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UNITED STATES SENATE
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To: Medicare Commission

DRAFT–2/16/1999

From: Jeff Lemieux

I have attached an estimate of the February16 study proposal. Based on the earlier proposal introduced by Senator Breaux, the new proposal includes adds several items and clarifies others. It requires HCFA to organize a privately-run fee-for-service plan, which would operate under the auspices of the Board like any other private plan. All plans, including the privately-run fee-for-service plan, would be required to offer a "standard option" that contained the benefits available in the traditional government-run Medicare plan, and a "high option" that would include prescription drug benefit. Extra costs of high option plans would be born by beneficiaries in their premiums. The premium formula would allow zero-premium plans. Conforming to the decisions of the Modeling task force, the estimate is focused on the long-term, and uses many different measures to gauge the impact of the proposal.

Highlights:

- Using an extension of CBO's projections of health spending as a basis for the estimate, the proposal would gradually slow the growth of Medicare spending. Although the growth in outlays would be slowed by a modest 1.3 percent a year on average, the savings would compound to significant amounts in the long-run. By 2030, annual Medicare spending would be $550-$800 CHECK billion less under Senator Breaux's proposal than under current law. (Absent changes in the law, the Modeling task force projected that Medicare spending would reach $2.2 to $2.9 trillion in 2030.)

- Under the proposal, Medicare would grow from 12 percent of the federal budget to in 2000 to 20-26 percent in 2030. (Under current law, Medicare is projected to grow to 28-38 percent of the budget.) Due to rapid growth in the number of beneficiaries, and because per-beneficiary spending under the proposal would grow faster than per-capita GDP, Medicare spending would rise from 2.7 percent of the economy in 2000 to approximately 4.4-5.8 percent in 2030. (Under current law, Medicare spending would rise to 6.3-8.5 percent of GDP).

- Although beneficiaries' premiums would vary based on the plan selected, average premiums would remain at 12 percent of program costs. Because the proposal would slow the growth of program costs, beneficiary premiums would be 20-30 CHECK percent less than those expected under current law on average. If the government-run fee-for-service plan used the management tools available under Senator Breaux's proposal to slow the growth of its costs, premiums would be lower in the fee-for-service plan than under current law.

- Because the savings would accumulate slowly over time, Senator Breaux's proposal would not significantly extend the insolvency date of the Part A fund. The proposal does not lend itself to continuing the distinction between Parts A and B, however, and although the estimates attempt

to compute results for the Part A fund, those results are especially uncertain. (Recently enacted transfers of obligations between Parts A and Part B of Medicare and proposed transfers of funds from the general Treasury to Part A have weakened the analytic usefulness of the Part A fund's finances. The Modeling task force concentrated on broader measures, such as those above.)

- The uncertainties of long-term projections and estimates are high. The logic of long-term projections and estimates is often more helpful than the numerical results, and relative measures are more meaningful than dollar amounts in the long-run.

Data Update:

- Medicare spending grew very slowly in fiscal year 1998, and Medicare spending will probably grow slowly in 1999 as well. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

- New Medicare estimates from CBO show slightly lower Medicare spending and slowed enrollment in private plans in the short run. Because the reasons for those changes are probably temporary, neither change would significantly affect the 30-year projections used in the estimate of Senator Breaux's plan.

- With Medicare contributing significant, if temporary, controls on its costs, the growth of national health spending will probably continue its remarkably slow pace in 1998 and 1999.

Preliminary Staff Estimate: Medicare Proposal of February 16, 1999
DRAFT--2/16/99

This estimate takes the form used by the Modeling Task Force. Following a short introduction that highlights the major estimating issues, the estimate includes an expanded description of the proposal, basis of the estimate, and consideration of the impact on health plans and on beneficiaries. The estimate includes the detailed tables developed by the task force.

Introduction: Major Estimating Issues

Estimates of the long-run savings from a premium support proposal are dependent on the ability of a competitive system to reduce annual growth rates in Medicare spending. In this estimate, those savings are based on projections of the difference between the growth of Medicare's fee-for-service spending under current law and the growth of premiums in private plans.

Under current law, the growth of Medicare spending will be determined by the growth of spending in the current fee-for-service program. That is because Medicare law links the growth of Medicare's payments to private plans to the growth in spending under the fee-for-service program. Under the proposal for an premium support system, however, the growth of Medicare spending would be determined by the average growth in premiums for all plans, private plans as well as the government-run fee-for-service plan, weighted by the enrollment in those plans.

Staff estimates for the Commission use projections for the growth of private health insurance premiums from the Congressional Budget Office (CBO) as a guide to the likely growth of premiums for private plans under a premium support system for Medicare. In general, CBO assumes that private premiums will grow considerably more rapidly in the future than they have in the last 5 or 6 years. Specifically, CBO projects that private premiums will grow faster than the economy as a whole in the coming years, but will grow more slowly than current-law Medicare spending, at least after the major impact of the Balanced Budget Act has ended.

Using CBO's projections, therefore, Medicare spending under a premium support system (based on premiums for private plans and the fee-for-service plan) would grow more slowly than Medicare spending under current law (based on the fee-for-service plan alone). The annual reduction in the growth of Medicare spending would be modest, but would accumulate to a considerable savings in the long-run.

HCFA's projections of health spending, by contrast, assume that the growth of premiums for private plans will equal that of the fee-for-service program, even under the assumption that current law is not

changed.[1] HCFA projects that both Medicare spending and private insurance premiums will return to an 8 percent annual growth rate. Those projections have been criticized for assuming that the power of purchasers and health plans to achieve savings compared to fee-for-service is over.[2] That assumption is critical in determining the potential for a competitive system, like premium support, to reduce the growth in Medicare spending.

Description of the Proposal

The proposal would replace Medicare's Part B premium and the Medicare +Choice system with a premium support system patterned after the Federal Employees Health Benefits (FEHB) program and run by a Medicare Board.

The Medicare Board

A Medicare Board would be created to oversee the premium support system. The duties of the Board would include providing information about plans' benefits and premiums to beneficiaries, computing payments to plans (including risk and geographic adjustment), and computing beneficiaries' premiums (which would be based on individual enrollees' selections of plans, including the government-run plan). Premiums would be collected through Social Security system, as Part B premiums are collected under current law.

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

Specifically, the Medicare Board would ensure that all private plans offered a standard option that covered those benefit items covered by the government-run fee-for-service plan, and that all standard option plans covered those items to an extent comparable to the government-run plan. In addition, all plans would be required to offer a high option plan, which would also contain coverage for prescription drugs. To encourage innovations by plans and broad competition among various types of plans, plans

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1 Sheila Smith and others, "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs* (September/October 1998).

2 See for example, letters by Paul Ginsburg, Jon Gabel, and John Sheils in *Health Affairs* (January/February 1999).

would be given the flexibility to propose benefit design options. The Board would approve any proposed changes.

Risk adjusters for plans would include

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

The geographic payment adjuster would include elements of historical Medicare costs and the cost of providing health services in areas. This estimate assumes that the areas would be defined as Metropolitan Statistical Areas with one additional area for non-metropolitan areas of each state. The geographic adjustment factors would be budget-neutral; the magnitude of the geographic adjusters would be a policy decision. This estimate assumes that the geographic adjuster would have approximately 75 percent of the variation currently embedded in the Medicare's AAPCC payment adjusters.[3] That would prevent private plan enrollees in high- or low-cost areas from facing disruptively large premium changes when the premium support system was implemented.

Modernizing the Government-Run Fee-For-Service Plan

The proposal would modernize the traditional government-run fee-for-service plan, and would create a new privately-run fee-for-service plan under the auspices of the Board.

Government-Run Fee-For-Service Plan. The proposal would make it easier for the fee-for-service plan to compete by authorizing the use of management tools currently available to private plans. Those tools would include enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting, and preferred provider arrangements. As under current law, Congressional approval of major benefit or service changes would be required.

In addition, the proposal would modify the benefit package for the fee-for-service plan. For example,

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[3] Within a reasonable range, the choice of a budget-neutral geographic adjustment factor does not affect the estimate. In this estimate, an index of 1998 AAPCC variation was combined with an index of the cost of providing outpatient care. The resulting index has approximately 75 percent of the variation of the AAPCC index alone.

the proposal would create a combined deductible of approximately $380 (in 2000 dollars) to replace the Part B deductible and the per-episode hospital deductibles and limits in the current Part A package, and coinsurance of 10 percent would be extended to home health care. The combined deductible would be indexed to the Consumer Price Index (CPI).

Privately-Run Fee-For-Service Plan. The proposal would require HCFA to organize a privately-run fee-for-service plan or preferred provider plan with out-of-network benefits. The benefit package for that plan would include a standard option with the same benefit requirements as private standard option plans and the government-run fee-for-service plan, and a high option, which would include prescription drugs. Like any other private plan, proposed benefit or service changes would require Board approval. Although the objective of the privately-run fee-for-service plan is ensure that at least one plan with an integrated drug benefit would be available to all beneficiaries nationwide, the Board could allow the plan to operate only in particular regions during a start-up period. The government-run fee-for-service plan would not operate in areas where HCFA had provided for a privately-run fee-for-service plan.

Premium Schedule

Medicare premiums would be based on a national schedule similar to that used in the FEHB system. The premium schedule would be based on each year's national weighted average premium. The weighted average premium would be based on plans' standard option premiums and the premium for the government-run fee-for-service plan. Any extra costs of high-option plans would not be included in the national weighted average; for calculating the weighted average, a plan's total enrollment would be multiplied by the plan's standard option premium. The premium schedule would be based on the following rules:

- For plans with premiums below **85** percent of the national weighted average, the beneficiary would pay nothing.
- For premiums between **85** and **100** percent of the national weighted average, the government's share would increase by roughly $1 for every $3 required of the beneficiary.
- For premiums above **100** percent of the national weighted average, the government's share would be capped.

(On average the enrollee's share of the plans' premium would be about 12 percent.)

Schedule 1 (attached) summarizes the government and enrollee shares of a plan premiums as they increase through a hypothetical range. (Those figures are meant to be illustrative, not estimates of future premiums. For reference, the Medicare Part B premium is projected to be about 12 percent of program costs when the Balanced Budget Act of 1997 is fully implemented.)

Assistance for Low-Income Beneficiaries

Low-income beneficiaries would be eligible for premium and cost-sharing assistance via Medicaid as under current law. (Beneficiaries with incomes below poverty are eligible for premium and cost-sharing assistance under current law; beneficiaries with incomes between 100 percent and 135 percent of poverty are eligible only for premium assistance.) In a premium support system, those beneficiaries would be absolved of any premium payments for plans available to them up to cost of the government-run fee-for-service plan, the standard option privately-run fee-for-service plan or the lowest-cost standard option plan available to them.

Under the proposal, assistance for low-income beneficiaries would be expanded in two ways:

- Coverage for prescription drugs would be available under Medicaid for Medicare beneficiaries under 135 percent of poverty.

- Premium assistance would be expanded to included beneficiaries between 135 and 200 percent of poverty, based on a sliding scale.

In both cases, the expanded assistance would be funded at a 100 percent matching rate by the federal government. (Rather than explicitly subsidizing drug coverage under Medicaid for those below 135 percent of poverty, states could add premium assistance up to the cost of a high option plan.)

Raising the Normal Age of Eligibility to that of Social Security

The proposal would conform the normal age of Medicare eligibility to that of Social Security. Over approximately 25 years, that would raise the age from 65 years to 67 years. The proposal would allow certain beneficiaries affected by the delayed eligibility to participate in Medicare, but does not specify how. For the purposes of this estimate, the usual 2-year waiting period would be waived for those affected beneficiaries who became disabled between ages 65 and 67, and reduced for those beneficiaries who became disabled between ages 63 and 65. This estimate assumes that the savings from this provision would be reduced by approximately 10 percent due to waived or reduced waiting periods for certain beneficiaries who otherwise would not have been eligible.

Medigap Reform

The proposal would significantly rearrange the Medigap market. The proposal would limit the effect of first dollar coverage by requiring Medigap plans to cover beneficiaries' coinsurance only after the combined deductible was met. All Medigap plans would be required to cover prescription drugs, and a prescription drug only plan would be authorized. Medigap plans would not be allowed to cover coinsurance for private Medicare plans or the privately-run fee-for-service plan.

Carving Out Direct Medical Education

The proposal would end Medicare payments for direct medical education, instead funding those activities elsewhere in the budget. The proposal also recommends reducing payments for indirect medical education by 20 percent, and revisiting Medicare payments to Disproportionate Share Hospitals (DSH) to ensure that DSH payments are reasonable and appropriate. For the purposes of this estimate, DSH payments were assumed to be unchanged.

Restraining Growth of Payment Rates in Government-Run Fee-For-Service Plan

The Balanced Budget Act of 1997 temporarily slowed the growth of payments to fee-for-service providers under the traditional Medicare plan. Senator Breaux's proposal includes a continuation of some such restraint after the BBA savings end in 2002. The magnitude of the proposed reduction in the growth of fee-for-service payments is similar to the slowing that would be achieved by extending certain provisions of the Balanced Budget Act of 1997.[4] Importantly, extending some moderation in the growth of fees under the fee-for-service plan need not imply a literal extension of the listed provisions, and the listed provisions would not slow the growth of payments nearly as much as the Balanced Budget Act did. In the short run, spending in the fee-for-service plan can be profoundly affected by changes in payment rules or more careful scrutiny of providers' claims. Also, the growth of other fees could be trimmed to the same effect. The listed policies serve only as a concrete example.

Financing

Both the premium support system and the modernizations of the government-run fee-for-service plan indicate–but do not require–that Parts A and B of Medicare be combined. The proposal does not address that issue, or how a combined trust fund would be financed. For the purposes of this estimate, Parts A and B are presumed to continue, and the financing results for the Part A fund are shown. Those results are highly uncertain, however, and may not be relevant if a combined trust fund is proposed.

Minor and Conforming Changes

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[4] For example,

- PPS Hospital update at market basket - 1.1 percent;
- PPS Capital 2.1 percent reduction
- Exempt Hospitals Capital 15 percent reduction
- Exempt Hospitals update using BBA criteria
- Skilled Nursing Facilities updated at market basket -1 percent
- Hospice update at market basket -1 percent
- Ambulance update at market basket – 1 percent
- Lab, Durable Medical Equipment, and PEN freeze update 2003-2007
- Prosthetics and Orthiotics update at 1 percent
- Outpatient Hospital update at market basket -1 percent
- Update for Ambulatory Surgical Center facility costs at CPI -2 percent

The premium support system would not be compatible with the Part A only coverage available under current law. Also, the option for Part B only coverage under current law would have to be folded into Medicaid or some other program. The hold-harmless provision in current law, which stipulates a beneficiary's net Social Security payment not be reduced on a year-to-year basis by the annual increase in the Part B premium, would probably require some modification to be consistent with a premium support system. To accommodate persons eligible for Medicare because of End-Stage Renal Disease (ESRD), a special payment adjuster, risk pool, or other arrangement would have to be made. Alternatively, ESRD coverage could be separated from the premium support system and maintained as under current law.[5] In this estimate, no savings were assumed for the ESRD population.

Basis of the Estimate

Under current law, the growth of Medicare spending will be determined by the growth of spending in the fee-for-service program. That is because Medicare law links the growth of Medicare's payments to private plans to the growth in spending under the fee-for-service program.[6] Under Senator Breaux's proposal for a premium support system, however, the growth of Medicare spending would be determined by the average growth in premiums for all plans, private plans as well as the government-run fee-for-service plan, weighted by the enrollment in those plans.

Under a premium support system, federal outlays and beneficiaries' out-of-pocket costs would ultimately depend on the sensitivity of beneficiaries to price differences among plans. In the FEHB program for federal workers and retirees, that sensitivity operates in two ways. First, plans set their premiums knowing that high premiums may cause enrollees to switch to less expensive plans, and, second, some enrollees actually switch each year. Enrollee switching behavior is easy to measure. The following table shows the weighted average growth in premiums in FEHB before and after the annual open season, when enrollees select plans.[7]

Annual Growth in Premiums under the FEHB Program, 1990-1998 (in percent).

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5 This is certainly not an exhaustive list of technical issues that would have to be considered to form a legislative package from this sort of proposal.

6 Changes in the way Medicare pays private plans made by the Balanced Budget Act of 1997 will temporarily break the connection between the growth of fee-for-service spending and the growth of payments to private plans.

7 Pre-open season premiums are weighted by the previous years' enrollment patterns–that measures what the growth of premiums would have been if no workers or retirees switched plans. The Post-open season measure weights the growth of premiums using actual enrollment decisions–that is the amount by which government payments grow in the FEHB system.

