DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED AND USE AMONG MEDICARE BENEFICIARIES

- Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. (Davis et al., 1999).

- Medicare beneficiaries with coverage for drugs used, on average, 20.3 prescriptions per year, compared to 15.3 per year for beneficiaries without coverage. (Davis et al., 1999)

- One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. (Soumerai et al., 1987)

- Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. (Soumerai et al., 1991)

- The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. (Stuart & Grana, 1998)

SPENDING

- 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. (HCFA, 1998)

- Although the elderly comprise 12 percent of the population, they account for over one-third of all prescription drug spending. (Mueller, Schur & O'Connell, 1997)

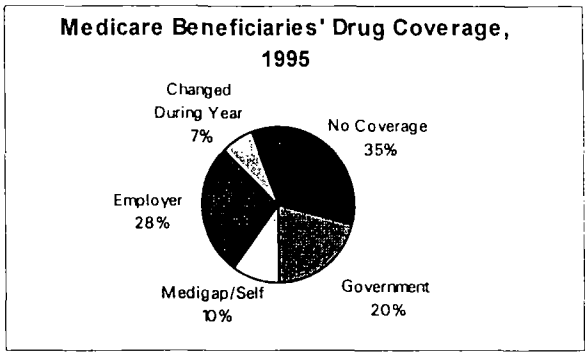
- The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication. (Mueller, Schur & O'Connell, 1997)

- Spending on prescription drugs represents one-third of Medicare fee-for-service beneficiaries' out-of-pocket spending (excluding premiums payments). (AARP, 1998)

- About half of Medicare beneficiaries have prescription drug spending of more than $500 per year; over one in ten have more than $2,000. (HCFA Office of the Actuary, 1999)

INSURANCE 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. (Davis et al, 1999)



- **Retiree health insurance**: The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). (Mercer/Foster Higgins, 1997).

- **Medigap**: 3 of the 10 standard Medigap plans offer prescription drugs. Their benefits includes: a $250 deductible; 50 percent coinsurance; and a cap of $1,250 or $3,000.

  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. (Eppig & Chulis, 1997)

  Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. (Medicare Commission staff analysis)

  Medigap premiums range from $402 to $7,196, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage (Medigap Plan H) to one with virtually identical benefits except for drugs (Medigap Plan D) is well over $1,000 or more than twice as costly ($2,073 v 913 in 1998). (Medicare Commission staff analysis). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

- **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; unpublished HCFA analysis]

BENEFICIARIES WITHOUT ANY INSURANCE COVERAGE

- **Not just a problem for low-income beneficiaries**: Over 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty.

- **Beneficiaries without drug coverage are not much healthier than those with coverage**: Although some argue that beneficiaries without coverage may not need it, 26 percent of beneficiaries without coverage report fair to poor health, compared to 29 percent of beneficiaries with drug coverage. Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs.

- **Older beneficiaries are less likely to have drug coverage**: 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

- **Nearly half of rural beneficiaries have no insurance coverage for drugs**: 46 percent of rural beneficiaries do not have drug coverage

Source: Unpublished analysis of the 1995 Medicare Current Beneficiary Survey

SPENDING BY BENEFICIARIES WITHOUT DRUG COVERAGE

- Even after controlling for health status and income, elderly people with private insurance for drugs had half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent hgiher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. (Rogowski et al., 1997)

- A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs. (Committee on Government Reform and Oversight, 1998)

- A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine. (Families USA, 1995)

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WHY DEFINED BENEFITS IS IMPORTANT

Improves Competition

- **Reischauer and Aaron's premium support creating the idea of premium support**: "A standard benefit package and standardized cost-sharing regimes are important, at least initially, because they will reduce risk segmentation among plans and help participants to compare the cost and quality of different plans. Numerous benefit packages and cost-sharing arrangements would make comparisons difficult. Furthermore, higher-income, younger, and healthier participants would be attracted to plans with limited benefits and high cost sharing, which would place a greater burden on the yet-to-be-developed mechanism for making risk adjustment payments to the different plans." *Health Affairs*, Winter 1995.

- **Enthoven's original managed competition article**: In the article that originally described the idea of managed competition, standardization of benefits was a central concept: "Standardization should deter product differentiation, facilitate price comparisons, and counter market segmentation. There are powerful reasons for as much standardization as possible within each sponsored group. The first is to facilitate value-for-money comparisons and to focus comparison on price and quality. The second is to combat market segmentation -- the division of the market into groups of subscribers who make choices based on what each plan covers (such as mental health or vision care) rather than on price. The third is to reassure people that it is financially safe to switch plans for a lower price with the knowledge that the lower-priced plans did not realize savings by creating hidden gaps in coverage." *Health Affairs*, Supplement 1993.

