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THE WHITE HOUSE

WASHINGTON

May 29, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

Modernizing Traditional Medicare. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated $14 billion over 10 years.

Competitive Managed Care Payments. A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion. Although this option does not produce as much savings as does the Breaux-Thomas premium support model ($10 versus $50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Income-Related Premium. An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. All of your advisors recommend that it begin at $80,000 for singles, $100,000 for couples, which produces about $25 billion over 10 years and affects about 2 million beneficiaries. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

Cost Sharing. Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost $3 billion over 10 years and is unanimously recommended by your advisors.

- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about $5-10). It would save about $9 billion over 10 years and is supported by your advisors.

- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly $100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about $60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves $4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.

- Index the Part B deductible to inflation: The $100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be $135) and save about $2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to $150) if it would avoid the need for surplus spending.

- Add $5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves $7 billion over 10 years).

Provider Payment Reductions. Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about $40 billion over 10 years (more or less depending on the degree of fixes).

PRESCRIPTION DRUG BENEFIT. The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent $4,200 on drugs. This bill costs over $300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

PRESCRIPTION DRUG BENEFIT OPTIONS ($ BILLIONS -- Preliminary -- Excludes State Maintenance of Effort)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	**123.0**
Premiums		***$24***	***$25***	***$31***	***$36***	***$41***	***$43***	***$45***	***$48***	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	**164.1**
Premiums		***$16***	***$17***	***$21***	***$24***	***$27***	***$29***	***$30***	***$32***	
$10,000 LIMIT*	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**141.6**
Premiums		***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**188.8**
Premiums		***$21***	***$22***	***$25***	***$27***	***$30***	***$31***	***$34***	***$36***	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	**134.8**
Premiums		***$24***	***$30***	***$31***	***$36***	***$41***	***$51***	***$54***	***$58***	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	**179.9**
Premiums		***$16***	***$20***	***$21***	***$24***	***$27***	***$34***	***$36***	***$39***	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least $5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to $5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under $20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

FINANCING GAP. If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about $100 billion over 10 years. This is about $30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly $10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.

- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.

- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A $0.50 tax (on top of your budget's $0.55 tax) would generate about $45 billion in revenue from 2000-09.

- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline ($240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

ILLUSTRATIVE PACKAGES. On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:		**Base:**		Base:	
Competition	-10	Competition	-10	Competition	-10
Modernize Medicare	-14	Modernize Medicare	-14	Modernize Medicare	-14
Income-Related		Income-Related		Income-Related	
Premium ($80/100)	-25	Premium ($80/100)	-25	Premium ($80/100)	-25
Cost Sharing		Cost Sharing		Cost Sharing	
Preventive buy-down	+3	Preventive buy-down	+3	Preventive buy-down	+3
Lab 20% coinsurance	-9	Lab 20% coinsurance	-9	Lab 20% coinsurance	-9
Nursing home 20%	-5	Nursing home 20%	-5	Nursing home 20%	-5
Indexing Deductible	-1	Indexing Deductible	-1	Indexing Deductible	-1
Provider Savings	-40	Provider Savings	-40	Provider Savings	-40
Subtotal:	**-100**	**Subtotal:**	**-100**	**Subtotal:**	**-100**
Additions:		**Additions**:		**Additions**:	
Income-Related		Tobacco Tax	-45	Surplus	**-90**
Premium ($60/90)	-7	Income-Related			
More Provider Cuts	-7	Premium ($60/90)	-7		
Raise Deductible to $150 and index	-10				
Subtotal:	**-24**	**Subtotal:**	**-52**		
Drug Benefit:		**Drug Benefit**:		**Drug Benefit**:	
$5,000 Limit 50% Premium: $24/$48*	**+123**	$5,000 Limit 67% Premium: $16/$32*	**+164**	$5,000 Limit 67% Premium: $16/$32*	**+164**
		$10,000 Limit 50% Premium: $31/$55*	**+142**	$10,000 Limit 67% Premium: $21/$36*	**+189**
		No Dollar Limit 50% Premium: $24/$58*	**+135**	No Dollar Limit 67% Premium: $16/$39*	**+180**
State MOE	**-5**	State MOE	**-5**	State MOE	**-5**
TOTAL**	**-6**	**TOTAL ****	**+7-22**	**TOTAL ****	**-6-31**

*Monthly premiums in 2002 and 2009. Part B premium is $57 / $95 in 2002 / 2009.

** This amount is a necessary "cushion" pending final cost estimates.

Drug estimates assume about $5 billion in savings from state maintenance of effort.

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

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News Release

FOR IMMEDIATE RELEASE
May 27, 1999

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BLUES URGE CONGRESS TO 'HARNESS POWER OF THE PRIVATE SECTOR' IN PROPOSED MEDICARE REFORMS

(WASHINGTON) — Any reforms to the Medicare program should build on the success of private-sector health plans in developing high-quality, innovative products that meet customer needs, a Blue Cross and Blue Shield Association (BCBSA) official told the Senate Finance Committee today.

"Medicare reform should harness the power of the private sector to bring Medicare beneficiaries the types of choices and innovations that working-age Americans now enjoy," said Mary Nell Lehnhard, senior vice president in BCBSA's Office of Policy and Representation. "Accomplishing this will demand a fundamental change in how the government partners with private health plans."

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Along with adopting more business-like policies and procedures, Lehnhard said the federal government should make several critical improvements in the Medicare+Choice program; preserve the viability of Medicare supplemental policies; adequately fund administrative costs; and proceed cautiously on any proposed drug benefit.

Improving Medicare+Choice is a critical first step, because this program is the bedrock for future private-sector innovations, Lehnhard said. To make the program operate more efficiently, the Health Care Financing Administration (HCFA) should reduce the regulatory burdens it imposes on health plans and learn to act more like a private-sector purchaser.

Since Congress enacted Medicare+Choice, HCFA has issued thousands of detailed instructions, including the 800-page "Mega-Reg," 98 operational policy letters, and the Quality Improvement System for Managed Care (QISMC), Lehnhard explained. These massive regulations — unheard of in the private sector — set out detailed requirements for virtually all aspects of a health plan's operations.

(more)

Private-sector purchasers, by contrast, treat health plans as their business partners, Lehnhard said. These customers establish clear performance expectations and payments in advance, but they do not micro-manage every aspect of a health plan's operations. They focus on broader, critical goals such as the price they pay, the satisfaction of their employees, and the quality of service.

In addition to changing HCFA's regulatory mindset, Lehnhard urged Congress to produce more realistic payments for Medicare+Choice plans. Annual payment increases have been capped at 2 percent for two years, and many health plans will remain capped at this level into the foreseeable future, she said.

"By 2004, this trend will open up a yawning gap," Lehnhard said. "Many Medicare+Choice plans will receive less than 75 percent of the amounts spent per person in traditional fee-for-service Medicare."

Compounding the trend in payment levels is the uncertainty introduced by HCFA's new risk adjustment methodology, which is scheduled to begin in 2000, Lehnhard noted. In many areas, the risk adjuster could lead to severe reductions in plan

payments that will result in higher premiums and reduced benefits for beneficiaries.

"HCFA's new risk adjustment method will penalize health plans that promote wellness by keeping people out of the hospital," Lehnhard explained. "This payment methodology gives plans 'credit' only for members who have been hospitalized. This strategy defies good medical and business planning. As the American Academy of Actuaries has noted, 'A plan which manages care [appropriately] may be paid less than a plan which does not manage care for exactly the same type of patient.'"

To alleviate these concerns, Lehnhard urged Congress to delay enactment of the risk adjuster.

"This step is essential to the viability of the Medicare+Choice program," she said. "It will give HCFA and industry time to develop a risk adjuster with the right incentives. It also will provide enough time to test a new system and avoid the serious data and systems problems currently plaguing health plans."

(more)

As Congress debates Medicare reform, it will also be important not to undermine the existing Medicare supplemental programs that currently serve 12 million seniors, Lehnhard said. Many beneficiaries are likely to remain in fee-for-service Medicare — and thus need Medigap coverage — for the foreseeable future.

Medigap plans offer Medicare beneficiaries valuable protection from Medicare's cost-sharing requirements, and they are very popular in the marketplace, Lehnhard noted. A July 1998 report from the Department of Health and Human Services Inspector General found that 88 percent of beneficiaries are satisfied with their Medigap coverage.

"Tampering with Medigap — for example, by expanding guarantee issue, requiring community rating, and mandating prescription drug coverage in all plans — would ultimately result in significant increases in Medigap premiums," Lehnhard warned. "We must not disrupt this highly successful marketplace in our desire to modernize Medicare."

(more)

Finally, Lehnhard urged Congress to learn from the experience of the private sector in any efforts to develop a prescription drug benefit for Medicare beneficiaries.

"BCBSA shares Congress' concern that beneficiaries have access to affordable drug coverage," she said. "We recognize that since Medicare's inception, prescription drugs have assumed an increasingly important role in improving and maintaining the quality of health care. However, we would urge Congress to proceed with caution in developing any drug benefit because drug costs are the fastest-growing segment of health care costs."

Any Medicare drug proposal should include incentives for appropriate drug utilization as well as cost management provisions, Lehnhard said.

The Blues collectively are the nation's second-largest source of Medicare+Choice coverage, providing Medicare HMO benefits to more than 1 million beneficiaries. Additionally, Blue companies process 90 percent of Medicare Part A claims and about 57 percent of all Part B claims. Blue Plans also are trusted

sources of Medigap and Medicare Select policies, which supplement Medicare fee-for-service benefits.

BCBSA is a federation of 51 independent Blue Cross and Blue Shield Plans that collectively provide health coverage to 71.4 million — one in four — Americans. For more information about BCBSA and its member companies, visit www.bluecares.com.

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TESTIMONY OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE REFORM

FOR THE

COMMITTEE ON FINANCE
U. S. SENATE

PRESENTED BY

MARY NELL LEHNHARD
SENIOR VICE PRESIDENT
BLUE CROSS AND BLUE SHIELD ASSOCIATION

May 27, 1999

Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. BCBSA represents 52 independent Blue Cross and Blue Shield Plans throughout the nation that together provide health coverage to 71.4 million Americans. I appreciate the opportunity to testify on some of the key issues in Medicare reform.