Year	Pre-Open Season	Post-Open Season	Result of Switching
1990	13.3	8.0	-5.3
1991	5.7	4.1	-1.6
1992	8.0	7.3	-0.7
1993	9.0	8.5	-0.5
1994	3.0	2.7	-0.3
1995	-3.4	-3.8	-0.4
1996	0.4	-0.1	-0.5
1997	2.4	1.6	-0.8
1998	8.5	7.2	-1.3

This estimate is based on projections of Medicare spending, premiums for private insurance, and the share of Medicare beneficiaries enrolled in private plans from the Congressional Budget Office (CBO).[8] CBO's baseline for Medicare spending has been extended to 2030 by the Commission using two alternatives: the Trustees Intermediate baseline, which assumes that the growth of Medicare spending will slow after 2010, and the No Slowdown baseline, which assumes no such slowing. The Commission is using both scenarios as current-law baselines–projections of Medicare spending that would occur if Medicare laws were not changed.

This estimate uses CBO's projection for the growth of private health insurance premiums as a guide to the likely growth of premiums for private plans under a premium support system for Medicare. In general, CBO assumes that private premiums will grow considerably more rapidly in the future than they have in the last 5 or 6 years. Specifically, CBO projects that private premiums will grow faster than the economy as a whole in the coming years, but will grow more slowly than current-law Medicare spending, at least after the major impact of the Balanced Budget Act has ended.[9]

CBO projected private insurance premiums through 2008. To be consistent with both the Trustees Intermediate and No Slowdown baselines for Medicare, two extensions of CBO's baseline for private premiums were created. For the No Slowdown baseline, no change in CBO's relationship between the growth of private premiums and the economy was needed. For the Trustees Intermediate baseline, which assumes that the growth of health spending will slow relative to the economy, the growth of private spending was slowed in proportion to the slowdown assumed for Medicare spending.

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8 As with previous estimates prepared through the Modeling task force, this estimate uses CBO's January 1998 economic and health baselines. Although those baselines changed in January 1999, the changes do not imply significant changes to the 30-year projections used by the Commission.

9 Congressional Budget Office, "Projections of National Health Expenditures: 1997-2008," *The Economic and Budget Outlook* (January 1998).

CBO assumes that competition among health plans, and careful purchasing by the employers who arrange most private health insurance, will help hold the growth of private premiums to a slower rate than that seen prior to the early 1990s. This estimate assumes that a premium support system in Medicare would create a similarly competitive purchasing environment to that expected in the market for private insurance for workers. That would justify a similar growth rate for private plans serving Medicare beneficiaries.

To some extent, the additional premiums that some private plans in Medicare currently charge would be folded into the premium support system. Because only standard option premiums would be included in the national weighted average, however, the net impact of the transition to a premium support system under this proposal would be minimal. Leaving allowing only standard option premium to form the national weighted average would protect the government from the high or escalating costs of high option plans. That would lower the growth of Medicare spending over time as well.

Modernizing the Fee-For-Service Plan and Reforming Medigap

Based on preliminary estimates from CBO, implementing a combined deductible of $380 (in 2000 dollars) indexed to the growth of the Consumer Price Index would initially be approximately budget neutral. If Part A and Part B remained separate, the combined deductible would raise Part A costs by about 4 percent and reduce Part B costs by the same percentage. Limiting first-dollar coverage in Medigap plans by forbidding coverage of the combined deductible would lower Medicare's costs by about 1 percent. Because the combined deductible would be indexed to the CPI, it would gradually fall as a percent of Medicare spending, adding slightly to Medicare's costs over time. Instituting a 10 percent coinsurance for home health services would lower costs by about 1 percent in Part A and 1.5 percent in Part B.

Because few beneficiaries choose Medigap plans with a drug benefit currently, requiring all Medigap plans to have a drug benefit would significantly the market for those plans. If all current Medigap enrollees continued to purchase such coverage, the extra cost of the drug benefit would roughly offset the savings from prohibiting coverage of the combined deductible, leaving the cost of a more common Medigap plan (without drugs) roughly unchanged. If, on the other hand, the requirement that all Medigap plans have a drug benefit caused many healthier beneficiaries to drop their Medigap coverage, the average price of a Medigap plan would probably be increased.

The premium support proposal is designed to pressure the fee-for-service plan to stay competitive with private plans. Traditionally, CBO would not recognize savings from granting HCFA additional authority or flexibility to manage the government-run fee-for-service plan in a more cost effective way. That is because there is no guarantee that HCFA would exercise the new powers, or that those powers would effectively reduce Medicare costs.

This estimate reduces the growth of fee-for-service spending in the government-run plan only by the

amounts implied by extending certain provisions of the Balanced Budget Act of 1997.[10] Following CBO's custom, therefore, the estimate assume any additional savings from HCFA's new management authority. Alternatively, the estimate could be viewed as assuming that HCFA's new authority caused savings in the government-run fee-for-service plan equivalent to the BBA extension example shown, making the extension policies unnecessary, in a sense.

Importantly, extending some moderation in the growth of fees under the fee-for-service plan need not imply a literal extension of the listed provisions. In the short run, spending in the fee-for-service plan can be profoundly affected by changes in payment rules or more careful scrutiny of providers' claims. Also, the growth of other fees could be trimmed to the same effect. The listed policies serve only as a concrete example.

With a more competitive fee-for-service plan, the estimate assumes that by 2030, 50 percent of beneficiaries were in private plans. (That is the same as CBO's long-term baseline.) The summary estimate for the estimate is shown in Table 1; the detailed tables developed by the Modeling task force are shown in Tables 2-5.

Low Income Subsidies

Extending Medicaid drug coverage to Medicare beneficiaries eligible for the QMB and SLMB programs with a 100 percent federal matching rate would raise federal spending for Medicaid by about 3 billion a year if the program was implemented in the year 2000. Assuming the participation rate in the QMB and SLMB programs rose to 60 percent, Medicaid costs for premium and cost-sharing assistance would rise $2 billion as well. Federal spending for premium assistance for those between 135 and 200 percent of poverty be about $1 billion if the program was implemented in 2000. All told, the low-income subsidies would cost about $6 billion in 2000. (All amounts would be higher in later years.) This estimate adds the cost of the expanded low income subsidies to Medicare spending. All of the cost is assumed to be a federal responsibility.

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[10] For example,

- PPS Hospital update at market basket - 1.7 percent
- PPS Capital 2.1 percent reduction
- Exempt Hospitals Capital 15 percent reduction
- Exempt Hospitals update using BBA criteria
- Skilled Nursing Facilities updated at market basket -1 percent
- Hospice update at market basket -1 percent
- Ambulance update at market basket – 1 percent
- Lab, Durable Medical Equipment, and PEN freeze update 2003-2007
- Prosthetics and Orthiotics update at 1 percent
- Outpatient Hospital update at market basket -1 percent
- Update for Ambulatory Surgical Center facility costs at CPI -2 percent

Impact on Health Plans and Beneficiaries

In the short run, the FEHB-style premium schedule is intended to be roughly budget neutral if plans initially made similar offerings to those expected under current law, and beneficiaries initially made similar choices to those they otherwise would have made. The impact on plans would be straightforward–fundamentally, plans would receive the amount they charged.[11] The impact on beneficiaries would be relatively modest–the premium formula would require that fee-for-service beneficiaries pay a premium similar to the Part B premium under current law.[12] If the geographic adjuster was less variable than the AAPCC adjusters used under current law, enrollees in private plans in very high-cost areas could face increases in their overall premium obligations; private plan enrollees in low-cost areas could see reductions in their premiums.

In any given year, beneficiaries would choose from plans available to them based on the incentives in the premium schedule–higher cost plans would cost them more and lower cost plans would cost them less. Beneficiaries in certain rural areas could have additional choices of plans to the extent that national or regional private plans were developed, or if the privately-run fee-for-service plan was offered in their area.

In the long run, if the premium support system increased competition among plans and improved beneficiaries' incentives to make price-conscious choices, the beneficiaries and the government would effectively share the benefits of slower-growing premiums. Beneficiary premiums and government costs would grow together, at the rate of growth of premiums in the plans beneficiaries chose.

Impact on Other Programs

Medicaid spending would not necessarily be changed by the implementation of an FEHB-style system. Medicaid programs supporting Medicare premiums and/or cost-sharing could be adapted to mimic the FEHB-style system. For example, low-income Medicare beneficiaries qualifying for Medicaid assistance could use a premium schedule that required no beneficiary contribution up to the cost of a particular plan. To the extent that the growth of costs in those plans were slower than that expected in baseline, the growth of Medicaid spending for Medicare premiums would be slowed as well. Although the cost estimate includes as Medicare spending the expanded low-income subsidies discussed above, it does not include savings that a slowing of the growth of premiums would cause for the Medicaid program.

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11 Government payments would be adjusted as specified above.

12 The premium schedule is calibrated to the Part B premiums that would be applicable after the transfer of most home health spending from Part A to Part B in the fee-for-service program. By the time a premium support system was implemented, the transfer would be largely complete.

Item #FEB16: Preliminary Staff Estimate

Table 1. February 16 Proposal

DRAFT

16-Feb-99

	Medicare Spending Growth Rate, 2000-		Medicare Spending as a Percent of GDP /1/2		Medicare as a Percent of Federal Revenues		Medicare Spending (in billions of dollars) /3		Part A Insolvency Date (approx.)	Premiums as a Percent of Beneficiaries' Income		Budgetary Costs (+) or Savings (-) (in billions) /4	
	2015	2030	2015	2030	2015	2030	2015	2030		2015	2030	2015	2030
Baselines													
Trustees Intermediate	6.2%	7.6%	4.4%	6.3%	19%	28%	801	2,212	2008	7%	7%	0	0
No Slowdown	6.3%	8.6%	4.5%	8.5%	19%	38%	817	2,972	2008	7%	10%	0	0
Viability Standard Based on Spending (Could also use Premiums, Taxes)													
Slow Growth of Per Beneficiary Spending to that of Per Capita GDP													
Trustees Intermediate	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-182	-615
No Slowdown	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-195	-1272
Preliminary Estimate													
February 16 Proposal													
Trustees Intermediate	6.9%	6.3%	3.7%	4.4%	16%	20%	669	1,560	~2014	5%	5%	-106	-548
No Slowdown	7.0%	7.3%	3.7%	5.8%	16%	26%	681	2,031	~2014	5%	6%	-108	-793

Policy: The Part B premium and the Medicare +Choice system for private plans would be replaced by a premium support with standard and high options under formula that allows zero-premium plans. Normal age of eligibility would be gradually increased, but waiting period for eligibility for disabled would be waived or reduced the those affected. Low-income subsidies expanded; sliding scale premium from 135-200 percent of pove drug coverage for <135 percent. Benefits package change would include coinsurance for home health and combin deductible (indexed to CPI). Direct eduction carved out and IME reduce by 20%. Additional management tools in Premium formula anchored to standard option premiums.

Considerations: Depending on the geographic payment adjustment used, some enrollees in private plans in high-cost areas could face higher total premiums; some private plan enrollees in low-cost areas could see lower total premiums. Medicaid spending for Medicare premiums would be reduced somewhat.

SOURCE: Medicare Commission Staff.

1. In 2000, Medicare spending will be 3 percent of GDP and 12 percent of the federal budget (revenues). Total projected Medicare spending will be $247 billion in 2000.
2. Payroll is approximately half of GDP. For example, in 2015 under the Trustees Intermediate baseline, Medicare spending would be 9.0 percent of payroll.
3. All spending estimates after Part A fund insolvency are hypothetical.
4. Medicare cost or savings in the year shown

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Package 1—Draft Medicare legislative package introduced by Senator Breaux at January 22 Commission meeting[1]

Category	Provision	Comment
Fee-for-service:		
Cost sharing	Combined A & B deductible of $350 (indexed to CPI) 0% coinsurance on inpatient and preventive care; 10% coinsurance on home health care; present law OPD coinsurance; 20% coinsurance on all other services	
Modernization	Standard BCV package	
BBA extenders	Option (1): None Option (2): Current Jeanne Lambrew package: 2007 / no M+C / no DSH	
Medical education	Remove DME funding from Medicare; no IME provision	
DSH	No provision	
Medigap reforms	Prohibit coverage of Medicare deductible(s)	
Premium support:		
Administration	Medicare Board would have considerable authority to negotiate premiums & benefit packages, enforce financial & quality standards, approve service areas, etc.	
Benefit packages	Option (a): Standardized "core" package required as minimum Additional benefits beyond core package are allowed Private plan packages must be ≥ government FFS plan Actuarial value of package may not exceed 110% of core value Peripheral benefits such as dental care, cosmetic surgery, vision care, OTC drugs, expanded Rx coverage are not permitted Option (b): Standardized "core" package only; no benefit package flexibility	
Premium allocation	Gov't FFS plan must bid nationally; others may bid nationally or regionally Partial geographic adjustment of payments; full risk adjustment "Optimal rebate" premium allocation formula: At or above 100% of WAP, gov't contrib = .88 WAP Below 100% of WAP, Δgov't contrib/Δplan cost = optimal "Optimal" means where direct + indirect Medicare savings are maximized	Assume PL blending rules and GJS rule on premium arithmetic 1st guess: 25%
Income related premium	For QMB/SLMB incomes, no bene prem if plan cost ≤ WAP Singe bene's: 10% at $24,000 - 25% at $40,000+ Bene couples: 10% at $30,000 - 25% at $50,000+ Brackets indexed by CPI Intent is to have balanced redistribution of costs within bene population	10% vs. 12.3% inconsistency: use 12.3% for now
FFS and PS:		
Eligibility age	Increase age of eligibility following OASDI schedule	
Voluntary coverage	No provision	
Drug coverage	Option (i): No requirement Option (ii): $250 deductible $7/$15 copayments per generic/brand name script Maximum benefit per beneficiary of $1,250 All parameters indexed to general inflation 50% of drug benefit cost to be included in bene prem determination	Per Darla & Sarah
Budget surplus revenue	No provision	

[1] Specifications reflect clarifications and modifications received from Bobby Jindal, Darla Romfo, and Sarah Lyons on 1-29-99, 2-11-99, 2-12-99, and 2-17-99.

Office of the Actuary
February 20, 1999

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(a)(i): No extenders; benefit flexibility; no drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Income-related premium	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Premium support subtotal	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Drug coverage:																	
Expenditure impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Premium impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Drug coverage subtotal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6
Total savings	-5.5	-11.3	-12.4	-14.6	-16.8	-18.6	-20.3	-22.6	-25.3	-28.5	-30.0	-31.7	-35.1	-38.6	-40.5	-42.9	-45.5
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-2.2%	-4.3%	-4.5%	-4.9%	-5.3%	-5.4%	-5.4%	-5.6%	-5.8%	-6.0%	-5.8%	-5.6%	-5.7%	-5.8%	-5.6%	-5.5%	-5.3%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

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Office of the Actuary
Health Care Financing Admin.
2/21/99

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(a)(i): No extenders; benefit flexibility; no drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0	$0	0.0%	0.0%	0.0%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
0.6	0.7	0.7	0.7	0.8	1.0	1.0	1.0	1.1	1.2	1.2	1.3	1.3	1.4	0	2	19	0.0%	0.1%	0.1%
-48.3	-51.5	-54.7	-58.1	-64.5	-71.1	-75.8	-80.8	-86.1	-91.8	-97.8	-104.1	-110.4	-117.2	-61	-176	-1,552	-4.3%	-5.1%	-5.3%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-5.3%	-5.2%	-5.2%	-5.1%	-5.3%	-5.4%	-5.4%	-5.4%	-5.4%	-5.3%	-5.3%	-5.3%	-5.3%	-5.2%	—	—	—	—	—	—

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Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(a)(ii): No extenders; benefit flexibility; drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Income-related premium	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Premium support subtotal	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Drug coverage:																	
Expenditure impact	0.0	18.0	19.3	20.7	22.3	24.0	25.9	27.9	30.0	32.4	35.2	38.0	41.2	44.5	47.9	51.4	55.1
Premium impact	0.0	-9.4	-10.0	-10.8	-11.6	-12.5	-13.4	-14.4	-15.5	-16.7	-18.0	-19.4	-21.0	-22.7	-24.4	-26.1	-27.9
Drug coverage subtotal	0.0	8.6	9.3	9.9	10.7	11.5	12.5	13.5	14.5	15.7	17.2	18.6	20.2	21.8	23.5	25.3	27.2
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6
Total savings	-5.5	-2.7	-3.1	-4.7	-6.2	-7.1	-7.8	-9.1	-10.8	-12.8	-12.8	-13.1	-14.9	-16.8	-17.0	-17.6	-18.3
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-2.2%	-1.0%	-1.1%	-1.6%	-1.9%	-2.0%	-2.1%	-2.3%	-2.5%	-2.7%	-2.5%	-2.3%	-2.4%	-2.5%	-2.3%	-2.2%	-2.1%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(a)(ii): No extenders; benefit flexibility; drug coverage—

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total savings, nominal dollars 2000-04	2000-09	2000-30	Total savings, % of PL expend's 2000-04	2000-09	2000-30
$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0	$0	0.0%	0.0%	0.0%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
59.0	63.1	67.4	72.0	76.9	82.3	87.9	93.9	99.4	105.7	112.3	119.0	125.8	132.5	80	221	1,830	5.7%	6.4%	6.3%
-29.9	-32.0	-34.1	-36.5	-39.0	-41.7	-44.5	-47.6	-50.7	-54.0	-57.4	-60.8	-64.3	-67.8	-42	-114	-934	-3.0%	-3.3%	-3.2%
29.1	31.1	33.3	35.5	37.9	40.6	43.4	45.7	48.7	51.7	54.9	58.2	61.5	64.7	38	106	896	2.7%	3.1%	3.1%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
0.6	0.7	0.7	0.7	0.8	1.0	1.0	1.0	1.1	1.2	1.2	1.3	1.3	1.4	0	2	19	0.0%	0.1%	0.1%
-19.2	-20.4	-21.4	-22.6	-26.6	-30.5	-32.4	-35.1	-37.4	-40.1	-42.9	-45.9	-48.9	-52.5	-22	-70	-656	-1.6%	-2.0%	-2.2%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-2.1%	-2.1%	-2.0%	-2.0%	-2.2%	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	—	—	—	—	—	—

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Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(b)(i): No extenders; no benefit flexibility; no drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	-2.6	-5.9	-7.6	-9.2	-10.5	-11.4	-12.3	-13.3	-14.4	-15.7	-17.0	-18.6	-20.2	-22.0	-23.9	-25.9	-28.1
Income-related premium	0.2	0.0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.8	-2.3	-2.9	-3.5	-4.2	-5.0	-5.9	-6.9	-8.0	-9.2
Premium support subtotal	-2.3	-5.8	-7.7	-9.6	-11.2	-12.4	-13.7	-15.2	-16.7	-18.5	-20.5	-22.8	-25.2	-27.9	-30.8	-33.9	-37.2
Drug coverage:																	
Expenditure impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Premium impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Drug coverage subtotal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.7	0.8	0.8	0.9	0.9
Total savings	-10.3	-14.0	-16.2	-19.2	-21.9	-24.3	-26.8	-29.9	-33.6	-37.8	-40.5	-43.5	-48.5	-53.5	-57.2	-61.6	-66.2
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-4.1%	-5.3%	-5.8%	-6.5%	-6.8%	-7.0%	-7.2%	-7.4%	-7.7%	-8.0%	-7.9%	-7.7%	-7.9%	-8.0%	-7.9%	-7.8%	-7.8%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.