- **CBO's assessment of managed competition**: "If managed competition proposals did not require that benefits and coinsurance rules be standardized, savings in health care spending would be smaller than otherwise for three reasons.

  First, differences in coverage among plans could continue to cause premiums to vary. That would make difference among premiums more difficult to interpret and would lead consumers to give less weight to them when choosing among plans.

  Second, insurers would have greater opportunities than otherwise to design their plans in such a way as to pursue favorable selection -- a phenomenon for which risk adjustments would offer only an imperfect remedy. This course of events would exacerbate a further source of premium differences among plans and would also diminish the pressure on insurers to compete by developing more cost effective ways to deliver care.

  Third, failing to standardize covered benefits and to eliminate balance-billing could decrease the differences in premiums that would otherwise arise between traditional indemnity insurers and health maintenance organizations. .... This would tend to protect the market share of indemnity insurers that did not adopt cost-effective forms of managed care and so would reduce the savings in overall use of resource." CBO. *Managed Competition and Its Potential to Reduce Health Spending.* May 1993

Medicare Beneficiaries Are Less Able to Make Informed Choices

RURAL

- About 11 million beneficiaries -- nearly 30 percent of all Medicare beneficiaries -- do not have access to a private plan in Medicare.

- Only 24 percent of beneficiaries in rural areas will have access to a managed care plan in 1999.

The President's Plan to Preserve Medicare

and

An Analysis of the Alternatives

Report Prepared by
U.S. Senate Budget Committee Democratic Staff
Frank R. Lautenberg, Ranking Member

February 25, 1999

Introduction

As our population ages, financing retirement and health care expenses for older Americans is among our greatest challenges. The rising costs of Social Security and Medicare in the next century is perhaps the greatest threat to our long-term fiscal solvency. The President has proposal a plan to meet those challenges.

The President's plan would reserve 77 percent of the budget surplus to preserve Social Security and strengthen Medicare. Over the next 15 years, 62 percent of the projected budget surplus — more than $2.7 trillion — would be transferred to the Social Security Trust Fund, and 15 percent of the surplus — $686 billion — would be reserved for Medicare's Hospital Insurance (HI) Trust Fund. *These transfers would extend the solvency of the Social Security trust fund through 2049, and the solvency of the Medicare Trust Fund through 2020.* The President expressed his willingness to work with the Congress to identify further changes that would extend the life of both Trust Funds through the retirement of the babyboom generation..

Republicans proposals reserve a portion of the surplus for Social Security but use all remaining amounts for tax cuts. Not a single penny of the projected $4.9 trillion surplus is reserved for the Medicare program. The $686 billion allocated to Medicare in the President's plan would be used instead to pay for an across-the-board tax cut, totaling $1.5 trillion over 15 years. These Republican tax cuts would benefit the highest-income taxpayers while providing little or no tax relief to seniors and other moderate-income Americans. The average tax cut for the lowest-income taxpayers — those with incomes below $38,000 — would be just $99. By contrast, taxpayers in the top 10 percent of income distribution would enjoy an average tax cut of nearly $4,000 a year.

By choosing tax cuts over Medicare (again), Republicans will be forced to rely on sharp cuts in spending or painful revenue increases to sustain the HI Trust Fund through 2020. Over ten years, the Republicans will be forced to save at least $349 billion through these reforms — on top of the $394 billion in savings enacted for a similar period in the Balanced Budget Act for 1997. Savings of this magnitude could result in the following:

- Beneficiary contributions that double by 2009;
- Provider payments reduced across-the-board by 18 percent beginning in 2000;
- A payroll tax increases of 38 percent, beginning in 2000.

This report will describe the President's plan to preserve Medicare and explain the spending cuts and revenue increases that would be required to extend Trust Fund solvency in the Republican's plan. In the coming months, the American people will have an opportunity to choose between the President's budget and the Republican proposals. We hope that this report will help Congress and the public make informed judgements about these competing approaches.

The President's Proposal to Strengthen Medicare

The President wants to ensure that the projected budget surplus is preserved for the benefit of all Americans. To help accomplish this goal, he has proposed to reserve 15 percent of the surplus, or $686 billion, to extend the life of Medicare's Hospital Insurance (HI) Trust Fund from 2008 to 2020. The transferred funds cannot be used for any other purpose, guaranteeing that the money will reduce debt in the short term and will help older and disabled Americans meet their long-term health needs. Table 1 shows the amounts of the transfer over the next 15 years.

