MEDICARE PRINCIPALS' MEETING

DRAFT: MAY 13, 1999

I. Update on Drug Estimates

II. Graduate Medical Education

I. UPDATED DRUG ESTIMATES

OPTIONS:	2001 Premium	2000-04	2000-09
LIMIT: $10,000 IN SPENDING			
• **$0 Deductible, 50% copay** ($5,000 cap): Fully Implemented: 7/1/01			
° 50% Premium Subsidy	$33/mo	$45 b	$154 b
° 67% Premium Subsidy	$23/mo	$69 b	$206 b
° 75% Premium Subsidy	$17/mo	$70 b	$232 b
• **$0 Deductible, 50% copay** ($5,000 cap): Fully Implemented: 2008			
° 50% Premium Subsidy	$29/mo	$42 b	$147 b
° 67% Premium Subsidy	$20/mo	$57 b	$197 b
° 75% Premium Subsidy	$15/mo*	$64 b	$222 b
LIMIT: $5,000 IN SPENDING			
• **$0 Deductible, 50% copay** ($2,500 cap): Fully Implemented: 2005			
° 50% Premium Subsidy	$29/mo	$37 b	$133 b
° 67% Premium Subsidy	$19/mo	$50 b	$177 b
° 75% Premium Subsidy	$15/mo	$56 b	$199 b
• **$0 Deductible, 33% copay** ($2,500 cap): Fully Implemented: 2005			
° 50% Premium Subsidy	$37/mo	$46 b	$170 b
° 67% Premium Subsidy	$25/mo	$61 b	$226 b
° 75% Premium Subsidy	$19/mo	$69 b	$254 b
• **$0 Deductible, 50% copay up to $5000; 20% copay after $5000**: Fully Implemented: 2005**			
° 50% Premium Subsidy	$29/mo	$37 b	$150 b
° 67% Premium Subsidy	$19/mo	$50 b	$200 b
° 75% Premium Subsidy	$15/mo	$56 b	$225 b

Assume start of July 1, 2001. Fiscal years, cash basis, dollars in billions. ** Not from actuaries / extrapolated from Kennedy estimates

SELECTED ANNUAL DRUG COSTS, LIMITS, AND PREMIUMS

(Dollars in billions; cash basis; fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
50% COPAY UP TO $10,000 OF COSTS												
Fully Implemented in 2008 *Cap:*		*$2,000*	*$4,000*	*$4,000*	*$6,000*	*$6,000*	*$8,000*	*$8,000*	*$10,000*	*indexed*		
50% Subsidy		0.4	13.0	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**42.7**	**147.8**
Monthly Premium		*$29*	*$31*	*$33*	*$38*	*$40*	*$45*	*$47*	*$51*	*$55*		
67% Subsidy		0.5	17.3	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**57.0**	**197.1**
Monthly Premium		*$20*	*$21*	*$22*	*$25*	*$27*	*$30*	*$31*	*$34*	*$36*		
75% Subsidy		0.6	19.5	20.7	23.3	25.8	28.5	31.2	34.3	37.7	**64.1**	**221.6**
Monthly Premium		*$15*	*$16*	*$16*	*$19*	*$20*	*$22*	*$24*	*$26*	*$27*		
50% COPAY UP TO $5,000 OF COSTS												
Fully Implemented in 2005 *Cap:*		*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*					
50% Subsidy		0.4	11.2	11.9	13.9	16.0	17.6	19.0	20.5	22.2	**37.3**	**132.6**
Monthly Premium		*$29*	*$24*	*$29*	*$34*	*$38*	*$40*	*$43*	*$45*	*$48*		
67% Subsidy		0.5	14.9	15.8	18.5	21.3	23.4	25.3	27.4	29.6	**49.7**	**176.8**
Monthly Premium		*$19*	*$16*	*$20*	*$23*	*$25*	*$27*	*$28*	*$30*	*$32*		
75% Subsidy		0.5	16.7	17.8	20.9	24.0	26.3	28.5	30.8	33.3	**55.9**	**198.8**
Monthly Premium		*$15*	*$12*	*$15*	*$17*	*$19*	*$20*	*$21*	*$23*	*$24*		
50% COPAY UP TO $5,000, 20% COPAY ABOVE *												
Fully Implemented in 2005 *Cap:*		*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*					
50% Subsidy		0.4	11.2	11.9	13.9	18.9	20.7	22.5	24.3	26.4	**37.3**	**150.1**
		$29	*$24*	*$29*	*$34*	*$42*	*$45*	*$47*	*$50*	*$53*		
67% Subsidy		0.5	14.9	15.9	18.6	25.1	27.6	30.0	32.5	35.2	**49.8**	**200.2**
		$19	*$16*	*$20*	*$23*	*$28*	*$30*	*$32*	*$33*	*$35*		
75% Subsidy		0.5	16.7	17.8	20.9	28.3	31.1	33.7	36.5	39.6	**56.0**	**225.1**
		$15	*$12*	*$15*	*$17*	*$21*	*$22*	*$24*	*$25*	*$27*		
Medicare Part B Premium		*$52*	*$57*	*$62*	*$66*	*$70*	*$75*	*$80*	*$85*	*$90*		

All options have no deductible

* Not estimated by the actuaries. Assumes that catastrophic protection begins in 2005 (calculated by adding marginal cost of Kennedy proposal to base proposal).

GRADUATE MEDICAL EDUCATION

- **Medicare Spending.** In 1999, Medicare will spend an estimated:

  - 2.5 billion in direct medical education (DME) and
  - 3.7 billion in indirect medical education (IME).

  This is about half of all funding for graduate medical education

- **Issues**:

  - Funded from the Part A Trust Fund, which will run out in 2015

  - Medical education is a societal benefit, and should be funded more broadly

  - Amount and distribution of funding determined by formula automatically

- **Proposals**

  - Breaux-Thomas plan: Removes DME without specific plan for financing, etc.

  - Moynihan, Cardin bills: Create separate trust funds with premium assessment financing to complement and, in Cardin bill, reduce Medicare spending

CREATING A NEW MEDICAL EDUCATION TRUST FUND

- **Pros:**
  - Viewed as structural reform by experts
  - Could reduce the need to give back funding to academic health centers, thus freeing up savings for funding the drug benefit
- **Cons:**
  - May not be enough for teaching hospitals – especially if they do not support the non-Medicare sources of financing
  - Does not produce savings, since proposals that significantly reduce Medicare's contribution to medical education would not be viable

OPTION 1: TRUST FUND FINANCED BY PREMIUM ASSESSMENT

Option:

- Move Medicare direct medical expenditure payments out of Part A to new trust fund

- Complement Medicare funding with private health insurance premium assessment:
  - 1.5% premium assessment (Moynihan): $5 billion / year
  - 1.0% premium assessment (Cardin): $3.2 billion / year

- **Pros:**

  - Would be viewed as most credible option, more responsible than Breaux-Thomas

  - Supported in Health Security Act; favored by academic health centers

  - More progressive and appropriate source of financing

- **Cons:**

  - Some Democrats and all Republicans will oppose tax

  - Could complicate patient bill of rights debate

2. TRUST FUND FINANCED BY SURPLUS

Option:

- Move Medicare direct medical expenditure payments out of Part A to new trust fund
- Dedicate some fraction of surplus to trust fund