3. "Savings" are defined as either expenditure reductions or increases in premium revenues.

4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package
introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(b)(i): No extenders; no benefit flexibility; no drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0	$0	0.0%	0.0%	0.0%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-30.3	-32.5	-34.9	-37.4	-40.1	-43.1	-46.3	-49.6	-53.1	-56.8	-60.8	-65.0	-69.3	-73.8	-36	-103	-952	-2.5%	-3.0%	-3.3%
-10.5	-11.9	-13.4	-15.0	-16.8	-18.7	-20.9	-23.5	-26.1	-29.0	-32.3	-35.8	-39.7	-44.0	-1	-10	-391	-0.1%	-0.3%	-1.3%
-40.9	-44.4	-48.2	-52.4	-56.9	-61.9	-67.2	-73.1	-79.2	-85.9	-93.1	-100.8	-109.1	-117.9	-37	-113	-1,343	-2.6%	-3.3%	-4.6%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
0.9	1.0	1.1	1.1	1.3	1.5	1.6	1.6	1.7	1.8	1.9	2.0	2.1	2.2	1	3	30	0.1%	0.1%	0.1%
-71.3	-76.8	-82.5	-88.5	-97.8	-107.6	-115.8	-124.8	-134.1	-144.2	-155.2	-166.8	-178.8	-191.7	-82	-234	-2,341	-5.8%	-6.8%	-8.0%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-7.8%	-7.8%	-7.8%	-7.8%	-8.0%	8.2%	-8.3%	-8.3%	-8.3%	-8.4%	-8.4%	-8.5%	-8.5%	-8.6%	—	—	—	—	—	—

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Office of the Actuary
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Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(b)(ii): No extenders; no benefit flexibility; drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	-2.6	-5.9	-7.6	-9.2	-10.5	-11.4	-12.3	-13.3	-14.4	-15.7	-17.0	-18.6	-20.2	-22.0	-23.9	-25.9	-28.1
Income-related premium	0.2	0.0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.8	-2.3	-2.9	-3.5	-4.2	-5.0	-5.9	-6.9	-8.0	-9.2
Premium support subtotal	-2.3	-5.8	-7.7	-9.6	-11.2	-12.4	-13.7	-15.2	-16.7	-18.5	-20.5	-22.8	-25.2	-27.9	-30.8	-33.9	-37.2
Drug coverage:																	
Expenditure impact	0.0	18.0	19.3	20.7	22.3	24.0	25.9	27.9	30.0	32.4	35.2	38.0	41.2	44.5	47.9	51.4	55.1
Premium impact	0.0	-9.4	-10.0	-10.8	-11.6	-12.5	-13.4	-14.4	-15.5	-16.7	-18.0	-19.4	-21.0	-22.7	-24.4	-26.1	-27.9
Drug coverage subtotal	0.0	8.6	9.3	9.9	10.7	11.5	12.5	13.5	14.5	15.7	17.2	18.6	20.2	21.8	23.5	25.3	27.2
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.6	0.7	0.8	0.8	0.9	0.9
Total savings	-10.3	-5.4	-6.9	-9.3	-11.3	-12.8	-14.3	-16.4	-19.1	-22.1	-23.3	-24.9	-28.3	-31.7	-33.7	-36.3	-39.0
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-4.1%	-2.1%	-2.5%	-3.1%	-3.5%	-3.7%	-3.8%	-4.1%	-4.4%	-4.7%	-4.5%	-4.4%	-4.6%	-4.8%	-4.6%	-4.6%	-4.6%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.

3. "Savings" are defined as either expenditure reductions or increases in premium revenues.

4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (1)(b)(ii): No extenders; no benefit flexibility; drug coverage—

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total savings, nominal dollars 2000-04	2000-09	2000-30	Total savings, % of PL expend's 2000-04	2000-09	2000-30
$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0	$0	$0	0.0%	0.0%	0.0%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-30.3	-32.5	-34.9	-37.4	-40.1	-43.1	-46.3	-49.6	-53.1	-56.8	-60.8	-65.0	-69.3	-73.8	-36	-103	-952	-2.5%	-3.0%	-3.3%
-10.5	-11.9	-13.4	-15.0	-16.8	-18.7	-20.9	-23.5	-26.1	-29.0	-32.3	-35.8	-39.7	-44.0	-1	-10	-391	-0.1%	-0.3%	-1.3%
-40.9	-44.4	-48.2	-52.4	-56.9	-61.9	-67.2	-73.1	-79.2	-85.9	-93.1	-100.8	-109.1	-117.9	-37	-113	-1,343	-2.6%	-3.3%	-4.6%
59.0	63.1	67.4	72.0	76.9	82.3	87.9	93.3	99.4	105.7	112.3	119.0	125.8	132.5	80	221	1,830	5.7%	6.4%	6.3%
-29.9	-32.0	-34.1	-36.5	-39.0	-41.7	-44.5	-47.6	-50.7	-54.0	-57.4	-60.8	-64.3	-67.8	-42	-114	-934	-3.0%	-3.3%	-3.2%
29.1	31.1	33.3	35.5	37.9	40.6	43.4	45.7	48.7	51.7	54.9	58.2	61.5	64.7	38	106	896	2.7%	3.1%	3.1%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
0.9	1.0	1.1	1.1	1.3	1.5	1.6	1.6	1.7	1.8	1.9	2.0	2.1	2.2	1	3	30	0.1%	0.1%	0.1%
-42.2	-45.7	-49.2	-53.0	-59.9	-67.0	-72.4	-79.1	-85.4	-92.5	-100.3	-108.6	-117.3	-127.0	-43	-128	-1,445	-3.1%	-3.7%	-5.0%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-4.6%	-4.6%	-4.7%	-4.7%	-4.9%	-5.1%	-5.2%	-5.3%	-5.3%	-5.4%	-5.4%	-5.5%	-5.6%	-5.7%	—	—	—	—	—	—

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(a)(i): BBA extenders; benefit flexibility; no drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$13.2	-$14.3	-$15.5	-$16.8	-$18.2	-$19.7	-$21.3
Cost sharing changes	1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	2.6	-3.1	-3.9	4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Income-related premium	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Premium support subtotal	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Drug coverage:																	
Expenditure impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Premium impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Drug coverage subtotal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.0	0.1	0.1	0.2	0.3	0.5	0.6	0.8	0.9	1.0	1.1	1.1	1.2	1.4	1.4	1.5	1.6
Total savings	-5.5	-11.3	-12.8	-16.9	-21.0	-24.8	-28.9	-33.2	-36.1	-40.1	-42.6	-45.3	-49.9	-54.6	-57.8	-61.7	-65.8
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-2.2%	-4.3%	-4.6%	-5.7%	-6.6%	-7.2%	-7.7%	-8.2%	-8.3%	-8.5%	-8.2%	-8.1%	-8.1%	-8.2%	-8.0%	-7.9%	-7.7%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(a)(i): BBA extenders; benefit flexibility; no drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-$22.9	-$24.6	-$26.3	-$28.2	-$30.3	-$32.7	-$35.0	-$37.5	-$40.0	-$42.8	-$45.7	-$48.8	-$52.0	-$55.3	-$7	-$57	-$698	-0.5%	-1.7%	-2.4%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
1.6	1.8	1.9	2.0	2.3	2.5	2.7	2.8	3.0	3.2	3.4	3.5	3.7	3.9	1	4	52	0.1%	0.1%	0.2%
-70.2	-74.9	-79.8	-85.0	-93.4	-102.2	-109.1	-116.5	-124.3	-132.5	-141.4	-150.6	-160.0	-169.9	-68	-231	-2,218	-4.8%	-6.7%	-7.6%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-7.6%	-7.6%	-7.6%	-7.5%	-7.7%	-7.8%	-7.8%	-7.8%	-7.7%	-7.7%	-7.7%	-7.6%	-7.6%	-7.6%	—	—	—	—	—	—

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Office of the Actuary
Health Care Financing Admin.
2/21/99

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(a)(ii): BBA extenders; benefit flexibility; drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$13.2	-$14.3	-$15.5	-$16.8	-$18.2	-$19.7	-$21.3
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Income-related premium	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Premium support subtotal	2.6	-3.1	-3.9	-4.9	-6.1	-6.6	-7.1	-7.7	-8.3	-9.0	-9.8	-10.7	-11.6	-12.7	-13.8	-14.9	-16.2
Drug coverage:																	
Expenditure impact	0.0	18.0	19.3	20.7	22.3	24.0	25.9	27.9	30.0	32.4	35.2	38.0	41.2	44.5	47.9	51.4	55.1
Premium impact	0.0	-9.4	-10.0	-10.8	-11.6	-12.5	-13.4	-14.4	-15.5	-16.7	-18.0	-19.4	-21.0	-22.7	-24.4	-26.1	-27.9
Drug coverage subtotal	0.0	8.6	9.3	9.9	10.7	11.5	12.5	13.5	14.5	15.7	17.2	18.6	20.2	21.8	23.5	25.3	27.2
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.0	0.1	0.1	0.2	0.3	0.5	0.6	0.8	0.9	1.0	1.1	1.1	1.2	1.4	1.4	1.5	1.6
Total savings	-5.5	-2.7	-3.5	-7.0	-10.3	-13.3	-16.4	-19.7	-21.6	-24.4	-25.4	-26.7	-29.7	-32.8	-34.3	-36.4	-38.6
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-2.2%	-1.0%	-1.3%	-2.4%	-3.2%	-3.8%	-4.4%	-4.9%	-4.9%	-5.1%	-4.9%	-4.7%	-4.8%	-4.9%	-4.7%	-4.6%	-4.5%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(a)(ii): BBA extenders; benefit flexibility; drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-$22.9	-$24.6	-$26.3	-$28.2	-$30.3	-$32.7	-$35.0	-$37.5	-$40.0	-$42.8	-$45.7	-$48.8	-$52.0	-$55.8	-$7	-$57	-$698	-0.5%	-1.7%	-2.4%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
-17.5	-18.7	-20.1	-21.5	-23.1	-24.8	-26.6	-28.6	-30.6	-32.7	-35.0	-37.4	-39.9	-42.5	-15	-54	-543	-1.1%	-1.6%	-1.9%
59.0	63.1	67.4	72.0	76.9	82.3	87.9	93.3	99.4	105.7	112.3	119.0	125.8	132.5	80	221	1,830	5.7%	6.4%	6.3%
-29.9	-32.0	-34.1	-36.5	-39.0	-41.7	-44.5	-47.6	-50.7	-54.0	-57.4	-60.8	-64.3	-67.8	-42	-114	-934	-3.0%	-3.3%	-3.2%
29.1	31.1	33.3	35.5	37.9	40.6	43.4	45.7	48.7	51.7	54.9	58.2	61.5	64.7	38	106	896	2.7%	3.1%	3.1%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
1.6	1.8	1.9	2.0	2.3	2.5	2.7	2.8	3.0	3.2	3.4	3.5	3.7	3.9	1	4	52	0.1%	0.1%	0.2%
-41.1	-43.8	-46.5	-49.5	-55.5	-61.6	-65.7	-70.8	-75.6	-80.8	-86.5	-92.4	-98.5	-105.2	-29	-124	-1,322	-2.1%	-3.6%	-4.5%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-4.5%	-4.4%	-4.4%	-4.4%	-4.6%	-4.7%	-4.7%	-4.7%	-4.7%	-4.7%	-4.7%	-4.7%	-4.7%	-4.7%	—	—	—	—	—	—

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Office of the Actuary
Health Care Financing Admin.
2/21/99

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(b)(i): BBA extenders; no benefit flexibility; no drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$13.2	-$14.3	-$15.5	-$16.8	-$18.2	-$19.7	-$21.3
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	-2.6	-5.9	-7.6	-9.2	-10.5	-11.4	-12.3	-13.3	-14.4	-15.7	-17.0	-18.6	-20.2	-22.0	-23.9	-25.9	-28.1
Income-related premium	0.2	0.0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.8	-2.3	-2.9	-3.5	-4.2	-5.0	-5.9	-6.9	-8.0	-9.2
Premium support subtotal	-2.3	-5.8	-7.7	-9.6	-11.2	-12.4	-13.7	-15.2	-16.7	-18.5	-20.5	-22.8	-25.2	-27.9	-30.8	-33.9	-37.2
Drug coverage:																	
Expenditure impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Premium impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Drug coverage subtotal	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.1	0.1	0.2	0.3	0.5	0.7	0.9	1.1	1.2	1.4	1.4	1.5	1.7	1.9	2.0	2.1	2.2
Total savings	-10.3	-14.0	-16.6	-21.5	-26.0	-30.4	-35.2	-40.3	-44.2	-49.2	-52.9	-56.9	-63.0	-69.3	-74.3	-80.1	-86.2
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-4.1%	-5.3%	-6.0%	-7.2%	-8.1%	-8.8%	-9.4%	-10.0%	-10.1%	-10.4%	-10.2%	-10.1%	-10.3%	-10.4%	-10.2%	-10.2%	-10.1%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(b)(i): BBA extenders; no benefit flexibility; no drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-$22.9	-$24.6	-$26.3	-$28.2	-$30.3	-$32.7	-$35.0	-$37.5	-$40.0	-$42.8	-$45.7	-$48.8	-$52.0	-$55.3	-$7	-$57	-$698	-0.5%	-1.7%	-2.4%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.8%
-30.3	-32.5	-34.9	-37.4	-40.1	-43.1	-46.3	-49.6	-53.1	-56.8	-60.8	-65.0	-69.3	-73.8	-36	-103	-952	-2.5%	-3.0%	-3.3%
-10.5	-11.9	-13.4	-15.0	-16.8	-18.7	-20.9	-23.5	-26.1	-29.0	-32.3	-35.8	-39.7	-44.0	-1	-10	-391	-0.1%	-0.3%	-1.3%
-40.9	-44.4	-48.2	-52.4	-56.9	-61.9	-67.2	-73.1	-79.2	-85.9	-93.1	-100.8	-109.1	-117.9	-37	-113	-1,343	-2.6%	-3.3%	-4.6%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
2.3	2.5	2.6	2.8	3.1	3.5	3.7	4.0	4.2	4.4	4.7	5.0	5.3	5.6	1	6	73	0.1%	0.2%	0.2%
-92.9	-99.9	-107.2	-115.0	-126.3	-138.3	-148.6	-159.9	-171.7	-184.4	-198.1	-212.6	-227.6	-243.6	-89	-289	-2,997	-6.3%	-8.4%	-10.3%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-10.1%	-10.1%	-10.1%	-10.2%	-10.4%	-10.6%	-10.6%	-10.6%	-10.7%	-10.7%	-10.7%	-10.8%	-10.8%	-10.9%	—	—	—	—	—	—

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Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(b)(ii): BBA extenders; no benefit flexibility; drug coverage—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$13.2	-$14.3	-$15.5	-$16.8	-$18.2	-$19.7	-$21.3
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-2.2	-2.2	-2.2	-2.2	-2.2	-2.1	-2.1
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact	-2.6	-5.9	-7.6	-9.2	-10.5	-11.4	-12.3	-13.3	-14.4	-15.7	-17.0	-18.6	-20.2	-22.0	-23.9	-25.9	-28.1
Income-related premium	0.2	0.0	-0.2	-0.4	-0.7	-1.0	-1.4	-1.8	-2.3	-2.9	-3.5	-4.2	-5.0	-5.9	-6.9	-8.0	-9.2
Premium support subtotal	-2.3	-5.8	-7.7	-9.6	-11.2	-12.4	-13.7	-15.2	-16.7	-18.5	-20.5	-22.8	-25.2	-27.9	-30.8	-33.9	-37.2
Drug coverage:																	
Expenditure impact	0.0	18.0	19.3	20.7	22.3	24.0	25.9	27.9	30.0	32.4	35.2	38.0	41.2	44.5	47.9	51.4	55.1
Premium impact	0.0	-9.4	-10.0	-10.8	-11.6	-12.5	-13.4	-14.4	-15.5	-16.7	-18.0	-19.4	-21.0	-22.7	-24.4	-26.1	-27.9
Drug coverage subtotal	0.0	8.6	9.3	9.9	10.7	11.5	12.5	13.5	14.5	15.7	17.2	18.6	20.2	21.9	23.5	25.3	27.2
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
"Budget surplus" revenues	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions	0.1	0.1	0.2	0.3	0.5	0.7	0.9	1.1	1.2	1.4	1.4	1.5	1.7	1.9	2.0	2.1	2.2
Total savings	-10.3	-5.4	-7.3	-11.6	-15.4	-19.0	-22.7	-26.8	-29.7	-33.5	-35.7	-38.3	-42.8	-47.5	-50.8	-54.8	-59.0
Total present law expend's	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's	-4.1%	-2.1%	-2.6%	-3.9%	-4.8%	-5.5%	-6.1%	-6.6%	-6.8%	-7.1%	-6.9%	-6.8%	-7.0%	-7.1%	-7.0%	-7.0%	-6.9%

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.

