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CHANGE IN DEPLETION DATE

QUESTION:

Why has the HI depletion date been changed to 2015 from the earlier estimate of 2008?

ANSWER:

- ▶ The estimate of the depletion date has been extended by seven years since the Trustee's last report in 1998.
- ▶ The improvement is the result of higher payroll tax revenues in 1998 than had been estimated and lower benefit expenditures, together with adjustments to projected income and expenditure growth for the future based on this experience.
- ▶ Robust economic growth in 1998 led to the significant increase in HI payroll tax revenues.
- ▶ Lower HI expenditures reflect:
 - low increases in health care costs generally;
 - the success of our continuing efforts to combat waste, fraud, and abuse in the Medicare program;
 - the ongoing effect of payment reforms in the Balanced Budget Act of 1997.
- ▶ This extension of the depletion date is magnified because the trust fund is now expected to experience small surpluses for the next 8 years rather than small deficits, as previously estimated. This change extends the life of the trust fund more than proportionately, in part because of the interest savings.

TRUST FUND SOLVENCY STILL NEEDS WORK

QUESTION:

When the Trustees report was released, you and your colleagues in the Administration focused exclusively on the extension of solvency to 2015. Isn't it true that the Trustees also concluded that Congress and the Administration must still move forward to reform the program?

ANSWER:

- ▶ Yes. While the long-range actuarial deficit is now only one-third of the level projected in 1997, the trustees did send a strong message that we should still move forward to strengthen the program for the future.
- ▶ The President and the Administration's trustees have been very clear that we should not be lulled into thinking that nothing more needs to be done. Now is the time to take additional steps to strengthen the program, when our economy is strong and we can phase in changes over a longer period.
- ▶ We can and should take steps to enhance competition in the program. But we also need to remember the Trustees' conclusion that the primary challenge facing the program is financing the tremendous increase in the number of beneficiaries in the future.
- ▶ One of the main reasons we are unable to support the Breaux-Thomas proposal is because it failed to address this central challenge. The President would address this issue by dedicating 15% of the budget surplus to extend the life of the trust fund for another decade.

IMPROVING TRUST FUND SOLVENCY THROUGH REDUCING FRAUD AND ABUSE

QUESTION:

Repeated reports by the IG have revealed massive waste and fraud in the Medicare payment system. Isn't it true that the solvency picture would be much better if the Administration dealt with these problems adequately?

ANSWER:

- ▶ Since 1993, the Clinton Administration has focused unprecedented attention on fighting fraud, waste, and abuse in Medicare. During the last two years alone we have returned over \$1.2 billion to the trust fund. This is the first time in the history of Medicare that an Administration's effort to end waste, fraud, and abuse has been identified as having a positive impact on the trust fund. In addition, the Administration has increased health fraud convictions by nearly 20 percent in 1997 and another 16 percent in 1998.
- ▶ On February 9, 1999, the HHS Inspector General reported in the CFO audit that improper Medicare payments declined by 45 percent in the last two years. The hospital case mix is down for the first time since we began measuring it in the early 1980s, thanks to our crackdown on "upcoding," or billing for more serious diagnoses than patients actually had. And our success in fighting what was widespread fraud, waste, and abuse in home health is partly responsible for the drop in home health spending, according to the CBO.
- ▶ There is still a great deal of work to be done:
 - HCFA will soon be hiring special program integrity contractors under the HIPAA Medicare Integrity Program, as well as a Coordination of Benefits Contractor, to help assure that we don't pay claims when another insurer is actually responsible.

- We are using sophisticated technology to prevent payment errors. In 1996, Medicare implemented the Correct Coding Initiative, a series of more than 100,000 computerized edits that automatically stop improper payments. And we are cataloging other fraud detection technologies, so that we keep abreast of the field and incorporate any additional technologies that could serve Medicare.
- We implemented a new prospective payment system that includes incentives to provide care efficiently for skilled nursing facilities. And we are developing similar systems for home health care, outpatient hospital services, and rehabilitation hospitals.
- And we are increasing efforts to help providers file claims correctly. Last year, we used satellite broadcasts to educate more than 10,000 providers and billing agents about proper billing. We also taught more than 6,000 medical residents -- almost one-quarter of all the residents who graduated nationally -- about how to set up their practices to bill Medicare correctly.

BBA AND THE LOWER BASELINE

QUESTION:

The Medicare baseline is now lower than the baseline projected after BBA was passed. Does this mean that BBA has "saved more money" than originally estimated?

ANSWER:

- ▶ Not necessarily. Many other changes that occurred during the same time that BBA provisions were implemented also affected Medicare spending, such as the implementation of expanded program integrity activities to fight waste, fraud and abuse.
- ▶ Economic factors such as the effect of low inflation in health costs generally also affected the baseline.
- ▶ The Trustees report highlights how the baseline and trust fund solvency was affected by multiple, interactive factors: a strong economy (resulting in increased payroll tax revenues and lower price inflation); the effects of our fight against fraud, waste, and abuse; and the effectiveness of the BBA.

WHAT CAUSED THE LOWER BASELINE?

QUESTION:

If BBA didn't save more money than expected, what accounts for the drop in the baseline?

ANSWER:

- ▶ Several factors account for the drop in the Medicare baseline compared to previous projections, including:
 - Lower hospital case-mix because of elimination of inappropriate upcoding.
 - The hospital prospective payment system pays in part by diagnosis of the patient. The sicker the patient the higher the payment. FY 1998 was the first year in well over a decade that saw a drop in the severity of illness billed by hospitals. The drop in diagnosis 'creep' (where hospitals categorize for the worst type of pneumonia for example), we think is due to the sentinel effect on hospital coding practices of vigorous scrutiny by DOJ in certain hospitals.
 - Our program integrity efforts in general, and for home health services in particular, were paying off during the same time that BBA policies were starting to take effect.
 - We expanded our Operation Restore Trust from a five-state demonstration to a nationwide program. Several investigations and prosecutions, and the incarceration of at least one home health agency operator, were highly publicized.
 - Some improvements in the economic projections.
 - Expectations of slightly lower inflation translate into slightly lower projections of updates for Medicare services. The April 1999 Trustees baseline projects CPI to be 0.2 percent per year lower than last year. In addition, the hospital and physician market baskets are projected to be slightly lower than last year's Trustees baseline.

- There were some increases in the average time to process Medicare claims for certain services in FY 1998. A change in the average claims processing time will shift money between fiscal years and give the illusion that spending is down, because it is a temporary effect.

BACKGROUND:

- ▶ Medicare spending in FY 1998 is lower than expected. This change in spending "level" carries forward into future years. The "rate" of Medicare spending growth in the 1999 Trustees baseline is not much lower than the rate of growth in spending projected after BBA.

INCREASED PROVIDER FUNDING

QUESTION:

If the Medicare baseline is now down doesn't that mean BBA went too far in cutting home health, SNF and managed care funding? Shouldn't we return some of the baseline savings to affected provider groups?

ANSWER:

- ▶ Through administrative action we will continue to do everything the law allows to address these concerns where appropriate and make sure that beneficiaries continue to have access to the care they need. We will continue to do everything the law allows to minimize the adverse effects of BBA implementation on health care services for beneficiaries. At the same time, we must realize that changes in the BBA, made by Congress, may require offsetting cuts elsewhere. These changes also could adversely affect the progress we've made together in extending the life of the Trust Fund. As we continue to monitor the effects of BBA, we look forward to working in a bipartisan fashion to ensure that Medicare beneficiaries continue to receive quality health care services.
- ▶ I also would note that the Breaux-Thomas plan assumes savings of \$39 billion over 10 years from extending the payment provisions of the BBA (or from other similar changes). Any payment changes made for providers would reduce the savings assumed in that plan.
- ▶ It also is important to remember that BBA is not the only reason for the lower baseline. The Trustee's report highlights how the baseline and trust fund solvency were affected by multiple interactive factors: a strong economy (resulting in increased payroll taxes and lower price inflation); the effects of our fight against fraud, waste, and abuse and the effectiveness of the BBA
- ▶ The purpose of Medicare is to ensure that beneficiaries obtain access to covered services. The purpose of Medicare is not to create an entitlement for providers in an industry to a certain level of spending.

- ▶ That said, we are closely monitoring beneficiaries access to services in the nursing home and home health industries in particular. If we detect problems in access, then we can best assess how to address the issue. Further, we will be refining the nursing home prospective payment system as we obtain more data. For home health, we are working to put in place the prospective payment system by the statutory deadline.

BACKGROUND:

Home Health

- ▶ Home Health agencies continue to be upset by the interim payment system and do not appreciate that the \$1.1 billion increase provided last year was funded in part by future update reductions.
 - The CBO overall 5-year Medicare home health baseline for FY 1998-FY 2002 is now projected to be \$79.1 billion compared to a projection of \$111.0 billion after BBA. This represents a notable 29.1 percent drop.
 - The drop in the post-BBA Medicare home health baseline is attributable in large part to our payoff from our program integrity efforts.
 - The Inspector General found that the rate of erroneous Medicare payments declined by 45 percent over the last two years. Program integrity efforts such as highly publicized investigations and prosecutions and a background check requirement for home health agency employees also may have discouraged inappropriate claims from being submitted in the first place.
 - In addition, the drop in the "cash" baseline for home health is partly attributable to a slowdown in receipt of claims and a slowdown in claims processing times. When we ultimately compare "incurred" expenditures for services actually furnished in 1998 to a prior year, it is very possible that the drop in spending will be much smaller.

SNF

- ▶ Nursing homes are concerned that the PPS does not accurately reflect the costs of non-therapy ancillary costs for high acuity patients (drugs, x-rays, etc.). The industry agrees that we did not have sufficient data to develop a system other than the one we have and are aware we intend to modify the system next year – once we have appropriate data. [This is a big issue for Senate Democratic leadership offices and Senator Domenici.]
 - The CBO overall 5-year Medicare SNF baseline for FY 1998-FY 2002 is now projected to be \$66.7 billion compared to a projection of \$74.0 billion after BBA. This represents a 9.9 percent drop.
 - The drop in the post-BBA Medicare SNF baseline is attributable to payoffs from our program integrity efforts, some payment lags, and a slight improvement in the economic projections.

Managed Care

- The managed care industry wants the Medicare payment rates increased as well and there is some sympathy in the Senate to do this.
 - Since managed care rates are tied to fee-for-service spending, lower per capita spending in fee-for-service Medicare carries over into Medicare managed care. CBO managed care spending projections now reflect managed care risk-adjustment but the post-BBA baseline did not include the effects of this policy.
 - It is not clear that managed care rates are inappropriately low: they include a 4 percent overstatement as a result of the 1997 rates being too high.

GENERAL PARTICIPATION

- ▶ In 1999, the number of physicians and other practitioners who signed participation agreements (i.e., agreements to accept assignment for all services furnished to Medicare beneficiaries in 1999) increased by more than 6 percent. In addition, the percent of physicians and other practitioners who signed participation agreements increased from 83 percent in 1998 to 85 percent in 1999.