- **Pros**:
  - Since all people benefit from medical education, general revenue may be an appropriate financing source
  - Relieves pressure on Medicare without new tax
- **Cons:**
  - Spends the surplus without significantly helping to fund the drug benefit
  - Likely to be criticized by Republicans as a gimmick

MEDICARE:

ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

April, 1999

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MEDICARE: ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

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

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

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

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

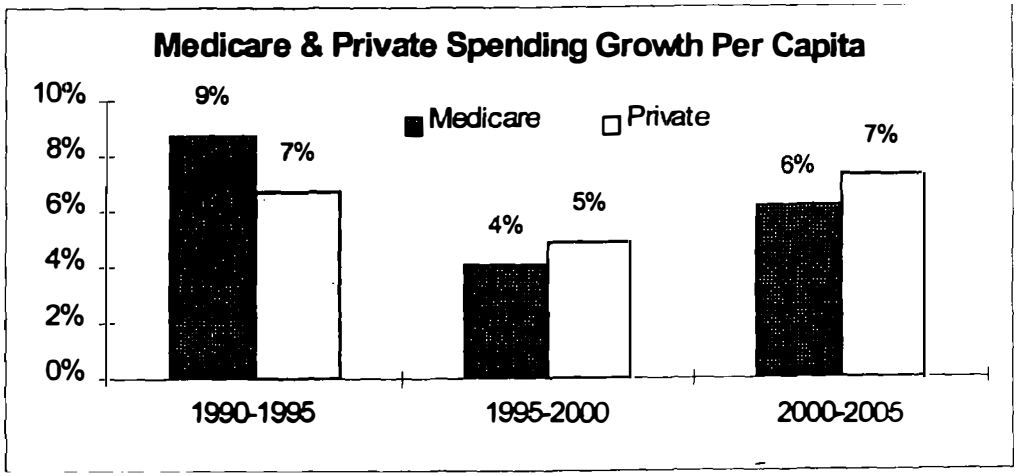
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)

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

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

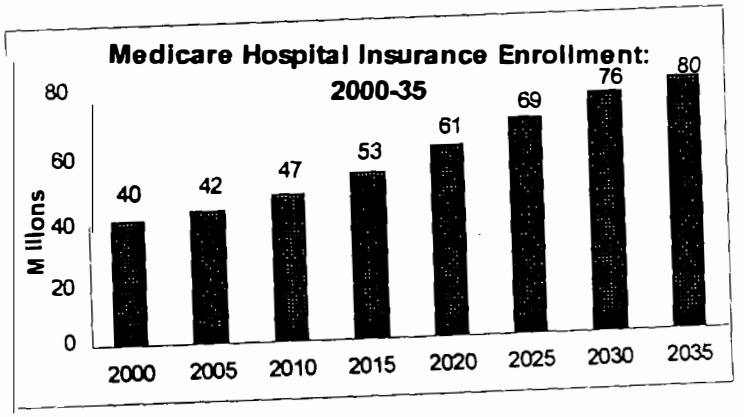
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999. Through commitment to a strong economy, coupled with actions that improve Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015.

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

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



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

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

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

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits:** Medicare's benefits are not very generous. In particular:

  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.

  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.

  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.

  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.

- **Insufficient private tools for reducing costs:** Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:
  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). This is:
  - One-fourth of BBA 1997 savings (CBO: $386 billion over 10 years); and
  - One-third of amount from committing 15 percent of the surplus to Medicare ($343 billion over 10).

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
*BUDGET SAVINGS**	*+6*	*-66*

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare:** The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

- **The Breaux-Thomas proposal has advanced the debate.** The plan has recommended a number of ideas worth serious consideration, including:

  - Making Medicare's traditional plan more competitive: It recommends that Medicare adopt many of the competitive management tools that are used in the private sector.

  - Rationalizing Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their health care needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area.

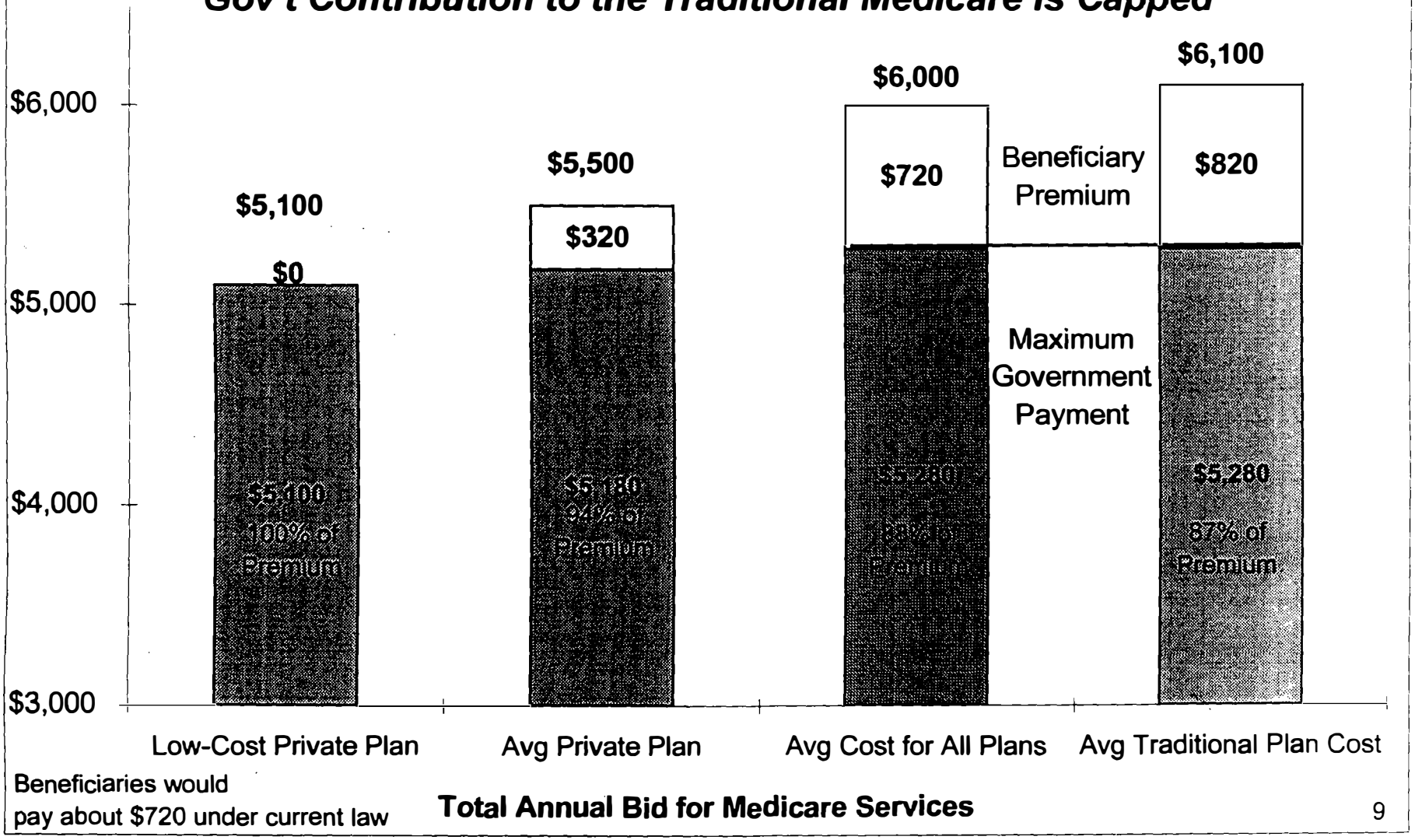
- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries, who generally have access to managed care, would not be protected against higher traditional program premiums. They would also likely pay more for private plans, since plans would raise premiums for beneficiaries to compensate for government payments that do not fully account for local costs, which are higher in most urban areas.