3. "Savings" are defined as either expenditure reductions or increases in premium revenues.

4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 22 Commission Meeting

(Calendar year estimates; amounts in billions)

—Option (2)(b)(ii): BBA extenders; no benefit flexibility; drug coverage—

														Total savings, nominal dollars			Total savings, % of PL expend's		
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-$22.9	-$24.6	-$26.3	-$28.2	-$30.3	-$32.7	-$35.0	-$37.5	-$40.0	-$42.8	-$45.7	-$48.8	-$52.0	-$55.3	-$7	-$57	-$899	-0.5%	-1.7%	-2.4%
-1.9	-1.8	-1.6	-1.4	-1.1	-0.8	-0.4	0.0	0.5	1.0	1.6	2.3	3.1	4.0	-9	-20	-31	-0.7%	-0.6%	-0.1%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-30.3	-32.5	-34.9	-37.4	-40.1	-43.1	-46.3	-49.6	-53.1	-56.8	-60.8	-65.0	-69.3	-73.8	-36	-103	-952	-2.5%	-3.0%	-3.3%
-10.5	-11.9	-13.4	-15.0	-16.8	-18.7	-20.9	-23.5	-26.1	-29.0	-32.3	-35.8	-39.7	-44.0	-1	-10	-391	-0.1%	-0.3%	-1.3%
-40.9	-44.4	-48.2	-52.4	-56.9	-61.9	-67.2	-73.1	-79.2	-85.9	-93.1	-100.8	-109.1	-117.9	-37	-113	-1,343	-2.6%	-3.3%	-4.6%
59.0	63.1	67.4	72.0	76.9	82.3	87.9	93.3	99.4	105.7	112.3	119.0	125.8	132.5	80	221	1,830	5.7%	6.4%	6.3%
-29.9	-32.0	-34.1	-36.5	-39.0	-41.7	-44.5	-47.6	-50.7	-54.0	-57.4	-60.8	-64.3	-67.8	-42	-114	-934	-3.0%	-3.3%	-3.2%
29.1	31.1	33.3	35.5	37.9	40.6	43.4	45.7	48.7	51.7	54.9	58.2	61.5	64.7	38	106	896	2.7%	3.1%	3.1%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0	0.0%	0.0%	0.0%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
2.3	2.5	2.6	2.8	3.1	3.5	3.7	4.0	4.2	4.4	4.7	5.0	5.3	5.6	1	6	73	0.1%	0.2%	0.2%
-63.8	-68.8	-73.9	-79.5	-88.4	-97.7	-105.2	-114.2	-123.0	-132.7	-143.2	-154.4	-166.1	-178.9	-50	-182	-2,101	-3.5%	-5.3%	-7.2%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-6.9%	-7.0%	-7.0%	-7.0%	7.3%	-7.5%	-7.5%	-7.6%	-7.6%	-7.7%	-7.8%	-7.8%	-7.9%	-8.0%	—	—	—	—	—	—

SENATOR BREAUX'S MEDICARE REFORM PROPOSALS

(Calendar years, dollars in billions)

	00-04	00-09
Premium Support		
Limited Flexible Benefits	-26	-75
No Flexible Benefits	-37	-102
Income Related Premium (Begins $24/30 ends $40/50)		
Limited Flexible Benefits	-36	-96
No Flexible Benefits	-38	-95
Raising Age Eligibility	-2	-25
Cost Sharing / Medigap Changes		
Cost sharing changes (including unlimited home health copay)	-9	-20
Medigap: Prohibiting coverage of deductible	-5	-11
Subtotal	**-14**	**-31**
Medicare Fee-For-Service Reforms		
BBA Extenders	-7	-57
Modernizing fee-for-service	-9	-22
Subtotal	**-16**	**-79**
Removing direct medical education from Medicare	-20	-46
Drug Coverage	Not Included	
Surplus	Not Included	
Interactions	1	6
MEDICARE SAVINGS		
Total Package Plus Premium Support #1	**-114**	**-346**
Total Package Plus Premium Support #2	**-126**	**-373**
FEDERAL SAVINGS (Minus Income-Related Premium; DME)		
Total Package Plus Premium Support #1	**-58**	**-204**
Total Package Plus Premium Support #2	**-69**	**-231**

THE WHITE HOUSE

WASHINGTON

February 5, 1999

RECOMMENDED TELEPHONE CALL

TO: Senator Pete Domenici

DATE: February 5, 1999

RECOMMENDED BY: Larry Stein LS
Gene Sperling GBS

PURPOSE: Respond to Senator Domenici's phone call made to you this morning about Medicare and the budget.

BACKGROUND: Although there was no advance staff notice about this call, it is likely Senator Domenici called to discuss two issues.

First, he may raise the concern that dedicating 15 percent of the surplus to Medicare makes it impossible to finance any "reasonable" tax cut and may suggest that its inclusion in the surplus debate provides too little flexibility to work out a bipartisan agreement on this year's budget.

You should be firm in insisting that while you want reform there is no way that Medicare can be made solvent to 2020 without significant surplus revenues. Indeed, we estimate that without surplus revenues spending would have to be reduced 15-18% -- or, in other words, growth would have to be withheld to general inflation for over a decade. You might recall that last year Sen. Domenici wanted tobacco revenues to be used for Medicare under his "Medicare First" theme.

Second, Senator Domenici has repeatedly expressed his belief that you implied in the State of the Union Address that a new and expensive Medicare prescription drug benefit would be financed by the surplus. You, Jack Lew and others have publicly and accurately made the point that the SOTU did not link the surplus to any new drug benefit. You have also expressed your firm belief

that any such benefit should only be provided in the context of reform. (Senator Domenici recently acknowledged this clarification.) Regardless, he believes the public perceives that the two issues are directly linked and he may well push you to tell him how you would finance the drug benefit without the surplus.

Financing a drug benefit is complicated by the fact that, although we believe we can finance one solely through Medicare savings over the long run (10-15 years), its costs would exceed savings in the early years of the benefit. (This is because, post the Balanced Budget Act of 1997, virtually every health policy expert believes that there are no significant additional savings for the next five years.) As such, reforms, the surplus, and any new benefits would need to be included in the same package. Therefore, you probably want to be careful about making any explicit commitment that absolutely no surplus dollars would ever be used for the drug benefit. What you can say, however, is that you would not support a drug benefit if it is not included in the context of broader Medicare reforms.

Attached are talking points.

CONTACT PERSON AND
TELEPHONE NUMBER(S): Senator Pete Domenici 202/224-6621

DATE OF SUBMISSION: February 5, 1999

ACTION: _____

Talking Points:

- I want to work with you on the budget, Social Security and Medicare in a way that produces an acceptable, positive result for all sides. I have been encouraged about the reception my Social Security framework has generally received from a number of Republicans.

- I appreciate your longstanding interest in Medicare. You were always one of the leaders of the party who highlighted the need for additional revenue to be dedicated to Medicare. (Background: Senator Domenici supported dedicating any revenue from tobacco taxes to Medicare last year. He also said, "For every dollar you divert to some other program, you are hastening the day when Medicare falls into bankruptcy, and you are making it more and more difficult to solve the Medicare problem in a permanent manner into the next millennium." NOTE: Clearly, funding programs is completely equivalent to funding a big tax cut.)

- I share your concern about Medicare. We both know it will only get harder to address the Medicare financing challenges as time goes by. I truly believe this is our best opportunity to add the necessary revenues to strengthen the program.

- Moreover, I think that the new revenues increase the chances for needed, sensible reforms to Medicare because we would not have to rely on excessive reductions to Medicare to significantly extend the life of the Trust Fund.

- But I also want you to know that I am not interested in supporting a drug benefit outside the context of needed reforms to Medicare. I firmly believe that a prescription drug benefit for all beneficiaries is absolutely necessary as medicine becomes more reliant on breakthrough drugs. However, it needs to be part of a broader set of reforms and should not be directly linked to the surplus.

February 21, 1999

For Medicare, a Rocky Road to Competition

By MICHAEL M. WEINSTEIN

Remember **Medicare**? With all the attention these days focused on President Clinton's proposal to salvage Social Security, it is easy to forget that **Medicare** -- the program that provides about 39 million elderly and disabled Americans with basic health insurance -- is riddled with far deeper, more imminently threatening financial problems.

Medicare's trust fund will run out of money as early as 2008 (compared with 2032 for Social Security's). And because the elderly are living longer and medical costs are rising faster than most other prices, **Medicare** costs are going up more quickly than spending by Social Security.

This week, the 17 members of the federal commission created by Congress in 1997 to fix **Medicare** will meet to decide what, if any, proposals they will submit to Congress by their March 1 deadline.

And what many of the members have in mind is the most radical surgery on the program since it was created over 30 years ago.

A faction of 10 democratic and Republican appointees wants to scrap the existing **Medicare** system in favor of creating a market of competing public and private plans. A faction of liberal democratic appointees is fighting to preserve the existing government-run fee-for-service plan, which reimburses doctors for nearly any bill they submit.

The commission's rules require 11 votes to forward a proposal to Congress. That puts make-or-break power in the hands of two economics professors appointed by the White House -- Stuart Altman of Brandeis University and Laura D'Andrea Tyson of the University of California at Berkeley.

The question for the commission is whether competition in health care can be instituted without threatening the safety of vulnerable families. As economists, the two swing voters agree that competition is needed to modernize a sclerotic **Medicare** system. As liberals, they say the price of their votes is the guarantee of a specific set of benefits, including coverage for prescription drugs, which **Medicare** does not provide now. Drugs could add $20 billion to $40 billion a year to the $215 billion program.

Last week, the chairman of the commission, John Breaux, a democratic senator from Louisiana, agreed to add drug coverage. But he gave no indication how complete the coverage would be. If he concedes too much to Altman and Ms. Tyson, he risks losing support of some Republicans.

Sen. Phil Gramm of Texas says he would be "reluctant to sign onto a brand-new benefit when we have not dealt with the financial predicament of **Medicare**."

So what began as a high-minded debate over competition could quickly become an old-fashioned spat over money that may well stretch past the March 1 deadline.

If the commission can come up with an affordable way to add an adequate drug benefit while avoiding a tax increase and creating enough genuine competition to help curb costs, it will present a package to Congress that Democrats and Republicans will have a difficult time opposing. And even if such a plan ran into roadblocks on Capitol Hill, it would still be likely to set a framework for whatever is ultimately done to rescue **Medicare** from its perils.

Medicare has two components. Part A covers hospital bills, paid from a trust fund that receives revenues from payroll taxes on workers and employers. Part B covers doctor bills, home health services and other outpatient costs. About 25 percent of these outpatient costs are covered by a monthly premium on retirees, now set at $45.50 but scheduled to double by 2007. The balance of the outpatient bills is paid from general tax revenues. The government spends about $5,700 a year per person.

The vast majority of participants choose the government's fee-for-service coverage. It provides patients the widest possible choice of doctors but also compels them, or employers on their behalf, to spend an average of about $1,500 each a year on co-payments and other out-of-pocket costs, including those for drugs.

About 30 percent of the elderly buy Medigap policies, supplemental insurance that pays for some of the bills that **Medicare** does not. About 15 percent enroll in private managed-care plans. But government price controls and other regulations have choked off wider availability.

The system is under threat from two directions. The first is financial. government actuaries estimate that the cost of **Medicare**, relative to the size of the federal budget, is likely to double over the next 20 years, from 12 percent to about 24 percent.

The second problem is inadequacy. **Medicare** omits key features of most employer-provided health insurance plans. It has no cap on out-of-pocket costs, so patients are vulnerable to large costs from catastrophic illness. It excludes coverage of prescription drugs. And as Alain Enthoven, a professor at the Stanford Business School, points out, it "offers few of the innovative techniques that the best private plans have adopted to improve patient care, like elaborate data-scanning systems that flag potentially dangerous combinations of drugs that a patient's physicians have unknowingly prescribed."

For both reasons, **Medicare** cries out for overhaul.

Breaux, as chairman of the commission, has provided an outline of a solution -- the only outline the commission is actively considering. It rests on the notion of managed competition, the idea behind the Clinton health care proposal of 1994.

The Clinton plan shipwrecked over the complexity of extending coverage to tens of millions of uninsured Americans. But that problem does not apply to **Medicare** because the elderly are already guaranteed coverage.

The Breaux plan embodies ideas that have been embraced by liberals like Henry Aaron and Robert Reischauer of the Brookings Institution, conservatives including Stuart Butler of the Heritage Foundation, and many in between. The

goal, proponents say, is to harness competition to drive down costs, encourage innovation and improve quality.

Under Breaux's plan, **Medicare** participants could stick to the government-run fee-for-service program. But they would also have a choice of private managed-care plans offering all of the benefits in the government plan, plus, possibly, others.

An oversight board would solicit bids from private plans, asking them how much they would charge to cover participants. The premium for the government plan, meanwhile, would be set at its average cost per person.

The government would contribute, say, 88 percent of the premium charged by each plan, up to a limit. **Medicare** participants would pay the balance, typically 12 percent of the premium.

As an added incentive for people to choose low-cost plans, Breaux's proposal would pick up more than 88 percent of their cost, perhaps leaving individuals nothing to pay on their own. And he would set higher charges for high-income families and provide low-income subsidies so "everyone could afford an average-priced plan that provides essential benefits."

A family that chose a more expensive plan than the average for all the plans in the market -- perhaps lured by a wide roster of specialists or low deductibles -- would pay all the additional cost ($300 a year over the cost of the government plan, or 17 percent of the premium, in one example provided by the commission).

A family that chose the low-cost plan in the example, which might restrict enrollees to a small network of doctors, would pay $132 less than the cost of the government plan, or 11 percent of the premium.

To cut costs, Breaux's plan would gradually raise the age of eligibility to 67 over a period of 25 years, mirroring changes that are scheduled for Social Security. And he would allow the agency that runs the government's fee-for-service plan to acquire powers like those wielded by private purchasing cooperatives to win big discounts, including the right to do business with selected doctors and hospitals.

Bruce Vladeck, a commission member who used to run **Medicare** for the Clinton administration, thinks the new tools could make the government plan itself a formidable competitor in the **Medicare** marketplace.

The purpose of competition, Altman said, is "to breathe innovation into the otherwise bureaucratically stiff system that is too often controlled by a politically motivated Congress."

He noted that **Medicare** once introduced new approaches, like the system for paying hospitals according to diagnosis rather than length of stay. "But in recent years," he said, "**Medicare** has fallen far behind the private sector in figuring out new ways to treat patients." Competing private plans could be the stimulus, he said, to improving care and driving spending lower.

Vladeck disagreed, saying that the "notion that competition in health care for the elderly will cut costs and improve quality is a fantasy." He predicted that the Breaux plan would "segment the market," steering the poor into low-cost, poor-quality HMOs while "the rich will flock to fee-for-service."