Blue Cross and Blue Shield (BCBS) Plans have a unique point of view because they are a major presence in all aspects of the Medicare program. Collectively, BCBS Plans provide Medicare HMO coverage to more than one million Medicare beneficiaries, making them the second largest Medicare+Choice (M+C) provider in the country. On the fee-for-service side of Medicare, BCBS Plans process 90 percent of Medicare Part A claims and about 57 percent of all Part B claims. Finally, BCBS Plans are a trusted source of Medigap and Medicare Select coverage, which provide supplemental coverage of Medicare fee-for-service benefits.

BCBSA supports Medicare reforms that will assure that the program remains financially stable and secure so that it can successfully serve both current and future beneficiaries. As the Finance Committee debates the future direction of the Medicare program, I would urge that you consider these key points:

- **First, any reform should harness the power of the private sector to bring Medicare beneficiaries the types of choices and innovations that working-age Americans now enjoy.** Accomplishing this will demand a fundamental change in how the government partners with private health plans.

- **Second, Congress should view the Medicare+Choice program as the foundation of any broader private sector based reform.** Congress should assure a strong working relationship between the government and the private sector by making Medicare+Choice payments more reasonable and predictable, and by reducing excessive regulatory mandates.

- **Third, because a substantial number of beneficiaries are likely to stay in fee-for-service Medicare for the foreseeable future, it is vital that Congress maintain the viability of Medigap and assure the proper administration of the Medicare fee-for-service program.**

- **Finally, Congress should look to and learn from the experience of the private sector in efforts to develop a prescription drug benefit for Medicare beneficiaries.**

I. HARNESS THE POWER OF THE PRIVATE SECTOR

Over the last two decades, a wave of innovation and vitality has swept through much of the private health care industry. Today, the market offers more choices of products and benefits than ever before. Medicare+Choice, created in 1997, was meant to infuse the Medicare program with this innovation and vitality. Unfortunately, this has not happened. Because of unnecessarily complex federal regulations, a high level of business risk, and unpredictable and inadequate payment rates, the private sector has not played as great an expanded role as the Congress envisioned when it created Medicare+Choice.

We believe the success of Medicare reform will depend on a fundamental change in the government's relationship with the private sector:

- The government must act more like a private sector purchaser and partner with plans;
- The government must provide for reasonable and predictable payments; and
- The government must assure that any reform will be fair and workable.

Model Behavior After the Private Sector

Since Congress enacted Medicare+Choice, the Health Care Financing Administration (HCFA) has issued hundreds upon hundreds of pages of regulations and literally thousands of detailed conditions, including the 800+ page "mega-reg," 98 operational policy letters, and the Quality Improvement System for Managed Care (QISMC). HCFA's massive

regulations – unheard of in the private sector – set out detailed requirements for virtually all aspects of a health plan's operations. Given the tremendous changes still to come in health care, in medicine, technology, pharmacy, electronics, and organization, the government must abandon this highly regulatory approach and act more like a private sector purchaser, partnering not micromanaging.

Private sector purchasers treat health plans as their business partners and establish clear performance expectations and payments in advance. They do not, however, become involved in every aspect of a health plan's operations. They focus on broader, critical goals such as the price they pay, the satisfaction of their employees, and the quality of service.

Let me provide you with two examples of requirements that would **never** be imposed by private purchasers:

- **Excessive business risks:** The Medicare+Choice program requires that health plans agree to an exceptionally high level of compliance with numerous, complex and detailed rules. The risk of unintentionally failing to comply with a particular requirement is immense. For example, health plans are asked to certify that all the data they submit, including data developed by providers, are 100 percent accurate. Penalties for non-compliance are extremely severe. These penalties could ultimately put a plan's entire corporation, including its private business, at risk and expose senior officials to the possibility of criminal penalties. This is clearly unreasonable, especially when one realizes that no claims operation is set to achieve a 100 percent accuracy rate.

- **Rigid and unreasonable "one-size-fits-all" quality standards:** In recent years, private sector purchasers have worked closely with health plans and private accrediting organizations to develop workable models for quality measures for HMOs. Instead of using these private standards, HCFA has developed their own quality standards for Medicare+Choice plans that are far more stringent, arbitrary and rigid than the "gold

standard" used in the private sector for HMOs. Moreover, HCFA unilaterally applied these HMO standards to PPOs, a very different type of health plan option, making it extremely difficult for PPOs to participate in Medicare+Choice. To date, the program offers virtually no PPO options.

Provide Reasonable and Predictable Payment Rates

Transforming the government's regulatory mindset is essential for long-term Medicare reform. But it must be be accompanied by appropriate payment rates to ensure private sector interest in Medicare. Payments to private plans should keep pace with changes in spending in the government-run fee-for-service program. If payments to private health plans fall significantly below per person spending in the Medicare fee-for-service program – as is currently projected under Medicare+Choice – plans will have difficulty attracting sufficient numbers and types of providers to their networks and in providing the Medicare benefit package.

While adequate payments to health plans are critical, stability and predictability in future year payments are just as important. Blue Cross and Blue Shield Plans are committed to a "retention strategy." In other words, our Plans place a high priority on **both** attracting new beneficiaries and keeping current beneficiaries satisfied over the long term. One of the most important ways of retaining members is to avoid large increases in premiums and instability in benefits. Significant increases in premiums can trigger "shopping" by individuals who will look for a better price. The way to avoid the disruption of this "churning" is to assure that payments do not fluctuate significantly from one year to the next.

A key element of predictability is having sufficient information in order to price premiums properly. This means that all the requirements for a given year must be spelled out in advance. It is especially problematic when the government demands big "change orders" in the middle of the year, increasing the expenses of the plan, without providing a corresponding increase in payment levels. Such actions will invariably require plans to

adjust their premiums in future years simply to catch up with the government's actions in the previous year. This is a recipe for market instability.

Assure Fair and Workable Reforms

If Medicare reform is to engender widespread private sector participation, it must assure that all players are treated fairly, the reforms are workable, and that the steps to full implementation are well designed and practical.

Today's most discussed model for reform is Senator Breaux's and Congressman Thomas' "premium-support" proposal. Fashioned, in part, after the Federal Employees Health Benefits Program, and building on the current Medicare+Choice structure, the premium-support proposal would replace the government-set formula payments now used to pay private plans with a new competitive pricing model. It would also include the traditional fee-for-service (FFS) Medicare program in the competitive pricing formula. Private plans and the government-run FFS plan would submit annual bids for the basic Medicare package. The government would contribute a set percentage of the national weighted average of all plans' bids (adjusted for geography, demographics and health status); beneficiaries would be responsible for the remaining premiums. A brand-new "Medicare Board" would oversee this process, and possibly negotiate premiums.

While the details of this proposal are now being developed, many design issues, such as the following, should be resolved to assure the success of the program:

- How can adverse selection be minimized? The premium-support proposal envisions a nationally priced government-run fee-for-service program competing against locally or regionally priced private plans (e.g., PPOs and HMOs). Private plans will have an incentive to compete in low cost areas, where they can offer lower premiums than the nationally priced fee-for-service plan. This is likely to increase the cost of the Medicare program. Alternatively, if the government fee-for-service program is locally priced, consistent with private plans, equity and political issues are raised. For

example, beneficiaries could pay twice as much for the fee-for-service program in high cost areas as in low cost areas. (For example, in 1996, Medicare fee-for-service per beneficiary costs ranged from $3,199 in rural Nebraska to $6,592 in urban Louisiana).

- How will plan bids compare to the government contribution? The proposal calls for the government contribution to be a percentage of the weighted average of all bids across the country. Actual payments to plans will be the government contribution, adjusted by a new geographic index.

- How will the new government contribution rates compare to current Medicare+Choice payments? This will be especially significant in the first year of the program, where major changes in the government contribution and, therefore, premiums to beneficiaries could cause upheaval in the marketplace.

- Can the Medicare Board handle a nationwide annual competition, all at once?

- Can the Social Security Administration, which currently handles collection of the Medicare Part B premiums, handle deducting the new premiums (that will replace the Part B premium and will vary by beneficiary) from Social Security checks and send the appropriate share to plans? (A portion of these premiums will have to be deposited in the Medicare trust fund and the balance will have to be mailed to private plans.)

- What would happen if plans' bids significantly exceed projected Medicare estimates?

- What happens if Medicare fee-for-service outlays in a given year significantly exceed the government's bid? Would beneficiaries have to pay more? How would this effect private plan payments?

Given Medicare's complexity and importance to its beneficiaries, as well as the health care system overall, the reforms should be designed carefully so that all stakeholders – beneficiaries, private plans, and providers – understand the new program and that

unintended consequences are avoided. This calls for a detailed, multi-year transition plan. Congress may want to consider phasing in the program, such as on a geographic basis or with newly eligible beneficiaries.

II. STRENGTHEN MEDICARE+CHOICE AS THE FOUNDATION FOR MEDICARE REFORM

Medicare+Choice is and must continue to be the foundation of any future Medicare reform. Medicare+Choice was designed to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options" (H.R. Conf. Rep. No. 105-217, p. 585). Unfortunately, for reasons alluded to earlier in my testimony, Medicare+Choice has fallen short of expectations. If Medicare+Choice is to serve as a stepping stone to future reform, then it is vital that Congress garner the private sector's confidence in the program.

HCFA's highly regulatory approach has not inspired confidence. Nor have current trends in payment levels for Medicare+Choice plans. As you know, in the first two years of Medicare+Choice all health plans (except for those serving "floor" counties) were capped at annual payment increases of 2 percent. A substantial number of plans (enrolling more than one-third of beneficiaries) will stay at 2 percent next year and into the foreseeable future. By 2004 this trend will open up a yawning gap, with these Medicare+Choice plans receiving less than 75 percent of the amounts spent per person in traditional fee-for-service Medicare.