Comparison of CBO Baselines, Post-BBA and March 1999
(in billions)

5-years						
	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 98-02</u>
<u>Total Medicare</u>						
Post-BBA	\$219.3	\$230.7	\$241.8	\$263.2	\$270.3	\$1,225.3
March 1999	\$210.0	\$212.1	\$227.6	\$243.1	\$253.1	\$1,145.9
<u>Home Health</u>						
Post-BBA	\$20.0	\$21.2	\$21.2	\$23.4	\$25.2	\$111.0
March 1999	\$14.9	\$15.0	\$16.6	\$15.6	\$17.2	\$ 79.3
<u>SNF</u>						
Post-BBA	\$14.1	\$14.1	\$14.6	\$15.3	\$15.9	\$ 74.0
March 1999	\$13.2	\$12.7	\$12.9	\$13.6	\$14.3	\$ 66.7

WHAT HAPPENS WHEN THE TRUST FUND RUNS OUT?

QUESTION:

What happens when the HI Trust fund runs out?

ANSWER:

- ▶ We do not believe that Congress and the Administration would allow the trust fund to become depleted. Full benefits have always been paid on time.
- ▶ Speaking theoretically, if the trust fund balance becomes zero, payroll tax and other revenue will continue to flow into the treasury. In 2015 for example, these revenues are projected to pay about 86% of the amount required to pay benefits. Even in 2070, these revenues will pay roughly 50% of expenditures.
- ▶ It is important that this trustees' report not be used by anyone to frighten Medicare beneficiaries. We fully expect Congress and the President to work together to ensure that the trust fund is healthy and able to pay benefits in the future.

TRUST FUND PROJECTIONS AND A POOR PERFORMING ECONOMY

QUESTION:

You've said so much of the credit goes to the economy. What happens if the robust economy goes south?

ANSWER:

- ▶ If the economy worsens, the trust fund may be exhausted at an earlier date, just as it may be solvent for a longer period if the economy remains strong, as it is today. As trustees, we make our best efforts to develop appropriate estimates of program experience. We show estimates under three different sets of assumptions to illustrate the sensitivity of program costs to different economic and demographic trends. In the current report, the exhaustion date of the HI trust fund ranges from 2007 (most pessimistic assumptions); 2015 (mid-range assumption); and under the most optimistic assumption, the HI trust fund remains solvent during the entire 75 year projection period.

TRUST FUND IMPROVEMENT NOT OUR DOING

QUESTION:

You claim that much of the improvement in Trust fund solvency is due to “tough management” and internal reforms. Isn’t it true that almost all of the improvement in the health of the trust fund was due to the strength of the economy?

ANSWER:

- ▶ The strong economy is certainly part of the reason why the health of the Hospital Insurance trust fund improved. However, our continued implementation of the Balanced Budget Act and our efforts to combat fraud, waste, and abuse were also significant factors. For example, BBA implementation and aggressive program management led to a 4 percent decline in hospital payments in 1998. These expenditure reductions have contributed to the improvement in the trust fund. Moreover, due to our Administration’s adoption and enforcement of a zero tolerance policy for fraud and abuse in the Medicare program, in just the last 2 years we have returned \$1.2 billion to the Trust Funds.

CHANGE IN 1998 ESTIMATE

QUESTION:

The 1998 Trustees Report projected that the HI trust fund would lose about \$7.7 billion in 1998. Why was this estimate incorrect?

ANSWER:

- ▶ The reduction in losses was a result of several factors, including the strong economy, BBA implementation, and the Department's vigorous management of Medicare and our efforts to reduce waste, fraud and abuse.

COMPARISON TO CBO ESTIMATES

QUESTION:

What are the differences between the depletion date in the 1999 HI report and CBO's estimates of trust fund depletion?

ANSWER:

- ▶ CBO has only made available estimates through 2009. Our rough extrapolation of their estimates would result in an exhaustion date of between 2012 and 2014. The HI Trust Fund report projects a depletion date of 2015. Although we have not extensively analyzed the differences in assumptions, it appears that the CBO estimates lead to an earlier projected depletion date because they assume higher Medicare expenditures beginning in 2004.

SHORT-RANGE FINANCIAL ADEQUACY

QUESTION:

What savings level is needed for the HI trust fund to meet the Trustees' test of short-range financial adequacy, and does the trust fund currently meet that test?

ANSWER:

- ▶ The HI trust fund does not meet the short-range test, although by a relatively small margin. To meet the short-range test for this report, the ratio of funds in the trust fund to projected expenditures would have to rise to 100 percent within 5 years. Instead, it is at least 80 percent for each year through 2005 but then starts declining to a level of 69 percent in 2008.

BACKGROUND:

- ▶ The short-range test of financial adequacy has two scenarios:
 1. If the ratio of funds in the trust fund to projected expenditures for the year (the HI trust fund ratio) is at least 100 percent at the beginning of the projection period, then it must be projected to remain at or above 100 percent throughout the 10-year projection period;
 2. If the HI trust fund ratio is less than 100 percent, it must be projected to reach a level of 100 percent within 5 years (and not be depleted at any time during this period) and then remain at or above 100 percent throughout the remainder of the ten-year period.

SOURCES OF INCOME FOR TRUST FUND

QUESTION:

What are the sources of income for the HI trust fund ?

ANSWER:

- ▶ In CY 1998, about 88 percent of income to the HI trust fund came from the HI payroll tax.
- ▶ About 6% of HI income came from interest on trust fund assets.
- ▶ About 4% of income was from tax on Social Security benefits.
- ▶ An additional 2% came from miscellaneous sources.
- ▶ Income to the HI trust fund totaled \$140.5 billion in calendar year 1998.

MONEY GAINED BY TRUST FUND

QUESTION:

How much money did the trust fund gain last year ? For how many more years will the trust fund gain money?

ANSWER:

- ▶ HI income exceeded program expenditures by \$4.8 billion in calendar year 1998.
- ▶ Because income will exceed expenditures, the trust fund is estimated to increase through 2006. The fund is estimated to begin running a deficit in 2007 and thereafter. By drawing down on trust fund assets, the program could continue to pay benefits for several more years until 2015.

BACKGROUND:

- ▶ 1998 was the first year since 1994 that the HI Trust Fund gained assets. Under the new estimates in the 1999 report, it will gain assets through 2006.

WHY ASSETS FLUCTUATE MONTH TO MONTH

QUESTION:

Why does the level of the assets in the HI trust fund fluctuate month-to-month?

ANSWER:

- ▶ Although Trust Fund outlays vary from month to month based on utilization of services, most of the month to month variation in Trust Fund performance is explained by variation in receipts.
- ▶ Because month to month changes in the Trust Fund balance tend to vary significantly, it is not advisable to extrapolate annual Trust Fund performance from partial year data.
- ▶ Trust Fund receipts include payroll taxes, premium income, interest payments, and taxes from Social Security benefits of high income Medicare beneficiaries.
- ▶ Payroll taxes and premium income are deposited in the Trust Fund every month, and therefore do not account for a significant portion of month to month variation in receipts.
- ▶ By contrast, most interest paid on Trust Fund assets is deposited only twice a year, in December and June.

BACKGROUND:

- ▶ The 1999 Trustees report projects that the Trust Fund balance will increase by \$.5 billion in 1999.

VARIATION IN DEPLETION DATES BETWEEN ASSUMPTIONS

QUESTION:

Why is there such a variation in depletion dates between high, low, and intermediate assumptions?

ANSWER:

- ▶ We show estimates under 3 sets of assumptions to illustrate the sensitivity of program costs to different economic and demographic trends. The low and high cost alternatives provide for a fairly wide range of possible experience. In some prior year's reports, when the depletion of the fund was expected to occur sooner, the depletion dates under the alternatives did not show as much variation. This was due to the fact that there was not enough time before the fund was depleted for the differences in the assumptions to compound and therefore result in significantly different depletion dates.

CAUSES OF LONG TERM PART A SPENDING?

QUESTION:

What are the underlying causes of the increases in Medicare Part A expenditures over the long term?

ANSWER:

- ▶ There are three underlying causes for the increase in long term Part A expenditures: rising costs of medical services, rising numbers of beneficiaries, and rising utilization of services. These are the same trends that we discussed last year, and they have not changed.
- ▶ The Part A trust fund covers payments for inpatient hospital services, skilled nursing facility care, home health care (some of which is being shifted to Part B over a six-year period) and hospice care. The BBA slowed spending in all categories, with declines recorded for inpatient hospital and home health services in 1998. Spending is expected to resume growing steadily for a few more years.
- ▶ One primary cause of increasing Medicare Part A expenditures is the growth in the Medicare population and the changing composition of that population. Currently, the Medicare population is growing at 1.2 percent per year.
- ▶ Changes in patterns of utilization across providers also have contributed to increasing Part A expenditures. Historically, hospitals were the primary providers of services. In recent years, we have seen higher growth in the use of post-acute services (SNF, home health care) after hospital stays. Although these services constitute less than 30 percent of Part A expenditures, they grew rapidly during the early 1990s. After a period of flatter growth resulting from the BBA and other effects, spending is projected to rise steadily in the future.

HOME HEALTH TRANSFER FROM PART A TO PART B

QUESTION:

How has the shift of home health services from Part A to Part B affected the SMI trust fund and beneficiaries' SMI premiums?

ANSWER:

- ▶ The phased-in transfer of home health adds to SMI costs, but this increase is roughly offset by other Part B savings enacted in the BBA. The transfer also generates new revenue for the trust fund by increasing Part B premiums

SMI EXPENDITURE GROWTH

QUESTION:

How fast are SMI expenditures growing and why are expenditures rising ?

ANSWER:

- ▶ The program has grown rapidly -- about 41% over the last 5 years (33% on a per-beneficiary basis). During this period the program grew about 9% faster than the overall economy.
- ▶ SMI expenditures are projected to continue to grow faster than the economy, growing from less than 1% of GDP in 1998 to about 2% in 2020. The average annual growth rate from 1998 to 2020 is projected to be 8.3%.
- ▶ SMI spending has been growing due to the continuous growth in the volume and intensity of services covered by SMI. The growth of the Medicare population (currently, 1.2 percent per year) and the changing composition of that population are also factors driving the increase in SMI spending.

PAYMENT CUTS TO PROVIDERS

QUESTION:

Given the good news in the Trustees' Report, do we still need to make the Medicare payment cuts to providers that were proposed in the President's budget?

ANSWER:

- ▶ We welcome the good news in the Trustees' Report that the solvency of the Part A Trust Fund has been extended seven years to 2015. Nevertheless, we remain committed to rooting out fraud, waste, and inefficiencies in the program while placing it on a stronger financial footing.
- ▶ Our budget takes these steps and has been crafted in such a way that it won't reduce benefits, or erode the quality of care furnished by providers.
- ▶ The first part of our proposal is a \$2.9 billion waste, fraud and abuse package. It includes several recommendations by our Inspector General to eliminate excessive Medicare reimbursement for drugs, particularly Epogen; prevent abuse of Medicare's partial hospitalization benefit; ensure that Medicare doesn't pay for claims owed by private insurers; and expand HCFA's ability to contract with cost-effective institutions, and with a wider range of carriers.
- ▶ The second part includes payment reforms for hospitals, labs, orthotics and prosthetics. Our budget proposes to freeze Medicare reimbursements for hospitals. As stewards of the Medicare program, our job is to recommend changes to payment rates to ensure that Medicare pays appropriately. We based our budget proposal on the data we have. However, we are open to working with hospitals and members of Congress to update our analysis of the basis of any new data.

DO YOU STILL SUPPORT A HOSPITAL UPDATE FREEZE?

QUESTION:

Do you still support a hospital payment freeze even though it has been rejected by Congress in the Budget Resolution?