And he worries about cherry-picking -- the practice in which plans pick out the healthiest enrollees, leaving the chronically ill for fee-for-service coverage. That could eventually make the fee-for-service plan a high-cost outlier, affordable only to the rich.

Rep. Jim McDermott, D-Wash., worries that the Breaux plan leaves families vulnerable if Congress allows the value of the government contribution to shrink over time. Rep. John Dingell, D-Mich., adds that he remains "darkly suspicious" of the assumption that managed-care plans "will provide high-quality care."

But other commission members are quick to defend the Breaux plan. How could it "drive poor people into bad plans," asked Deborah Steelman, a Republican appointee, "if, as the chairman proposes, every plan is required to offer a complete set of benefits and government hands over enough money so that anyone can afford the average-cost plan?" And, she said, if the Breaux plan does not protect future retirees from congressional cutbacks, neither does the current system.

To answer the fears of cherry-picking, Breaux said the government would "risk-adjust" plans, transferring money from those that enrolled few chronically ill patients to those that treated a disproportionate number of very sick people. But Vladeck challenges government's ability to determine the necessary transfers.

There are many other technical problems in pushing **Medicare** toward competitive markets, but none are expected to drive Altman or Ms. Tyson away from handing Breaux the 11th vote he needs to approach Congress. That brings the commission back to the one issue that could prove fatal to consensus: prescription drugs. Everyone deems them essential, but their huge costs come atop a program that is already in financial straits.

The problem gets tricky because private insurers already pay a lot for drugs. About 65 percent of the elderly receive drug benefits, almost half of them through their former employers and the others through Medigap plans, Medicaid or other means.

The pharmaceutical companies oppose adding drug coverage to the government-run plan because they fear it will lead to price controls. The Republican members of the commission, ever mindful of adding expensive benefits and thereby cornering Congress into raising taxes, want to avoid a sweeping drug benefit that wipes out this private money, preferring to focus on those who do not yet have drug coverage.

But the number of employers providing drug coverage is falling rapidly, and over time fewer of the elderly will be able to afford to buy Medigap policies that cover drugs.

There are no easily affordable answers. Indeed, heading into next week's meeting, commission members have yet to see cost estimates for different types of drug coverage. Making matters worse are some poisonous feelings among the commissioners.

Several of the Democratic appointees say in private that they suspect the Republicans are only pretending to want a drug benefit. Some Democrats suspect that the Republicans want to line up the commission behind the notion of competition, so as to advance the GOP's campaign to privatize parts of the social safety net.

Several Republican members say in private that they suspect the Democrats will only pretend to back competition in order to win the drug benefit. Once drugs are covered, they fear, the commitment to competition will disappear.

Clinton tried to overcome the money problem by proposing in his budget to pump $700 billion into **Medicare** over the next 15 years. That is enough, his budget officials estimate, to plug the program's existing financial shortfall. But, if the commission wants to add new benefits, like drugs, it must find savings in the rest of the program.

Some of that money would come from competition. Based on studies that show medical costs are lower in markets where managed care thrives, the staff has come up with estimates that suggest competition would shave the growth rate of **Medicare** costs by at least half a percentage point a year.

If this is true -- and now all commissioners are convinced -- the savings could add up to hundreds of billions of dollars over time. That, along with other potential savings, should leave room to add some drug benefit. The question remains, how much?

Because the academics will provide the pivotal votes, it is worth listening carefully to them.

"No one knows what the right level of **Medicare** spending is or how much competition will really save," Ms. Tyson said. "The important task for this commission, and Congress, is to create a modern system that builds in powerful incentives for health providers to reduce costs and for plans to find innovative ways to care for patients. Breaux's plan moves in that direction -- if it builds in adequate protection for low-income families, including an adequate drug benefit."

While Breaux, the politician, appears content to approve broad principles of agreement and let Congress and regulators fill in the dots, the other academic, Altman, believes generalities are nearly meaningless. What does it mean to guarantee adequate **Medicare** insurance if the commission does not spell out what is in the basic benefits package? What does it mean to say that competitive bidding will drive down prices if the commission does not spell out what type of bidding it has in mind?

After all, economists point out that the bidding system used by the federal employees plan, upon which Breaux modeled his own plan, is clearly deficient. Will **Medicare** do any better?

So Breaux has a tough task ahead. He can try to provide enough drug benefits, low-income support and details to lure Altman or Ms. Tyson. But costly benefits and regulatory overkill could drive away his Republican support.

HCFA MEDICARE COMMISSION ANALYSIS, 2/24/99

SENATOR BREAUX'S PACKAGE

- **Total savings.** Although the total savings from the package looks to be $347 to 372 billion over 10 years, a closer reading of the analysis shows that premium support by itself saves about $75 to 100 billion over 10 years ($26 to 37 billion over 5 years). The $347 to 372 billion "savings" also includes about $100 billion in revenue from an income-related premium that is earmarked in its entirety for low-income protections and about $50 billion in reduced Medicare liability from transferring direct medical education out of the Medicare Trust Fund. As a consequence, almost one half -- about $150 of the $347 to 372 billion -- does not represent Federal savings.

- **Premium support ($26 to 37 billion over 5, $75 to 102 billion over 10).** The actuaries estimated savings from Senator Breaux's "alternative" model that was described for the first time in a memo from the Commission on 2/17. The higher savings estimate assumes that there is no ability for private plans to vary their benefits. The lower savings estimate assumes a limited amount of variation. These savings are higher than expected because Senator Breaux has made important modifications in his proposal, specifically reducing the benefits flexibility, even in the more "flexible" model.

- **Income-related premium ($36 to 38 billion over 5, $95 to 96 billion over 10).** This plan would start increasing the Medicare premium for beneficiaries with income at $24,000 for singles, $30,000 for couples. These income thresholds are half as high as the 1997 Chafee-Breaux proposal, and would affect more than twice as many people -- about 30 percent of beneficiaries (about 12 million beneficiaries) would pay higher premiums. Assuming 1999 costs, this premium would be $125 a month each for an elderly couple with $50,000 annual income -- more than a 100 percent increase. All $38 billion in revenue from this income-related premium, according to the description, would be reinvested in a yet- to-be designed low-income protections and therefore would be budget neutral (no savings).

- **Raising the age eligibility ($2 billion over 5, $25 billion over 10).** The real savings from this proposal are in the long-run -- a separate analysis indicated that this policy alone would produce as much savings as premium support over the 30-year period. The analysis does not include any proposal to assist people losing Medicare eligibility in finding new sources of coverage (e.g., Medicare buy-in).

- **Cost sharing and Medigap changes ($14 billion over 5, $31 billion over 10).** This plan would make a number of changes to Medicare cost sharing which, in total, would increase the amount that beneficiaries pay out-of-pocket ($9 billion over 5, $20 billion over 10). This primarily results from a new 10 percent home health copay. The plan would also prohibiting Medigap from covering Medicare's deductible ($5 billion over 5, $11 billion over 10).

- **Fee-for-service reforms ($16 billion over 5, 79 billion over 10):** This includes extending most Balanced Budget Act proposals from 2003 to 2007 ($7 billion over 5, $57 billion over 10) (note: since the BBA expires in 2002, only 2003 and 2004 savings count toward the 5 year savings). The plan would also modernize Medicare fee-for-service by giving it additional flexibility used by private health plans ($9 billion over 5, $22 billion over 10). These savings are more than we expected, and probably are more than CBO would estimate.

- **Transferring direct medical education out of Medicare ($20 billion over 5, $46 billion over 10).** This proposal does not actually save the Federal government any money -- it simply moves DME spending from Medicare to some other, unnamed place in the budget.

WHAT IS NOT IN SENATOR BREAUX'S PACKAGE

- **Surplus:** The plan contains no revenue proposals.

- **Prescription drug benefit**: Under the more flexible benefits version of premium support, plans could offer a limited drug benefit and possibly receive a government subsidy for it if its premium is below average. People in traditional Medicare or without access to a low-cost private plan would have no drug option.

- **Defined benefit:** Despite improvements in their structure, both premium support options allow some flexibility around the core benefits (e.g., offer varying but actuarially equivalent levels of physician visit coverage, home health, outpatient care). The more flexible option allows plans to offer whatever additional benefits they desire, so long as the value of those benefits doesn't exceed a limit. Benefits variability not only reduces effective competition, but could cause risk selection and confusion among beneficiaries faced with a wide array of slightly different benefits options.

- **Medicare buy-in:** The proposal raises age eligibility without offering any options whatsoever for people who lose Medicare eligibility as a result of the change.

There are also unanswered questions, like whether beneficiaries choosing private plans will pay more or less depending on where they live. We will you posted as we learn more.

SENATOR BREAUX'S MEDICARE REFORM PROPOSALS

(Calendar years, dollars in billions)

	00-04	00-09
Premium Support		
Limited Flexible Benefits	-26	-75
No Flexible Benefits	-37	-102
Income Related Premium (Begins $24/30 ends $40/50)		
Limited Flexible Benefits	-36	-96
No Flexible Benefits	-38	-95
Raising Age Eligibility	-2	-25
Cost Sharing / Medigap Changes		
Cost sharing changes (including unlimited home health copay)	-9	-20
Medigap: Prohibiting coverage of deductible	-5	-11
Subtotal	**-14**	**-31**
Medicare Fee-For-Service Reforms		
BBA Extenders	-7	-57
Modernizing fee-for-service	-9	-22
Subtotal	**-16**	**-79**
Removing direct medical education from Medicare	-20	-46
Drug Coverage	Not Included	
Surplus	Not Included	
Interactions	1	6
MEDICARE SAVINGS		
Total Package Plus Premium Support #1	**-114**	**-346**
Total Package Plus Premium Support #2	**-126**	**-373**
FEDERAL SAVINGS (Minus Income-Related Premium; DME)		
Total Package Plus Premium Support #1	**-58**	**-204**
Total Package Plus Premium Support #2	**-69**	**-231**

JOHN BREAUX
LOUISIANA

MINORITY
CHIEF DEPUTY WHIP

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MEMORANDUM

TO: Medicare Commission
FROM: Senator John Breaux
DATE: February 23, 1999
SUBJECT: **Premium support estimate from the HCFA Actuary**

Attached is the estimate from HCFA's Office of the Actuary on the premium support proposal I put forward at the Commission meeting last month. I am pleased that HCFA's actuaries have joined Commission staff in confirming that a premium support model would result in savings to the Medicare program.

The HCFA actuaries have produced estimates under two alternative versions: one assuming a core, standardized benefit package with no more than 10 percent variation and a second option assuming a benefit package with no variation at all. Under the first scenario, HCFA estimates that my proposal would save $347 billion through 2009 and produce savings equivalent to 11.2 percent of what Medicare expenditures otherwise would have been through 2030. If no variation were allowed in the benefit package, the proposal would save $372 billion through 2009 and produce savings equivalent to 11.9 percent of what Medicare expenditures otherwise would have been through 2030. Please note that savings from the income-related premium would be used to pay for enhanced low-income protections, thereby reducing total savings.

I look forward to discussing this and other premium support analyses at tomorrow's meeting.

Package 1—Draft Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting[1]

Category	Provision	Comment
Fee-for-service:		
Cost sharing	Combined A & B deductible of $350 (indexed to CPI) 0% coinsurance on inpatient and preventive care; 10% coinsurance on home health care; present law OPD coinsurance; 20% coinsurance on all other services	
Modernization	Standard BCV package	
BBA extenders	NBCFM "temporary" package (through 2007) except: no M+C / no DSH	
Medical education	Remove DME funding from Medicare; no IME provision	
DSH	No provision	
Medigap reforms	Prohibit coverage of Medicare deductible(s)	
Premium support:		
Administration	Medicare Board would have considerable authority to negotiate premiums & benefit packages, enforce financial & quality standards, approve service areas, etc.	
Benefit packages	Option (1): Standardized "core" package required as minimum Additional benefits beyond core package are allowed Private plan packages must be ≥ government FFS plan Actuarial value of package may not exceed 110% of core value Peripheral benefits such as dental care, cosmetic surgery, vision care, OTC drugs, are not permitted	
	Option (2): Standardized "core" package only; no benefit package flexibility	
Premium allocation	Gov't FFS plan must bid nationally; others may bid nationally or regionally Partial geographic adjustment of payments; full risk adjustment	
	2-headpoint premium allocation formula, based on full plan bids: At or below 85% of WAP, 100% / 0% Medicare / beneficiary allocation At 100% of WAP, 88% / 12% Above 100% of WAP, gov't contrib = 88% of WAP	
Income related premium	Single bene's: 12% at $24,000 – 25% at $40,000+ Bene couples: 12% at $30,000 – 25% at $50,000+ Brackets indexed by CPI	
	Revenue ear-marked for improving low-income beneficiary coverage	No specific provision
FFS and PS:		
Eligibility age	Increase age of eligibility following OASDI schedule	
Voluntary coverage	No provision	
Drug coverage	No provision	
Budget surplus revenue	No provision	

[1] Specifications reflect clarifications and modifications received from Bobby Jindal, Darla Romfo, and Sarah Lyons on 1-29-99, 2-11-99, 2-12-99, 2-17-99 and 2-22-99.

Office of the Actuary
February 23, 1999

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting

(Calendar year estimates; amounts in billions)

—Option (1): Limited variation in benefit package—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total savings, nominal $ 2000-04	Total savings, nominal $ 2000-09	Total savings, % of PL expend's 2000-04	Total savings, % of PL expend's 2000-09	Total savings, % of PL expend's 2000-30
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$7.1	-$57.1	-0.5%	-1.7%	-2.4%
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-9.2	-19.5	-0.7%	-0.6%	-0.1%
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-9.2	-21.8	-0.7%	-0.6%	-0.6%
Removal of DME	-3.8	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-20.1	-46.1	-1.4%	-1.3%	-0.9%
Premium support	-2.4	-3.8	-5.4	-6.7	-7.7	-8.3	-9.0	-9.7	-10.5	-11.4	-26.1	-74.9	-1.9%	-2.2%	-2.4%
Income-related premium	-6.6	-7.0	-7.5	-8.1	-8.8	-9.6	-10.5	-11.4	-12.5	-13.7	-38.1	-95.9	-2.7%	-2.8%	-3.1%
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-2.1	-25.2	-0.1%	-0.7%	-1.7%
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-5.2	-11.3	-0.4%	-0.3%	-0.2%
Interactions	0.1	0.1	0.1	0.3	0.4	0.5	0.7	0.9	1.0	1.1	1.0	5.2	0.1%	0.2%	0.2%
Total savings	-17.0	-19.2	-21.9	-26.8	-31.4	-36.0	-41.1	-46.5	-50.7	-56.0	-116.2	-346.6	-8.2%	-10.1%	-11.8%
Total present law expends	251	264	279	297	321	346	373	404	438	475	—	—	—	—	—
Savings as % of expend's	-6.8%	-7.3%	-7.9%	-9.0%	-9.8%	-10.4%	-11.0%	-11.5%	-11.6%	-11.8%	—	—	—	—	—

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.

3. "Savings" are defined as either expenditure reductions or increases in premium revenues.

4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative (age introduced by Senator Breaux at January 28 Commission meeting

(Calendar year estimates; amounts in billions)

—Option (2): No variation to benefit package—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total savings, nominal $ 2000-04	Total savings, nominal $ 2000-09	Total savings, % of PL expends 2000-04	Total savings, % of PL expends 2000-09	Total savings, % of PL expends 2000-30
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.9	-$11.0	-$11.3	-$12.2	-$7.1	-$57.1	-0.5%	-1.7%	-2.4%
Coll sharing changes	-1.5	-1.5	-1.5	-1.5	-1.5	-2.0	-2.0	-2.1	-2.1	-2.1	-8.2	-19.3	-0.5%	-0.6%	-0.4%
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-9.2	-21.8	-0.7%	-0.6%	-0.6%
Removal of DME	-3.5	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-20.1	-46.1	-1.4%	-1.3%	-0.9%
Premium support	-4.1	-5.8	-7.6	-9.1	-10.3	-11.1	-11.8	-12.8	-14.0	-15.2	-36.9	-102.0	-2.8%	-3.0%	-3.2%
Income-related premium	-3.6	-7.0	-7.5	-8.1	-8.5	-8.6	-10.1	-11.4	-12.7	-13.6	-37.8	-95.9	-2.7%	-2.8%	-3.1%
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.8	-2.1	-25.2	-0.1%	-0.7%	-1.7%
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-5.2	-11.3	-0.4%	-0.3%	-0.2%
Interactions	0.1	0.1	0.2	0.3	0.5	0.7	0.8	1.0	1.2	1.4	1.2	6.5	0.1%	0.2%	0.2%
Total savings	-16.5	-21.0	-24.0	-29.0	-33.8	-38.8	-43.9	-49.5	-53.9	-59.5	-128.5	-372.0	-9.0%	-10.6%	-11.9%
Total present law expends	251	264	279	297	321	346	373	404	438	475	—	—	—	—	—
Savings as % of expends	-7.4%	-8.0%	-8.6%	-9.8%	-10.6%	-11.2%	-11.8%	-12.3%	-12.3%	-12.6%	—	—	—	—	—

Notes: 1. Refer to specification summaries for description of provisions.