Risk Adjustment

Compounding the trend in payment levels is the uncertainty introduced by HCFA's new risk adjustment methodology, scheduled to begin in 2000. In many areas, the risk adjuster could lead to severe reductions in plan payments that will result in higher premiums and reduced benefits for beneficiaries. HCFA estimates that risk adjusters will reduce payments to M+C plans by 7 percent, or $11 billion between 2000 and 2004, and by an

additional 7.5 percent from 2005 through 2009. The Congressional Budget Office has said this cumulative reduction is not sustainable for the program.

A major success of managed care has been reducing hospital costs through prevention and expansion of outpatient treatments. Yet HCFA's new risk adjustment method will penalize plans that keep people out of the hospital because it only gives "credit" for members with selected inpatient hospital stays of two or more days (i.e., the method pays plans higher amounts only for patients who have been hospitalized). It defies good medical and business planning: according to the American Academy of Actuaries, "A plan which manages care [and keeps beneficiaries out of the hospital] may be paid less than a plan which does not manage care for exactly the same type of patient."

HCFA does plan eventually to incorporate selected outpatient data, but it will be several years before this happens and the exact effects cannot be predicted. Even over the next couple of year, plans face the prospect of wide and unpredictable swings in payment because HCFA will phase in the hospital-based risk adjuster (i.e., 10 percent in 2000, 30 percent in 2001, etc.) and the switch to yet another methodology in 2004. As I mentioned earlier, significant changes in premiums will undermine efforts by plans to attract new beneficiaries and keep them satisfied over the long term.

We urge Congress to delay enactment of the risk adjuster. This step is essential to the viability of the Medicare+Choice program; it will give HCFA and industry time to develop a risk adjuster with the right incentives and time to test a new system and avoid the serious data and systems problems currently plaguing plans.

III. MAINTAIN THE VIABILITY OF MEDIGAP AND MEDICARE ADMINISTRATION

As the Congress decides to reform Medicare, it is highly likely that many beneficiaries will continue to receive coverage through Medicare's traditional, fee-for-service program, at least for the foreseeable future. That makes it important that beneficiaries continue to have

access to affordable Medigap policies, and that the administration of the fee-for-service program receives adequate support.

Medigap

As Congress debates Medicare reform, it will be important not to undermine the existing Medicare supplemental programs that serve 12 million seniors. Medigap plans offer Medicare beneficiaries valuable protection from Medicare's cost-sharing requirements, and they are very popular in the marketplace. A July 1998 report from the Department of Health and Human Services Inspector General found that 88 percent of beneficiaries are satisfied with their Medigap coverage.

One serious risk to the affordability of Medigap is the possibility of a federal mandate for all Medigap options to cover drugs. Tampering with Medigap, such as expanding guarantee issue, community rating, and prescription coverage would have the unintended consequence of significantly increasing Medigap premiums. Of the 10 current standardized Medigap packages, only three include prescription drug coverage (H, I, and J). A study recently released by BCBSA and the Health Insurance Association of America found that mandated drug coverage could increase all Medigap premiums by $1,000 or more a year. Such increases would force many Medicare beneficiaries to drop coverage, thus leaving them to bear the full cost of copays and deductibles. As you consider reforming Medicare, I would urge that you keep Medigap affordable.

Proper Administration of Medicare

Inadequate administration of fee-for-service Medicare could wreak havoc with overall reform plans. Fee-for-service Medicare will always need to pay claims timely and accurately, provide high quality customer service to providers and beneficiaries, handle numerous appeals and hearings, and fight fraud, waste, and abuse. But the contractors who

administer these activities must receive adequate financial support because they can perform required functions only when their payments for such tasks are adequate.

It takes experienced, efficient, and properly funded contractors to limit improper Medicare payments. With adequate funding, contractors can act effectively as Medicare's first line of defense against fraud and abuse. Indeed this year's Inspector General's report shows that recent strides in rooting out fraud, waste, and abuse have brought about a drastic reduction in improper Medicare payments.

In 1996, Congress strengthened contractors' ability to fight fraud and abuse by establishing a separate funding source for specific fraud and abuse initiatives through the Medicare Integrity Program (MIP). Claims processing activities continue to be funded in the program management account.

Unfortunately, HCFA is proposing to break up program management activities and fraud and abuse among different organizations. We believe this will undercut fraud and abuse detection efforts. Program management and fraud and abuse are not autonomous services; they require constant coordination and communication. Nearly all program management activities – including educating providers on how to bill correctly, determining appropriate payment amounts, and detecting duplicate claims – safeguard the Medicare trust funds and are closely integrated with fraud and abuse activities.

IV. PROCEED WITH CAUTION ON DRUG COVERAGE

The final topic I would like to address is adding a prescription drug benefit under the Medicare program, whether constructed as a government-financed program or as a mandatory offering by Medicare+Choice and Medigap plans. BCBSA shares the Congress's concern that beneficiaries have access to affordable drug coverage. We recognize that since Medicare's inception, prescription drugs have assumed an increasingly important role in improving and maintaining the quality of health care. However, we

would urge Congress to proceed with caution in developing any drug benefit because drug costs are the fastest-growing segment of health care.

High Costs

Private sector experience suggests that a Medicare drug benefit would be costly:

- Private insurance payments for drugs increased 18 percent per year over the past 3 years; overall annual growth rate in private insurance payments was less than 4 percent.

- For many health plans, prescription drugs now account for 11 percent to 14 percent of total medical expenses, up from 7 percent a few years ago.

- One Northeastern BCBS Plan experienced an increase in its prescription drug spending from just over 10 percent of premium in 1996 to more than 16 percent last year. This Plan now spends more on prescription drugs than it does on primary medical care. A Midwestern Plan spent more last year on prescription drugs than on either inpatient hospital or physician spending: 25 percent of premium versus 24 percent each for inpatient hospital and physicians.

Given the potentially high costs, any Medicare drug proposal would have to include incentives for appropriate drug utilization as well as cost management provisions. In fact, many health plans and employers have responded to double-digit increases in drug costs by redesigning their prescription drug benefits. Many health insurers are now assessing the usefulness and cost-effectiveness of prescription drugs and developing lists of drugs that they will cover (i.e., formularies). In instances where the only difference in a particular therapeutic category is that one drug costs less than the other, it makes sense for plans to free up money by covering the less expensive drug. In other instances, where studies prove that one drug is more effective than another, plans will promote those drugs even though they may be more expensive than the other drugs in the therapeutic category.

Plans are also introducing innovative three-tier benefit systems to address cost concerns, as well as consumer demands for flexible coverage. These new systems provide varying levels of coverage for generic drugs (e.g., a $5 copay), for brand-name formulary drugs (e.g., a $15 copay), and for drugs that are not on the formulary (e.g., a $30 copay).

Even with these cost-containment tools, prescription drug costs continue to rise in the private sector. Congress must confront the challenge of managing costs and an adequate benefit design if it moves toward a Medicare drug benefit.

CONCLUSION

In conclusion, reforming Medicare poses monumental challenges. First and foremost, Congress must stabilize the Medicare+Choice program. If a future Medicare program is to harness fully the power of the private sector, Congress should act now to make the Medicare+Choice program a true partnership with the private sector: this includes providing stable and predictable payment rates and sensible regulatory rules. Expanded participation by the private sector will also raise beneficiaries' confidence in the Medicare+Choice program, which is important for the program to withstand the stresses of change. In addition, Congress should support both existing Medicare supplemental programs and the contractors who administer the traditional fee-for-service program.

We look forward to working with this Committee as you craft a stronger Medicare program for the 21st century.

Congress of the United States

Washington, DC 20515

306195

May 27, 1999

NEC

cc: DPC

President Bill Clinton
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

As you develop your plan to ensure the solvency of the Medicare program, we would like to share our thoughts with you on the importance of this program to our constituents. Further, we would like to suggest some changes that we believe would strengthen traditional Medicare.

We are in strong agreement with you that Medicare must continue to guarantee benefits for all our nation's seniors and individuals with disabilities, as it has since 1965 when it was created to provide universal health insurance coverage to these populations. As you know, before the passage of Medicare, 85 percent of seniors lacked health insurance. Tragically, we already have 43 million uninsured individuals in our nation and adding to that number would be disastrous. Today, about 60 percent of Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL) and ten percent have incomes below 100 percent of the FPL. Eliminating the current guarantee of benefits will erode the safety net relied on by our elderly and disabled constituents.

The Bipartisan Commission on the Future of Medicare's plan contained a number of proposals which we strongly oppose. These concepts, such as "vouchering out" Medicare, raising the eligibility age from 65 to 67 and imposing a copayment on home health care, would be a disaster for millions of seniors and individuals with disabilities and have an especially negative impact on minorities and women.

While we were pleased that the Medicare Commission's plan did not receive the needed super-majority, we are concerned that elements of that plan will reappear in specific legislation. We hope you will join us in opposition to these disastrous "reforms" and hope that as you develop your Medicare reform plan that you will give serious thought to the suggestions we are offering:

1) **Eliminating the Medicare guarantee and replacing it with a "voucher" system will hurt current and future beneficiaries.** This proposal must be rejected. A premium support or "voucher" plan - by moving healthier and wealthier beneficiaries into private health plans - will destroy the guarantees that Medicare beneficiaries have relied on for 34 years.

A "voucher" model lacks effective cost control mechanisms for the Medicare program. It assumes that competition among private health plans will keep costs down. There are several problems with this assumption. First, as we have seen in the case of prescription drugs, competition does not always keep costs down. Second, from 1997 to 1998, Medicare expenditures increased by only 1.5 percent compared with a 6.1 percent increase for the private health plan competitive marketplace. Medicare does a much better job controlling costs than the private insurance marketplace.

Premium support plans will be a form of corporate welfare for the private insurance industry, and particularly HMOs. Tens of billions of dollars currently paid by the government to health providers each year will instead be paid to HMOs and other private insurers.

Private health care plans are not available in many parts of the country. Of America's 3,100 counties, seven out of ten - nearly 2,200 - do not currently have Medicare managed care.

Because of the lack of providers, these areas are unlikely to ever develop HMO-type programs.