- **Unclear commitment to defined guarantee of benefits**: Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** Since traditional Medicare premiums would rise under this proposal, so, too, would Medicaid costs since states pay for premiums for low-income beneficiaries.

Breaux-Thomas Premium Support Proposal

Gov't Contribution to the Traditional Medicare is Capped



Beneficiaries would pay about $720 under current law

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

- **Not a Medicare benefit.** One of Medicare's strengths is that it provides health services to all beneficiaries, regardless of their residence, income or health status. By not providing a drug benefit through Medicare, the Breaux-Thomas proposal does not modernize Medicare. Instead, it restricts eligibility to beneficiaries with incomes below 135 percent of poverty (about $11,000 a year for a single senior) through a means-tested, Medicaid benefit.

  - **Helps only a fraction of beneficiaries without drug coverage:** Nearly 60 percent of beneficiaries without any drug coverage would not qualify. For example, a widow with $11,500 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

  - **Fewer people enroll in Medicaid programs:** Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program.

- **Medigap and unsubsidized options are unworkable.** The Breaux-Thomas proposal would also require all Medigap plans, private managed care plans, and traditional Medicare to offer drug coverage. However, without premium assistance, the costs would likely be high, so that only those with high drug costs would sign up. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or it would become impossible to offer the coverage altogether.

OTHER SHORTCOMINGS OF THE BREAUX-THOMAS PLAN

- **Does not address Medicare's long-term solvency**: The Breaux-Thomas proposal ignores the need for new revenues to finance the care of the growing numbers of beneficiaries. According to Commission staff, the plan's net Medicare savings of around $100 billion over 10 years would extend Medicare's solvency for about 4 years. Probably about half of that effect results from the shift of graduate medical education out of Medicare Part A. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **Raises the age eligibility for Medicare**: The most rapidly growing group of the uninsured is ages of 55 to 65. Raising the Medicare eligibility age without a policy to prevent even more uninsured would exacerbate this problem.

- **Includes an unlimited home health copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits. For the over 1 million beneficiaries who have more than 60 visits per year, this copay would represent a large financial burden.

- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. This does not produce Federal budget savings and does not assure that teaching hospitals are funded to continue their important mission.

- **Creates new bureaucracy:** A separate Board would oversee premium support, using new staff to approve benefits packages and rates in every single plan, decide on service areas, enforce financial and quality standards among other activities. Not only would it have little accountability to Congress, it would remove billions of taxpayer dollars from traditional government oversight.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare**: Neither the President nor his four appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conforms to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;

  - Maintaining and modernizing Medicare's guaranteed benefits, including a prescription drug benefit; and

  - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare**: Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:

  - Competitive pricing for services like medical supplies; and

  - Selectively contracting with lower-cost, high-quality providers.

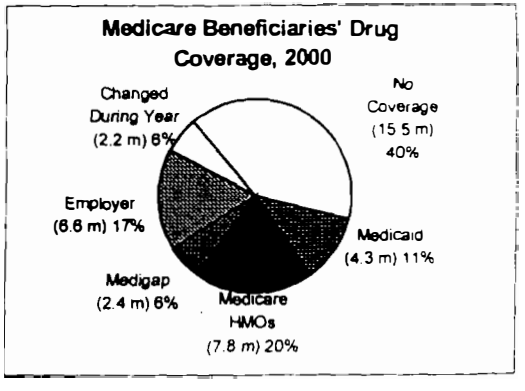
- **Examining other policies to reduce overpayment and increase competition**: The Administration will also examine specific options to reduce fraud, constrain costs and make both the traditional program and managed care payments more competitive and efficient.

MAINTAINING AND MODERNIZING MEDICARE'S GUARANTEED BENEFITS

- **Ensuring that Medicare's guarantee is strong**: Medicare protects some of our most vulnerable citizens – the elderly and people with disabilities -- from excessive health care costs. Proposals to strengthen Medicare must not do so at the expense of this guarantee to a defined set of benefits.

- **Providing a long-overdue prescription drug benefit:**

  - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.



  - Existing coverage is unstable and expensive: Those beneficiaries who have private coverage are vulnerable, since employers are dropping retiree coverage and Medigap is becoming more costly and less accessible.

  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable.

DEDICATING PART OF THE SURPLUS TO MEDICARE

- **Providing new financing by dedicating part of the surplus to Medicare**: The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years. This amount would equal $686 billion over the period and extend the life of the trust fund for another decade.

  - Investing now prevents larger problem later: Even though the Medicare shortfall is projected to accumulate to over $1 trillion over the next quarter century, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing later.

  - One-time, fixed contribution: The plan does not create an unlimited tap on general revenues. Instead, it invests a fixed proportion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees.

  - Funded by the baby boom generation -- not tomorrow's workers: The surplus was largely created by the baby boom generation, and makes sense as a one-time funding source for Medicare. In contrast, waiting until future generations are faced with raising taxes to support Medicare would shift this burden to younger and low-income workers.

AGENDA: MEDICARE PRINCIPALS' MEETING

June 4, 1999

I. PROVIDER PAYMENT POLICIES

II. MISCELLANEOUS ISSUES:

- Medigap Alternatives
- Information and Demonstrations on Prevention and Care Coordination
- Medicare Board and Alternative

I. PROVIDER PAYMENT POLICIES

- **Balanced Budget Act of 1997:**
  - In 1997, Medicare actuary estimated that the BBA would save about $150 billion between 1998-2002, over $400 billion over 10 years
  - If policies that expire in 2002 are extended through 2009, savings another $62 billion (approximately) from 2003 through 2009
- **Provider Concerns:**
  - BBA reduced spending more than anticipated.
  - BBA is exacerbating larger trends in the health care system: reductions in Medicaid; aggressive cost-cutting by private insurers; increasing health inflation
- **Validity of Claims**:
  - Since changes have only taken effect recently, very limited data
  - Some (albeit limited) evidence about problems in payment polices for skilled nursing facilities; therapy services; and, to lesser degree, academic and rural hospitals. Policies in 2000-01 are, in most cases, more severe.
  - Baseline spending has dropped ($240 billion between 1998 and 1999, due to multiple factors, including BBA, anti-fraud efforts, and lower inflation).

HOSPITALS

- **Issues:** Large proportion of savings in BBA from hospitals. Also affected by aggressive rate negotiation by private plans. Specific complaints from academic and rural hospitals. General fear of hospital outpatient prospective payment (not yet implemented). Moynihan, Cardin, Rangell, Kennedy, unions are concerned about academics, Daschle, Baucus, Conrad about rurals.

- **Minimal Help: About $10.6 billion over 10 years**
  - **Administrative**: (1) Delay hospital transfer policy for 2 years (+$1.6 billion); (2) ease restrictions on hospital reclassification as urban for payment; (3) study occupational mix for rural hospitals; (4) use inpatient wage index for prospective payment for rural hospitals; (5) implement time-limited, budget-neutral transition to full outpatient prospective payment system; (6) delay implementation of volume control system for outpatient departments.