ANSWER:

- ▶ Senator, I have a fiduciary obligation to assure that Medicare does not overpay providers regardless of the status of the Trust Fund, regardless of the baseline.
- ▶ We developed our FY 2000 budget proposals using the best available data and evidence available. That evidence, from MedPAC and others, showed unexpectedly large hospital inpatient profit margins.
- ▶ If there is new evidence out there that demonstrates that our data is out of date, we welcome the opportunity to look at it and work with the industry and Congress.

ADMINISTRATION DOESN'T SUPPORT BREAUX-THOMAS

QUESTION:

Why does the Administration not support the Breaux-Thomas Medicare reform proposal?

ANSWER:

- ▶ We appreciate the Commission's hard work and recognize the significant contribution it has made to highlighting the need to strengthen and modernize the program. However, the proposal falls short in a number of key areas.
- ▶ First and foremost, the proposal does not adequately address the demographic challenge facing Medicare - that the number of beneficiaries will roughly double over the next 35 years. To meet this challenge, increased revenues are necessary. Commission staff estimated that the final Breaux-Thomas plan would produce only \$102 billion in net savings over 10 years, less than one-third of the savings achieved in the BBA, and less than one-third of the amount we derive from committing 15 percent of the surplus to Medicare. We should take steps to make the program more competitive and efficient. But we must also address the financing challenge through the President's plan.
- ▶ Much of the savings in the Breaux-Thomas plan are derived from shifting costs and risks to beneficiaries. In fact, the centerpiece of the Breaux-Thomas plan -- premium support -- gets a substantial portion of its savings from increasing beneficiary costs.
- ▶ The Breaux-Thomas proposal raises the eligibility age for Medicare. Without a realistic policy to ensure affordable insurance for this population, we are deeply concerned that this proposal would increase the number of uninsured in the country. As you know, this Administration has worked hard to develop policies to increase the number of people with health insurance in America.
- ▶ The premium support model included in the Breaux-Thomas plan would increase premiums for beneficiaries who choose to remain in traditional Medicare. The Medicare actuary has estimated that the Breaux-Thomas proposal that was presented in February will raise fee-for-service premiums (18-30 percent or 10-20 percent if Congress enacted the traditional program reforms). While the actuaries were unable to estimate the impact of the Breaux-Thomas plan, there is no reason to expect a significant change.
- ▶ The premium support model also creates regional inequities in beneficiary premium contributions through its geographic adjustment.
- ▶ We also believe the proposal's prescription drug coverage is inadequate. Because it is administered as a means-tested Medicaid benefit, nearly 60 percent of Medicare beneficiaries without drug coverage would not qualify. Experience also has shown the elderly are reluctant to sign up for Medicaid.

The President has committed to propose a plan that meets the following core principles:

- ▶ **Modernize Medicare and Make it More Competitive.** We should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with private spending. Moreover, strong and effective Federal administration of Medicare should be assured.
- ▶ **Maintaining and Improving Medicare's Guaranteed Benefits, Including a Prescription Drug Benefit.** Medicare protects some of our most vulnerable citizens from excessive health care costs. We must maintain the guarantee of access to a defined set of benefits, including prescription drugs. Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. Any proposal should provide prescription drug coverage that is available and affordable.
- **Assure Adequate Financing by Dedicating 15% of the Surplus.** One of the fundamental goals is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century.

BACKGROUND:

- ▶ The number of beneficiaries is expected to double in the next 35 years - from 39 million now to 80 million in 2035. Increased program efficiency through market competition and prudent purchasing is not sufficient to fund the program without more revenues.
- ▶ Under Breaux-Thomas, the fee-for-service program is considered a health plan like any other and is included in the calculation of the national average premium -- the benchmark against which Medicare will pay a percentage of premium below the cost of the fee-for-service plan -- causing beneficiaries to pay more for fee-for-service coverage than under current law.

- ▶ Breaux-Thomas provides fully subsidized drug coverage for beneficiaries with incomes below 135% of the federal poverty level (using the Medicaid program but paying 100% of those costs). It also requires highly inefficient Medigap plans to cover drugs with no government subsidy, which raises serious risk selection issues and could make already expensive Medigap plans unaffordable.
- ▶ 10 year gross savings in the most recent version of Breaux-Thomas that the actuaries were able to score (these savings are partially offset by spending on the Medicaid drug benefit.)
 - Premium support provides about 34% of the gross savings (a substantial portion of which come from shifting costs to beneficiaries).
 - Raising the eligibility age provides 6% of gross savings.
 - Changes to cost sharing and Medigap produce 14% of gross savings.
 - The remaining gross savings come from moving GME out of Medicare (23%) and slowing fee-for-service reimbursements growth (24%).

WHEN WILL THE PRESIDENTS' PLAN BE READY?

QUESTION:

What is the timetable for presenting a Clinton plan? What will be in the President's Medicare plan?

ANSWER:

- ▶ The President's Medicare plan will address an important and complicated challenge. We are working hard to do it right. The President has instructed his health care advisors to take the best ideas from the Breaux-Thomas proposal, from other members of the Commission, and from members of Congress, and to draft a proposal that can receive bipartisan support and truly prepare Medicare for its future challenges. In addition to the complexities of policy, we also must analyze the impact of the Trustees' recent report on the options that we are considering.
- ▶ The President's plan will be based on the following core principles:
 - We must modernize Medicare and make it more competitive, adopting the best practices from the private sector and maintaining high quality services.
 - We must ensure that it continues to provide every citizen with a guaranteed set of benefits, and we must make prescription drugs more accessible and affordable to Medicare beneficiaries.
 - We must address the long-term financing of the program, seizing the opportunity created by our balanced budget and surplus to devote 15 percent of the surplus to strengthen the trust fund.
- ▶ While we have no specific time frame, we hope to complete our work within the next several weeks.

WHY REFORM IF SOLVENCY IS IMPROVED?

QUESTION:

With such substantial improvement in the extension of the Medicare trust fund, do we still need a major reform plan this year?

ANSWER:

- ▶ As the President said last month, we cannot allow the recent good news from the Medicare trustees to lull us into thinking that nothing more needs to be done.
- ▶ Under any scenario, the program will face dramatic demographic challenges over the next 25-35 years that will require significant new revenues. Most independent health experts have concluded that the retirement of the baby boom generation will necessitate a major infusion of new resources to offset this burden. As a result, the need for the President's dedication of 15 percent of the surplus (almost \$700 billion over 15 years) to the Medicare program continues, even though the projected exhaustion date has been extended. And as the President has made clear, we should also take concrete steps to modernize and strengthen the program, and provide a long overdue prescription drug benefit.

BREAUX-THOMAS GETS US TO 2020

QUESTION:

One of your main criticisms of the Breaux-Thomas plan is that it fails to meet the President's goal of extending the solvency of the trust fund to 2020. But the trust fund, absent any statutory changes, will be able to pay full benefits until 2015. Given that the Breaux-Thomas plan adds an additional 4 years of solvency, doesn't that mean it essentially achieves the president's goal of 2020?

ANSWER:

- ▶ First, inadequate financing is not the only reason that the Administration is unable to support the Breaux-Thomas plan. We also have serious concerns about its impact on beneficiaries, and the inadequacy of the prescription drug benefit.
- ▶ Second, given the enormity of the demographic challenge facing the program, it is absolutely critical that we take advantage of the trustees' recent good news to extend the life of the trust fund even further. Keep in mind that Medicare is still projected to become insolvent almost 20 years earlier than Social Security. The President's plan to dedicate 15% of the surplus to Medicare will add about another decade.
- ▶ The Breaux-Thomas plan lacks enough specifics for the HCFA Actuary to estimate its effect on trust fund solvency, but we expect it to be minimal. And much of the effect of the Breaux-Thomas plan on the trust fund is derived from shifting the costs of Medicare direct medical education to general revenue.
- ▶ Most independent health experts have concluded that the retirement of the baby boom generation will necessitate a major infusion of new resources to offset this burden.
- ▶ However, the Breaux-Thomas plan does not propose necessary new revenues for Medicare and passes up a historic opportunity to dedicate 15 percent of the budget surplus to the program.

THROWING MONEY AT THE PROBLEM

QUESTION:

Your main criticism of Breaux-Thomas is that it didn't include the President's proposal to devote 15 percent of the surplus to Medicare. But the truth is that Breaux-Thomas savings are achieved through tough program reforms and not from throwing more money at the problem. Isn't your criticism just an excuse to be against real reform and to prevent the Congress from returning the surplus to the people through tax cuts?

ANSWER:

- ▶ Absolutely not. Given that the number of Medicare beneficiaries will double over the next 35 years, the central challenge facing Medicare is the financing issue. However, the President also is committed to proposing real changes to strengthen and modernize the program and provide a long overdue prescription drug benefit.
- ▶ The lack of adequate financing, while important, is only one reason why we are unable to support the Breaux-Thomas proposal. In addition, we believe that the Breaux-Thomas proposal achieves too much of its savings at the expense of Medicare beneficiaries. According to Medicare Commission staff estimates, almost a quarter of the savings achieved under the proposal come from increasing the cost sharing requirements of beneficiaries and increasing the eligibility age. And a substantial portion of the savings derived from the premium support plan come from higher beneficiary premiums in FFS.

WHAT'S WRONG WITH BREAUX PREMIUM SUPPORT?

QUESTION:

Why don't you support the Breaux-Thomas "premium support" model? You have criticized its effect on premiums, but beneficiaries always will have a choice of plans, and if they don't their premiums will be protected.

ANSWER:

- ▶ The President is committed to enhancing competition and introducing private sector approaches to Medicare, but not at the risk of significant increases in premiums for the majority of beneficiaries who will remain in the traditional program.
- ▶ According to the Medicare actuary, the Breaux-Thomas premium support proposal that was presented in February would raise premiums for traditional Medicare by 18-30 percent (10 to 20 percent if Congress enacts the traditional program reforms such as BBA extenders and moderization). While the actuaries were unable to estimate the impact of the Breaux-Thomas plan, there is no reason to expect a significant change. Although the final Breaux-Thomas proposal attempted to address this problem for beneficiaries with no private plan options, those with limited or unattractive private options would be forced to pay more to stay in the system. That is unacceptable.
- ▶ And, when the first plan enters an area, no matter how new it is or how it is structured, beneficiaries will be forced to join it or see their FFS premium soar.
- ▶ For the first time ever, Medicare beneficiaries in different parts of the country would pay different amounts for the same fee-for-service benefits. Even among neighbors, one beneficiary who lives in a county with no private plan option would receive the price protection but a neighbor who lives in a county with a private plan option would have to pay more to stay in fee-for-service.
- ▶ The premium support model in Breaux-Thomas also would cause beneficiaries in higher cost urban areas to face higher premiums for private plans and fee-for-service since the original Breaux-Thomas proposal includes only a partial geographic adjustment.

BREAUX-THOMAS IN RURAL AREAS

QUESTION:

You have criticized the effect of Breaux-Thomas on rural areas, but fee for service beneficiaries in rural areas would be protected against premium increases.