Table 1: The President's Transfer to the Medicare Trust Fund ($ billions)

	2000	2001	2002	2003	2004	2005-09	2000-09	2000-14
Transfer	18	20	28	27	30	226	349	686

- *This proposal is necessary because like Social Security, Medicare will be impacted by the retirement of the baby boom generation.* Total enrollment is expected to double from 39 million in 1999 to 78 million in 2032. Compounding these demographic changes, are escalating health care costs due to changing disease patterns, technological advances, and a high value placed on health. As a result, the HI trust fund is projected to become insolvent in 2008, just as the baby boom generation begins to retire.

- *The surplus is the fairest and most appropriate source of new revenue for Medicare*, since it was created largely by the people who soon will become Medicare beneficiaries — the baby boom generation, and those nearing retirement

- *These budget surplus dollars do not preclude larger-scale changes to the program.* However, proposals aimed at restructuring the Medicare program generally take many years to fully implement. Since these reforms are largely untested, they offer no real guarantee that they will slow the growth of Medicare spending and in the short term, none of the current proposals address the nearer term insolvency issue. The staff of the Bi-partisan Commission n the Future of Medicare found that a proposal to transfer Medicare to a premium support program "would not significantly extend the insolvency date of the Part A trust fund."

- The President's plan buys time to evaluate the implications of restructuring proposals on beneficiaries and providers and to phase in reform gradually, reducing the need for arbitrary cuts in providers, higher premium costs, or a payroll tax increase.

What are the Alternatives to the President's Plan?

If the President' plan is rejected in exchange for a tax cut that consumes the entire on-budget surplus, extending Trust Fund solvency through 2020 would require sharp reductions in HI spending or increased revenues. These options are described in more detail in this report, using data from the Office of the Actuary of the Health Care Financing Administration (HCFA), and estimates from the Congressional Budget Office (CBO). The analysis considers the potential impact of these alternatives on health care providers, beneficiaries, and working Americans. .

Table 2: Extending HI Trust Fund Solvency through 2020: The Alternatives

The President's Plan	Alternatives
▸ Transfer $686 billion of surplus to HI trust fund over next 15 years	▸ Increase beneficiary contributions by $686 billion over 15 years, or ▸ Cut Medicare provider payments and services by $686 billion, or ▸ Increase Medicare payroll tax to 3.46 percent beginning in FY 2000

Methodology

There are a number of ways to estimate the size and nature of spending reductions and revenue increases that would required to achieve HI Trust Fund solvency through 2020. The analysis in this report relies on the following assumptions and estimates.

- *Beneficiary contributions.* The beneficiary contributions were derived by dividing the Medicare transfer in each year by the projected number of Medicare beneficiaries.

- *Reductions in spending growth*: The HCFA actuaries produced an estimate of the reduction in per beneficiary HI spending growth necessary to extend the solvency of Medicare's Hospital Insurance Trust Fund through 2020. Based on their estimates, per beneficiary growth is frozen at 2.8 percent a year, starting in 2000. Aggregate HI spending growth would decline by 1.3 percent each year from current law levels.

- *Reductions in provider payments.* Cuts in provider payments were derived by simply allocating the transfer in each year to Part A providers in the form of spending reductions on a pro-rata basis.

- *Payroll tax increase.* Estimates of the payroll tax increase required to extend Trust Fund solvency through 2020 were provided by the HCFA actuaries.

Beneficiary Contributions Required to Extend Solvency to 2020

One option for increasing revenues into the HI Trust Fund is to require every beneficiary to contribute an amount, that in the aggregate, are equivalent to the President's $686 billion general fund transfer. Table 3 shows the additional amounts beneficiaries would have to pay under this scenario in 2000, 2009, and over the next 10 years.

Table 3: Medicare Premium Increase Required for Solvency through 2020 (in dollars)

	2000 Monthly	2000 Annual	2009 Annual	2000-09 Annual
New contributions	38.07	456.85	1,236.20	8,206.26
Current SMI premium	50.60	607.20	1,262.40	9,219.40
Total	**88.67**	**1064.05**	**2,498.60**	**17,425.86**

- In order to extend the fund to 2020, each beneficiary would be required to pay an additional $38 per month in the year 2000.
- On an annual basis, these contributions would rise from $457 in 2000 to $1,236 in 2009.
- The estimates on the table include current Part B premiums, but do not include other out-of-pocket expenses incurred for the Part A deductible, various co payments and other services not covered by Medicare.
- The Republican alternative, which would give each taxpayer a 10 percent cut, does little to offset the impact of these premium increases on Medicare beneficiaries. The median taxable income of Medicare beneficiaries aged 65 was $14,834 in 1996.[1] Most of the elderly in this income category do not pay taxes, but if they did, their tax cut would be $49 a year compared to an increased contribution of $456.
- Low-income beneficiaries would be [Add section]

[1]Source: Income of the Population 55 or older, 1996, Social Security Adminsitration, Office of Research and Evaluation, and Statistics, April 1998.