  - **Legislative**: Carve disproportionate share hospital (DSH) payments out of managed care payments and pay hospitals directly (no cost).

  - **Extenders**: (1) Increase hospital update (+$3.9); (2) Increase rural hospital update to -0.5 (+$2.1 billion); (3) eliminate DSH reduction (+$2.6).

- **Maximum Help: About $21.4 billion over 10 years**
  - **Administrative**: Same as above
  - **Legislative**: Same as above, plus: (1) Keep indirect medical education at 6.5 percent (+$6 billion); (2) Change policy on outpatient department multiple procedures (+$4.0 billion); (3) non-budget neutral outpatient transtion to full prospective payment system (+$0.8).

  - **Extenders**: Same as above plus eliminating outpatient extender (+$8.0)

SKILLED NURSING FACILITIES

- **Issues**: Several major chains are nearing bankruptcy, and blaming the new prospective payment system that was implemented in 1998. Special concern for Republicans (e.g., Domenici) as well as Democrats (e.g., Daschle, Harkin, Bingamin, Cardin). Note: May be concerned about change in nursing home copayment in plan.

- **Minimal Help**: About $2.1 billion over 10 years

  - **Administrative**: None.

  - **Legislative**: None.

  - **Extender**: Eliminate extender (+$2.1 billion).

- **Maximum Help**: About $7.0 billion over 10 years.

  - **Administrative**: None.

  - **Legislative**: (1) Increase payments to high-cost cases (+$1.0 billion); (2) option of going to full national rates in prospective payment system (+$0.5 billion); (3) increase 2000 update (+$3.4)

  - **Extender**: Eliminate extender (+$2.1 billion).

HOME HEALTH AGENCIES

- **Issues:** BBA included an interim payment system that dramatically changed how Medicare pays for home health. Some problems addressed in 1998. Special concern for: Chafee, McGovern, Contrad

- **Minimal Help**: About $2.2 billion over 10 years (extending 1998 update reductions)

  - **Administrative**: (1) Increase time period for repayment of overpayments; (2) fix surety bond provisions (no cost).

  - **Legislative**: None. Do not include home health copay.

  - **Extenders**: Drop extender +$2.2 billion

- **Maximum Help**: About $15.2 billion over 10 years

  - **Administrative**: (1) Increase time period for repayment of overpayments; (2) fix surety bond provisions.

  - **Legislative**: (1) Restore 1998 reductions used to pay for 1999 fixes (+$3.3 billion); (2) reduce from 15% to 7.5% the interim payment system reduction (+$9.7 billion)

  - **Extenders**: Drop extender +$2.2 billion

OTHER PROVIDERS

- **MANAGED CARE:** Strongly opposed to BBA policies; seeking administrative relief (postponing / eliminating risk adjustment) as well as legislative rate increases.

- **THERAPY**: Administration opposed BBA policy of imposing caps in spending per beneficiary for therapy services. Has resulted in clearly documented problems. Congress in general supports legislative fix. Options include:

  - **Administrative:** Delay implementation of therapy caps

  - **Legislative:** (1) Raise therapy caps to $2,200 (+$6.3); (2) $3,000 (+$9.8); or (3) separate $1,500 caps (+$1.9).

- **LABS:** Not vocally concerned, but will probably feel like they are hit twice with extender (which is an extension of a payment freeze) and the new 20% copay.

- **AMBULANCE, DURABLE MEDICAL EQUIPMENT, PARENTAL NUTRIENTS**: The BBA froze payments for these services through 2002.

BASE PROPOSALS

- **Administrative actions**:
  - Delay hospital transfer policy for 2 years (+$1.6 billion)
  - Ease restrictions on hospital reclassification as urban for payment (helps rural hospitals)
  - Study occupational mix for rural hospitals
  - Use inpatient wage index for prospective payment for rural hospitals
  - Implement time-limited, budget-neutral transition to full outpatient prospective payment system
  - Delay implementation of volume control system for outpatient departments
  - Increase time period for repayment of home health overpayments
  - Fix home health surety bond provisions

Modified BBA extenders:	Original	Modified	Change
° Hospital inpatient update	-35.4	-29.4	+6.0
° Hospital capital reduction	-1.8	-0.9	+0.9
° Hospital PPS exempt update	-4.7	-4.7	--
° Hospital PPS exempt capital reduction	-0.7	-0.7	--
° Disproportionate Share Hospital cut	-2.6	--	+2.6
° Outpatient department	-8.0	-8.0	--
° Skilled nursing facilities update	-2.1	--	+2.1
° Home health update	-2.2	--	+2.2
° Lab update	-3.5	-1.1	+2.4
° Other (Hospice, ASC, ambulance, DME, P&O, PEN)	-4.3	-3.0	+1.3
° Interactions	+3.6	+3.6	--
TOTAL	**-61.2**	**-44.2**	**+17.0**

OPTION 1: NO LEGISLATIVE FIXES

OPTION: Base Proposals Plus Eliminating Outpatient Extender: **-36.2**

PROS:

- Makes plan look more like a true reform package rather than a vehicle for fixes, especially since it does not need to tap into the surplus for provider fixes.

- Administrative actions address some concerns of hospitals and home health care, and low hospital and no nursing home extenders would be appreciated.

- Delays a "bidding war" on who can help providers the most.

CONS:

- Considered by providers and some Congressman as ignoring – and compounding – real problems in Medicare payment. Does not help nursing homes in the near term.

- Providers more concerned about next 2 years, not out-years

- If Republicans have a bill that includes objectionable policies and provider fixes, could gain provider groups' support. Some Democrats may need fixes and find it difficult to support the plan without them.

OPTION 2: LIMITED LEGISLATIVE FIXES

OPTION: Base Proposals	**-44.2**
° Pay for transition to national rates for hospital outpatient departments	+0.8
° Keep indirect medical education adjustment at 6.5% through 2002:	+1.6
° Nursing homes: address high-cost cases; option for national rates:	+1.6
° Relieve pressure on therapy caps	+1.9
TOTAL	**-38.3**

PROS:

- Providers will appreciate our recognition of flaws in BBA.

- Could makes some providers support plan, since they care more about in-year fixes than out-year savings.

- May dissuade groups from launching summer-long campaign against our plan.

CONS:

- Would have to use Social Security surplus or other financing source since Medicare plan savings do not begin until 2001 and would not cover the costs.

- Will offend provider groups not included (e.g., home health). Could establish a floor for a give-back package.

- Risks lowering the credibility of the plan as about reform and solvency.