ANSWER:

- ▶ It is true that the Breaux-Thomas proposal includes a provision limiting the liability of Medicare beneficiaries residing in rural areas if there are ***no options at all*** other than the traditional fee-for-service program. However, once there is a single private plan offered in a particular rural area, the cost to beneficiaries of the traditional fee-for-service option can be expected to rise significantly, regardless of the cost or adequacy of the private option, and whether the available option or options meet the needs of residents in that area.
- ▶ Rural beneficiaries would thus face a dilemma. If they have no plan choice, their premium remains the same, but if one private plan comes to their area -- and that plan does not include their physician -- they would have to pay a much higher premium to keep that physician.
- ▶ This effect on fee-for-service premium costs, taken together with the variation allowed in health plans benefits, could mean that some beneficiaries can only be adequately served in fee-for-service. For example, if a health plan uses its ability to reduce the value of home health coverage by 10 percent and it is the only plan choice in an area, sicker beneficiaries may feel the need to use traditional Medicare, but face higher costs as a result.
- ▶ The rural premium price protection in Breaux-Thomas could create an unprecedented situation where Medicare beneficiaries would pay different amounts for the same set of fee-for-service benefits in the traditional program. This would happen county by county in some areas, where neighbors and family members could pay different premiums for traditional Medicare.

CONCERNS WITH RAISING ELIGIBILITY AGE

QUESTION:

Isn't it true that the Administration opposes raising the eligibility age because of political concerns about being criticized by the seniors lobby and House Democrats? How can you be against this modest step supported by many Senate Democrats that would begin to conform Medicare to steps we've already taken with Social Security?

ANSWER:

- ▶ We have serious concerns about raising the Medicare eligibility age:
 - There has been no improvement in the availability or affordability of health insurance for people in their early 60s that would justify raising Medicare's eligibility age. In fact, people ages 55-65 are the fastest growing group of uninsured Americans. Unlike Social Security, where the effects of raising the eligibility age to 67 are mitigated by the increased wealth and longer working lives of Americans, there is no comparable improvement in the health insurance system that would justify raising the eligibility age.
 - There are also significant differences between Social Security and Medicare. First, there is no Medicare component comparable to Social Security where someone can access the system at 62 and receive partial benefits. And the Breaux-Thomas plan does not include such an option. Second, you cannot postpone health care needs like you can retirement. Retirement is a fairly predictable event for which most families plan years in advance. Illness and disability, in contrast, are rarely foreseeable and are increasingly likely as people age.
 - Raising Medicare's eligibility age would take away guaranteed health insurance from people with the greatest risk of health problems and the lowest probability of finding affordable private health insurance. In fact, even if you assume the same proportion of those ages 65 and 66 would be uninsured as those age 64 (16 percent in 1998), nearly 600,000 people would have no insurance.
 - Raising the eligibility age would shift costs to employers who currently provide health coverage to older workers prior to their eligibility for Medicare, and to retirees as a Medicare wrap-around. It also would be a significant unfunded mandate to states because Medicaid would become the primary payer for the 65 and 66 year olds on the Supplemental Security Income Program, or who improvish themselves through medical expenses.

- The Medicare buyin discussed in the Breaux-Thomas proposal is not a substitute for Medicare. Because it would be unsubsidized, only a small number of those who lose Medicare would take this option.

BUY-IN AND RAISING THE ELIGIBILITY AGE

QUESTION:

Wouldn't your Medicare buy-in proposal make it possible to raise the eligibility age from 65 to 67 -- making it consistent with the phase-in for Social Security? What is the Administration's position on such a proposal?

ANSWER:

- ▶ The President's plan was not designed to be a substitute for Medicare. It was designed to provide an option to Americans ages 55 to 65 who lack access to insurance, but it does not subsidize their health care costs. As a result, CBO estimated that only about 9 percent of the uninsured ages 62-65 would participate. The same would be true if this policy were extended to those ages 66 and 67. Because it would be unsubsidized, only a small number of those who lose Medicare would take this option.
- ▶ As we have said many times, we have serious concerns about raising the Medicare eligibility age in the absence of a policy to ensure access to affordable coverage. Indeed, the President has emphasized that we need to focus our attention on the most rapidly growing group of uninsured Americans -- Americans between the ages of 55 and 65. Adding to this growing population by increasing the number of uninsured in the 65-67 year old group just doesn't make sense.
- ▶ The buy-in proposal is designed to cover some portion of the 55-64 year olds who are uninsured and who have the greatest need. It is not designed to be a substitute for the already insured.

GUARANTEED BENEFITS IN BREAUX-THOMAS

QUESTION:

Why are you falsely claiming that the Breaux-Thomas proposal does not include a defined guarantee of benefits?

ANSWER:

- ▶ Compared to earlier drafts of the Breaux-Thomas plan, the final version did improve the level of benefit protection.
- ▶ However, the benefits package in the final Breaux-Thomas plan can vary by up to 10% of actuarial value from the standard benefits package. Therefore, categories of benefits (e.g. hospital benefits, physician benefits) would be specified in law, but plans could reduce the value of certain benefits and enhance others. In addition, they are free to vary coinsurance, copay and deductible levels subject to the approval of the national board. We are concerned that this level of variation in the core Medicare benefits presented in the context of price competition could erode Medicare's promise of a defined benefit package.
- ▶ Much less variation exists in Medicare today. Under current law, managed care plans can vary copays and deductibles as long as total out-of-pocket costs in the plan do not exceed total out of pocket costs in Medicare for **the core Medicare benefit package**. They are free to add to the core package with excess premium dollars paid to them, but they cannot offer less of a given benefit than that offered in Medicare fee-for-service.
- ▶ The variation allowed by Breaux-Thomas is significant and would reduce savings to the extent that benefit variations encourage healthier beneficiaries to select private plans.
- ▶ If all the private plans in a given area decided to vary their benefits in such a manner that all offered less home health and more of something else, beneficiaries with home health needs may only be able to obtain such services from traditional, fee-for-service Medicare, which is expected to cost more than the average private plan in the Breaux-Thomas proposal.

HOME HEALTH COPAY

QUESTION:

The Breaux-Thomas plan includes a 10 percent copay for home health visits. Do you support a home health copay?

ANSWER:

The Breaux-Thomas plan derives a significant portion of its savings from increasing costs to beneficiaries. For example, the proposals to raise the eligibility age from 65 to 67 and to impose unlimited per visit home health copays comprise over 20 percent of the savings. For the over 1 million beneficiaries who have more than 60 home health visits per year, a 10 percent copay would represent a large financial burden. We believe that as we work to strengthen and protect the program, we must not place undue burdens on beneficiaries.

DRUG COVERAGE WILL ERODE CRITICAL SAVINGS

QUESTION:

You have criticized the groundbreaking new drug benefit put forward as part of the Breaux-Thomas plan as inadequate. How do you propose to establish a more generous benefit without eroding critical savings?

ANSWER:

- ▶ One of the Commission's positive contributions was to highlight how essential it is for Medicare beneficiaries to have drug coverage. Many Medicare beneficiaries now pay the highest price for drugs, either because they have no coverage at all, or they pay for expensive Medigap coverage. Unfortunately, nearly 60 percent of beneficiaries without drug coverage would not qualify under the Breaux-Thomas proposal. In addition, experience with Medicaid-run benefits for Medicare beneficiaries shows that only half of those qualified may actually enroll. The Breaux-Thomas plan is a good starting point, but inadequate to meet the needs of all beneficiaries.
- ▶ The actuary projects that 40% of beneficiaries will have no drug benefits in 2000, up from 35% a few years ago.
- ▶ While we are still working on design options, the President is committed to fully financing an affordable and accessible prescription drug benefit within the context of his plan. We also believe there is strong bipartisan support for the introduction of a drug benefit, as evidenced by the work of Senators Snowe, Wyden, and others, and by the inclusion in the Majority's Budget Resolution of language concerning the drug benefit. We must keep in mind the costs we already bear as a society because of the high out of pocket costs and access problems that Medicare beneficiaries currently face.

WOULD MEDICARE PRESCRIPTION DRUGS SUPPLANT PRIVATE COVERAGE

QUESTION:

Is it true that since 65 percent of Medicare beneficiaries already have some type of coverage, a new Medicare drug benefit would simply replace private dollars with government subsidies?

ANSWER:

- ▶ Absolutely not. The actuary estimates that about 30 percent of all Medicare beneficiaries will receive primary drug coverage through public programs in 2000: Medicare HMOs, Medicaid, and other public programs, including VA, DoD, and state drug programs. And note that the federal government substantially subsidizes employer-provided prescription drug coverage through the tax code. Thus, the government is already paying for their benefit. This number is up from 20% just a few years ago.
- ▶ Another 23 percent of beneficiaries will receive drug coverage through primary employer-sponsored insurance or through expensive and limited Medigap policies. This number is down from 38% a few years ago. Thus, Medicare beneficiaries who can afford to purchase private coverage have limited and declining options. About 6 percent of beneficiaries have coverage but will switch their coverage during the year; e.g., go from a Medicare HMO to a Medigap insurance policy.
- ▶ Finally, it is important to remember that 40 percent -- 15.5 million beneficiaries -- will have no coverage. This is up from 13 million beneficiaries a few years ago. In contrast, virtually all employer-based health plans cover prescription drugs.
- ▶ In the next 10 years, the share of national health spending devoted to prescription drugs will increase by almost 30 percent so that prescription drugs will consume nearly one in ten health care dollars.

NO FUNDING FOR PRESCRIPTION DRUGS?

QUESTION:

How can you criticize the lack of financing in the Breaux-Thomas proposal, when the President has announced his intention to include the most costly benefit in the history of the program, without any plan to pay for it?

ANSWER:

- ▶ We do believe the Breaux-Thomas plan falls short in a number of key areas, particularly the lack of adequate financing to address the central challenge facing the Medicare program -- a tremendous influx of new beneficiaries in the future. We also believe the drug benefit included in Breaux-Thomas, while a good start, excludes too many beneficiaries who currently lack coverage.
- ▶ The President's plan will seek to address both of these issues. We propose to dedicate a portion of the surplus to extend the life of the trust fund by another decade. We also intend to include an affordable and accessible prescription drug benefit that is fully financed within the context of our plan.
- ▶ The President believes that a prescription drug benefit is long overdue. Drugs have revolutionized our treatment of illness and disease and hold incredible promise for the future. But their high cost and gaps in insurance coverage present problems for many Medicare beneficiaries, not just the poorest.

REPUBLICAN MEDICARE PRESCRIPTION DRUG MONEY

QUESTION:

Does the Administration support the Republican budget plan to use approximately \$100 billion in on-budget surplus funds over 10 years to pay for a Medicare prescription drug benefit?

ANSWER:

- ▶ We are pleased that members of Congress are seriously examining the issue of prescription drug coverage for Medicare beneficiaries, particularly Senators Snowe and Wyden on this committee. The President believes that a prescription drug benefit must be included in a broader set of steps to strengthen and modernize the program.
- ▶ Drugs have revolutionized our treatment of illness and disease, and hold incredible promise for the future. But their high cost and gaps in insurance coverage present problems for many Medicare beneficiaries, not just the poorest.
- ▶ As I understand the structure of the Budget Resolution, the reserve fund could be accessed for a Medicare prescription drug benefit without a point of order only if the Medicare authorizing committee reported legislation that significantly extends the life of the Medicare trust fund -- without using a transfer from the general fund.
- ▶ As members will quickly see, this is highly problematic. The major challenge facing Medicare is demographic and the major solution is new revenue. As the Breaux-Thomas plan illustrates, efficiency and competition alone will not significantly enhance the life of the Trust Fund.
- ▶ It would appear then that the language of the budget resolution puts us in a difficult situation. For example, if the Finance Committee were to report out a legislative version of the Breaux-Thomas plan without dedicating a portion of the surplus to Medicare as the President has proposed, it would seem to fall short of the test to "significantly" extend the life of the trust fund. Furthermore, if the Finance Committee decided to include fewer savings from providers, and decided to forego the transfer of GME, the effect on the trust fund would be even smaller.
- ▶ In our view, any meaningful action to strengthen Medicare must include both dedicating a portion of the surplus to Medicare, and an affordable, accessible prescription drug benefit financed in the context of the overall package.

