggressive efforts to reduce Medicare fraud and the general health of the economy. Despite these improvements, Medicare is spending more than its annual income from payroll taxes and other sources. As such, it has begun to use up its assets -- as the baby boom generation begins to retire, these assets will be gone. Although Medicare's prognosis in the Trustees' 1999 report will almost inevitably be better due to strong revenues and continued low spending, the fact remains: current income sources will not be able to finance health care services for the baby boom generation.

2. Income-Related Premium (Beginning at $100/120,000)

Policy: Under this proposal, all Medicare beneficiaries would continue to receive a significant subsidy for Medicare Part B (Supplemental Medical Insurance) premium, but high-income beneficiaries would bear a greater share of its cost. This policy would:

- **Target truly high-income beneficiaries:** The income-related premium would begin at a high enough income level to exclude middle-class beneficiaries, who may have more difficulty affording the premium. Beneficiaries whose income (AGI plus tax-exempt interest) is above $100,000 (single) or $120,000 (joint) would pay an extra $10 premium per month for every $100 in additional income up to a limit. Additionally, the income thresholds for beginning the income-related premium would be indexed to inflation to prevent an ever-increasing proportion of elderly from paying the higher premium.

- **Limit the amount that beneficiaries pay:** No beneficiary would pay more than 50 percent of the premium. This prevents most high-income beneficiaries -- who typically have good health -- from opting for less expensive, private alternatives. The result of healthy beneficiaries leaving Medicare would be an increase in the average Federal spending per beneficiary.

- **Administered by Treasury.** Only the Treasury Department already collects the income information

owner

AA RIP

(1) Kristan Testa is handling the Finance Drug hearing on Wednesday – looking for witnesses.

(2) Maynihan is looking to write a bill

TO:	Dan M.	395 4995
	Nancy Ann	690 6262
	Rich T.	690 7380
	Gary C.	401 7321
	Mark M.	622 2633
	Melissa S.	690 5673
	Jane H.	690 8425
	Mark M.	395 3910
	Bonnie W.	690 8168

FROM: Chris and Jeanne

Attached is a draft of the prescription drug paper for tomorrow's event. It would be great to get comments back from folks by 4:00 pm.

Thanks a lot for the quick turnaround.

DRAFT

THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

- **Medical revolution since 1965.** When Medicare was created in 1965, most heath care focused on doctors and hospitals. As such, Medicare benefits were patterned on the typical private insurance plan of the time. However, the past 35 years have seen a revolution in medical science; advances in pharmaceuticals and biotechnology leading to improvements in the health, quality and length of peoples' lives. Prescription drugs serve as:

  - Complements to other health care: For example anti-coagulants significantly improve success of heart valve replacement surgery and angioplasty (a very common procedure to improve blood flow to the heart without major surgery); better antibiotics reduce the infection complications from surgery and other medical procedures, especially in frail patients and patients with chronic illnesses;

  - Substitutes for surgery and other interventions: For example, lipid lowering drugs lessen need for bypass surgery; more and better drugs that control diabetes reduce costly complications such as dialysis and limb amputation; better treatments for rheumatoid arthritis lead to fewer joint replacements; curative drugs for ulcers avoid the need for costly surgeries to stop stomach bleeding.

  - Treatments where few or no options existed before: Depression, dementia, breast cancer, osteoperosis, glaucoma, prostate cancer, Parkinson's Disease, many types of anemia, multiple sclerosis are just some of the conditions that can now be treated and, in some cases, cured with prescription drugs.

- **The elderly and people with disabilities are most reliant on prescription drugs.** Not only do the elderly and people with disabilities experience greater health problems, but these health problems are typically chronic diseases like hypertension, diabetes or arthritis that can be managed through medications. As a result, over 85 percent of Medicare beneficiaries use at least one prescription drug annually. The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults, and nearly 10 times that of children. While only 12 percent of the population, the elderly account for 33 percent of drug spending.

- **Medicare beneficiaries' spending on prescription drugs is high.** The elderly spend more out-of-pocket than other age groups. In 1997, spending on prescription drugs accounted for 17 percent of total out-of-pocket medical expenditures by Medicare fee-for-service beneficiaries, higher than any other single spending category except payments for Medicare Part B and supplemental premiums. It is estimated that median drug expenses for Medicare beneficiaries will be about $600 per year in 2000, or a little over $40 per month. Over one-third of Medicare beneficiaries have drug costs that exceed $500 in a year. Notably, out-of-pocket spending for drugs is growing more rapidly than any other type of medical expenditure by the elderly.