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4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

NATURE OF THE DRUG BENEFIT FOR MEDICARE BENEFICIARIES

- **Employer plans:** Typically, employer plans for retirees offer the same generous coverage that the nonelderly workers receive (e.g., no limits on benefits payments, low deductibles).

- **Medigap**: Three of the 10 standard Medigap plans offer prescription drugs. The benefit includes:

  - $250 deductible
  - 50% coinsurance
  - Cap of $1,250 or $3,000, depending on the plan

  Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996.

  The median premium for a 65-year old choosing a plan with prescription drug coverage (H) to one with virtually identical benefits except for drugs (D) is well over $1,000 or more than twice as costly ($2,073 v 913 in 1998).

- **Medicare Managed Care:** Typical Medicare managed care plans have no deductibles and relatively low copayments, but caps on the benefit:

  - 40 percent of enrollees are in plans with unlimited benefits
  - 18 percent of enrollees are in plans with limits greater than $1,000
  - 17 percent of enrollees are in plans with a limit at $1,000
  - 24 percent of enrollees are in plans with limits less than $1,000

  [Note: these data are for 1998; expectations are that for 1999, the proportion of beneficiaries in plans with caps and deductibles will rise significantly]

  There is a strong relationship between the Medicare payment rate and the generosity of the drug benefit. The average monthly Medicare capitation payment averaged:

  - $491 for beneficiaries with unlimited drug coverage
  - $434 for beneficiaries with limited drug coverage
  - $375 for beneficiaries with no drug options or coverage

DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED FOR COVERAGE

- **Prescription drugs are a growing part of health care in the U.S.** In the past 10 year, spending on prescription drugs has risen as a percent of total spending, by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.

- **Medicare does not pay for prescription drug coverage.** Although virtually all private health insurance plans cover prescription drugs, Medicare does not.

- **The elderly and people with disabilities have a greater need for prescription drugs.** Over 80 percent of Medicare beneficiaries use at least one prescription drug. Although the elderly comprise 12 percent of the population, they use one-third of all prescription drugs. This reflects the greater prevalence of conditions like arthritis and high blood pressure that require daily medicines.

- **Higher spending on drugs.** About half of Medicare beneficiaries have more than $500 per year in expenditures on prescription drugs; over one in ten have more than $2,000.

- **Fall back on expensive Medigap insurance, former employers, or Medicaid.** Low-income beneficiaries rely on Medicaid to pay the costs of drugs. Others either turn to former employers or pay for Medigap coverage. Medigap premiums range from $402 to $7,196, depending on the state and type of coverage. The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. In 4 years, the percent of large firms offering employer-sponsored coverage for Medicare eligibles dropped about 20%.

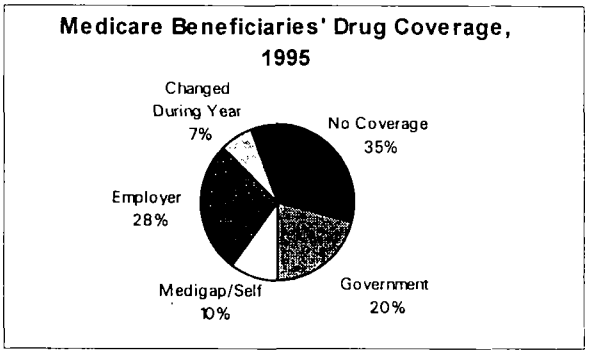
- **Millions of beneficiaries have inadequate coverage**. About 13 million Medicare beneficiaries have no coverage at all. Millions more have drug coverage through Medicare managed care plans, but the amount of that coverage is increasingly low. For example, about one-third of beneficiaries' managed care plans pay less than $1,000 for drugs annually.

- **Older Americans pay more.** A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs.

- **Difficult choices**. According to one survey, one in eight older Americans had to choose between buying food and buying medicine.

ADDITIONAL INFORMATION ON MEDICARE BENEFICIARIES AND DRUG COVERAGE

- **Only 38 percent of Medicare beneficiaries have private drug coverage.** Employer-based, retiree coverage is the largest source of private coverage, but recent studies show a dramatic decline in this coverage. About 10 percent of beneficiaries have Medigap or other private sources of coverage. Similarly, as the cost of Medigap insurance climbs, the proportion of beneficiaries who can afford it has been declining.



- **Income**: The lack of drug coverage is not just a problem for low-income beneficiaries. Beneficiaries without drugs have only slightly lower income than Medicare beneficiaries in general:

	All Benes	Benes w/o Drug Coverage
- < 100% Poverty:	21%	21%
- 100-199% Poverty:	33%	38%
- 200-299% Poverty:	20%	20%
- > 300 % Poverty:	26%	21%
Total	100%	100%

- **Health Status**: Beneficiaries with drug coverage tend to be sicker than people without drug coverage, although the difference is not large. Fully one in four beneficiaries without drug coverage is in fair to poor health and may need prescription drugs.

	With Drug Coverage	Without Drug Coverage
Excellent/Very Good Health	42%	45%
Fair/Poor Health	29%	26%

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

- **Age**: The proportion of beneficiaries without drug coverage rises with age:

  - 38 percent of people ages 80 to 84
  - 41 percent of people ages 85 or older

- **Rural beneficiaries**: 46 percent of rural beneficiaries do not have drug coverage

Source: Analysis of the Medicare Current Beneficiary Survey, 1995

NEC MEDICARE COMMISSION PRINCIPALS' MEETING

Roosevelt Room; 3:15pm
February 22, 1999

AGENDA

I. **PREMIUM SUPPORT (15 minutes)**

- **Policy**
- **Politics**

II. **OPTIONS (45 minutes)**

- **Guidance for Upcoming Commission Meetings**

POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- Would likely reduce Medicare costs through competition.
- Better aligns Medicare with private health insurance.
- Gives beneficiaries more choices.

CONS

- Puts beneficiaries at risk for higher fee-for-service premiums and less stable private plan premiums.
- Could reduce extra benefits that current Medicare managed care enrollees receive.
- Significant regulation would be required to avoid two-tiered Medicare.

OPTIONS

IF COMMITMENT THAT THE PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

- **Work to improve details**

IF NO COMMITMENT THAT PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

1. **Rest on principles**

2. **Develop an alternative that includes premium support**

3. **Develop an alternative that includes the common denominator provisions, states an openness to premium support that is consistent with principles.**

CHRIS - YOUR VERSION

NEC MEDICARE COMMISSION PRINCIPALS' MEETING

Roosevelt Room; 3:15pm
February 22, 1999

AGENDA

I. PREMIUM SUPPORT (15 minutes)

- **Policy**
- **Politics**

II. OPTIONS (45 minutes)

- **Guidance for Upcoming Commission Meetings**
- **Response to Commission Vote**

POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- **Would likely reduce Medicare costs through competition.** Premium support encourages beneficiaries to choose lower cost health plans by giving them a financial incentive to do so. Depending on how premium support is structured, efficient plans can attract beneficiaries by offering lower premiums or additional benefits. As beneficiaries move to lower-cost plans, the national average Medicare spending is reduced (or doesn't grow as fast as it would have), thus reducing Federal Medicare costs over time.

- **Better aligns Medicare with private health insurance.** Today, Congress and the President must make explicit changes to Medicare reimbursement levels to control program costs. While over time the growth in Medicare has roughly matched private health insurance growth, cost control is cumbersome and subject to significant political constraints. Under premium support, Medicare spending is more dependent on the ability of private plans to achieve efficiency, which should more closely align the growth of future government Medicare spending with the overall level of efficiency achieved by private health insurers.

- **Gives beneficiaries more choices.** Today, beneficiaries enroll in managed care plans because, in some areas, those plans can offer extra, free benefits. Under this proposal, beneficiaries can lower their Medicare premiums by enrolling in low-cost plans and, under some proposals, also get some extra benefits. Premium support also has the potential to attract more private plans to participate in Medicare or extend their market area, since they would have new flexibility to use financial incentives to attract beneficiaries.

CONS

- **Puts beneficiaries at risk for higher fee-for-service premiums and less stable private plan premiums.** Under premium support, the Medicare fee-for-service premium would likely be higher than that of private plans -- especially if traditional Medicare is not allowed to use the same management tools as private plans. This could be exacerbated if sicker people stay in fee-for-service, driving up costs. Also, beneficiaries choosing private plans could face premiums that vary considerably from year to year, similar to what happens in the private sector. This instability could cause anxiety for beneficiaries.

- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under premium support, a greater share of the efficiency savings accrue to the government, reducing the amount that can be provided as additional benefits.

- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- rather enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, premium support could have the unintended effects of creating higher premiums for people who are sick and low-income.

POLITICAL PROS AND CONS OF SUPPORTING PREMIUM SUPPORT

PROS

- **Increases the likelihood of bipartisan agreement on Medicare -- and Social Security.** Without premium support, it is unlikely that Republicans will consider any type of Medicare legislation -- including a bill that includes the surplus or a prescription drug benefit.

- **Enhances credibility as real reformers, increases elite validation.** Most economist and elite media consider premium support "real" reform. An openness to it would end Republican criticism that we only want an election issue or only more revenues and benefits for Medicare.

- **Although still challenging, would increase the likelihood of a drug benefit for all beneficiaries and new purchasing tools for the traditional program.** Republicans will clearly not consider either a drug benefit or the modernization proposals for Medicare fee-for-service without premium support. Thus, an openness to premium support could open the door to these desired changes.

- **Winning a drug benefit and the dedication of the surplus in return for premium support may be a good trade.** The complexity and controversy surrounding premium support will necessitate it being phased in and otherwise altered. Therefore, it is likely the surplus transfer would begin in 2000, the drug benefit in 2001, but premium support on a more phased-in basis. Thus, we could get credit for being supportive without having to address its immediate effects.

- **Defining acceptable premium support at the beginning of the debate could give us more credibility in opposing it if, at the end, Congress passes a flawed version. .** An early openness to premium support may prevent criticism that we only signed onto this idea because we want to get prescription drugs. It could also offer us the opportunity to define what a good premium support plan would be -- laying the groundwork for a veto if necessary.

CONS

- **Lose the opportunity to end the momentum toward a Commission recommendation that will likely produce a flawed premium support and inadequate prescription drug benefit.**

- **Will alienate Democratic base, particularly in the House, which is concerned that premium support undermines Medicare's guarantees.** Base Democrats generally think that the risk of something bad coming out of any negotiation far exceeds any potential for a positive outcome -- even if that means a prescription drug benefit. Moreover, they believe that a Medicare compromise will help the Republican party far more than the Democratic party in 2000.

- **Even if accompanied by a drug benefit and the surplus, the fear of higher premiums and elderly dissatisfaction may outweigh benefits.** High costs and less certainty will always be much more threatening and politically volatile to the elderly than the promise of a new benefit. This is particularly the case given the low odds that a good drug benefit and premium support proposal could emerge from a Republican Congress.

- **Weakens our leverage during the legislative process and could make it difficult to oppose premium support at the end of the process -- particularly if included in a broader reconciliation.** The only message that the public will hear will be our support for premium support. Once that message is solidified, it will be extremely difficult to justify any opposition to premium support, no matter how flawed the particular proposal. Such opposition would be considered a political rather than substantive.

- **Opposition to premium support could unify beneficiary and provider groups.** Political weapon.

DRAFT PRELIMINARY ESTIMATES OF MEDICARE COMMISSION PROPOSALS
February 22, 1999

Limited Benef Flex: $16 L. ~~No~~ No Flex $35 L, Aggress $ 70

Attached are some preliminary estimates from the HCFA Office of the Actuary on various Commission proposals.

Highlights include:

- **Premium support does save money:** A model similar to that put out by Senator Breaux on January 22 would save about $16 billion over 5 years, $52 billion over 10. A very aggressive model could save more. These savings occur because the Commission limited the benefit variation allowed and offered an explicit prescription drug benefit -- changes in these parameters would change savings. This estimate will likely be used by Breaux as confirmation that premium support is a good proposal to improve Medicare's efficiency.

- **Fee-for-service reform could save as much as Breaux's premium support:** A package that includes the President's budget proposals, extending the BBA for 5 years, giving HCFA private sector tools (modernization), and rationalizing cost sharing and Medigap could save $30 billion over 5 years -- almost twice as much as Breaux's premium support.

- **A moderate prescription drug benefit for all beneficiaries may be affordable:** The estimates suggest that a benefit with a $250 deductible, copays of $7 / 15 per generic/ brand-name prescription, and a cap on payments at $1,250 or $1,500 (typical of Medicare HMOs) costs $38 to 43 over 5 years, $106 to 120 billion over 10 years. This could almost be fully offset by fee-for-service reforms without premium support or an income-related premium.

- **Income-related premiums could save as much as Breaux's premium support**: An income-related premium that begins at $50,000 for singles, $75,000 for couples would by itself save more than premium support.

- **Raising the age eligibility has little short-term but large long-term effects:** It only saves $2 billion over 5 years, but $509 billion over 30 years -- by itself as much as premium support.

There were two sets of estimates: those done for the Administration (which are not private) and those done for the Commission which it received yesterday. Breaux, Jindal, etc. all have this information, in various forms. It is not clear if / when / how this will be shared with the Commission appointees and general public.

MEDICARE REFORM PROPOSAL
(Calendar years, dollars in billions)

	00-04	00-09	00-30
Surplus	-120	-344	-690
Removing DME	-20	-46	-257
PB 2000 Proposals	-8	-20	-172
BBA Extenders	-7	-57	-698
Modernization FFS	-9	-22	-173
Cost Sharing Changes	-1	1	140
Medigap	-5	-11	-60
Subtotal	**-30**	**-109**	**-963**
Drug Coverage			
$1250	38	106	898
$1500	43	120	1036
Premium Support			
2/17 Version	-16	-52	-515
Most aggressive version*	-79	-205	-1800
Income Related Premium			
HSA (90/110)	16	42	462
BBA (60/90)	18	47	489
C-B (50/75)	23	58	556
Raising Age Eligibility	-2	-25	-509

*NOTE: Also includes a decrease in the gov't contribution
DRAFT/PRELIMINARY; subject to change

2/22/99

OPTIONS FOR FEBRUARY 23, 24 MEETINGS

IF COMMITMENT THAT THE PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

- **Work to improve details**

IF NO COMMITMENT THAT PLAN THAT WILL BE VOTED ON INCLUDES SURPLUS, DRUG BENEFIT, DEFINED BENEFITS:

1. **Rest on principles**

   PROS
   - Slows down momentum for flawed Breaux plan.
   - Probably the most acceptable to Congressional Democrats who want neither a plan nor an extension of the Commission.
   - Sets the stage for a specific plan by the President.

   CONS
   - Would be criticized by Breaux, Republicans and elite media as evidence of our interest in the status quo rather than reform.
   - Undermines chances for a reasonable compromise with Republicans on Medicare reform.

2. **Develop an alternative that includes premium support**

   PROS
   - Extricates ourselves from the Commission process while maintaining support for premium support, which will be validated by elites as "true" reform.
   - Increases the likelihood that the elite media will critique and undermine the work product of the Commission.
   - Could serve as a trial balloon for an Administration proposal.

   CONS
   - Probably impossible to get base Congressional Democrats to agree on a plan with premium support.
   - Onus of developing a viable Medicare reform package falls completely on us; there would therefore be no bipartisan political cover for controversial provisions. Also, may not be feasible given its complexity in a short time frame.
   - Preempts the option of a proposal by the President.

3. **Develop an alternative that includes the common denominator provisions, states an openness to premium support that is consistent with principles.**

PROS

- Extricates ourselves from the Commission process without having to lay out all the details of a controversial and difficult to design premium support plan.
- We might be able to maintain elite support if Laura and Stuart suggest that we are seriously open to a premium support option.
- Gives us the time to find common ground between base Democrats and moderate Republicans and Democrats on premium support.

CONS

- Just as serious likelihood that elites will critique us as not being serious.
- Democrats will still be nervous that we are validating premium support as a credible reform proposal.

Fiscal Analysis of Senator Breaux's Premium Support Proposal

I. Overview

II. Why does premium support result in savings?

III. How much savings will result from Senator Breaux's premium support plan?

IV. Design details and their impact

I. **Overview** - CBO, OACT, and staff analyses all suggest that a properly designed premium support proposal would allow plans to compete on price and quality and will result in significant savings.

- CBO (Feb. 18)
  - "Your proposal would foster greater competition among plans and greater choice for beneficiaries. We believe increased competition will reduce costs."
  - "We believe that introducing competition into the Medicare program could help to reduce costs in both the short and the long run. A premium support system that resulted in effective price competition among plans would most likely lower Medicare costs."

- Office of the Actuary, HCFA (Feb. 23)
  - Their analysis shows that Senator Breaux's plan would result in savings of over 10% of present law expenditures by 2005.

- Commission staff (Feb. 17)
  - Analysis shows proposal slows Medicare spending. Growth in outlays is slowed by approximately 1% a year, and savings compound to significant amounts over long run.