Spending Reductions, Provider Cuts, and Program Terminations Required to Extend Solvency to 2020

The HI Trust Fund provides direct funding to providers of inpatient hospital care, skilled nursing facility care (SNF) , home health services, and hospice care. The Trust Fund also provides direct funding to Medicare managed care organizations for the provision of Part A services to their enrollees. This section describes the reductions in spending based on estimates by HCFA actuaries, along with estimates of provider cuts and program changes that would be required to extend Trust Fund solvency through 2020.

Spending Reductions

Medicare payments to Part A providers are projected to grow at an average annual rate of 6.7 percent between 1999 and 2020. By reducing per capital spending to 2.8 percent a year, beginning in 2000 results in an annual decline in overall spending equivalent to 1.3 percent a year. The growth reductions under the scenario are clearly unsustainable:

- Medicare spending growth per-beneficiary would be 60 percent below projected private health insurance spending per-person, now estimated to be 7.3 percent.

- By 2020, per-beneficiary spending would be 40 percent below current law levels for that year and 10 percent below today's level

- Aggregate HI expenditures, now projected to grwoth at an average annual rate of 6.7 percent, would grow at 5.3 percent. By 2020, Part A spending would be nearly 25 percent below current law levels resulting in cuts totaling $163 billion over the first ten years, $417 billion by 2014, and more than $1 trillion over the period, 2000-2020.

Provider Cuts

Provider cuts total $394 over the next ten years, the same dollar amount as the President's transfer. These cuts are just slightly below the levels contained in the in the Balance budget Act (BBA) for all Medicare spending ($394 billion) for an overlapping period (1998-2007).

Applying this cut on a pro-rata basis reduces Part A provider payments by 18 percent over the next 10 years.

- ***Hospital payments*** decline by $188 billion. These cuts would be in addition to the $83 billion in hospital-related savings contained in the BBA of 1997 that the hospitals are just now beginning to absorb. This category includes funding for teaching hospitals for the costs of graduate medical education (GME) and makes disproportionate share payments (DSH)

to hospitals that serve a high percentage of low-income individuals. These programs would also have to be reduced, significantly diminishing the Federal Government's ability to support physician training and to preserve access to medical services for low-income individuals

- ***Payments to Group Plans*** would be cut by $105 billion over 10 years.
- ***Skilled nursing facilities*** would receive $31 billion less over the 10 years. These programs were also reduced in the BBA of 1997 by more than $32 billion over the period 1998-2007.
- ***Home health and hospice expenditures*** would decline by $25 billion over the first 10 years. These programs were cut by nearly $50 billion in the BBA.

The major HI expenditure cuts are shown in Table 4, below.

Table 4: HI Expenditure Cuts Required to Extend Solvency to 2020
(Outlays in $ billions; 2000-2009)

Program	Baseline	Alternative	Reduction	% Change
Hospital inpatient care	1,025	838	-188	18.3%
Group Plans	572	467	-105	18.3%
Skilled Nursing Facilities	170	139	-31	18.3%
Home Health (Part A)	112	91	-20	18.3%
Hospice	29	24	-5	18.3%
TOTAL	**1,908**	**1,559**	**-349**	**18.3%**

Source: CBO program estimates from January, 1998. Estimates for this fiscal year not yet available.

Another way to illustrate the magnitude of the cuts required to achieve solvency is by eliminating certain Part A benefits and services. For example, removing any one of the following services from the Medicare Trust Fund would still not be sufficient to extend the life of the Trust Fund through 2020:

- *All* skilled nursing facilities plus hospice spending, or
- *All* Part A home health spending, or
- *All* indirect medical education, graduate medical education, and disproportionate share hospital spending.

The difficult task of reducing Part A spending in the amounts required to extend solvency to 2020 is illustrated in Table 5, below. The table contains a fairly comprehensive list of the savings options that could be considered for reducing Part A spending. Even this list sums to just $79 billion over 10 years, far below the President's $349 billion transfer for that same time period.