MEDICARE BENEFICIARIES WITHOUT DRUG COVERAGE

- **A wide range of Medicare beneficiaries lack drug coverage.** About 13 million beneficiaries had no drug coverage in 1995. This is estimated to increase to nearly 15 million by 2000. Lack of drug coverage is not just a problem for low-income beneficiaries.

  - About 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $16,000 for a single, $22,000 for a couple).

  - Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs.

  - Fewer old beneficiaries have drug coverage. About 41 percent of beneficiaries older than age 85 had no drug coverage, compared to 34 percent of beneficiaries ages 65 to 70.

  - Nearly half (46 percent) of rural beneficiaries lack insurance coverage for drugs.

- **Many beneficiaries need drugs but do not use them because they are uninsured.** Most research has found that lack of coverage reduces needed drug utilization. Studies have found:

  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.

  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, the millions of Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, dose reduction, or discontinuation of needed drugs.

- **Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that are at least 15-30 percent higher than large HMOs and employers. One study found that, for the 10 most prescribed drugs, seniors are often charged twice as much as other payers.

- **Larger financial burden.** Elderly without private insurance for drugs spend about twice as much out-of-pocket for drugs than those with drug coverage. This burden is on average 35 percent higher for rural than urban elderly since they are less likely to have coverage for drugs. Women have, on average, out-of-pocket costs as a percent of income that are 20 percent higher than men, primarily because many are widowed and have lower income.

DRAFT

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES TODAY

- **Fragmented coverage for Medicare beneficiaries who have it.** In 1995, about 55 percent of Medicare beneficiaries had constant insurance coverage for prescription drugs. An additional 10 percent switched coverage during the year or received other public assistance.

  - Today's drug coverage resembles general insurance coverage when Medicare was created in 1965. Although 56 percent of the elderly had insurance before Medicare, this coverage was expensive, inadequate and unreliable – much like the drug coverage today. Medicare would not have been created if this "coverage" was considered acceptable.

- **Private supplemental drug coverage is low and declining:** About 37 percent of Medicare beneficiaries had private employer-based or Medigap insurance for drug coverage in 1995. Both sources of coverage have been declining as the cost of coverage rises.

  - Employer-sponsored retiree health insurance, the most generous type of drug coverage for beneficiaries, covers about 29 percent of beneficiaries, but is declining. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped 20 percent. This trend was more pronounced among employers with greater than 5,000 employees, over a third of whom dropped coverage.

  - Medigap, the standardized private insurance supplement for Medicare, covers about 8 percent of beneficiaries. Its drug benefit (offered in some of its plans) has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Premiums are almost always underwritten, meaning that premiums are based on the person's health. The premium for a plan with drug coverage is typically about $1,000 more than a plan without drug coverage. Medigap premiums have been rising at double-digit inflation (35 percent since 1994), and coverage has been declining.

- **Public coverage exceeds private coverage:** About 18 percent of beneficiaries had coverage through Medicare managed care plans or Medicaid in 1995.

  - Medicare managed care: About 7 percent of beneficiaries get drug coverage by joining Medicare managed care. Most managed care plans offer drug coverage as a way to attract beneficiaries. While plans typically have no deductibles and relatively low copayments, over half (55 percent) limit the amount that they pay for benefits and, of these plans, about 65 percent limit plan spending to $1,000 or less. Reports suggest that benefits are likely to be reduced or dropped in the future.

  - Medicaid: About 11 percent of Medicare beneficiaries had drug coverage as "dual eligibles" in 1995 – meaning that they are fully eligible for Medicaid as well as Medicare. This is about 4.3 million beneficiaries, less than half of Medicare beneficiaries below poverty. This low coverage rate results both because of Medicaid eligibility limitations and low participation rates (55%) for those who are eligible.

DRAFT

MEDICARE PRESCRIPTION DRUG BENEFIT: MEDICARE PART D

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost about $120? Billion over 10 years. It would be fully financed, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare. The amount of savings exceed the amount from the surplus by a ratio of 3 to 2.

- **Meaningful coverage**. Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. When fully implemented, Medicare would pay for half of drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in plan payments). This limit would be phased in from 2002 to 2008 and, in subsequent years, be increased to keep pace with inflation. Beneficiaries would have access to discounts negotiated by private pharmacy managers, after the limit is reached.