NASI STUDY ON DRUG BENEFIT COSTS

QUESTION:

The National Academy of Social Insurance (NASI) recently released a study reporting that adding a prescription drug benefit would increase Medicare costs 7 to 13 percent over the next decade. Can Medicare afford this?

ANSWER:

- ▶ Today, America's elderly pay the highest prices for drugs because drugs are not covered by Medicare. Seniors buy drugs without discounts or pay for expensive Medigap insurance to obtain drug coverage. The NASI study focuses attention on the vital issue of expanding Medicare to cover prescription drugs. Drugs are a central component of modern healthcare and senior citizens deserve the health benefits and piece of mind that come from having needed medicines at an affordable price. While expanding the scope of benefits entails certain added costs, we are confident that Medicare can afford a drug benefit without imposing undue burdens on beneficiaries. Spending money on prescription drugs can actually save money in other areas by decreasing rates of hospitalization.
- ▶ For example, according to one study, every \$1 spent on drugs is associated with a \$3.65 reduction in inpatient expenditures (only some of these savings were offset by higher outpatient expenditures). [Lichtenberg FR. Do (more and better) drugs keep people out of hospitals? Health Economics 1996;86:384-88.]

WHAT WILL YOU DO THAT'S PAINFUL?

QUESTION:

In all the criticism we've heard about the Commission, the Administration's only proposal is to throw more money at the problem. Can you name one specific proposal the Administration is for that involves a politically painful but necessary step to reform the program?

ANSWER:

- ▶ The President's Medicare plan will address an important and complicated challenge, and we are working hard to do it right. The President has instructed his health care advisors to take the best ideas from the Breaux-Thomas proposal, from other members of the Commission, and from members of Congress to draft a proposal that can receive bipartisan support and truly prepare Medicare for its future challenges. The plan is under formulation and difficult choices will be made. However, it must meet the principles the President has outlined:
 - ▶ **Modernize Medicare and Make it More Competitive.** We should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with private spending. Moreover, strong and effective Federal administration of Medicare should be assured.
 - ▶ **Maintaining and Improving Medicare's Guaranteed Benefits, Including a Prescription Drug Benefit.** Medicare protects some of our most vulnerable citizens from excessive health care costs. We must maintain the guarantee of access to a defined set of benefits, including prescription drugs. Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. Any proposal should provide prescription drug coverage that is available and affordable.
 - **Assure Adequate Financing by Dedicating 15% of the Surplus.** One of the fundamental goals is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century.

HOW CAN BBA INFORM WHAT WE DO ON REFORM

QUESTION:

What can we learn from our experience with implementing the changes of the BBA as we consider legislation to reform the Medicare program?

ANSWER:

- ▶ BBA was a very significant undertaking, both legislatively and more recently, administratively as HHS implements the law. I believe we have learned a great deal from our experience with the BBA, and I'm sure you, as members of Congress, have too.
- ▶ One of the key things that BBA implementation makes clear, in the context of strengthening the program further, is that it will be extremely difficult to achieve the goal of adding another decade or so to the life of the Trust Fund by looking solely at Medicare reimbursement systems. We should always be assessing whether we are paying providers appropriately, but it is not feasible to extend solvency significantly beyond the 2015 depletion date relying solely on changes reimbursement and payment systems.
- ▶ Because we cannot count on payment or reimbursement reforms to add significantly to the life of the Trust Fund, we must look at sources of new revenues. That is why the President's proposal to dedicate 15% of the surplus is so critical to any effort to strengthen and modernize the program. It is not the whole answer, but it is a very significant part of the answer.
- ▶ I think we have learned a great deal from implementation of the BBA Medicare+Choice provisions as well.
- ▶ We have developed a successful M+C beneficiary outreach campaign but we are always looking for ways to improve and make the program easier to understand. Creating a more competitive program will require new outreach and information strategies.
- ▶ We had a difficult fall last year as plans announced withdrawal or scaled back participation in the program. As a result, we have looked at ways to make facilitate participation of health plans and improve beneficiary protections, which are reflected in our regulations and the President's FY 2000 budget proposal.

- ▶ Our proposals provide a base from which to move forward.
- ▶ The most significant lesson from M+C implementation has been the continued need for a viable traditional program. We will always work to minimize disruption to beneficiary choice but when there are larger marketplace forces governing health plan decisions to serve particular markets, beneficiaries will need access to an affordable, viable traditional program.

SAVINGS IN ADMINISTRATION PROPOSAL

QUESTION:

You have criticized the Commission savings (\$102 b) as inadequate. Does that mean the President's plan will achieve higher savings?

ANSWER:

- ▶ The President's plan to dedicate a portion of the surplus to the Medicare trust fund would provide about three times the net savings included in the Breaux-Thomas plan in the first ten years. We also plan to achieve additional savings through steps to strengthen and modernize the program.
- ▶ The savings achieved under the Breaux-Thomas proposal are inadequate for a number of reasons. The \$102 billion in savings over 10 years amounts to less than one-third of what was achieved by the Balanced Budget Act, and less than one-third of what could be achieved by the President's proposal to set aside 15% of the surplus.
- ▶ Equally important, much of the savings are achieved at the expense of Medicare beneficiaries, through increases in cost sharing requirements, raising the eligibility age, and higher premiums for those who stay in traditional Medicare.

BENEFICIARY COSTS UNDER PRESIDENT'S PLAN

QUESTION:

Have you completely ruled out the notion of any additional contribution from beneficiaries? If not, what are you considering?

ANSWER:

- ▶ We have not ruled out additional contributions from beneficiaries. However, any new cost burdens must not be excessive. Certainly, we expect that most beneficiaries will pay some portion of the cost of a new drug benefit. Our goals are to extend the life of the trust fund, maintain and improve Medicare's guaranteed benefits, including a prescription drug benefit, and make the program more efficient and competitive.

HCFA BIAS AGAINST MANAGED CARE

QUESTION:

Members of Congress and others who support a premium support system run by a Private Sector board believe that HCFA is institutionally biased against managed care. They also believe that HCFA's government sponsored pricing system is incapable of bringing efficiency and competition to the Medicare System. How do you respond?

ANSWER:

- ▶ Before I respond, let me note that we should all approach very carefully any proposal to turn over an essential government function that millions of seniors depend on to an untested private sector entity. There are functions -- for example, maintaining eligibility and enrollment records -- that go to the heart of the entitlement to health care that Medicare has offered our senior citizens for over 30 years. One also has to ask how a private sector board would guard against conflicts of interest; protect against waste, fraud and abuse like our Inspector General and the Justice Department; and conduct evaluations and surveys to ensure service quality. HCFA administers the Medicare program with an overhead of 1%, far lower than any private sector insurer.
- ▶ Second, let me assure you that HCFA Administrator DeParle and I are committed to the implementation of the BBA's Medicare+Choice program and we have devoted a great deal of effort to its implementation. We are committed to making the program work.
- ▶ Under the 1997 HCFA reorganization, beneficiary education, operations, and quality for both fee-for-service and managed care were integrated throughout the agency. HCFA Administrator DeParle has hired a number of individuals with private sector experience in managed care operations and outreach education to lead our efforts.
- ▶ We have initiated the largest Medicare education campaign in history to ensure that beneficiaries know their options and choices, which also speaks to our commitment to the program. In December 1992, there were 95 risk plans with 1.6 million Medicare enrollees. In April 1999, there were 300 risk plans with 6.1 million Medicare enrollees. This kind of growth hardly speaks of a bias against managed care for Medicare enrollees.

- ▶ We also are committed to ensuring that HCFA becomes a more prudent purchaser of care, which means leveraging market forces and competition on behalf of Medicare.
- ▶ Unfortunately, the Congress has denied us full use of several of the tools we have repeatedly requested to ensure competitive prices. The BBA does provide for a demonstration of competitive pricing in setting Medicare capitation rates. This included an advisory committee of outside experts to design the demonstration and designate sites. Their meetings were open to the public and minutes of their meetings are on HCFA's web site. They have chosen Phoenix and Kansas City as the two demonstration sites. We believe experience from this demonstration is very important as we examine alternative ways of operating the Medicare program in the future.
- ▶ We are gearing up for a Durable Medical Equipment competitive bidding demonstration in Polk County, Florida
- ▶ We need more authority to leverage competition in the market. The President's budget asks for this authority to expand competitive bidding and our Centers of Excellence Initiative among others as part of our Prudent Purchasing Initiative.

BACKGROUND

Competitive Pricing Demonstration - Status Update

- ▶ The Kansas City Area Advisory Committee has met twice and meets again Thursday, April 22. It has taken action on some of the matters that the CPAC designated for AAC action.
- ▶ The Phoenix Area Advisory Committee has met once and is meeting again on Tuesday, April 20. At its first meeting it recommended that the CPAC delay the demonstration in Phoenix for one year.
- ▶ The CPAC will meet soon (tentatively May 13) to consider the Phoenix AAC's recommendation and other matters related to the demonstration.

Competitive Bidding Demonstration - Status Update

- ▶ Bids for the Polk County demonstration were due to HCFA's contractor by March 29th. HCFA was pleased with the number of suppliers submitting bids. These bids are currently being processed by HCFA's contractor. The next step in the process will begin in early May when bidders in the competitive range will receive a site visit. Based on these visits and other data, HCFA's contractor will determine which bidders provide the best value in

in terms of price and quality. Winning bidders will begin receiving payment for items provided on or after on or after October 1.

A suit was filed by the Florida Association of Medical Equipment Dealers and two individual suppliers. The judge denied a request for a temporary restraining order against opening bids. The request for a preliminary injunction is still pending.

CONTROLLING MEDICARE COMMISSION APPOINTEES

QUESTION:

Isn't it true that you and the President prevented the Administration's appointees from voting for the Commission's plan in order to undermine the prospects for reform in this Congress?

ANSWER:

- ▶ Absolutely not. We did not ask our appointees to take any position other than what they believed was necessary to improve and strengthen the Medicare program. Our appointees are well respected health care experts who have long standing opinions on this important issue. They did not support the Breaux-Thomas proposal because, like us, they had serious reservations about several aspects of the proposal. We opposed the proposal because it fell short in a number of key areas. In particular the plan:
 - Failed to address the long-term financing needs of the Medicare program; Increased the Medicare eligibility age without a policy to protect against large increases in the number of uninsured;
 - Proposed a premium support model that would raise beneficiary premium costs for the traditional Medicare program; and
 - Did not provide adequate coverage of prescription drugs.
- ▶ The President believes we must take advantage of an historic opportunity presented by the surplus and the new estimates of prolonged Trust Fund Solvency to place the Trust Fund on strong financial footing well into the next century and at the time, modernize the program to make it more efficient and competitive.

TRANSFERRING BUDGET SURPLUS TO TRUST FUND

QUESTION:

How does transferring a portion of the budget surplus to the Medicare trust fund fix Medicare's long-term problems?