Rural communities will be particularly hard-hit. The 11 million Medicare beneficiaries in rural areas make up 30 percent of the Medicare population. They will be left behind under a "voucher" plan. In those areas where managed care is available for Medicare, only 21 percent of beneficiaries have chosen to leave traditional Medicare to join managed care plans. Additionally, many managed care plans have pulled out of the Medicare program since 1997, leaving more than 400,000 seniors with no health insurance.

Even in areas that have managed care available, most low-income seniors will not be able to afford to purchase these plans. Women and minorities are disproportionately harmed by a "defined contribution" plan because they tend to be poorer and less able to pay additional costs for a good health plan. The average Medicare beneficiary spends about one-fifth of income on out-of-pocket health costs, but beneficiaries at or below the poverty line spend over a third of their income on health care out-of-pocket expenses. Low-income women and minorities will be most hurt by a "voucher" program.

It is also troubling that, at a time when Congress is concentrating on fixing the problems of managed care programs, some in Congress and the Medicare Commission are willing to subject our Medicare beneficiaries to problematic HMOs. Speaker Dennis Hastert has promised a vote on managed care reform legislation this year. We have concerns about moving seniors and individuals with disabilities into managed care and certainly do not support subjecting them to the risks of the current managed care system before any patient protection legislation is passed.

2) The Medicare Commission's premium support model is not the same as the Federal Employees Health Benefits Plan (FEHBP), which covers federal workers and Members of Congress. Many supporters of a "voucher" plan compare it to the FEHBP. However, the FEHBP population is far more healthy and wealthy, on average, than the Medicare population. Median pay for federal employees is about twice that of seniors. Thus, it is easier for federal workers to afford more expensive plans than Medicare beneficiaries. Most Members of Congress choose Blue Cross/Blue Shield, which most resembles traditional Medicare, as their plan. However, this choice might not be an option, due to its higher cost, for many beneficiaries under a premium support model.

Additionally, the eight national plans open to all federal employees are PPOs with broad access to providers. The only Medicare plan with that same availability is traditional Medicare. While the 1997 Balanced Budget Act opened up participation to a wide variety of health plans, only HMOs have chosen to participate. Converting traditional Medicare to a premium support model would seriously limit beneficiaries' choice of providers and plans.

Interestingly, the FEHBP saw premium increases of 8.5 percent in 1998 and is looking at an increase of 10.2 percent in 1999. This dwarfs the 1998 Medicare increase of 1.5 percent.

3) We must not increase the eligibility age for Medicare. Raising the eligibility age from 65 to 67 is a very dangerous idea. Many older Americans will become uninsured under this plan. Under this proposal, one and one-half million Americans will be needlessly added to the rolls of the uninsured at an extremely vulnerable time in their lives.

We find it rather extraordinary that in this period of economic "boom," some in Congress would force seniors to work and wait for an additional two years until they can receive full medical benefits. Many employers are cutting back on workers' health insurance or eliminating it completely. How will we provide for individuals who lose their coverage and then must wait an additional two years to enroll in Medicare?

Additionally, many African-Americans and other minority populations will be particularly hard-hit by this proposal as they tend to have shorter life expectancies and less retirement savings than other seniors.

4) We must not impose any copayment on home health care. The proposal offered by the Medicare Commission included a 10 percent copayment for home health care, which would mean that the average Medicare beneficiary needing home health care would have to pay $470 a year out-of-pocket. Nearly one-half of seniors live on less than $15,000 a year and about 12 percent live in poverty. Forcing them to pay hundreds of dollars more annually for a benefit that is currently provided at no cost to them will force even more seniors into poverty.

It is also ironic that at a time when you and many Members of Congress are supporting access for long-term care for the elderly, some members of the Medicare Commission supported cutting home health care, a vital source of long-term care. Past efforts to institute a copayment for home health care have failed repeatedly in Congress and we hope you will join us in rejecting this misguided proposal.

Elderly women are especially affected by home health copayments. In fact, the Medicare home health population is mostly old and poor, predominantly female, and likely to live alone. Two-thirds of home health beneficiaries are women.

Seniors with medically complex needs require more home health visits per year than other beneficiaries. These "high utilizers" are more likely than other home health recipients to have severe functional impairments. They are also more likely to be African-American and from the South. Many of these elderly Americans are low-income and with 200 visits per year, which is not uncommon for medically complex patients, their home health tax, as proposed by the Medicare Commission, would be $1,760 per year. This cost makes home health care prohibitive to low-income African-Americans and other minority groups, as well as women. The bottom line is that any copayment for home health care is counterproductive and a health care disaster.

Having discussed with you our concerns about some proposals of the Bipartisan Medicare Commission, which we urge you to reject, let us now make some suggestions as to how we believe Medicare should be improved:

1) We agree with you that we need to commit 15 percent of the projected budget surplus to ensure Medicare's solvency. Under this proposal, which you have advocated, Medicare would remain solvent for the next 28 years. This would enable us to continue to provide strong guaranteed benefits for a prolonged period of time, as well as sufficient time to take a hard look at our entire health care system.

2) We must provide an outpatient prescription drug benefit for all Medicare beneficiaries. Thirty-five percent of seniors currently lack any kind of prescription drug benefit. Seniors are charged outrageously high prices for their needed medications. They are forced to pay much more than drug companies' favored customers, such as hospitals, HMOs, and even the federal government. Often, seniors and Americans with disabilities go without groceries or without paying their heating bills to afford their prescription drugs. It is disgraceful that our elderly and disabled Medicare beneficiaries are getting sicker and even dying because they cannot afford their drugs. We must provide a comprehensive drug benefit under Medicare.

3) We should automatically enroll eligible Medicare beneficiaries into the Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualified Individuals Program and improve their protections. Low-income beneficiaries whose incomes are slightly higher than the Medicaid eligibility limit benefit greatly from these programs, which cover Part B premiums and, in some cases, other

Medicare costs. Millions of Americans who are eligible for these programs are not taking advantage of them because they do not know they are eligible. We should also increase the eligibility limits above the current 135 percent so that more low-income beneficiaries can benefit.

In conclusion, we want to thank you for your strong support of Medicare and look forward to working with you to make certain that all elderly and disabled Americans continue to receive guaranteed high-quality health care. In our great and wealthy nation, no senior or individual with a disability should be denied access to this very basic necessity of life.

Sincerely,

Bernard Sanders
Member of Congress

cc: Members of the Ways and Means Committee
Members of the Finance Committee
Members of the House Commerce Committee

MEDICARE LETTER SIGNERS

1) Bernard Sanders
2) Jan Schakowsky
3) Henry Waxman
4) James McGovern
5) Sherrod Brown
6) Barney Frank
7) Lynn Woolsey
8) Earl Hilliard
9) Maurice Hinchey
10) William Coyne
11) Robert Matsui
12) Barbara Lee
13) George Miller
14) Neil Abercrombie
15) Max Sandlin
16) José Serrano
17) Michael Capuano
18) Ruben Hinojosa
19) Martin Frost
20) Joseph Crowley
21) Marcy Kaptur
22) Anthony Weiner
23) Elijah Cummings
24) Juanita Millender-McDonald
25) Dennis Kucinich
26) John Conyers
27) Sam Farr
28) John Olver
29) Jerrold Nadler
30) John LaFalce
31) Nick Rahall
32) Gene Green
33) Jim Maloney
34) Tammy Baldwin
35) Nancy Pelosi
36) George Brown
37) Melvin Watt
38) RobertWise
39) Bobby Rush
40) Jesse Jackson, Jr.
41) John Tierney
42) Howard Berman
43) Jim Barcia
44) Debbie Stabenow
45) Danny Davis
46) Martin Meehan
47) Gregory Meeks
48) Rosa DeLauro
49) David Bonior
50) Julian Dixon
51) Cynthia McKinney
52) Michael McNulty
53) Frank Pallone
54) Carolyn McCarthy
55) Eni Faleomavaega
56) Patsy Mink
57) Bennie Thompson
58) Eliot Engel
59) Sheila Jackson Lee
60) Diana DeGette
61) Tom Lantos
62) Tom Allen
63) Bobby Scott
64) Nydia Velásquez
65) Lane Evans
66) Alcee Hastings
67) Eleanor Holmes Norton
68) Rod Blagojevich
69) Peter DeFazio
70) Luis Gutierrez
71) Anna Eshoo
72) Julia Carson
73) Charles Rangel
74) Maxine Waters
75) Ed Markey
76) Major Owens
77) Joe Moakley
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81) William Clay
82) Robert Brady
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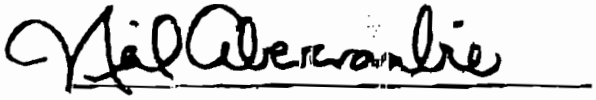
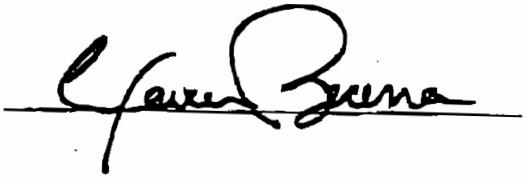
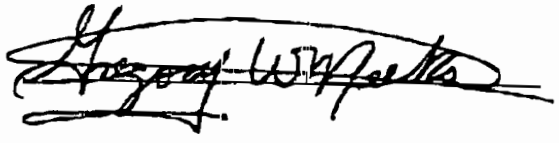
84) James Oberstar
85) Robert Borski
86) Chaka Fattah
87) Nick Lampson
88) Corrine Brown
89) Sam Gejdenson
90) William Jefferson
91) Eva Clayton
92) Donna Christensen
93) Carolyn Maloney
94) William Delahunt
95) Darlene Hooley
96) Ted Strickland
97) Carlos Romero-Barceló
98) Stephanie Tubbs Jones
99) Xavier Becerra
100) Ron Klink