- Lewin Group (Sept. 1998)
  - "Based upon these studies, the increase in managed care enrollment implied by a [premium support program] would result in a long-term reduction in the long-term annual rate of growth in health spending of between 0.5 and 1.5 percentage points."[1]

[1] September 1998 report by John Shiels and Andrea Fishman for National Coalition on Health Care. Authors use terms such as defined benefit competitive bidding program or defined benefit voucher program to denote what the Commission would call a premium support program.

II. Why does premium support result in savings?

Analysts cite different ways that the beneficiary choice and competition associated with a premium support model result in savings. For example, Commission staff analysis emphasizes reduction in growth rates, and OACT analysis emphasizes savings from switching from more expensive to less expensive plans.

- Beneficiaries would face more incentives to choose less expensive plans, since they will share in premium savings. (see Figure 1) Medicare's costs will be reduced as beneficiaries switch from less efficient to more efficient plans.

- Plans would face incentives to compete on price, in order to attract beneficiaries, and this will result in a slowing of growth rates in Medicare spending. (see Figure 2 and Appendix) Plans may achieve this reduction for many reasons, e.g.:

    - negotiating power for purchasers due to excess provider capacity
    - increased productivity through series of innovations
    - selective contracting arrangements and other management tools result in slowdown in long-term growth rates
    - slow growth in unit costs and wage growth
    - managed care brought permanent cost-consciousness to providers

- Premium support will allow beneficiaries to coordinate multiple sources of financing and coverage into one plan.

    - "[Supplemental insurance] coverage increases Medicare spending by encouraging greater use of services. To the extent reforms mitigate that incentive, Medicare spending would be reduced." CBO
    - Evidence by the Physician Payment Review Commission and CBO suggests that first dollar coverage associated with Medigap coverage increases Medicare's spending due to higher utilization. (see Figure 3)
    - Beneficiaries with employer-sponsored coverage are more likely to have prescription drug coverage and less likely to have first dollar coverage than those with Medigap coverage, and thus cost Medicare $500 less per year.
    - Integrated plans are less likely to offer first dollar coverage without tools to manage utilization.
    - Integrated plans will reduce administrative costs and facilitate coordination of coverage by employers.

III. How much savings will result from Senator Breaux's premium support plan?

- Commission staff analysis:
  - Slowdown in Medicare's growth will reduce annual Medicare spending by $475-$850 billion in 2030. (see Figure 4)
  - Medicare's portion of the federal budget would be reduced from 28-38 percent under current law to 21-29 percent. Medicare's spending as a portion of the economy (Gross Domestic Product) would be reduced from 6.3-8.5 percent to 4.6-6.3 percent. (see Figure 5)
  - Beneficiaries will share in savings, as their premiums will be 15-25 percent less than those expected under current law on average. (Individual beneficiary premiums would vary based on the plan selected. Beneficiaries would pay more for selecting more expensive plans.) (see Figure 6)

- OACT analysis:
  - Medicare savings will be over $40 billion in 2006, which is 11% of what Medicare expenditures would otherwise have been. The Senator's plan would save between $347 and $372 billion through 2009, and will produce savings of 11.2-11.9 percent of what Medicare expenditures would otherwise have been through 2030.[2] (see Figures 7-8)
  - Analysis shows higher savings in short run than those described by Commission staff, but lower savings in long run. (see Figure 9)

- Lewin Group analysis
  - "Based upon these studies, the increase in managed care enrollment implied by a [premium support program] would result in a long-term reduction in the long-term annual rate of growth in health spending of between 0.5 and 1.5 percentage points."[3] (see Figure 10)

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[2] OACT's parameters differ slightly from Commission staff parameters: First, OACT's analysis extends certain provisions of the BBA for 5 years (whereas Commission estimates assume continued savings in one case and no savings in the other). Second, OACT's analysis does not contain spending offset for low-income subsidies.

[3] September 1998 report by John Shiels and Andrea Fishman for National Coalition on Health Care. Authors use terms such as defined benefit competitive bidding program or defined benefit voucher program to denote what the Commission would call a premium support program.

IV. Design details and their impact

Some analysts have expressed concern that plans would continue to compete primarily on benefits and not on price. This could result in a reduction of savings if most of the resulting efficiencies would be channeled into additional benefits. Various design parameters can be modified to address this concern and achieve the appropriate balance, without fundamentally altering the core premium support principles contained in Senator Breaux's plan:

- Limit benefit variation
  - The Board could be required to limit range of actuarial value of benefits offered by plans to 10 percent, as OPM currently does with plans participating in FEHBP. Any additional benefits beyond the allowable range would be offered as supplemental riders, not subject to government contribution. This reduces adverse selection and also helps ensure that plans compete on costs as well as benefits.
- Include only certain benefits when calculating average premium
  - The Board could be required to consider only the cost of Medicare-covered services when calculating the average premium, exclude certain types of benefits from its calculation, or otherwise take steps to standardize the benefits being subsidized. (see Figure 11)
- Give beneficiaries more incentives to choose lower cost plans
  - Since this concern about plans competing on benefits, to the exclusion of competing on price, depends largely on consumer behavior, it is also possible to give beneficiaries more incentives to choose lower cost plans that still meet the Board's quality and benefit requirements. For example, CBO has traditionally criticized the FEHBP for not allowing zero premiums for low cost plans and always requiring a minimum beneficiary premium. Senator Breaux's proposal could be modified to allow beneficiaries to choose plans with no premium costs. (see Figure 12)

Appendix:
Competition and Reduction in Growth Rates

Many experts find that if plans are permitted to compete on price and quality, a reduction in growth rates will result:

- "... the payments that M+C plans receive bear no relationship to their performance, and the plans have no incentive to compete on the basis of price. By contrast, under the premium support model, plans would be given new flexibility to compete by reducing premiums or enhancing benefits. That additional element of price competition might result in beneficiaries having a broader array of plans from which to choose, thus enabling them to select a plan that meets their needs more appropriately than the choices currently available to them." CBO

- "I believe that each of these developments [changes in purchasers' behavior, the spread of managed care, and increased competitiveness] will have significant long-term effects on both the rate of spending growth and its level. As in other industries, productivity improvements often come from a series of one-time changes, and pressure to contain costs leads to a process in which a new crop of one-time changes is developed and implemented each year. For health care establishments, these changes have taken the form of slow growth in unit costs and wage growth that more closely matches that of the rest of the economy. If health care providers feel pressure to continually cut costs and perceive real competition from other providers, the result can be a permanent effect on the rate of growth of the prices they receive." Paul Ginsburg, Center for Studying Health System Change, Jan/Feb Health Affairs. (see Figure 13)

- "A major incentive for restructuring Medicare is to generate the same competitive forces within the program that the private sector experienced in the mid-1990s...controversy has arisen about the long-term effects of managed care on prices and costs in the private health care market and whether slower cost growth associated with the shift to managed care is a one-time phenomenon. Analysts generally agree that part of the recent slowdown in private health insurance premiums did, indeed, reflect a one-time change in the level of premiums, as employers switched their employees from higher-cost to lower-cost plans. But most analysts do not anticipate a return to the double-digit rates of growth in premiums that occurred before 1993. Both employers and health plans now function in a much more competitive health care environment than existed 10 years ago. Purchasers are likely to continue to be aggressive in pressuring plans to hold down premium growth, and plans will continue to seek innovative ways to control costs while constraining payments to providers. Moreover, persistent excess capacity in the health care system will continue to give plans leverage with providers." CBO

Appendix (continued)

- "The price competition among private health plans...would be a powerful force for controlling health costs. There is substantial evidence that competition has been successful in reducing the rate of growth in health care costs in the private sector. For example, between 1993 and 1997 the average annual rate of growth in per-capita premium costs was 2.7 percent for private insurance persons compared to 7.8 percent for Medicare beneficiaries. The rate of growth in per-capita costs under the FEHBP program, which adopts several of the principles of managed competition, has actually been lower than in the private sector....The crucial question in this analysis is whether competition will continue to slow the growth in health care costs in future years...Moreover, there are several studies of cost growth over the past two decades that show that the long-term rate of growth of health costs is significantly reduced as the share of the population covered under managed care plans with selective contracting arrangements increases." John Shiels, Andrea Fishman, Lewin Group (Sept. 1998).

- "After a decade of actively restructuring their health care plans to reduce medical expenses, employers will not simply roll over and pay the bill for inflationary rates of this magnitude....The dominance of managed care has imposed a cost-consciousness on providers that most analysts failed to predict a decade ago. The rate of increase in prices, use of services, and adoption of cost-increasing technologies will be far slower in a system in which providers must live within budgets that simply did not exist when indemnity insurance was dominant and when providers essentially could charge as they wished." Jon Gabel, KPMG Peat Marwick, Jan/Feb Health Affairs.

- "Employers are now accustomed to success in controlling health costs and are not likely to accept large premium increases without a fight. As long as there is excess capacity in the health care system, employers will find effective ways of slowing the growth in health spending." John Shiels, Jan/Feb Health Affairs.

Figure 1

Annual Growth Under the Federal Employees Health Benefits Program, 1990-1998			
Year	**Pre-Open Season**	**Post-Open Season**	**Result of Switching**
1990	13.3%	8.0%	-5.3%
1991	5.7%	4.1%	-1.6%
1992	8.0%	7.3%	-0.7%
1993	9.0%	8.5%	-0.5%
1994	3.0%	2.7%	-0.3%
1995	-3.4%	-3.8%	-0.4%
1996	0.4%	-0.1%	-0.5%
1997	2.4%	1.6%	-0.8%
1998	8.5%	7.2%	-1.3%

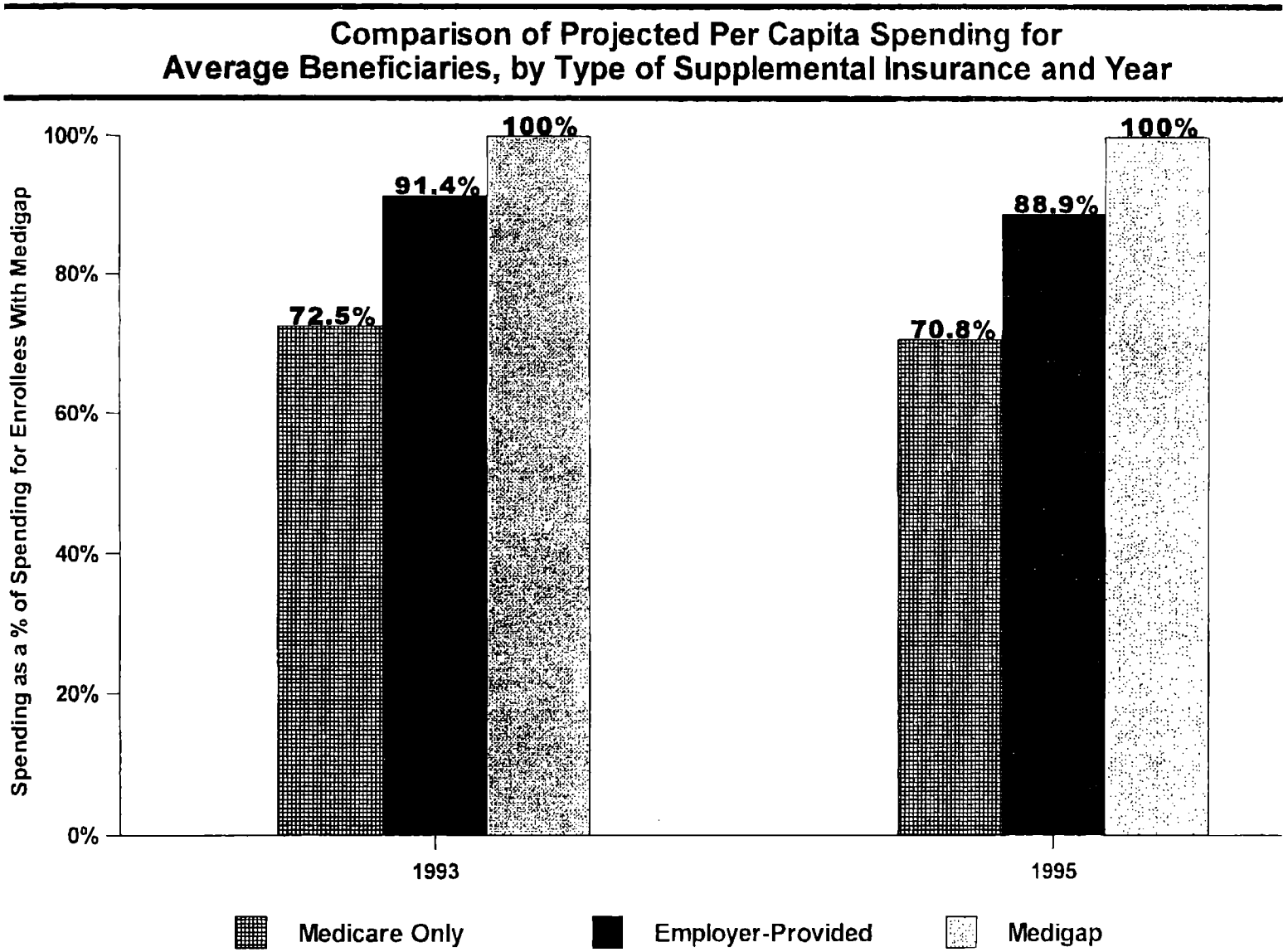
Source: Office of Personnel and Management.

Figure 2

Health Insurance Program	Average Annual Premium Growth Per Capita Compared to GDP Growth		
	1984-1998	1988-1998	1993-1998
Private Plans	8.00%	8.06%	2.09%
Medicare	7.37%	7.70%	6.59%
CalPERS	6.13%	6.55%	0.04%
FEHBP	6.20%	7.29%	2.67%
GDP	6.03%	5.51%	5.30%

Source: CBO (Medicare, GDP), OPM (FEHBP), CalPERS (CalPERS) and Hay/Huggins Co. Inc. (Private Plans).

Figure 3



Note: These spending levels represent the expected differences in outlays after other factors have been taken into account.
Source: Physician Payment Review Commission analysis of data from the 1993 and 1995 Medicare Current Beneficiary Survey. The sample size for 1993 was 11,285 and the sample size for 1995 was 13,261.

Figure 4

Medicare Spending
(in billions of dollars)

	2010	2020	2030
Commission Baselines			
Trustees Intermediate	536	1,148	2,212
No Slowdown	537	1,258	2,972
Staff Estimate of Original Breaux Proposal			
Trustees Intermediate	-37 to -51	-160 to -210	-474 to -587
No Slowdown	-37 to -51	-189 to -237	-745 to -847

Source: Medicare Commission Staff.

Notes: Staff estimate that proposal would slow the growth of Medicare spending by about 1 percent a year. Budgetary savings would be less than the reduction in Medicare spending, because premiums would also be reduced under the proposal.

Range of estimates reflects degree of savings assumed in gov't fee-for-service plan.

Figure 5

Medicare as a Percent of Federal Budget

	2010	2020	2030
Commission Baselines			
Trustees Intermediate	16	22	28
No Slowdown	16	24	38
Staff Estimate of Original Breaux Proposal			
Trustees Intermediate	15	18 to 19	21 to 22
No Slowdown	15	20 to 21	27 to 29

Source: Medicare Commission Staff.

Note: Range of estimates reflects degree of savings assumed in gov't fee-for-service plan.