ANSWER:

- ▶ In the State of the Union address, the President announced his proposal to transfer one-sixth of the projected budget surplus over the next 15 years to the Medicare Part A Trust Fund. We project that this transfer will extend the life of the Part A Trust Fund by about a decade beyond the projected depletion date of 2015.
- ▶ Our existing commitments to future retirees creates the real challenge facing Medicare. Like the need for schools in the 1960s, Medicare's challenge is demographic. The number of beneficiaries will roughly double over the next 35 years. One way or another, we must find the resources to meet the need. The President's framework is the way to begin moving toward long term solvency
- ▶ We believe that use of a portion of the surplus in this way will facilitate bipartisan efforts to strengthen and modernize the program.
- ▶ The President has specified principles that will guide this Administration as we seek to work with Congress on a bipartisan basis to strengthen and modernize the program:
 - **Modernize Medicare and Make it More Competitive.** We should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with private spending. Moreover, strong and effective Federal administration of Medicare should be assured.
 - ▶ **Maintaining and Improving Medicare's Guaranteed Benefits, Including a Prescription Drug Benefit.** Medicare protects some of our most vulnerable citizens from excessive health care costs. We must maintain the guarantee of access to a defined set of benefits, including prescription drugs. Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. Any proposal should provide prescription drug coverage that is available and affordable.
 - **Assure Adequate Financing by Dedicating 15% of the Surplus.** One of the fundamental goals is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century.

USE OF SET ASIDE

QUESTION:

The President indicated earlier this year that he wanted to dedicate 15 percent of the surplus to increase the solvency of the program, and that his plan would identify additional savings to pay for the new prescription drug benefit. Can you commit to us today that no surplus funds will be dedicated in the President's plan for prescription drugs?

ANSWER:

- ▶ The Administration is reviewing options for prescription drug coverage.
- ▶ Our first priority has been to see how to make Medicare more efficient and to use savings from efficiency for a prescription drug benefit.
- ▶ It is premature to discuss any other use of surplus dollars, before our analysis is completed.

HOW DOES THE SURPLUS PROPOSAL WORK

QUESTION:

Please explain how the President's proposal to devote 15% of the surplus to Medicare actually works.

ANSWER:

- ▶ I know that Secretary Rubin and OMB Director Lew have already appeared before the Committee, and I will leave it to them to provide the details on the accounting and operational issues involved in devoting a portion of the surplus to the Medicare Trust Fund. However, speaking as a Medicare trustee and the Administration's senior health official, I can tell you that the independent Medicare actuaries have certified the positive effect this proposal will have on trust fund solvency. I believe this is a critical first step toward strengthening Medicare for our children and grandchildren.
- ▶ I view the President's framework like a family that pays off credit card debt now so they will not have to pay monthly bills later. When the children grow older, they can take the money that the family would have been spending each month on credit card debt and use it to help pay for college.
- ▶ By reducing publicly held debt, the President's framework would reduce the amount of net interest that the government would have to pay to service debt in the future. This reduction in net interest costs will help free up resources to make Medicare affordable for decades to come.
- ▶ The President's framework would convey bonds to the Medicare Trust Fund. The framework thus uses a traditional means -- increasing Trust Fund balances -- to extend Trust Fund solvency. These bonds will give Medicare first claim (along with Social Security) on the increasing surpluses that debt reduction and lower net interest costs will bring about. Legally binding procedures -- a lockbox -- would prevent the government from using these funds for any other purpose.

GENERAL REVENUE AND THE HI TRUST FUND

QUESTION:

The Comptroller General has said that the President's proposal to shift 15 percent of the surplus to Medicare is a radical departure by using General Funds to prop up the Trust Fund?

ANSWER:

- ▶ First, let's consider the alternatives. Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases, and/or tax increases to extend the life of the trust fund.
- ▶ The President's proposal uses the budget surplus to put a financial obligation -- that we can well afford today -- behind a moral obligation that we have to pay benefits to current workers when they retire. If we pay down the debt now, future generations will have a stronger economy, lower interest costs, and a larger array of financing options when the obligation must be met.
- ▶ It is also somewhat ironic that some of those most opposed to the President's framework have advocated, either in the context of the Breaux-Thomas plan or elsewhere, moving a current trust fund obligation -- graduate medical education -- into the general revenue side of the budget. In fact, the Breaux-Thomas plan achieves about one-fifth of its savings and about half the effect on trust fund solvency, from this transfer of GME to general revenue.

WHERE THE SURPLUS MONEY GOES

QUESTION:

Would the 15% of the surplus be transferred to Part A only or to Parts A and B?

ANSWER:

In order to extend the life of the Trust Fund, the funds would have to be transferred to Part A.

15% PAY NOW? PAY LATER?

QUESTION:

Doesn't the President's proposal shift fiscal pain from current taxpayers to taxpayers yet to be born?

ANSWER:

- ▶ Bringing down our massive public debt now and putting our financial house in order expands our ability to meet our financial obligations in the future. Lowering the national debt now reduces interest costs in the future and will provide our children and grandchildren an environment with more options to meet future Medicare obligations than we have today.
- ▶ As you know, Treasury Secretary Rubin and OMB Director Lew have both appeared before the Committee to address these issues. I will leave it to them and to other senior economic advisors of the Administration to respond to the details.

HOW MANY ADDITIONAL YEARS?

QUESTION:

You claimed earlier that the President's proposal to dedicate 15% of the surplus would extend the life of the Trust Fund for twelve years beyond the expected depletion date of 2008. Now we hear you saying that 15% would bring us "about a decade" beyond the new depletion date of 2015. What accounts for the difference?

ANSWER:

- ▶ We believe our goal should be to add about a decade of solvency to the Medicare program beyond the new depletion date.
- ▶ Using 15% of the surplus can get us to that goal.
- ▶ The important question here, however, is whether we are ready and committed to extending the life of the trust fund significantly. This Administration is ready to do just that.

NO NEED FOR FULL 15%

QUESTION:

Now that the trust fund is extended to 2015, doesn't that mean that we can devote less of the surplus to Medicare, return more to the American people in tax cuts, and still meet the President's objective of solvency until the year 2020?

ANSWER:

- ▶ Under any scenario, the program will face dramatic demographic challenges over the next 25-35 years that will require significant new revenue. Every independent health expert has concluded that the retirement of the baby boom generation will necessitate a major infusion of new resources to offset this burden.
- ▶ As a result, the need for the President's dedication of 15 percent of the surplus to the Medicare program remains. We need to save some of today's prosperity for tomorrow's needs. And as the President has made clear, Medicare also requires steps to strengthen and modernize the program.

FINANCING FOR NEW BENEFICIARIES

QUESTION:

You have indicated that the primary challenge facing the Medicare program is the need for additional financing to deal with demographic changes. But isn't it true that under the President's plan to dedicate 15% of the surplus to Medicare, the trust fund will still go broke before the baby boom generation retires?

ANSWER:

- ▶ The President's plan would not completely solve the problem. Clearly, more needs to be done. But it would go a long way to address the central challenge facing the Medicare program, a huge influx of new beneficiaries in the future. The President's plan provides breathing room without draconian cuts or excessive tax increases.
- ▶ The President's proposal would extend the life of the trust fund about a decade beyond the recent Medicare trustee's projection. A lower national debt and lower interest costs will give Congress and American taxpayers a stronger economy and additional financing options to do even more to address the problem of Medicare solvency.

REPUBLICAN BUDGET RESOLUTION

QUESTION:

In the FY 2000 budget resolution, the majority in both Houses agreed to make available the projected 10-year, \$1.8 trillion Social Security surplus to shore up that program and Medicare. The budget resolution also provides in addition to that up to \$100 billion over 10 years in uncommitted on-budget surpluses that can be used for Medicare reform, and potentially to pay for a Medicare prescription drug benefit. Doesn't this plan go further than the President's plan in strengthening and improving Medicare? [The GOP budget also calls for \$15 billion in tax cuts next year, \$142 billion over the next five years, and \$778 billion over 10 years].

ANSWER:

- ▶ No, we believe the Republican's treatment of Medicare in the budget resolution falls short on several fronts.
- ▶ First, while the budget resolution does reserve the off-budget surplus for "retirement security" not one penny of those funds is set aside to strengthen and preserve the Medicare program.
- ▶ Similarly, my understanding is that the \$100 billion reserve fund made up of on budget surplus funds could also be used for non-Medicare purposes. In fact, I understand that the fund can be used to finance a prescription drug benefit only if the Finance Committee reports out legislation that "significantly" enhances the life of the trust fund without use of general revenue. It is questionable whether the Breaux-Thomas plan, if that is the starting point, would even meet this test.
- ▶ The President has specifically set aside 15% of the surplus to strengthen Medicare over the next 15 years. Further, he has specified other principles that will be part of his plan to strengthen Medicare for the future: making Medicare more efficient and competitive, guaranteeing benefits while preventing excessive new costs to beneficiaries, and adding prescription drug coverage.

PROGRESS REPORT ON HCFA IMPLEMENTATION OF THE BBA

QUESTION:

Can you give us a progress report on HCFA's implementation of the Balanced Budget Act?

ANSWER:

- ▶ HCFA has made solid progress in implementing the BBA. More than half of the 335 individual BBA provisions affecting HCFA have been fully implemented and many more are partially implemented. HCFA has promulgated 92 regulations and Federal Register notices to implement the BBA. More specifically:
- ▶ Medicare+Choice: HCFA has approved 12 new plans and service area expansions for 13 plans since last November 1998. HCFA has also developed new beneficiary and plan enrollment systems, payment systems, appeals and grievances procedures and quality assurance mechanisms.
- ▶ Medicare Beneficiary Education: HCFA has launched a National Medicare Education Campaign to inform Medicare beneficiaries about their new benefits, rights, and options under the BBA.
- ▶ New Medicare Preventive Benefits: HCFA has implemented the new preventive Medicare benefits under the BBA, including bone density measurement, colorectal screening, diabetes management, and enhanced women's preventive benefits such as screening mammograms, pap smears, and pelvic exams.
- ▶ CHIP: HCFA has approved 51 CHIP plans as of April 1999. Amendments expanding state plans have been approved for 13 states, and several other states have indicated that they also intend to expand their initial programs.
- ▶ Medicaid: HCFA proposed regulations for implementing strong, new Medicaid managed care patient protections and quality improvements last fall. These include enhanced information to Medicaid enrollees about their health plans, "prudent layperson" standard for emergency care, direct access to specialists, and enhanced appeal and grievance procedures.

SOURCE OF BBA SAVINGS

QUESTION:

Where did the savings generated by the Balanced Budget Act come from?

ANSWER:

- ▶ According to our actuaries' original estimates of the BBA after it was passed, it would generate about \$150 billion in savings (over five years) for the Medicare program.
- ▶ Approximately \$115 billion comes from Part A program changes that improve beneficiary choice, increase the emphasis on preventive benefits, and constrain cost growth.
- ▶ On the SMI side, about \$20 billion in savings come from Part B program changes, while about \$15 billion in savings result from higher Part B premiums.
- ▶ There is also about \$35 billion in additional savings to the HI Trust Fund resulting from the transfer of home health to Part B. This was budget neutral overall but had savings to the Part A Trust Fund.

[Some savings have already occurred – but note: these estimates are based on our original estimates of the BBA and have not been adjusted for actual changes in spending trends.]

BUDGET AND NURSING HOME ENFORCEMENT

QUESTION:

Will you pay states more to do this extra work on nursing home complaint investigations?