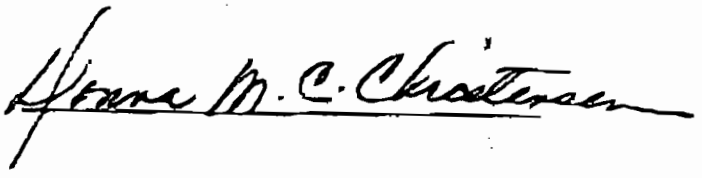
101) Tony Hall
102) Gary Ackerman
103) Eddie Bernice Johnson
104) Matthew Martinez
105) Lucille Roybal-Allard
106) Joseph Hoeffel
107) Thomas Sawyer
108) John Lewis
109) Nita Lowey
110) Robert Andrews
111) Bruce Vento

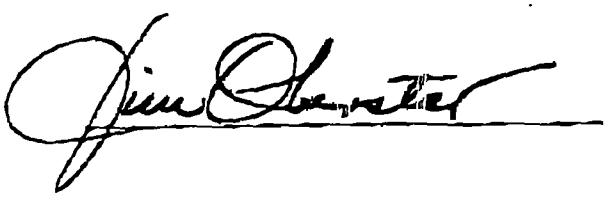
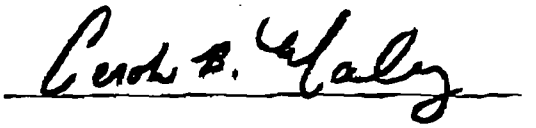
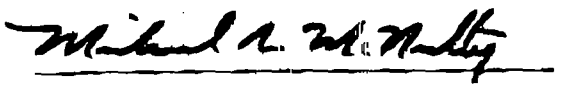
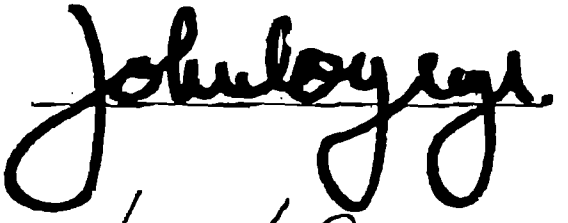
GROUPS
1) Gray Panthers
2) National Committee to Preserve Social Security and Medicare
3) Campaign for America's Future
4) Neighbor to Neighbor
5) Physicians for a National Health Program
6) Public Citizen
7) National Organization for Women

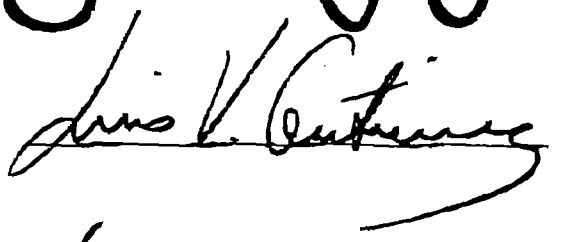
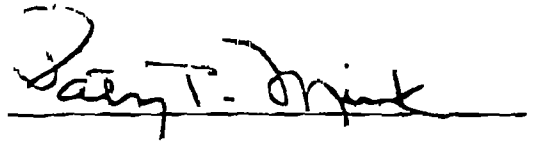
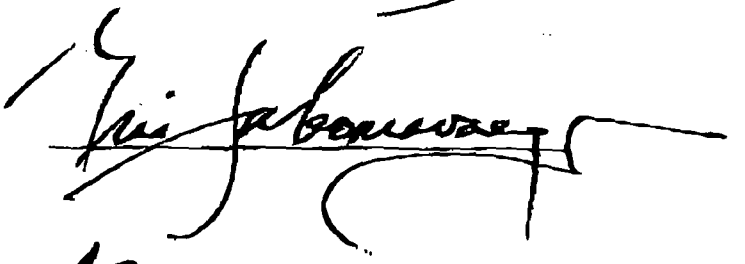
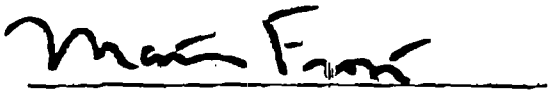
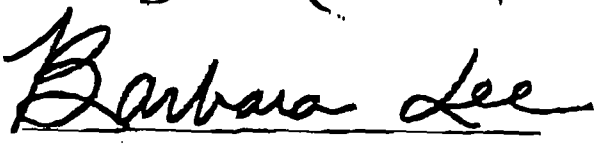


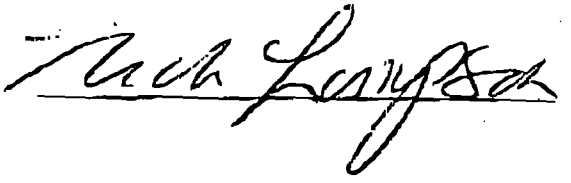
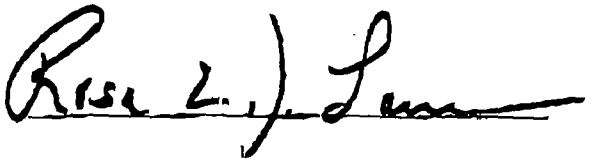
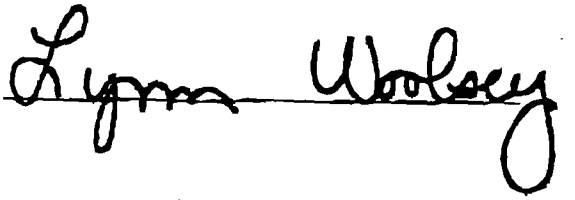
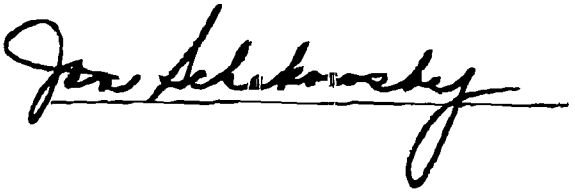
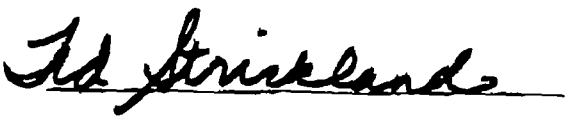






Tammy Baldwin

John W. Olver

Willie Stargell

Rubin Hinojosa

Hon C Watts

George Miller

Barney Frank

David E. Bonior

Donald M Payne

Edward J Markey

Bob Borski

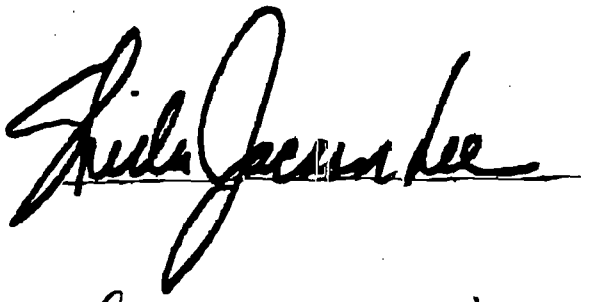
Jim Oberstar

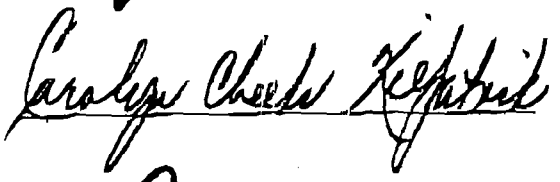
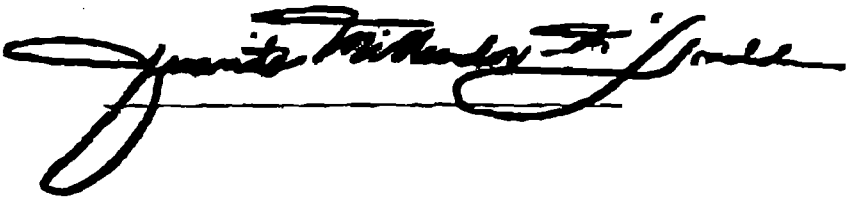
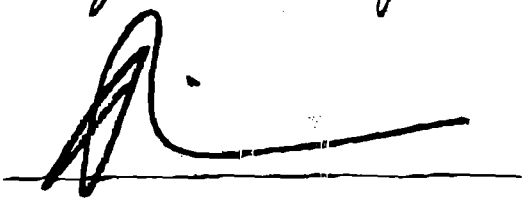
Floyd H. Flake

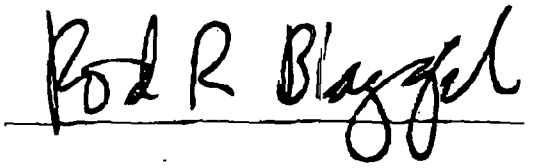
Alcee L. Hastings

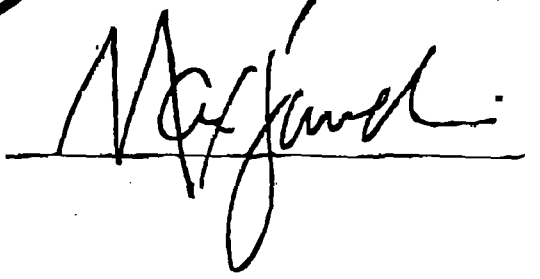
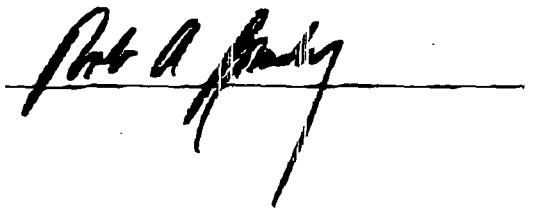
Sam Gejdenson

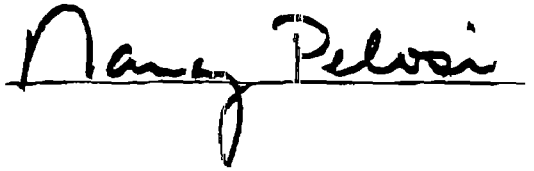
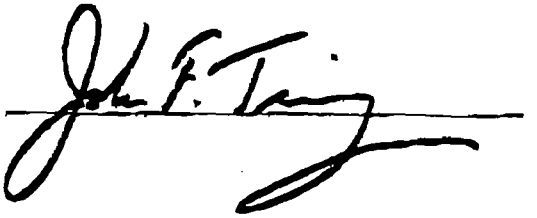
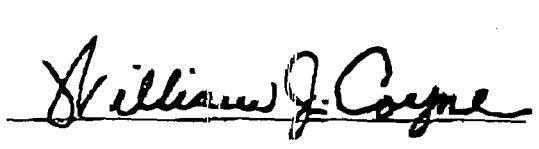
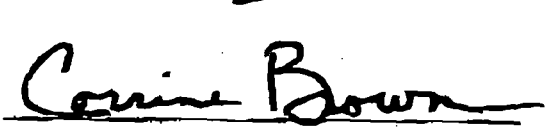
Jose E. Serrano