SUMMARY: POSSIBLE PROVIDER CHANGES

(Dollars in Billions, FY 2000-2009)

	Admin Actions	Reduction in Extenders	Option 1: Modified Extenders	Option 2: Limited Legislative Fixes
Hospitals	+1.6 [1]	+9.0 [3]	+8.0 [8]	+2.4 [9]
Skilled Nursing Facilities	--	+2.1 [4]	0	+1.5 [10]
Therapy	--	--	0	+1.9 [11]
Home Health	0 [2]	+2.2 [5]	0	0
Managed Care	--	+na [6]	0	0
Labs	--	+2.4 [7]	0	0
Other	--	+1.3 [7]	0	0
CHANGES	**+1.6**	**+17.0**	**+8.0**	**+6.8**
NET PROVIDER SAVINGS	**[na]**	**-$44 billion**	**-$36 billion**	**-$37 billion**

1. Delay expansion of hospital transfer policy (+$1.6) (helps rural, academics); ease restrictions on hospital reclassification (helps rural hospitals); study occupational mix for rural hospitals; use inpatient wage index for rural hospitals; implement time-limited, budget-neutral transition to full outpatient prospective payment system; delay implementation of volume control system for outpatient departments.
2. Increase time period for repayment of home health overpayments; fix home health surety bond provisions.
3. Increase general hospital update (+$3.9) and rural hospital update (+$2.1); reduce capital reduction (+$0.9); end disproportionate share hospital (DSH) cut (+$ 2.1)
4. Do not extend skilled nursing facility update reduction (+$2.1)
5. Do not extend home health update reduction (+$2.2)
6. Do not extend 2% floor (not estimatable)
7. Replace freeze in payments with update of CPI-1 (+$2.4 for labs, +$1.3 for P & O, PEN, DME)
8. Eliminate outpatient update reduction (+$8)
9. Indirect medical education at 6.5% for 2 years (+$1.6); non-budget neutral outpatient transition to PPS (+$0.8)
10. Provide add-on for high-cost cases (+$1.0); allow option to transition to national rates (+$0.5).
11. Create a third, $1,500 therapy cap that helps some nursing homes and eases pressure on existing caps (+$1.9)

II. MISCELLANEOUS OPTIONS
ALTERNATIVE MEDIGAP OPTIONS

- **Include President's Budget Policies**: These no-cost items include:
  - Initial Open Enrollment for Medigap for Disabled and ESRD (like elderly)
  - Special Medigap Open Enrollment Period and Expanded Choices for Beneficiaries Losing Access to Plans
  - Increase Civil Monetary Penalties for Violation of Medigap Open Enrollment Requirement.
- **Update Medigap Benefits:** Direct the Secretary of HHS and NAIC to revise the Medigap plans' benefits to conform with changes in cost sharing, the new prescription drug benefit, and the new Medicare PPO option.
- **New, more rational Medigap plan**: Authorize the creation of a new Medigap plan that has more rational cost sharing (e.g., low copays, no coverage of the deductible).

INFORMATION / DEMONSTRATIONS ON HEALTH PROMOTION, PREVENTION, AND COORDINATED CARE

- **Early detection of glaucoma**: Medicare would reimburse diagnostic services for early detection of glaucoma provided / overseen by physicians when referred by a specialist. (waiting on cost estimates) (Graham).

- **Smoking cessation demonstration**: Evaluate the effectiveness of Medicare coverage of smoking cessation programs or prescription drugs (Graham).

- **Demonstration of care coordination**: Medicare would fund a demonstration of three models to pay for care coordination for dual eligibles: (a) a managed care option, where Medicare and Medicaid pay capitation amounts to a single plan for coordination of care; (b) a "gatekeeper" model, where a primary care provider authorizes Medicare and Medicaid services; and (c) a coordinator model, where a provider suggests but does not authorize services.

- **Information campaign about Medicare benefits**: Many beneficiaries do not take advantage of existing Medicare benefit. Educational efforts would target:

  - **Preventive benefits**

  - **Coordinate of Medicare-Medicaid benefits**

MEDICARE BOARD

- **Commission Proposal: Medicare Board**. Stemming from IRS-like concerns about HCFA, the Commission proposed to create a new Board outside of Medicare to administer Medicare. One of the major reasons for the Board to remove any conflict of interest that HCFA has in running both the traditional plan and private plans, and to assure objectivity in oversight. The members would represent health care providers, beneficiaries, and working taxpayers.

- **Functions of the Board:**

  - Certify plans and negotiates over covered benefits and premiums

  - Operate annual open enrollment process, including information distribution

  - Enforce quality and program integrity requirements (including traditional Medicare)

- **HCFA Role**: Overall program management would be transferred to the Board. HCFA would remain responsible for the traditional program only. It would be treated as any other private health plan.

CONCERNS ABOUT AND ALTERNATIVE TO THE MEDICARE BOARD

- **CONCERNS:**

  - Removes control of Medicare from Administration and Congress, lessening accountability, program integrity and quality protections

  - Bifurcates responsibilities for administering Medicare, which results in duplicative bureaucracy and beneficiary confusion

- **ALTERNATIVE:**

  - **Increased Accountability**: New public/private boards to (1) improve coverage policy; (2) advise on management; and (3) review and strengthen beneficiary education efforts. Contracting reform to improve ability to use private sector for certain activities. Revamping the regional and central office relationship.

  - **Modernizing Management**: Strategic plan to improve hiring policies.

DISCUSSION OF COMPETITION IN MEDICARE

MAY 5, 1999

I. Competition in the Current System

II. Breaux-Thomas Premium Support

III. Principles for Alternatives

I. COMPETITION IN THE CURRENT SYSTEM
Traditional Medicare

- Secretary has virtually no flexibility to negotiate or competitively price services, even when it saves money.

- Many advisory commissions (e.g., National Academy of Social Insurance Study Panel on Fee-For-Service Medicare; Medicare Commission) advocate for additional authority to adopt private sector approaches to managing costs.

- To date, Congress has chosen to constrain proposals to make Medicare more competitive to demonstrations.

- Medicare is now moving to implement a competitive purchasing demonstration for durable medical equipment in Florida. Suppliers are unsuccessfully attempting to stop the demonstration.

MEDICARE MANAGED CARE
Payment Issues

- **Government payments have nothing to do with actual plan costs**: Plans are paid a fixed amount, depending on their location. Rates are based largely on historical traditional, fee-for-service costs.

  - ***No government savings from selecting low-cost versus high-cost private plans.*** In most places, Medicare saves money when beneficiaries leave traditional Medicare and enroll in Medicare managed care. However, since Medicare pays a flat rate, there are no government savings if beneficiaries choose low-cost plans.

- **High geographic variation.** Because of their basis in local fee-for-service costs in each county, managed care payments vary considerably. The highest payment rate ($814/mo in Richmond County, NY) is twice as high as the lowest payment rate ($410.61/mo in low-cost "floor" counties).

RISK ADJUSTMENT

- **Risk adjustment is needed to pay plans accurately and fairly.** Most experts – including the Medicare Payment Advisory Council – agree that adjusting managed care payments for the beneficiaries' expected health improves efficiency. Not only does it decrease the disincentives for plans to enroll sicker beneficiaries, but reduces overpayments for healthy beneficiaries, which in the past have resulted in Medicare losing rather than saving money on managed care.

- **Congress acknowledged the need for risk adjustment in 1997**. Although there is no perfect risk adjuster, even the partial risk adjustment, based only on inpatient hospital data, will improve payment accuracy by five-fold.

- **Phasing in risk adjustment.** To prevent disruptions and gather additional information for improving risk adjustment, it will be phased in over 5 years. This gradual transition should give plans sufficient time to adjust to the new payment system.

Problems with Competition Based on Benefits

- **Today, plans compete on offering supplemental benefits, not lower prices.** Plans whose Medicare managed care rates exceed their costs frequently offer extra benefits. Private plans also are allowed to charge an extra premium for supplemental benefits. Since traditional Medicare benefits are less generous than 4 out of 5 private plans', beneficiaries are enticed to enroll through the provision of extra benefits. However, this can cause problems.

- **Inequitable subsidy of benefits.** The government subsidizes extra benefits through its fixed Medicare managed care payment rates. There are no subsidies available for extra benefits for beneficiaries who choose to – or have not choice but – to stay in the traditional Medicare fee-for-service program.