ANSWER:

- ▶ States already are required to investigate complaints about nursing-home conditions.
- ▶ Today, we're simply telling them how quickly we expect them to respond when someone may have been harmed. And we're working to get more resources out there to help.
- ▶ The President's Fiscal Year 2000 budget does request a \$60 million increase to support our nursing-home initiatives, and we urge Congress to support the increase. Much of the increase will go to the states to support their stepped-up survey activities. In addition, we increased resources for survey and certification in our Fiscal Year 1999 budget, including \$4 million added by Congress. In addition, we have notified Congress that we intend to reprogram an additional \$4 million for the Nursing Home Initiative. [We should have final answer from Congress on this by Thursday, April 22.]

CHRONICALLY POOR PERFORMING NURSING HOMES

QUESTION:

What are you doing about what the IG calls chronically substandard homes?

ANSWER:

- ▶ We now require states to conduct regular surveys twice as often for certain homes with those kinds of troubled histories. We also have issued instructions to states requiring that nursing homes found guilty of a second offense for violations that harm residents, face sanctions without a grace period to correct problems and avoid penalties.
- ▶ The analysis highlighting this problem predates the initiatives begun last year. Those initiatives will promote continual compliance and further ensure that nursing home residents get the quality care that they deserve.

RISK ADJUSTMENT AND LOW PAID PLANS

QUESTION:

What about areas of the country where health plans claim they're underpaid? Won't risk adjustment hurt these plans?

ANSWER:

- ▶ No. Let me first clear up any misunderstandings. Risk adjustment will phase in the payment system mandated by the Balanced Budget Act of 1997 so that 90 percent of payments are based on the old system and 10 percent are based on risk adjustment. This will help plans transition in all parts of the country. Second, risk adjustment doesn't reduce payments across the board -- it pays all plans more for sicker beneficiaries while paying them slightly less for healthier beneficiaries.
- ▶ Without regard to risk adjustment, what will help lower-payment areas is the Balanced Budget Act payment formula that was designed to bring the rates among lower- and higher-payment areas closer together. Specifically, the BBA payment floor substantially raised the payment rate in many rural areas. Second, the blend provision is also expected over time to help reduce the variation in rates among areas. The blend becomes effective in this upcoming contract year.

RISK ADJUSTMENT HURTS PLANS

QUESTION:

Won't risk adjustment hurt plans and decrease their payments?

ANSWER:

- ▶ Introducing risk adjustment into Medicare managed care is an important step in making sure beneficiaries have access to the care they need and that Medicare pays plans fairly. We are taking a careful and balanced approach to risk adjustment, which for the first time will reduce incentives for plans to enroll only healthier beneficiaries. We also will closely monitor the impact of risk adjustment on both beneficiaries and plans.
- ▶ To ensure that plans have time to adjust to the new payment method, HCFA has incorporated a five-year transition period into the risk adjustment methodology. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. This will significantly reduce the impact on HMOs. If no transition period were built into the risk adjustment methodology, estimated aggregate payment reductions to plans would have been 7 percent or \$1.6 billion in 2000. With a transition, the aggregate reduction is now less than 1 percent or \$200 million in 2000 and risk-adjustment savings are expected to be \$11.2 billion over five years -- \$4.5 billion less than if no transition were used.

BACKGROUND:

- ▶ In CY 2001, payments will be based 30 percent on risk adjustment and 70 percent on the current system; in CY 2002, 55 percent risk adjustment, 45 percent current system; in CY 2003, 80 percent risk adjusted, 20 percent current system. In CY 2004, we will use a comprehensive risk adjuster that includes inpatient, outpatient and physician encounter data.

HCFA CONFLICT OF INTEREST

QUESTION:

It appears that Medicare+Choice is less than successful: massive numbers of HMOs have left Medicare, the new choices of managed health plans have not materialized and beneficiaries are confused about what it is they should do. Isn't this happening because HCFA is favoring its pet project -- fee-for-service Medicare? Isn't it true that HCFA has a "conflict of interest" when it comes to regulating managed care?

ANSWER:

- We have long said that we want Medicare beneficiaries to have the same choices as other Americans in how they get their health care. Our goal is not to convince anyone that any one delivery system -- fee-for-service or managed care -- is better than any other, but to make beneficiaries aware of all the choices they have so they can make informed choices about how they want to get their health care. In fact, massive numbers of HMOs have not left. Forty-five plans did not renew their contracts. At the same time, nearly 50 plans applied to start or expand service to beneficiaries. In total, more than 300 Medicare+Choice contracts have been signed.

HOME HEALTH COSTS

QUESTION:

Why were home health costs much lower than expected in 1998?

ANSWER:

- ▶ Total home health spending (Part A and Part B) was lower in FY 1998 than FY 1997 (\$14.8 billion vs. \$17.7 billion). This decline was due to two factors. We do not yet know how much of the decline to attribute to each of these factors:
- successful HHS efforts to combat waste, fraud, and abuse.
- a temporary slow down in receipt of and processing of claims.

TOO AGGRESSIVE ON HOME HEALTH?

QUESTION:

Have you been too aggressive in targeting home health agencies for spending cuts?

ANSWER:

- ▶ The home health interim payment system passed by Congress as part of the BBA made substantial changes to payment for home health services. Last year, Congress made important changes to the interim system to address concerns that those reforms might have unintended consequences. We are monitoring the impact of these changes on beneficiary access to care and are looking for evidence of whether access to care has been compromised.
- ▶ At the same time we are working aggressively to implement the prospective payment system as required by statute to which we know the industry looks forward.

IMPACT OF LOWER HOME HEALTH EXPENDITURES

QUESTION:

What's been the impact of lower home health expenditures on home health agencies and beneficiaries? How are you monitoring the impact?

ANSWER:

- ▶ We know some providers continue to have concerns about the home health interim payment system. Last year, Congress made important changes to the interim system to address these concerns. However, given the magnitude of change in home health payment, it is understandable that other concerns remain. We are committed to working with Congress to ensure fairness and protect access to appropriate home care services covered by Medicare as we proceed to prospective payment. We are monitoring the impact of these changes on beneficiary access to care and are looking for evidence of whether access to care has been compromised.

CAUSES OF LONG TERM PART A SPENDING?

QUESTION:

What are the underlying causes of the increases in Medicare Part A expenditures over the long term?

ANSWER:

- ▶ Although spending for hospital and home health services declined as a result of the Balanced Budget Act of 1997 and our aggressive management of the program, there are three underlying causes of the increase in long term Part A expenditures: rising costs of medical services, rising number of beneficiaries, and rising utilization of services. These are the same trends that we discussed last year, and they have not changed.
- ▶ The Part A trust fund covers payments for inpatient hospital services, skilled nursing facility care, home health care (some of which is being shifted to Part B over a six-year period) and hospice care. The BBA slowed spending in all categories, with declines recorded for inpatient hospital and home health services in 1998. Spending is expected to resume growing steadily for a few more years.
- ▶ One primary cause of increasing Medicare Part A expenditures is the growth in the Medicare population and the changing composition of that population. Currently, the Medicare population is growing at 1.2 percent per year.
- ▶ Changes in patterns of utilization across providers have also contributed to increasing Part A expenditures. Historically, hospitals were the primary providers of services. In recent years, we have seen higher growth in the use of post-acute services (SNF, home health care) after hospital stays. Although these services constitute less than 30 percent of Part A expenditures, they grew rapidly during the early 1990s. Steady growth in spending is expected to continue for a few more years.

SENSE OF THE SENATE PROVISION ON PAYMENT FOR PROVIDERS

QUESTION:

Are you aware of the Sense of the Senate provision in the Budget Resolution that calls on Congress to review payment levels for various Medicare providers to assure continued access to high quality care? What is your position on the provider concerns that the payment cuts have been excessive?

ANSWER:

- ▶ We know that members of Congress are hearing from a variety of providers in their states and districts about the effects of some of the payment reforms included in BBA. Ms. DeParle and I have received literally thousands of letters, and have discussed these issues at great length with members of Congress, providers and their trade association representatives. Through administrative actions, we will continue to do everything the law allows to address these concerns where appropriate and to ensure that beneficiaries continue to receive the care they need. At the same time, we also must recognize that statutory changes to BBA may require offsetting cuts elsewhere, and that these changes can adversely affect the progress we have made together in extending the life of the trust fund. As we continue to monitor the effects of BBA, we look forward to working in a bipartisan fashion to ensure that Medicare beneficiaries continue to receive quality health care services.

SUMMARY OF MEDICARE SAVERS

QUESTION:

What are the Medicare savers in the FY 2000 budget and why are you making these cuts?

ANSWER:

- ▶ I am very proud of our record fighting waste, fraud and abuse in the Medicare program, and these FY 2000 proposals build on that record. The HHS IG has determined that overpayments declined from 14% to 7% of program expenditures in just 2 years. But we are not through, we have pledged to reduce overpayments to 5% by 2002.
- ▶ Our budget takes additional steps to root out fraud, waste and inefficiencies in the Medicare program and has been crafted in such a way that it won't reduce benefits, or erode the quality of care, furnished by our providers.
- ▶ The first part of our proposal is the \$2.9 billion waste, fraud and abuse package we announced at the White House on December 7. It includes several recommendations by our Inspector General to eliminate excessive Medicare reimbursement for drugs, particularly Epogen; prevent abuse of Medicare's partial hospitalization benefit; ensure that Medicare doesn't pay for claims owed by private insurers; and expand HCFA's ability to contract with cost-effective institutions, and with a wider range of carriers.
- ▶ The second part includes payment reforms for hospitals, labs, orthotics and prosthetics. Our budget proposes to freeze Medicare reimbursements for hospitals. As stewards of the Medicare program, our job is to recommend changes to payment rates to ensure that Medicare pays appropriately. We based our budget proposal on the data we have. However, we are open to working with hospitals and members of congress to update our analysis of the basis of any new data.

BACKGROUND

The Department is expanding its fight against fraud waste and abuse by:

- ▶ Limiting physician mark-up for Medicare outpatient drugs to 83 percent of the average wholesale price. This would save \$140 million in FY 2000.
- ▶ Reduce the reimbursement rate for Epogen by \$1 to better reflect market prices, estimated savings of \$70 million in FY 2000.
- ▶ Create a Centers of Excellence program as a permanent part of Medicare, including more procedures and sites-this project creates out year savings of \$690 million over 5 years (\$0 savings in FY 2000).
- ▶ Requiring private insurance companies to provide Medicare secondary payer information. This would allow HCFA to know whether Medicare is responsible for making the primary payment for beneficiary care. The estimated savings are \$10 million in FY 2000.
- ▶ The Department also is looking at reducing the misuse of partial hospitalization services by prohibiting providers from furnishing partial hospitalization services in a beneficiary's home or other inpatient or residential setting. Savings from this proposal would be \$20 million in FY 2000.

The budget also includes the following payment reforms:

- ▶ The Department proposed to freeze hospital payment rates for FY 2000. This would save an estimated \$650 million in FY 2000 and \$3.9 billion over five years. The freeze falls within MedPAC's recommended range for the Prospective Payment Update.
- ▶ Changes in the lab industry along with increasing efficiencies have created a need to lower the lab fee schedule ceiling from 74 percent to 72 percent. This would save \$70 million in FY 2000.
- ▶ Creating a ceiling on carrier fee schedules equal to the national median for orthotics and prosthetics. This proposal is consistent with GAO studies and IG reports suggesting that HCFA should reduce the amount paid for orthotics and prosthetics. The change would create projected savings of \$70 million in FY 2000.

- ▶ Extend BBA and further reduce the reimbursement rate for hospital bad debt payments (uncollected debts from Medicare beneficiaries). This proposal also would apply the bad debt payment policy and reductions to non-hospital providers. The combined savings from the expansion and reduction of bad debt reimbursements equals \$360 million in FY 2000.