Figure 6

Average Medicare Premiums as a Percent of Beneficiaries Income

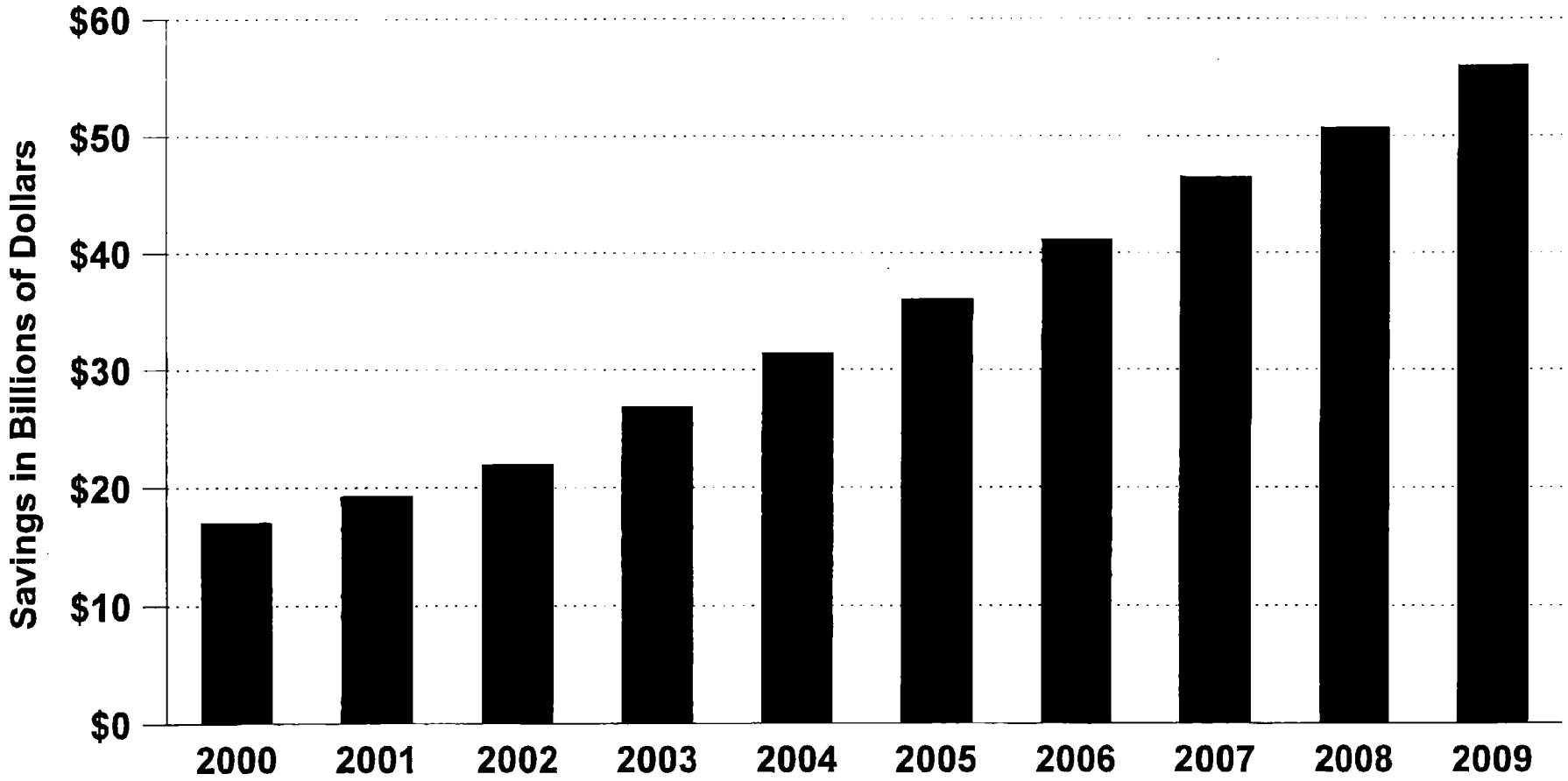
	2010	2020	2030
Commission Baselines			
Trustees Intermediate	6	7	7
No Slowdown	6	8	10
Staff Estimate of Original Breaux Proposal			
Trustees Intermediate	5	5	5
No Slowdown	5	6	6 to 7

Source: Medicare Commission Staff.

Note: Range of estimates reflects degree of savings assumed in gov't fee-for-service plan.

Figure 7

HCFA Actuary Estimate of the Savings of Breaux Proposal

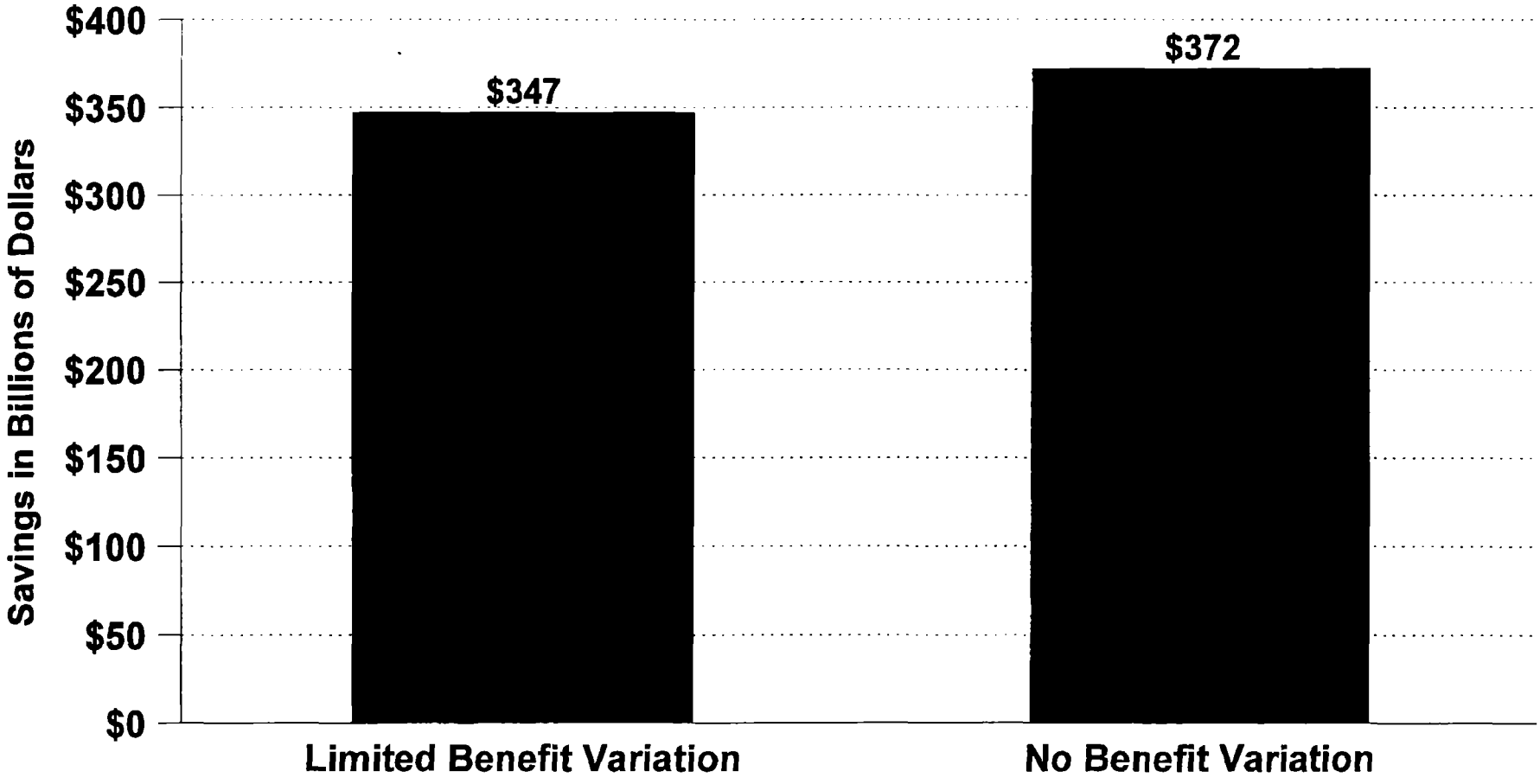


Note: Uses "Limited Variation" option. ("No Variation" results in slightly more savings.)
Does not include spending offset for additional low-income subsidies.

Figure 8

HCFA Actuary Estimate of the Savings of Breaux Proposal

2000-2009



Note: Does not include spending offset for additional low-income subsidies.

Figure 9

Comparison of Commission Staff and HCFA Actuary Estimates of Original Breaux Proposal

	2010	2020	2030
Budgetary Savings as a Percent of Medicare Spending			
Commission Staff			
Traditional Estimate	-6%	-12%	-20%
Non Traditional Estimate	-8%	-15%	-23%
HCFA Actuary			
Limited Variation	-12%	-11%	-12%
No Variation	-12%	-12%	-12%

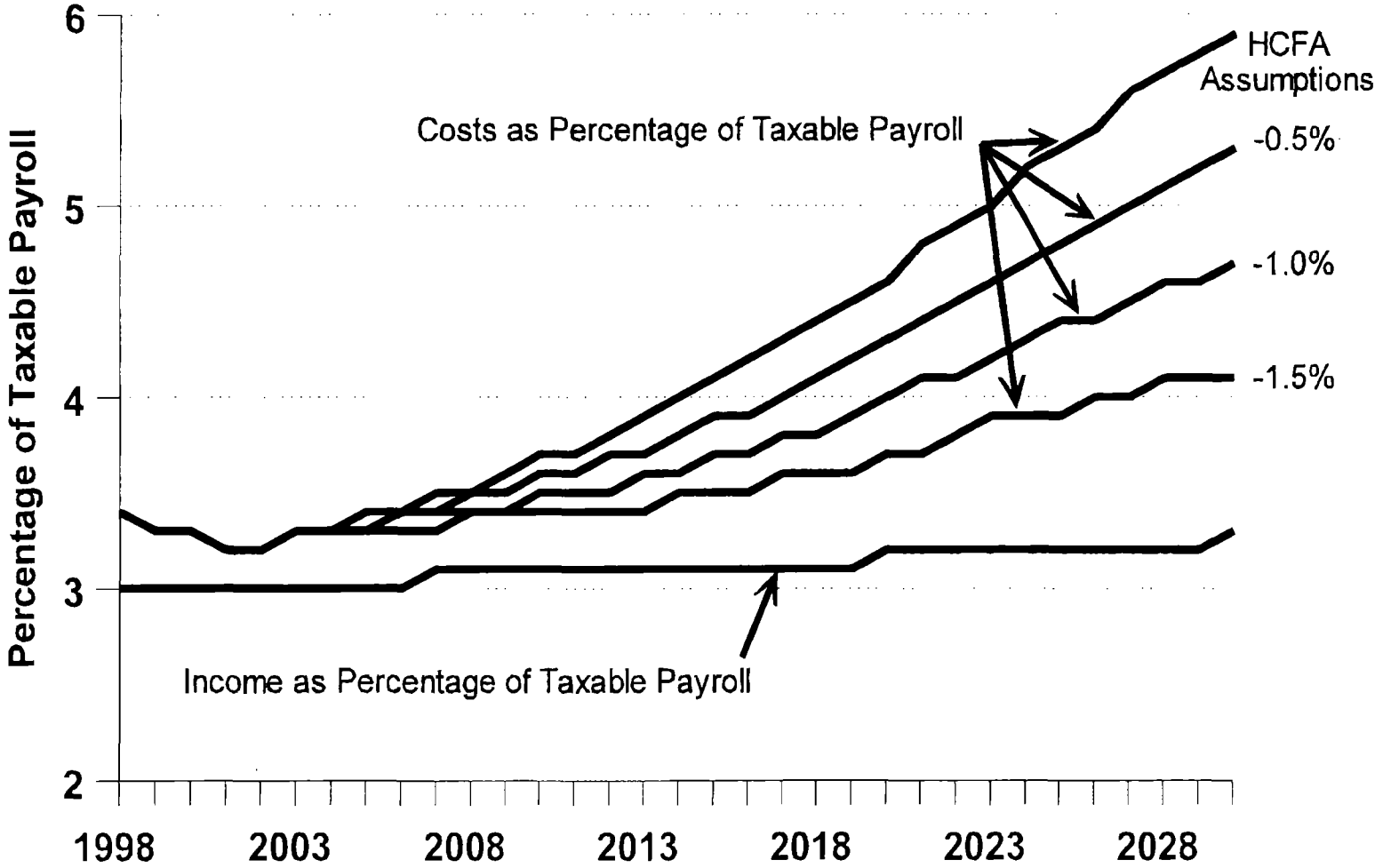
Note: Not all policy details are identical; for example, Actuary assumes BBA savings in government-run fee-for-service plan for 5 years, while Staff assumed additional fee-for-service savings continued indefinitely in nontraditional estimate, but no additional savings were assumed in traditional estimate. Also, Actuary did not include cost of additional low income subsudies.

Staff estimates represent average of results from Trustees Intermediate and No Slowdown baselines.

Figure 10

Hospital Insurance (Part A) Trust Fund Income and Costs Under Alternative Cost Growth Assumptions

(as a Percentage of Taxable Payroll)



SOURCE: Sheils, John F. and Fishman, Andrea, "Comprehensive Medicare Reform: Defined Benefit vs. Defined Contribution," The Lewin Group, Inc., prepared for the National Coalition on Health Care, Sept. 1, 1998, p. iii.

Figure 11

Sample Medicare Covered Services

- **Inpatient Hospital Care**
- **Skilled Nursing Facility Care**
- **Home Health Care**
- **Hospice Care**
- **Doctor's Services** (e.g., physician visits and limited chiropractic, podiatry, and mental health care)
- **Other Medical and Health Services** (e.g., laboratory tests and diagnostic imaging, radiation therapy, outpatient hospital services, rural health clinic services, durable medical equipment, kidney dialysis, prosthetics [artificial limbs], orthotics [braces], physical, occupational, and speech therapy, and ambulance services)
- **Specified Preventive Services** (e.g., mammography exams and pap smears)
- **Select Drugs and Vaccines**

Source: 1998 Green Book.

Figure 12

Alternate Formula

- For plans with premiums below 85 percent of the national weighted average, the beneficiary would pay nothing.

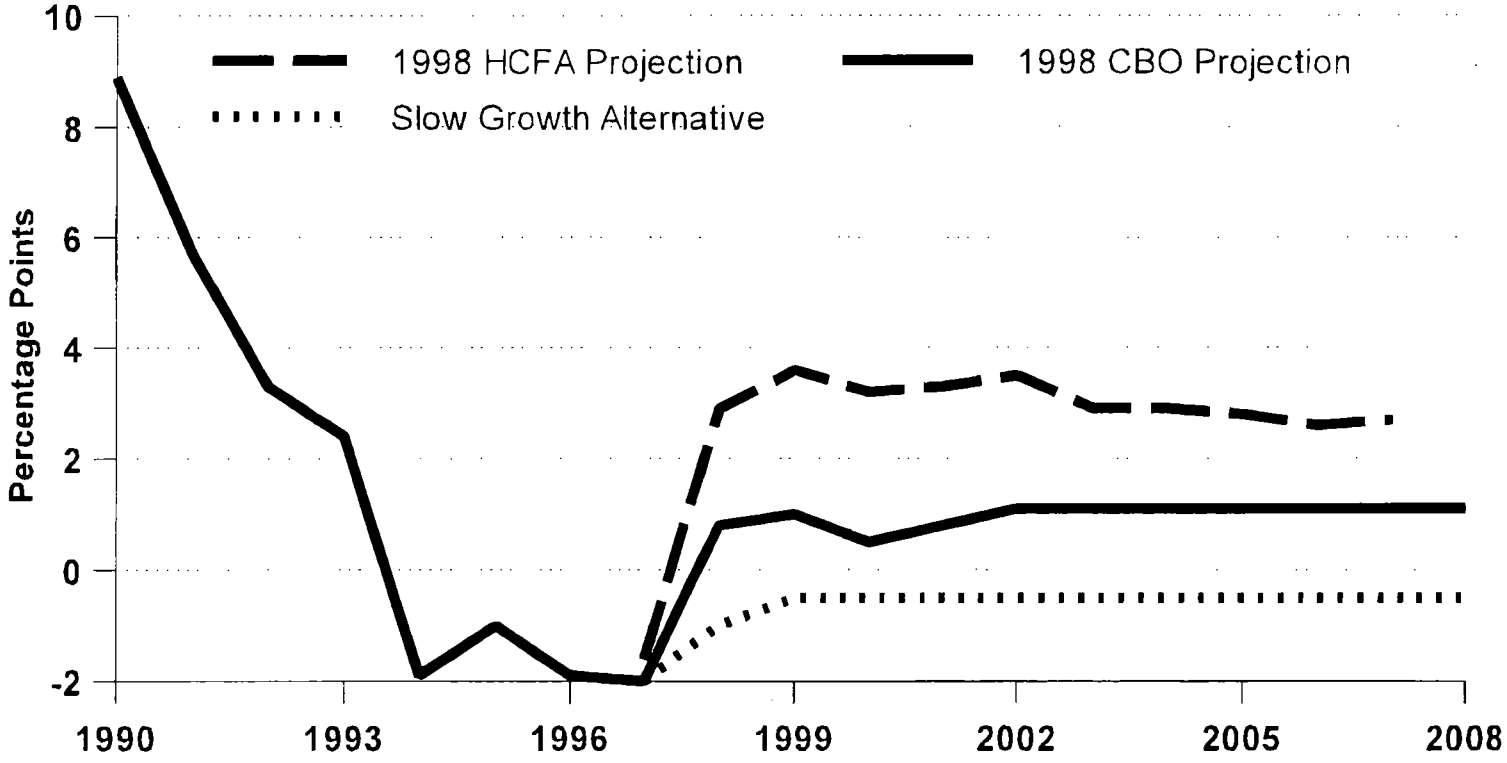
- For premiums between 85 and 100 percent of the national weighted average, the government's share would increase by roughly $1 for every $3 required of the beneficiary.

- For premiums above 100 percent of the national weighted average, the government's share would be capped.

(Again, on average the enrollee's share of the plans' premiums would be about 12 percent.)

Figure 13

Excess of Private Premium Growth Over GDP Growth, Based on Three Assumptions



SOURCES: Paul B. Ginsburg, Center for Studying Health System Change; "Health Affairs," January/February 1999, p. 273. Includes information from the Congressional Budget Office (CBO) and HCFA.
NOTE: GDP is gross domestic product. Excess premium growth averaged four percentage points during 1961-1997.