Bob Filner

Bobby L. Rush

Bob Scott

Jim Barcia

Marty Meehan

Maxine Waters

Lane Evans

Howard L. Berman

Jerrold Nadler

Melvin Watt

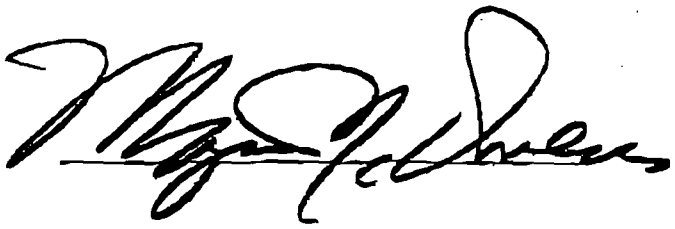
Charles B. Rangel

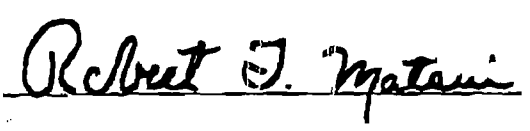
Major R. Owens

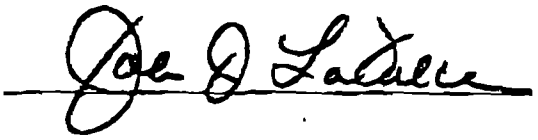
Bob Weygand

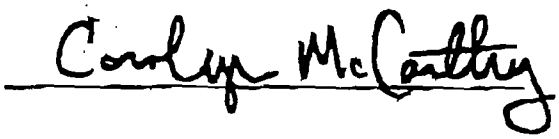
George E. Brown, Jr.

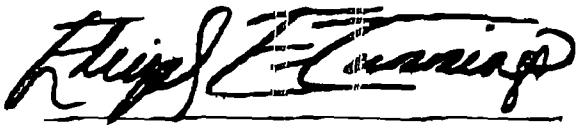
Eric L. Engel

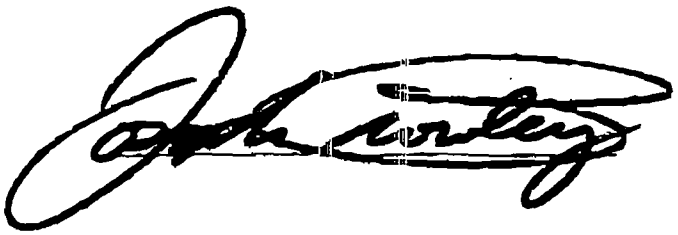


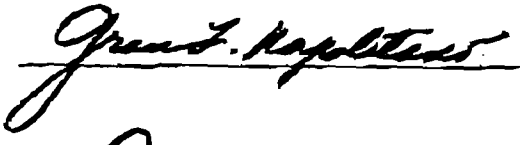


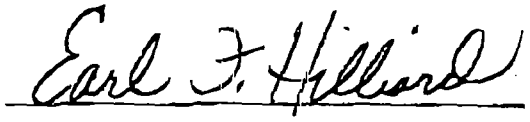


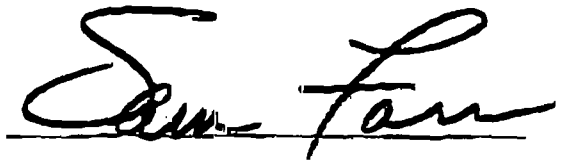


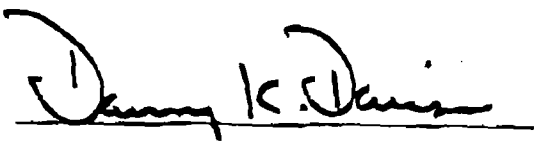


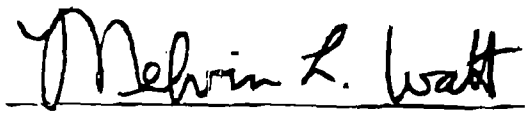


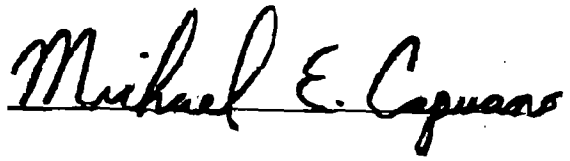












Eddie Bernice Johnson

Tony P. Hall

Juanita Millender-McDonald

Carlos Romero-Barceló

Jon Kyl

Gary A. Ackerman

Matthew G. Martinez

Rita Lowey

Robert E. Andrews

Eva M. Clayton

John Lewis

Joseph M. Hoeffel

Tom Sawyer

Bruce F. Vento

A fax from the office of Congressman

Bernie Sanders

VERMONT - AT LARGE

2202 Raybum Building
Washington, D.C. 20515

Phone: 202-225-4115
Fax: 202-225-6790

To: Eli Joseph

Fax #: 456 - 6221

From: Danielle LeClair

Date: 5/27/99 **# of Pages (Including Cover):** 13

Please call 202-225-4115 regarding any problems with this transmission.

Messages:

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CAUCUS FOR WOMEN'S ISSUES

CONGRESSIONAL ORGANIZATION
FOR THE ARTS
CHAIR

DEMOCRATIC LEADERSHIP
VICE CHAIR: RESEARCH

WHIP-AT-LARGE

306187

CONGRESS OF THE UNITED STATES
LOUISE M. SLAUGHTER
28TH DISTRICT, NEW YORK

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ROCHESTER, NY 14614-1309
716/232-4850
TTY 716/454-4805

E-mail: louiseny@mail.house.gov
web: http://www.house.gov/slaughter/

May 26, 1999

NEC

cc: DPC

President William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President,

Your continued leadership on Medicare and related health care issues is critical if we are to protect and improve the Medicare program. I look forward to working with you to accomplish meaningful Medicare reforms.

I am writing, however, to express my grave concern over the possible inclusion of any new Medicare or Medicaid payment reductions in the reform proposal being developed by the Administration. New York's hospitals, health systems, nursing homes, and home care providers are already buckling under the weight of the over $100 billion in cuts implemented since the passage of the Balanced Budget Act of 1997 (BBA). More than one-quarter of New York's hospitals were already losing money on Medicare prior to implementation of the BBA. With 85 percent of the BBA-mandated cuts still to come, hospitals will experience an additional $3.9 billion in reductions. Our institutions simply cannot sustain cuts of this magnitude and continue providing quality care to patients.

I am very proud of New York State's world-class health care system. Our state is home to renowned medical institutions like the University of Rochester Medical School, which have fostered countless advances in research, diagnosis, and treatment. For millions of people, these advances have eased suffering and improved quality of life. New York places a premium on quality health care and has established itself as a global leader in research and treatment.

The BBA impacts New York State institutions disproportionately and has already inflicted damage with excessive cuts. Many of my colleagues and I are advancing legislation that would reverse some of the BBA's excesses. The first two years of BBA cuts have already wiped out the aggregate surpluses of hospitals statewide; any new cuts will clearly imperil decades of accomplishment.

I must therefore urge you in the strongest possible terms not to include any new Medicare or Medicaid provider cuts in your reform proposal, including the extension of the BBA cuts beyond the year 2000. Thank you for your continued interest in New York's health care system, and for your ongoing commitment to improving health care for all Americans.

Sincerely,

Louise M. Slaughter
Member of Congress

LMS:cp

RITE AID Corporation

WILLIAM A.K. TITELMAN
Executive Vice President
Managed Care & Public Affairs

• MAILING ADDRESS
P.O. Box 3165
Harrisburg, PA 17105

• GENERAL OFFICE
30 Hunter Lane
Camp Hill, PA 17011

• (717) 975-3740
• (717) 975-3760 Fax
• wtitelman@riteaid.com

June 21, 1999

The Honorable Christopher C. Jennings
Deputy Assistant to the President
For Health Policy
Old Executive Office Building, Room 216
17th Street & Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Chris:

Thank you for taking the time to meet with us last week. During the course of that meeting you asked us to respond to two concerns that have been raised about a PBM-administered Medicare drug benefit.

The first concern is a suggestion emanating from some quarter that, depending upon the bidding process, a single PBM could be allowed to wield too much market power, particularly in densely populated regions. As manufacturers and pharmacies well know, it is PBMs ability to leverage a large number of covered lives that has enabled them to negotiate more competitive prices on behalf of health plans. Currently the three largest PBMs each provide services to roughly 50 million members (this includes some duplication where different PBMs provide different services to the same set of members). In addition to market leverage, there are important advantages to size and scale in the PBM business. For example, by covering a large number of members in a particular geographic area, a PBM can influence physician-prescribing habits in ways that result in better and more cost effective care. Given manufacturer sales force size and depth, PBM's may be the only effective countervailing influence.

The second concern is a suggestion emanating from some quarter that a "carve out" approach to managing prescription drugs for Medicare will not work because PBMs do not have the medical data necessary to make the best overall health decisions for beneficiaries. In fact, PBMs are increasingly being asked to integrate drug and medical information, and have the technological sophistication and clinical expertise to do so. Moreover, given the fact that HCFA will continue to bear the medical cost risk, we would expect that HCFA or some new oversight body would periodically evaluate the program to determine the impact on costs and the quality of life of beneficiaries. Finally, the record of PBMs as "carve outs" -- as indeed most continue to be -- is that they have succeeded in improving drug care and achieving savings and administrative efficiencies that other sectors of the health insurance industry have not even approached. The affordability, prevalence and popularity of drug benefits in the private sector are a testament to the success of "carve out" drug benefit management.

We greatly appreciated the opportunity to meet with you again, and would be pleased to provide any further assistance as you finalize your proposal.