- **Affordable premiums.** Beneficiaries would pay separate premium for Medicare Part D -- an estimated $x per month in 2002, and $y per month in 2008, when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and would occur, after an initial open enrollment for all beneficiaries, when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would be deducted from Social Security checks.

    - **Low-income protections.** Beneficiaries with income up to 135 percent of poverty ($11,000 for singles, $15,000 for couples) would pay no premiums or cost sharing, with the premium subsidy phased out from 135 to 150 percent of poverty. This assistance would be run through Medicaid but the Federal government would pay for all of the drug costs for beneficiaries with incomes above poverty.

- **Private management.** Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities to manage Part D benefits. Through competitive bidding, Medicare would award one contract per area. These private managers would use cost containment tools that have proven effective and would be required to have drug utilization review programs, prevent adverse drug interactions, and meet quality and consumer access standards. No price controls would be imposed.

- **Support for continued and new retiree coverage.** To encourage employers to continue retiree drug coverage, Medicare would pay for part of the premium costs. Specifically, Medicare would contribute 33 percent of the premium -- less than the 50 percent it would pay if the beneficiary enrolled in Medicare, thus reducing Medicare as well as employer costs.

- **Expanded coverage with funds from tobacco lawsuit.** Recognizing that a small but important percent of beneficiaries have costs that exceed the benefit limit, the President's plan would dedicate any funding from the Medicare tobacco lawsuit to expanding coverage.

DRAFT

ADVANTAGES OF THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT

- **Accessible and affordable to all beneficiaries.** This proposal would make prescription drug coverage accessible and affordable to all Medicare beneficiaries.

  - Broad-based need. Beneficiaries across the income, geographic, and socio-demographic spectrum have trouble accessing affordable prescription drugs. About 40 percent of beneficiaries who lack drug coverage have income over 200 percent of poverty ($16,000 for singles, $22,000 for couples). Only about half of rural beneficiaries have any drug coverage. Moreover, private coverage is expensive and declining, and Medicare managed care plans are beginning to restrict their coverage of prescription drugs.

  - Important to all beneficiaries – not just low-income. All workers pay taxes to support Medicare, and, as a result, all should have access to any new benefit. Medicare is built on the premise that all elderly and people with disabilities develop health problems at some point. It does not, for example, pay for hospital care only for the low-income. Limiting access to critical coverage of prescription drugs – especially when there are no guaranteed private sector alternatives – contradicts the principles that have made Medicare and Social Security strong and successful programs.

- **Addresses shortcomings of fragmented system of coverage.** The prescription drug benefit in the President's plan would provide stable, affordable protection against the high costs of prescription drugs. For the nearly 15 million beneficiaries who have absolutely no coverage, it would provide significant financial relief. For the several million beneficiaries who rely on Medigap or Medicare managed care, this benefit would assure that their coverage will always be there, without excessive rate increases or reductions in the generosity of the benefit. Low-income beneficiaries who do not qualify for Medicaid would gain new and expanded access to the Medicare benefit. And, Medicare beneficiaries with retiree coverage would worry less since employers would have a new incentive to continue offering retiree coverage.

- **New management for new benefit**. The prescription drug benefit would be created as a public-private partnership – with the government responsible for assuring that beneficiaries who opt for Part D get high-qualify, meaningful, affordable benefits. The private benefits managers would be responsible for using the latest, most effective tools for managing costs and improving quality. This partnership would both provide beneficiaries with the same high-quality benefits that they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used.

- **Fiscally responsible.** The prescription drug benefit is designed to be affordable and fully paid for though policies in this proposal. Beneficiaries would be equal partners in its costs, paying half of the premium and half of the drug costs. Government payments would be limited, both in dollar amounts and in growth, to ensure that the financing sources are adequate in the near and long-term. And, an incentive program would be included to prevent wholesale substitution for private retiree coverage.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule of the President re: phone number (partial) (1 page)	06/30/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20469

FOLDER TITLE:
Medicare [Folder 1]

2012-0463-S
rc786

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SCHEDULE OF THE PRESIDENT
FOR
WEDNESDAY, JUNE 30, 1999

Draft Schedule

SCHEDULING DIRECTOR:	STEPHANIE STREETT	
	HOME:	P6/(b)(6) [001]
	OFFICE:	202-456-2823
	WHCA PAGER:	4824
PRESS DESK:	DORI SALCIDO	
	HOME:	P6/(b)(6)
	OFFICE:	202-456-5771
	WHCA PAGER:	4844
TRIP COORDINATOR:	CECILY WILLIAMS	
	HOME:	P6/(b)(6)
	OFFICE:	202-456-5039
	WHCA PAGER:	4063
WEATHER:	WASHINGTON, D.C.	
	CHICAGO, ILLINOIS	