    - ***Rural beneficiaries lack access.*** As such, extra benefits are usually not available to rural beneficiaries whose access to managed care is limited. Nearly 75 percent of the 9 million rural Medicare beneficiaries do not have access to any private plans. Over half of those who do have access have only one option. Studies show that plans without competition do not offer as many extra benefits. Despite payment rate increases of 23 percent between 1997 and 1999, rural beneficiaries saw a decrease in access to prescription drug benefits through managed care.

- **Competition based on benefits and not price and quality is inefficient**. Since few beneficiaries know the value of supplemental benefits, it is difficult for them to compare plans. Beneficiaries may select plans that appear to be generous, but, in truth, provide fewer benefits than their competition.

- **Makes it easier for plans to "cream skim".** Competition on unstandardized benefits also makes it easier for plans to selectively offer benefits to attract the youngest and healthiest beneficiaries.

MEDICARE BENEFICIARIES' ACCESS TO PRIVATE PLANS, 1999

STATE	ACCESS TO PRIVATE PLANS			TOTAL	ACCESS TO PRIVATE PLANS		
	No Plans	One Plan	Two + Plans		No Plans	One Plan	Two + Plans
Alabama	476,600	33,500	182,800	**692,900**	69%	5%	26%
Alaska	33,900	-	-	**33,900**	100%	0%	0%
Arizona	-	67,500	602,100	**669,600**	0%	10%	90%
Arkansas	308,800	38,500	100,200	**447,500**	69%	9%	22%
California	86,600	1,146,300	2,693,500	**3,926,400**	2%	29%	69%
Colorado	87,700	18,700	360,700	**467,100**	19%	4%	77%
Connecticut	-	38,700	484,300	**523,000**	0%	7%	93%
Delaware	46,700	64,700	-	**111,400**	42%	58%	0%
District of Columbia	-	-	79,000	**79,000**	0%	0%	100%
Florida	299,700	221,300	2,306,900	**2,827,900**	11%	8%	82%
Georgia	562,500	20,700	335,700	**918,900**	61%	2%	37%
Hawaii	-	8,300	156,800	**165,100**	0%	5%	95%
Idaho	107,700	56,500	-	**164,200**	66%	34%	0%
Illinois	459,000	189,900	1,028,600	**1,677,500**	27%	11%	61%
Indiana	547,300	64,900	255,100	**867,300**	63%	7%	29%
Iowa	473,800	-	14,000	**487,800**	97%	0%	3%
Kansas	258,500	58,700	81,200	**398,400**	65%	15%	20%
Kentucky	469,200	5,100	158,200	**632,500**	74%	1%	25%
Louisiana	76,000	210,200	332,700	**618,900**	12%	34%	54%
Maine	80,900	136,500	-	**217,400**	37%	63%	0%
Maryland	-	108,400	538,400	**646,800**	0%	17%	83%
Massachusetts	-	30,800	949,700	**980,500**	0%	3%	97%
Michigan	532,100	156,200	735,300	**1,423,600**	37%	11%	52%
Minnesota	342,800	10,400	309,900	**663,100**	52%	2%	47%
Mississippi	425,900	-	-	**425,900**	100%	0%	0%
Missouri	369,500	138,800	368,300	**876,600**	42%	16%	42%
Montana	138,500	-	-	**138,500**	100%	0%	0%
Nebraska	191,200	7,000	60,200	**258,400**	74%	3%	23%
Nevada	26,200	6,700	197,800	**230,700**	11%	3%	86%
New Hampshire	60,300	30,700	78,800	**169,800**	36%	18%	46%
New Jersey	-	-	1,222,300	**1,222,300**	0%	0%	100%
New Mexico	80,900	39,800	113,300	**234,000**	35%	17%	48%
New York	248,700	351,500	2,157,100	**2,757,300**	9%	13%	78%
North Carolina	586,500	209,800	336,100	**1,132,400**	52%	19%	30%
North Dakota	105,500	-	-	**105,500**	100%	0%	0%
Ohio	102,000	219,300	1,415,800	**1,737,100**	6%	13%	82%
Oklahoma	94,100	68,600	353,800	**516,500**	18%	13%	68%
Oregon	74,000	53,100	368,100	**495,200**	15%	11%	74%
Pennsylvania	-	80,700	2,056,700	**2,137,400**	0%	4%	96%
Rhode Island	-	-	174,300	**174,300**	0%	0%	100%
South Carolina	501,600	65,400	-	**567,000**	88%	12%	0%
South Dakota	121,600	-	-	**121,600**	100%	0%	0%
Tennessee	222,100	299,900	314,500	**836,500**	27%	36%	38%
Texas	565,200	339,200	1,365,300	**2,269,700**	25%	15%	60%
Utah	204,700	-	-	**204,700**	100%	0%	0%
Vermont	89,400	-	-	**89,400**	100%	0%	0%
Virginia	414,900	235,700	233,100	**883,700**	47%	27%	26%
Washington	108,400	37,000	596,000	**741,400**	15%	5%	80%
West Virginia	219,700	101,900	23,000	**344,600**	64%	30%	7%
Wisconsin	456,200	63,400	278,000	**797,600**	57%	8%	35%
Wyoming	65,600	-	-	**65,600**	100%	0%	0%
Puerto Rico	537,300	-	-	**537,300**	100%	0%	0%
TOTAL	**11,259,800**	**5,034,300**	**23,417,600**	**39,711,700**	**28%**	**13%**	**59%**

Based on preliminary plan offerings in 1999 and September 1998 beneficiary enrollment. Rounded to the nearest hundred.

Private Plan "Churning": Is It Medicare's Fault?

- **Plan withdrawals from Medicare.** One of the widely debated facts in the last six months is the "dropping out" of nearly 100 plans from some or all of the areas that they served in 1998. Although about 400,000 beneficiaries (7 percent of all managed care enrollees) were affected, only 60,000 were left with no private plan options.

- **GAO study**: In a close examination of plan withdrawals, the independent General Accounting Office (GAO) issued a report in April entitled "Many Factors Contribute to Recent Withdrawals; Plan Interest Continues." Its major findings include:

  - ***Plans withdrew from Medicare "primarily [as] the normal reaction of plans to market competition and conditions."*** In contrast to the allegation that low payment rates caused the problem, plan decisions to withdraw were not strongly associated with payment rates. Instead, a number of factors contributed, including low enrollment and stiff competition in the area. Supporting this fact, a number of plans withdrew from the Federal Employees' Health Benefits Plan as well -- suggesting that Medicare policy was not the major contributor to plan decisions.

  - ***Very few plans withdrew from Medicare altogether.*** For the most part, plans withdrew from counties where they had little market penetration. The fact that most plans were satisfied enough to remain in Medicare in other counties suggests that local circumstances -- not Medicare in general -- caused their action.

  - ***More -- not less-- beneficiaries have access to managed care.*** If HCFA approves all of the applications from managed care plans, the number of beneficiaries with access to managed care will increase in 1999.

II. BREAUX-THOMAS PROPOSAL

- **Provides Additional Market Tools for Traditional Medicare Fee-For-Service Program**: Recognizing that the majority of beneficiaries will remain in the traditional program, the proposal include provisions such as:

  - Competitive pricing for services like medical supplies;

  - Selectively contracting with lower-cost, high-quality providers;

  - Use preferred provider organizations to get better prices; and

  - Paying one price for a specific conditions (e.g., diabetes or heart attacks) rather than on a service-by-service basis.