MEDICARE BUY-IN

QUESTION:

How will the Medicare buy-in proposal be financed? Will it affect the solvency of the trust fund?

ANSWER:

- ▶ Unlike any other previous changes to the Medicare program, this policy asks the people who benefit to pay for the costs associated with this coverage.
- ▶ First, the part of the proposal that allows individuals age 62 through 64 to buy into Medicare explicitly directs the Medicare actuary to set premiums at levels necessary to pay for the costs of this program. Participants age 62 through 64 would pay the premium in two parts-- the first part would be paid up front, and the second part is paid once they turn 65.
- ▶ Medicare is in effect loaning participants the second part of the premium until they reach age 65. That loan accounts for most of the costs of this policy. However, the loan is paid back, with interest, through the second part of the premium. These temporary costs, and the small amount of costs for those ages 55 through 61, are offset by other mandatory savings in the budget.
- ▶ The Administration is committed to strengthening and preserving the Medicare Trust Fund. In 1993, the budget signed into law by the President extended the life of the Trust Fund through 2002, and the Balanced Budget Act of 1997 and other policies have since extended the life of the trust fund to 2015.
- ▶ We estimate that the President's proposal to transfer 15 percent of the projected budget surplus over the next 15 years to the Medicare Part A Trust Fund will extend the life of the trust fund to approximately 2027.
- ▶ We project that approximately 200,000 to 300,000 people will participate in a given year when the program is fully implemented.

BACKGROUND:

- ▶ Net cost of buy-in will be \$1.4 billion over 5 years.

MEDICARE BAD DEBT

QUESTION:

The BBA limited payment of bad debt to 55 percent in FY 2000. Why does this need to be lowered to cover only 45% of bad debts in FY 2000?

ANSWER:

- ▶ We recognize our responsibility to cover a portion of bad debt but we also want to make sure that providers are doing everything they can to collect these payments.
- ▶ Medicare deductibles and coinsurance are the obligation of the beneficiary, not of Medicare. Private insurers typically do not reimburse for unpaid patient obligations because patient cost-sharing encourages prudent buying of necessary services.
- ▶ Bad debts are a risk of doing business. The more a provider is at risk for assuming bad debts, the greater their incentive to collect the bad debts. In addition, direct payment of bad debts is inconsistent with the concept of the prospective payment system (PPS) where risk is generally assumed under a fixed rate payment.

ADDITIONAL INFORMATION:

- ▶ Saves \$360 million in FY 2000 and \$2.5 billion over 5 years.

HOSPITAL UPDATE FREEZE

QUESTION:

The BBA reduced the growth in the hospital update through FY 2002. Why do we need to open up the BBA and make further reductions especially since the President has said that billions of dollars to shore up the Medicare Trust Fund are available by tapping the surplus. Are these cuts really necessary?

ANSWER:

- ▶ We wouldn't be proposing these changes in payment rates if we didn't believe they were appropriate based on the data available at the time.
- ▶ Our budget proposes to reduce Medicare reimbursements for hospitals and other providers. Part of our job as stewards for the Medicare program is to recommend changes to payment rates to ensure that Medicare pays appropriately. Available data show for example, that actual hospital profit margins, for example, are in excess of the margins that were projected at the time the BBA was adopted. Our policy represents a mid-course refinement to the BBA policy.
- ▶ However, we are open to working with members and providers to examine new data and rework our models based on new data.

BACKGROUND

- ▶ In ProPAC's June 1997 report, they estimated that PPS hospital margins in 1997 would be 12.7 percent. In fact, however, in FY 1997, PPS hospital margins reached an historical high of 16.1 percent, according to MedPAC data.
- ▶ Ernst and Young released a March 1999 report showing total hospital Medicare margins will decline from 4.3% in FY 97 to .1% in FY 99. However, the report specifies that FY 97 hospital Medicare inpatient margins are high (16.% in FY 97) which is consistent with MedPAC. [total Medicare hospital margins include inpatient, outpatient, SNF, HHA, but not rehab services.]

- ▶ The BBA included a provision that set the FY 2000 update at market basket minus 1.8 percentage points. The hospital market basket for FY 2000 was projected in the President's budget to be 2.7 percent, thus the update would be 0.9 percent. This proposal would freeze the hospital market basket at the current law level by setting the hospital update for FY 2000 at 0 percent, instead of 0.9 percent.
- ▶ In addition, PPS hospital Medicare margins have steadily increased in the past few years from 1.3 percent in FY 93 to 16.1 percent in FY 97.
- ▶ Five-year budget impact: Savings of \$3.88 billion.

IMPACT ON RURAL HOSPITALS

QUESTION:

How do you respond to concerns that the budget proposal to freeze the hospital update may put rural hospitals out of business?

ANSWER:

- ▶ The Administration's decision to freeze the hospital update represents, in effect, a mid-course refinement to the BBA policy based on the current data we have on FY 1997 PPS hospital profit margins. Our budget proposals are based on evidence available at the time that showed actual hospital profit margins in excess of the margins that were projected at the time the BBA was formulated.
- ▶ At the time the BBA update policy was formulated, PPS hospital margins were projected by ProPAC to be 12.7 percent for FY 1997. In fact, however, current estimates of FY 1997 PPS hospital margins reached an historical high of 16.1 percent, according to MedPAC analysis of HCFA data.
- ▶ A recent Ernst and Young report shows similar data on hospital inpatient Medicare margins, even though it predicts a decline in total Medicare hospital margins (from 4.3% in FY 97 to .1% in FY 99).
- ▶ In addition, MedPAC's March 1998 analysis of the BBA impact estimates that for FY 2002, PPS hospital margins will be 24.2 percent.
- ▶ However, we are willing to work with members to examine any new evidence concerning our assumptions and to rework our models based on that evidence.

Impact on Rural Hospitals

- ▶ The Administration recognizes the unique problems faced by rural hospitals and we are committed to ensuring access to care for rural populations. While rural hospitals are typically a critical link in the health care safety net for rural populations, they face higher per unit costs, have difficulty maintaining threshold occupancy, and have problems recruiting physicians. We remain concerned about the status of rural hospitals and will closely monitor the effects of our policies and work with you to ensure the access needs of the rural population are addressed. We are willing to examine any new evidence that has become available since we developed our proposals and modify our analysis accordingly.
- ▶ Over the last several years, there has been a steady increase in PPS margins for rural hospitals. In 1991, PPS margins for rural hospitals was -1.3 percent compared to 8.9 percent PPS margins in 1997.

- ▶ While the percent of hospitals with positive PPS margins is lower among rural hospitals than in urban hospitals, the Medicare statute provides for special treatment for some PPS rural hospitals and more than half of all rural hospitals are eligible to receive this special treatment. These include sole community hospitals, rural referral centers, and Medicare dependent hospitals.
- ▶ In addition, the BBA included a rural hospital flexibility program which allows limited-service hospitals -- known as Critical Access Hospitals (CAH) -- to be paid on a cost basis. This nationwide program, which became effective in FY 1998, will allow very small rural hospitals, some which currently have negative PPS margins, to be paid on a cost basis. Approximately 24 State (CAH) plans have been approved thus far, including Oklahoma, Maine, Minnesota, North Dakota, Wisconsin, and South Dakota [See list under background for other approved state CAH plans].
- ▶ There is a declining percentage of rural hospitals with negative margins. In 1997, approximately two-thirds of all PPS rural hospitals had positive PPS margins.
- ▶ 28 percent of rural hospitals with negative margins in FY 1996 are now eligible under the Medicare dependent hospital program which was reinstated by the BBA. [During FY 1996 and FY 1997, the latest years for which hospital margin data is available, the Medicare dependent hospital provision had expired. BBA reinstated it.]

BACKGROUND:

In 1997, Congress through the BBA revised the update factor for FYs 1998 to 2002 as follows:

Year	Projected Market Basket	BBA Reduction	Projected Update
1998	2.8%	2.8%	0.0%
1999	2.5%	1.9%	0.6%
2000	2.7%	1.8%	0.9%
2001	2.7%	1.1%	1.6%
2002	2.7%	1.1%	1.6%

Hospitals with Negative Margins - Steadily Decreasing

- ▶ The hospital industry argues that despite overall profitability, 23 percent of hospitals have negative margins. However, the percentage of hospitals with negative PPS margins has steadily decreased from approximately 60 percent in 1991.
- ▶ In 1997, the aggregate total margins for rural hospitals was 7.8 percent compared to 6.4 percent for the aggregate total margins for urban hospitals. (Total margins include all payment sources, not just Medicare).
- ▶ HCFA analysis shows that average payments per case to rural hospitals increased during FY 1999, while payments to urban hospitals decreased. This was because rural hospitals were much less impacted by the post-acute care transfer rule (particularly with the exemption of swing beds).

MedPAC Update Recommendation

- ▶ MedPAC's recommended range for the FY 2000 PPS update is between 0 and 2.6, and their market basket estimate is 2.5 percent. *(Note: MedPAC recommended that the update be kept at current law which is market basket minus 1.8 [.7 percent update]. MedPAC believes that the impact of the BBA on hospitals is only now beginning to take effect and will revisit the issue next year).*

MedPAC's Recommended Range for FY 2000

Market Basket Estimate	Update Range	Recommended Update
2.5 (differs from the President's estimate which is 2.7)	Between 0 and 2.6	.7 (2.5 minus 1.8)

**States with an approved Critical Access Hospital Plan covering rural hospitals
(as of 3/15/99)**

Alaska	North Carolina
Arkansas	North Dakota (Kent Conrad)
Colorado	New York
Georgia	Oklahoma (Don Nickles)
Idaho	South Dakota (Tim Johnson)
Iowa (Charles Grassley)	Texas (Phil Gramm)
Illinois (Richard Durbin)	Tennessee (Bill Frist)
Indiana	West Virginia
Kansas	Wisconsin (Russ Feingold)
Maine (Olympia Snowe)	Wyoming
Minnesota (Rod Grams)	
Mississippi	
Montana	
Nebraska	

Bold indicates Senator on Senate Budget Committee

Other Budget Committee Member States that **do not** have an approved CAH plan are: New Mexico, Washington, Michigan, Oregon, New Jersey, South Carolina, Maryland, California, Missouri, New Hampshire.

Specifically, New Jersey (Frank Lautenberg) will not be submitting a plan, because they do not have rural hospitals in New Jersey.

MEDICARE SAVINGS vs NEW SPENDING

QUESTION:

This budget seems to include more in Medicare cuts than are necessary to fund your Medicare spending proposals. Isn't it wrong for you to use Medicare dollars to fund other parts of your budget? Shouldn't these funds be used to shore up the Medicare Trust Fund?

ANSWER:

- ▶ The program changes we're proposing would shore up the Medicare Trust Fund. Overall, if Congress adopted our entire Medicare proposal, the savings to the Trust Fund would be \$7.8 billion.
- ▶ The important point is that we have a fiduciary obligation to suggest appropriate payment changes when it appears the program is paying too much for specific services to save Trust Fund dollars.
- ▶ We should also remember that several of our investments are designed to improve health care for our Medicare population: the long-term care initiative, the working disabled initiative, and the Medicare buy-in, among others.

BACKGROUND:

Overall, the five year cost of the Medicare expansions are \$1.7 billion, and the five year net savings from the proposed reductions in Medicare spending are \$9.5 billion.