Sincerely,

William Titelman

WT:gr

EDWARD M. KENNEDY
MASSACHUSETTS

306473

United States Senate

WASHINGTON, DC 20510–2101

This needs to be copied & distributed I couldn't get to it Sarah

June 2, 1999

The President
The White House
Washington, DC 20500

NEC

cc: DPC

Dear Mr. President:

I wanted to share some thoughts with you as you begin to make decisions on the Medicare drug benefit that you will be proposing. Your announcement that coverage of prescription drugs under Medicare would be a priority for your Administration has transformed the debate. We now have a real opportunity for a historic achievement in this Congress that can literally mean the difference between life and death and between poverty and comfort for millions of the elderly in the years to come.

In designing your benefit, it is critically important that it be generous enough for the elderly to be enthusiastic about it. That means we need basic coverage that will offer something to the vast majority of senior citizens who have only moderate drug costs, plus a catastrophic benefit that guarantees that those who need the most expensive drugs will be protected.

If we don't have both components, our plan will be difficult to defend. When Jay Rockefeller and I developed our bill, we found that most of the cost is in the basic benefit; the catastrophic benefit adds only a relatively small amount, but it is critical for those who need help the most. A catastrophic benefit is also especially important to the biotechnology industry, which is more likely to be supportive of our plan than the pharmaceutical industry. A catastrophic benefit is relatively inexpensive compared to the cost of a basic benefit. In the legislation that Jay and I introduced, the catastrophic stop-loss proposal accounts for only about 20% of the total cost to the government.

Obviously, any program you introduce has to be fully financed. It is important to keep in mind, however, that the financing sources you propose do not necessarily have to be enactable. Any program that is passed this year will be part of some broad budget compromise with the Republicans, in which hundreds of billions of dollars will be in play and no particular financing source need be identified with any particular program.

Plausible financing sources include:

(1) Use of part of the portion of the surplus that your budget has already committed to Medicare. Medicare cuts were the largest single spending reduction creating the surplus. Since your budget was announced, the projected solvency of the Medicare trust fund has increased

dramatically. Your commitment was to use the surplus to improve and strengthen Medicare, and few steps will contribute more to that goal than coverage of prescription drugs. If one-half of the portion of the surplus you have already designated for Medicare is used to pay part of the drug benefit, $172 billion would be available over the next 10 years for prescription drug coverage -- and it would still be possible to extend the solvency of the Trust Fund beyond 2020, your original target.

(2) Tobacco taxes are a likely way to bridge part of the remaining gap. As you know, tobacco is a huge cause of Medicare expenditures. You could reallocate the tobacco taxes already in the budget for this purpose, or you could propose additional tobacco taxes. A 55 cent per pack tax increase would raise $65-$70 billion over the next ten years.

(3) In making choices on the benefit package, the elderly are willing to pay more in premiums for real security. Retaining the 25% share for Part B is important, but a $15-$25 additional monthly premium would make sense too. In Massachusetts, 50% of the seniors in the Harvard Community health plan voluntarily chose to pay $70 a month for drug coverage. Obviously, special help for the low income elderly would have to be included.

(4) The elderly organizations are supportive of the relatively high $200 deductible included in the legislation that Jay and I introduced--and it largely financed the cost of the catastrophic share of the benefit. However, cost-sharing greater than 20% for expenses beyond the deductible was a red flag.

Enactment of a Medicare drug benefit will be one of the most significant achievements of your Administration. It will be a major step toward achieving the goal of retirement security that was begun with the passage of Social Security under President Roosevelt and extended under President Johnson with the passage of Medicare.

I look forward to working with you to achieve this essential coverage.

With respect and appreciation,

As ever,

Edward M. Kennedy

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Anna Willis to Barbara re: personal medical (3 pages)	06/28/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

FOLDER TITLE:
Medicare [Folder 7]

2012-0463-S
rc789

RESTRICTION CODES

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

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

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

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

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

OWL
THE VOICE OF MIDLIFE AND OLDER WOMEN

FAX

To: Chris Jennings

Fax Number: 456-5557

From: Deb Bruceland-Betts

Pages (including cover: 3

Comments:

666 11TH STREET, NW, SUITE 700 • WASHINGTON, DC 20001 • 202-783-6686 • FAX 202-638-2356

THE VOICE OF MIDLIFE AND OLDER WOMEN

June 14, 1999

The Honorable William Jefferson Clinton
The White House
Washington, DC 20500

Dear President Clinton:

Women are the majority of those who use Medicare, and we are writing to urge you to bring the same sensitivity to women's concerns to your proposals for modernizing and preserving that program that you have brought to Social Security. As you know, as far as older women's economic security is concerned, Social Security and Medicare go hand in hand OWL has been a strong supporter of your efforts to preserve and strengthen Social Security while taking into accounts the unique needs of America's older women. We share your commitment to alleviating poverty among older women and will continue to work with you to seek effective solutions for these problems.

We applaud your efforts to develop a universal benefit that will help address the huge costs of prescription drugs. A recent OWL report, **The Face of Medicare is a Woman You Know**, reports that almost eight out of ten women on Medicare use prescription drugs, and because they have more chronic illnesses than men--often more than one at a time--their prescription costs are significantly higher. A good pharmaceutical benefit would certainly benefit the many women who are now struggling to pay their medical bills.

We are hopeful, however, that your efforts to craft a pharmaceutical benefit will not put other critically needed initiatives at risk. If Medicare is to remain the foundation of health care services for older Americans, and well thought out long term solutions for the program's problems are to be developed, using the full 15 percent of the surplus that you originally proposed to bolster the Medicare Trust Fund remains an imperative.

Additionally, many of the changes in Medicare instituted through the Balanced Budget Amendments of 1997 have had a particularly harmful effect on women, who are a significant majority of those who need home health care services, as well as the physical and occupational therapy that can help them to regain their independence. We believe that the harmful provisions of the Balanced Budget Amendments that are leading to severe reductions in these services to women must be modified.

Mr. President, there is no question that women need a pharmaceutical benefit as a crucial element of a modernized Medicare. If such a benefit is to genuinely serve women, however, it must be only one part of a comprehensive plan for the whole program. Medicare is her access to health care. Even with the current system in place, she pays an average of 22

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2-2-2
OWL

percent of her approximately $975 monthly income on health care. A drug benefit by itself will not serve older women if increased costs reduces their access to the physicians who write their prescriptions.

We look forward to working with you to develop a Medicare program for the future that will benefit older women. We believe that if Medicare works for women, it will work for everyone.

Sincerely,

Betty Lee Ongley
President

Deborah Briceland-Betts
Executive Director

A fax from the office of Congressman

Bernie Sanders

VERMONT - AT LARGE

2202 Raybum Building
Washington, D.C. 20515

Phone: 202-225-4115
Fax: 202-225-6790

To: Chris Jennings

Fax #: 456-5557

From: Danielle LeClair

Date: 6/18/99 **# of Pages (Including Cover):** 3

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Messages:

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TELEPHONE: (802) 862-0697
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Congress of the United States
House of Representatives
Washington, DC 20515-4501

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DOMESTIC AND INTERNATIONAL MONETARY POLICY

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
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NATIONAL ECONOMIC GROWTH, NATURAL RESOURCES, AND REGULATORY AFFAIRS
HUMAN RESOURCES
CO-CHAIR: PROGRESSIVE CAUCUS

June 18, 1999

The Honorable William J. Clinton
The White House
Washington, DC 20500

Dear President Clinton:

I would like to take this opportunity to share with my deep concerns about adding a home health copayment to any Medicare reform plan. While I also have serious reservations about other proposals for Medicare reform, such as drastically augmenting the traditional fee-for-service model with a premium support model and raising the retirement age for Medicare eligibility, I am specifically urging your to reject any plan for a home health copayment.

As you know, there are currently no out-of-pocket costs for Medicare beneficiaries for home health care. This is appropriate as this population consists of some of the poorest and sickest citizens in America. Any copayment would cause enormous pain and hardship for low-income and sick elderly people, and would amount to an extremely regressive tax on some of the most vulnerable people in our country.

According to the most recent data from the Health Care Financing Administration, the average per beneficiary reimbursement for home health care was $4,704 in 1997. A 10 percent copayment would mean the average Medicare beneficiary would have to pay $470 out of pocket per year for home health services. More than one-half of seniors in our country have incomes of less than $15,000 a year, and about 12 percent live in poverty. In other words, the copayment would increase out-of-pocket health care costs by 3 percent of total income for half of all elderly Americans. Many of them today are finding it extremely difficult to pay their bills, provide for their prescription drugs, and take care of other basic necessities of life. The thought of adding a 10 percent copayment could be disastrous for our elderly Americans.

I also hope that in a year when you have proposed to increase access to long-term care for the elderly, you will reject cutting the major source of that care- home health care.

In 1997, $16 billion was slated to be cut from home health care in the Balanced Budget Act (BBA). In fact, new data has shown that $48 billion will be cut from home health care due to the BBA. These cuts are devastating to home health agencies, causing many efficient agencies to close. In fact, approximately 20 percent of home health agencies have closed since that time. We should not further devastate home health care with another fee.

Past efforts for copayments for home health care have met widespread opposition from

the American people and from Members of Congress. While the Senate approved a $5 copayment for home health in the 1997 BBA, it was ultimately rejected. Last year, a proposal for an $8 copayment for home health care also met widespread opposition and was rejected. No good reason exists for the adoption of a home health copayment this year.

The 1997 BBA cuts to home health especially hurt efficient, cost-effective agencies which are now struggling to meet the home health needs of our constituents. Many home health agencies have indicated that if a copayment is required, they will be forced to cover the additional fees themselves, rather than passing them along to home health patients. Clearly, if the home health agencies are paying the costs themselves, they will have fewer resources to provide home health services to their other beneficiaries – making a very bad situation even worse.

Mr. President, at a time when the gap between the rich and poor in this country is growing wider, and when so many poor and elderly people are struggling hard to survive, please do not support an extremely regressive proposal which would be a disaster for poor, elderly, sick people.