- **Saves about $14 billion over 10 years**, adding about a year of life to the Medicare Trust Fund.

PREMIUM SUPPORT

- **Limits Government Payments to Percent of Average Cost of All Plans:** Medicare's payments for health plans would be limited -- beneficiaries would pay more if they chose plans higher than average, less if they chose plans below the national average cost.

- **Reasons for savings:**

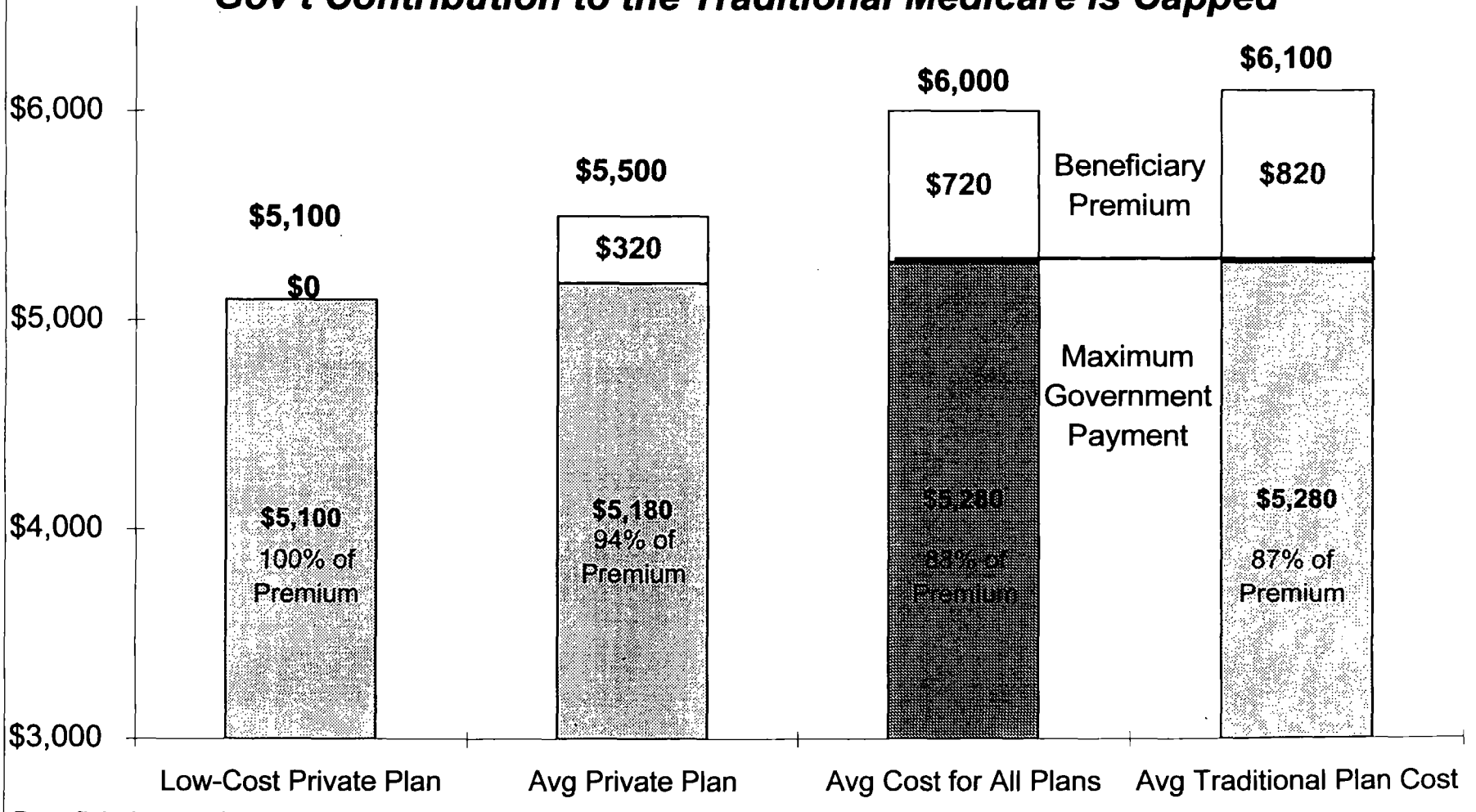
  - Higher premiums for traditional Medicare, since it would be a "high-cost plan" and require higher premiums;

  - Lower payments for lower-cost private plans (today, Medicare pays a flat payment rate regardless of plan costs); and

  - Increased enrollment in private plans lowers average cost, which is the basis for the maximum government contribution, thus reducing Federal costs.

Breaux-Thomas Premium Support Proposal

Gov't Contribution to the Traditional Medicare is Capped



Beneficiaries would pay about $720 under current law

Total Annual Bid for Medicare Services

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their health care needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area.

- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries, who generally have access to managed care, would not be protected against higher traditional program premiums. They would also likely pay more for private plans, since plans would raise premiums for beneficiaries to compensate for government payments that do not fully account for local costs, which are higher in most urban areas.

- **Unclear commitment to defined guarantee of benefits**: Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** Since traditional Medicare premiums would rise under this proposal, so, too, would Medicaid costs since states pay for premiums for low-income beneficiaries

III. PRINCIPLES FOR ALTERNATIVE

- **Goal**: Improve competition and efficiency without achieving savings through traditional plan premium increases

- **Principles:**

  - No premium increases for traditional Medicare

  - Competition should encourage beneficiaries to join managed care because of lower cost or better quality – not because of economic coercion of higher traditional Medicare premiums.

  - Guarantees defined set of benefits, including prescription drug benefit

  - Replaces competition on extra benefits with price competition (as under all competitive options, including Breaux-Thomas)

  - Phases in to avoid disruption, only when risk adjustment is fully phased in

  - Produces Federal savings

RISK ADJUSTMENT

- **Risk adjustment is needed to pay plans accurately and fairly.** Most experts – including the Medicare Payment Advisory Council – agree that adjusting managed care payments for the beneficiaries' expected health improves efficiency. Not only does it decrease the disincentives for plans to enroll sicker beneficiaries, but reduces overpayments for healthy beneficiaries, which in the past have resulted in Medicare losing rather than saving money on managed care.

- **Congress acknowledged the need for risk adjustment in 1997**. Although there is no perfect risk adjuster, even the partial risk adjustment, based only on inpatient hospital data, will improve payment accuracy by five-fold.