Schedule of the President
for
Wednesday, June 30, 1999
Draft Schedule

8:30	am	**THE PRESIDENT** departs The White House via Marine One en route Andrews Air Force Base [flight time: 10 minutes]
8:40	am	**THE PRESIDENT** arrives Andrews Air Force Base
8:55	am	**THE PRESIDENT** departs Andrews Air Force Base via Air Force One en route Chicago O'Hare International Airport [flight time: approximately 1 hour, 40 minutes] [time change: -1 hour]
9:35	am	**THE PRESIDENT** arrives Chicago O'Hare International Airport
		Greeters:
9:50	am	**THE PRESIDENT** departs Chicago O'Hare International Airport via motorcade en route Chicago Cultural Center [drive time: 30 minutes]
10:20	am	**THE PRESIDENT** arrives Chicago Cultural Center
		Greeters:
10:25 10:40	am- am	**MEET AND GREET** ROOM TBD Chicago Cultural Center Staff Contact: Bruce Reed Event Coordinator: Cecily Williams **CLOSED PRESS**
10:45 11:45	am- am	**MESSAGE EVENT** GRAND ARMY OF THE REPUBLIC MEMORIAL HALL Chicago Cultural Center Remarks: Staff Contact: Bruce Reed Event Coordinator: Cecily Williams **OPEN PRESS**

meet & greet list → time constraints not space 15-20 people

Anna Willis welcoming
Senior
member
Senior
POTUS

TO OPL

11:50	am	**THE PRESIDENT** departs Chicago Cultural Center via motorcade en route Chicago Hilton and Towers [drive time: 10 minutes]
12:00	pm	**THE PRESIDENT** arrives Chicago Hilton and Towers Greeters:
12:15 pm- 2:00	pm	**LUNCH** IMPERIAL ONE SOUTH Chicago Hilton and Towers Staff Contact: Minyon Moore Event Coordinator: Cecily Williams **CLOSED PRESS**
2:05	pm	**THE PRESIDENT** departs Chicago Hilton and Towers via motorcade en route Location TBD [drive time: tbd]
2:20	pm	**THE PRESIDENT** arrives Location TBD
2:30 pm- 6:00	pm	**DOWN TIME**
6:15	pm	**THE PRESIDENT** departs Location TBD via motorcade en route Private Residence [drive time: 15 minutes]
6:30	pm	**THE PRESIDENT** arrives Private Residence Greeters: Lew Manilow Susan Manilow
6:35 pm- 7:05	pm	**MIX AND MINGLE** GALLERY Private Residence Staff Contact: Minyon Moore Event Coordinator: Cecily Williams **CLOSED PRESS**

Note: There will be approximately 30-40 guests in attendance.

7:10 pm- **PHOTO RECEIVING LINE**
7:55 pm LIVING ROOM
Private Residence
Staff Contact: Minyon Moore
Event Coordinator: Cecily Williams
CLOSED PRESS

Note: There will be approximately 120 guests in attendance (60 photographs).

8:00 pm- **DNC DINNER**
8:45 pm TENT
Private Residence
Remarks: Josh Gottheimer
Staff Contact: Minyon Moore
Event Coordinator: Cecily Williams
PRINT REPORTER (REMARKS ONLY)

- **The President** proceeds to his seat at the head table and dinner is served.
- Joe Andrew makes brief remarks and introduces Susan or Lew Manilow.
- Susan or Lew Manilow makes brief remarks and introduces **the President.**
- **The President** makes remarks and departs.

8:50 pm **THE PRESIDENT** departs Private Residence via motorcade en route Chicago O'Hare International Airport
[drive time: 20 minutes]

9:10 pm **THE PRESIDENT** arrives Chicago O'Hare International Airport

9:25 pm **THE PRESIDENT** departs Chicago O'Hare International Airport via Air Force One en route Andrews Air Force Base
[flight time: approximately 1 hour, 35 minutes]
[time change: +1 hour]

12:00 pm **THE PRESIDENT** arrives Andrews Air Force Base

12:15 am **THE PRESIDENT** departs Andrews Air Force Base via Marine One en route The White House
[flight time: 10 minutes]

12:25 am **THE PRESIDENT** arrives The White House

BC/HRC RON **THE WHITE HOUSE**
WASHINGTON, DC