Sincerely,

Bernie Sanders
Member of Congress

Congressman

JERRY MORAN

Representing the First District of Kansas
United States House of Representatives

1519 Longworth
Washington, DC 20515
(202) 225-2715
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TO: Chris Jennings
At: White House
Fax: 456-5557

From: Congressman Jerry Moran
Phone: 225-2715
Date: June 15, 1999
Subject: The President's Medicare reform proposals
Pages: 2

Comments: Following is a letter to President Clinton regarding his proposed Medicare reforms. Hard copy to follow. Please do not hesitate to contact me, or Jilinda Bonine of my staff, if we can provide you with any additional information.

Congress of the United States

Washington, DC 20515

June 15, 1999

The Honorable William J. Clinton
President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

As you know, many health care providers are struggling to cope with the impact of the Balanced Budget Act. It is our understanding that you are currently formulating proposals to address Medicare payment reform. In doing so, we hope that you will consider those parts of the country which have truly been hit hardest by funding cuts – rural America.

Rural America continues to experience dramatic shortages in health professionals. We believe strongly that any efforts to increase Medicare funding for graduate medical education should be closely directed toward those programs which train professionals for rural and underserved areas. Failing to direct Medicare teaching funds to those areas with legitimate needs would be a regrettable use of trust fund dollars and would ignore the serious shortages that exist today.

Rural hospitals, home health agencies and nursing homes have also been hard hit by Medicare payment reductions. Many counties are losing access to even the most basic health services. We have introduced HR 1344, the Rural Health Improvement Act and believe that this legislation would be an excellent starting point for your proposals. We appreciate your attention to these critical health needs and look forward to working with you to develop bipartisan solutions.

Sincerely,

Jerry Moran
Rep. Jerry Moran

Jo Ann Emerson
Rep. Jo Ann Emerson

Charlie Stenholm
Rep. Charles W. Stenholm

Mike McIntyre
Rep. Mike McIntyre

Modernizing Medicare

Maroon: Pantone 1807U
Gold: Pantone 124U
Font: Garamond

Fax to Jeanne & Chris

Copies: Bonnie, Barb. Cooper, Rich, Jane

To: Andie

From: Bill Vaughan

Re: an idea to lessen impact of Rx drug benefit premium.

Attached memo from CBO makes the point that we could lower the average beneficiary's private medigap premium by a few dollars if Medicare would take over the offering of a catastrophic (non-drug) policy.

If to do a drug benefit, we need to raise Part B premiums by $20-$40 (Chris Jennings figure), then we could help lower the total burden on seniors a bit (~~$8-$10~~/month) through a Medicare-administered medigap policy with catastrophic protection. $7

Is this an option/idea we could talk about as a way to help make Rx benefit "costs" more attractive?

[Stark is asking CBO for runs on what the premium for the medigap policy would be if there were a $5, $10 or $20 copay for each relevant service; my guesstimite is each $5 copay reduces the cost of the medigap policy about 1/6th or $10 a month. For example, if the drug benefit costs $20 a month, we could offer seniors an option of a medigap policy with copays (but with a catastrophic limit) that would save them $20 a month—or roughly no out of pocket change.]

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

Dan L. Crippen
Director

June 14, 1999

MEMORANDUM

To: Carl Taylor

From: Sandy Christensen

Subject: Requested Estimates

As you requested, I've done some preliminary estimates of the premiums that would have to be charged to fully fund an optional supplement under Medicare to cover the basic program's cost-sharing requirements (see attached table). The three options shown are all variants of an approach that would simply cap an enrollee's cost-sharing liabilities--at either $100, $200, or $500 a year. I have not yet been able to estimate an option that would replace Medicare's current cost-sharing requirements with a small copay for each physician visit or inpatient day. As we discussed, to do that kind of estimate I will have to rebuild the model to incorporate information about the number of physician visits each enrollee has during the year.

An optional supplement that capped each enrollee's cost-sharing expenses for Medicare-covered services at $100 a year would be most closely comparable to three of the approved private medigap plans--plans D, E, and G, which cover all of Medicare's cost-sharing requirements except for the $100 SMI deductible and have no coverage for prescription drugs. However, each of those three medigap plans also cover some services not covered by Medicare, such as balance-billing, care while traveling in foreign countries, and preventive care.

Premiums Costs for an Optional Medicare Supplement

If a cost-sharing cap of $100 a year was offered as an option under Medicare, the average annual premium necessary to fund that benefit would be an estimated $754 in calendar year 2000, less than the $838 estimated average private medigap premium for comparable coverage. This estimate assumes that administrative costs for the Medicare option would be about 2 percent of total costs, while average administrative costs for private plans would be about 15 percent of costs. It also assumes that all current medigap policyholders would switch to the Medicare supplement; that employers now offering more generous supplemental coverage to retirees would enroll them for the Medicare supplement; and that Medicaid plans (which it is assumed would be required to enroll either all or none of their dual eligibles in the supplement) would take advantage of the option in those states where the premium charged for the supplement would be less than the average cost-sharing expenses Medicaid would otherwise have to pay directly. Because the premium charged

for the supplement would be substantial, it is assumed that enrollees with no supplement now would not purchase the Medicare supplement either.

An optional supplement with a higher cap on cost-sharing would have a lower premium but would expose enrollees to higher potential costs for premium and cost-sharing combined. With a $100 cap, enrollees would pay at most $854 to cover the supplemental premium and all of Medicare's cost-sharing requirements. With a $200 cap, the annual premium would be $676 in 2000, but enrollees would face potential costs up to $876. With a $500 cap, the annual premium would be $534 and enrollees would face potential costs up to $1034.

Effects on Outlays for Basic Medicare Benefits

The premiums shown were estimated so as to fully fund the benefits that would be paid by the optional supplement plan. However, introduction of a Medicare supplement would also have an effect on costs under the basic Medicare program. Costs in the basic Medicare program would fall somewhat because some of the participants moving to the optional Medicare supplement would be leaving private medigap or employment-sponsored retiree health plans that covered all of their cost-sharing liabilities under Medicare. Use of services by such enrollees would be a little lower than if they remained in plans with first-dollar coverage. For 2000, the estimates indicate that gross outlays for basic Medicare benefits would fall by about 0.5 percent under the supplement with a $100 cap; by 1.0 percent under the supplement with a $200 cap; and by 2.0 percent under the supplement with a $500 cap.

Caveats

There are a number of caveats associated with the estimates discussed above. First, note that for the supplement with either a $100 or $200 cap the assumption that all current medigap policyholders would switch is realistic (assuming the average medigap premium is representative of premiums actually facing enrollees--discussed more below). This is because both the premium and the maximum potential expense for Medicare-covered services would be lower for these two Medicare supplement options than for the average medigap plan. However, it is less clear that all medigap policyholders would switch, as the estimates assume, if the Medicare supplement had a cap of $500 because then the enrollee's maximum potential expense would be higher than under the average medigap plan. In particular, enrollees expecting to make relatively high use of services would tend to prefer a private medigap plan, while those with relatively low use might prefer the lower premium Medicare supplement.

A more fundamental concern is that participation in the Medicare supplement may not be accurately assessed simply by comparing the Medicare premium to the average medigap premium in the area. The estimates assume that the premium for the Medicare supplement would be uniform for all ages. (They also assume that the premium would vary geographically based on local costs--as private

premiums do. Otherwise, participation in the Medicare option would be high in high-cost areas and low or nil in low-cost areas, where it could not compete with private plans.) However, excepting plans offered through the American Association of Retired Persons, most private medigap premiums are now age-rated. Hence, the average medigap premium may not reflect the premiums actually faced by given enrollees. In particular, younger enrollees are likely to purchase private medigap plans because they would be cheaper than a Medicare supplement whose premium did not vary by age, while older enrollees would switch to the Medicare supplement once its price became competitive with private plans. Hence, the estimates shown in the table will understate the premiums required to fully fund the costs of the Medicare supplement because they assume that all current medigap policyholders would switch to the Medicare option when in reality (at least in the majority of states that do not require community rating) only the more costly older enrollees would do so.

TABLE 1. ESTIMATED AVERAGE ANNUAL PREMIUMS FOR MEDICARE SUPPLEMENTAL COVERAGE (Calendar Years)

Type of Supplemental Coverage	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
OPTIONAL SUPPLEMENT UNDER MEDICARE										
$100 Cap on Cost-Sharing Liabilities Under Medicare										
Average Premium	754	804	862	925	993	1067	1146	1227	1314	1406
Maximum Expense	854	904	962	1025	1093	1167	1246	1327	1414	1506
$200 Cap on Cost-Sharing Liabilities Under Medicare										
Average Premium	676	725	782	844	911	985	1063	1143	1229	1321
Maximum Expense	876	925	982	1044	1111	1185	1263	1343	1429	1521
$500 Cap on Cost-Sharing Liabilities Under Medicare										
Average Premium	534	579	64	690	753	822	896	972	1054	1142
Maximum Expense	1034	1079	564	1190	1253	1322	1396	1472	1554	1642
PROTOTYPE PRIVATE MEDIGAP PLANS										
Covering All Medicare Cost-Sharing										
Average Premium	880	931	989	1053	1122	1196	1275	1356	1443	1535
Maximum Expense	880	931	989	1053	1122	1196	1275	1356	1443	1535
Covering All Medicare Cost-Sharing except $100 SMI Deductible										
Average Premium	838	886	941	1002	1067	1139	1214	1291	1374	1461
Maximum Expense	938	986	1041	1102	1167	1239	1314	1391	1474	1561

SOURCE: Congressional Budget Office (March 1999 baseline). Estimates are preliminary.

NOTE: Estimates assume that administrative costs for the Medicare supplemental insurance would be 2 percent of total costs. They also assume that:

- All current medigap policyholders would switch to the Medicare supplement;
- Employers offering more generous supplemental coverage would take advantage of the Medicare option;
- Medicaid would be required to enroll dual eligibles in the option on an all-or-none basis, and that states would take advantage of the option in those states where the premium for the supplemental option would be less than the average cost-sharing expenses Medicaid would otherwise have to pay directly;
- No enrollees who do not now purchase a private supplement would purchase the Medicare supplement.