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MEDICARE PRINCIPALS' MEETING
DRAFT: MAY 20, 1999

I. **Elements of Reform Package**

II. **Draft Reform Packages**

- Senate Finance Democrats-Like Option
- Base Democrats-Like Option
- Moderate Option

III. **Updated Drug Estimates**

IV. **Budget-Neutral Options**

- Medicare "Medigap" Option
- Medicare Board
- Dual Eligible Coordinated Care
- Other

I. ELEMENTS OF REFORM PACKAGE
COMPETITION
(10-year costs / savings in billions of dollars, fiscal years)

- **Traditional Medicare: Adding Private Sector Tools** **-$14 b**
  - Series of ideas that are agreed to by all

- **Managed Care: Allowing Price Competition** **-$10 b**
  - Controversial since some argue that it resembles premium support
  - Options:
    - Do nothing
    - Link maximum government payment to fee-for-service costs
    - Link maximum government payment to national average costs

SAVINGS

- **Providers: Modifications and/or Extension of BBA Policies** **-$40-50 b**
  - Commission extenders through 2009 ($57 billion over 10)
  - Options:
    - Administrative actions: Can help hospitals, home health, therapy caps
    - Legislative changes
- **Beneficiaries: Cost Sharing** **-$5-10 b**
  - Help offsets drug benefit, but controversial
  - Options:
    - Lab, nursing facility, and home health / eliminate preventive cost sharing (-$10 b)
    - Combine A & B deductible ($400); prohibit Medigap deductible coverage (-$10 b)
- **Beneficiaries: Income-Related Premium** **-$25 b**
  - Recommended since previously supported, progressive financing source

PRESCRIPTION DRUG BENEFIT

- **Base Option:** **-$160-180**
  - $0 deductible
  - 50 percent coinsurance up to $5,000 in spending
  - Beginning in 2002, phased in by 2006
  - 50 percent premium subsidy
- **Additions:**
  - 67 percent premium subsidy
  - Catastrophic: 20 percent coinsurance beyond cap
  - Income-related premium
  - Employer maintenance of effort: If 67% premium subsidy, have employers pay 50% (savings the government 17%)

II. DRAFT REFORM PACKAGES
1: SENATE FINANCE DEMOCRATS-LIKE OPTION

Competition:

Modernizing Traditional Medicare -$15

Managed Care Competition: *Lower premiums for low-cost private plans* -$10

Savings:

Providers: **Reformed Balanced Budget Act Extenders** -$50

Legislative Balanced Budget Act Fixes --

Beneficiaries: **Income-Related Premium:** *($50,000 single, $75,000 couple)* -$35

Cost Sharing Changes: *Home health, nursing home & lab copay* -$20

No preventive copays, single deductible ($400), no Medigap deductible coverage

Prescription Drug Option:

67% premium ($25-30): *$0 deductible, 50% copay to $5,000, 20% thereafter* +$180

New Financing:

Tobacco tax: *Additional $0.45 on top of budget* -$40

Budget-Neutral Proposals:

Medicare Medigap Option: *Unsubsidized option to buy catastrophic cost sharing coverage*

New Medicare Board: *Private oversight board for private plans*

Dual Eligible Funding: *Gives states Medicare payments to manage care*

New Trustees' Report: *Combines Part A and B; creates new section on overall Medicare*

2: BASE DEMOCRATS-LIKE OPTION

Competition:

Modernizing Traditional Medicare -$15

Managed Care Competition: *na*

Savings:

Providers: **Reformed Balanced Budget Act Extenders** -$50

Legislative Balanced Budget Act Fixes +$10-25

Beneficiaries: Income-Related Premium: *na*

Cost Sharing Changes: *na*

Prescription Drug Option:

67% premium ($15-20): *$0 deductible, 50% copay to $5,000, 20% thereafter* +$180

New Financing:

Surplus: *One-third of amount dedicated to Medicare* -$115

Budget-Neutral Proposals:

Modernizing Medicare Management: *Series of admin, leg proposals to improve oversight*

Coordinated Care for Dual Eligibles: *Develop coordination model for Medicare/Medicaid*

3: MODERATE OPTION

Competition:

Modernizing Traditional Medicare -$15

Managed Care Competition: *Lower premiums for low-cost private plans* -$10

Savings:

Providers: **Reformed Balanced Budget Act Extenders** -$50

Legislative Balanced Budget Act Fixes +$10-25

Beneficiaries: Income-Related Premium: *($80,000 single, $100,000 couple)* -$25

Cost Sharing Changes: *Home health, nursing home & lab copay* -$10

No preventive copays,

***Prescription Drug Option*:**

67% premium ($25-30): *$0 deductible, 50% copay to $5,000, 20% thereafter* +$180

New Financing:

Tobacco tax & additional provider or beneficiary cuts OR surplus: -$80-100

Budget-Neutral Proposals:

Medicare Medigap Option: *Unsubsidized option to buy catastrophic cost sharing coverage*

Modernizing Medicare Management: *Series of admin, leg proposals to improve oversight*

Coordinated Care for Dual Eligibles: *Develop coordination model for Medicare/Medicaid*

New Trustees' Report: *Combines Part A and B; creates new section on overall Medicare*

III. UPDATED DRUG ESTIMATES
[done tomorrow]

IV. BUDGET-NEUTRAL OPTIONS
MEDICARE "MEDIGAP" OPTION

- **Issue:** About 90 percent of Medicare beneficiaries have some form of supplemental insurance to pay for Medicare's high cost sharing.
  - Typical Medigap premium: $1,000 to $3,000
  - Access problems: AARP is the only nationwide insurer [add]
- **Option:** Unsubsidized Medicare Medigap option
  - Provides stop-loss for base Medicare services ($2,500 annual)
  - Reduces cost sharing to nominal levels and eliminates hospital cost sharing
  - Expected premium (without selection): $50 to $60 per month

MEDICARE MEDIGAP OPTION

- **Pros**:
  - Viewed as structural reform – one of major points for premium support advocates and economists
  - Moves towards private sector benefits package
  - Mitigates against cost sharing increases
- **Cons**:
  - Opposed by insurers and conservatives as a government take-over
  - Risks being selected against / becoming expensive
  - Complicated policy that may not be worth the political gain

MEDICARE BOARD

- Commission Proposal:
- Alternative:

MAJOR MEDICARE POLICIES UNDER CONSIDERATION

POLICY	BREAUX-THOMAS	STATUS
Increasing Competition in Medicare		
Allowing traditional Medicare to use competitive, efficient private payment policies	Yes	Recommending yes: Includes a series of good management items
Adopting premium support to make HMO & traditional plan payments more competitive	Yes	Recommending reject Breaux-Thomas model but considering options that protect traditional Medicare
Reducing Medicare's Costs		
Raising Medicare's eligibility age	Yes	Recommending no
Extending/modifying BBA policies	Yes	Considering addressing concerns of providers while still achieving savings
Ending Medicare funding / liability for graduate medical education	Yes	Considering including all-payer proposal
Modernizing Medicare's Benefits		
Adding a voluntary Medicare prescription drug benefit	No (Medicaid)	Recommending yes (multiple designs under consideration)
Rationalizing cost sharing		
Adding copays: Home health (10% coinsurance) Laboratory services (20% coinsurance) Nursing homes (20% coinsurance)	Yes	Recommending yes, but with lower, capped home health copay and lower nursing home copay
Reducing copays: Preventive services Hospital copays after 60 days	Yes	Recommending yes on preventive, no on hospital copays, since affects few people & savings needed for drugs
Changing Medicare's deductibles	Yes	Under consideration
Prohibiting Medigap deductible coverage	Yes	Under consideration
Offering unsubsidized Medigap option	No	Under consideration; in Reischauer plan
Coordinating care for dual Medicaid eligibles	No	Under consideration; may be in Breaux bill
Medicare buy-in for certain 55 to 65 year olds	No	In budget, assumed in plan
Reformed review process for approving new technology/alternative therapies	Yes	Recommending administrative actions, but not recommending HCFA overhaul
Improving Medicare's Financing		
Dedicating part of surplus for Medicare	No	In budget, assumed in plan
Adding income-related premium	No	Recommending yes
Additional tobacco revenue/ Medicare suit	No	Under consideration (Wyden, Snowe)