Table 5. Menu of Savings Options for Part A Programs
(Outlay savings for 2000-2009; $ billions)

Budget Options to Reduce Hospital Insurance expenditures	2000-09
1. Reduce Medicare's payments for IME costs	-15.9
2. Reduce Medicare's direct payments for medical education	-10.9
3. Eliminate payments to sole community hospitals	-0.6
4. Increase and extend the reductions in the Medicare PPS market basket	-42.7
5. Reduce Medicare's payments for hospital's inpatient capital-related costs	-3.2
6. Eliminate Medicare's payments to hospitals for enrollees' bad debts	-5.8
Subtotal, options 1/	-79.1
President's Medicare Transfer for 2000-2009	-349.0

1/ These options are not necessarily additive.

Payroll Tax Increase Required to Extend Trust Fund to 2020

The HI Trust fund can be extended through 2020 by increasing the Medicare payroll tax. At present, the tax is 2.9 percent, evenly split between employees and employers (self-employed individuals pay the full 2.9 percent). Without the transfer of the surplus, the Part A payroll tax would have to be increased by 18 percent to 3.46 percent — starting in 2000 — to extend solvency until 2020.

Transferring 15 percent of the surplus into the Part A trust fund protects working Americans and their employers from higher payroll taxes, which is a more regressive form of taxation than other taxes. This point is illustrated on Table 6, which compares the average tax cut under the Republican proposal, with the average payroll tax increase by income category.

- Individuals making less than $10,000 a year would get an average tax cut of $1 and pay $217 in higher payroll taxes.
- The payroll tax increase exceeds the Republican tax cut for all income categories below $100,000.

Table 6: Payroll Tax Increase Compared to Republican Tax Cut (in dollars)

Income Group	Average Tax Cut	Average Payroll Tax Increase	Difference
Less than $10,000	$1	$217	-$216
$10,000 to $19,999	$35	$761	-$726
$20,000 to $29,999	$130	$1,083	-$953
$30,000 to $39,999	$244	$1,192	-$948
$40,000 to $49,999	$383	$1,095	-$712
$50,000 to $75,999	$614	$2,594	-$1,980
$75,000 to $99,999	$994	$1,697	-$703
$100,000 and over	??	$3,629	??

EDWARD M. KENNEDY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510–2101

February 11, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

At Steve Grossman's lunch in Boston on February 2, you spent some time talking to Arthur Ullian, a respected leader on health care and disability issues, about a new approach to Medicare solvency by improving the health of senior citizens, rather than through benefit cuts or tax increases.

This approach is increasingly entering the academic debate on Medicare, and I believe it should be an important part of the solution. I understand that OMB and the Medicare actuaries are reluctant to estimate savings based on this idea, but it seems very likely to me that the savings will be substantial.

At the lunch, you asked me to get you some more information about the idea. I'm enclosing a letter from Arthur laying out his thoughts in more detail.

With respect and appreciation,

As ever,

Edward M. Kennedy

Arthur is a very special innovative thinker and doer - as you probably know - I hope you will take 10 minutes to read this - Great news Friday -

Task Force on Science, Health Care and the Economy

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February 11, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

I'm writing to follow up on our discussion at Steve Grossman's luncheon in Boston on Tuesday, February 2. I am grateful for the opportunity to raise these issues with you.

As we discussed, our long-term strategy to keep Medicare solvent through the 21st century should focus on making senior citizens healthier, rather than on benefit cuts or payroll tax increases. Your proposal to allocate 15% of the surplus to Medicare is a bold plan that will be effective in dealing with the program's current financial problems, and will buy time to implement a future-oriented approach that can produce real savings for the program over the long-term.

Our Task Force has been thinking about these issues since 1996, when we came together to look at problems of spiraling health care costs and the impact of an aging population on Medicare and Medicaid. Initially, these problems appeared to be without acceptable solutions. The proposed remedies — capitation, rationing, reduction of services and benefits, etc. — inevitably deny people the quality of care needed to keep them healthy. By making people sicker, they become all the more costly over time.

Facing this range of unacceptable solutions for controlling health care costs, we looked at the state of medical technology, and determined that it contained a better solution of the health care crisis. In nearly every decade of this century, our country has met critical challenges by relying in large part on innovation and technology.

In the area of health care, molecular biology is proving to be the transforming technology. Our ability to observe and understand human biological processes at their molecular level is rapidly enabling us to treat disease much earlier (even before it becomes symptomatic, in many cases), to treat or cure diseases for which palliative care was once the only option, to expressly target computer-engineered drugs, and to identify and develop

new drugs at an unimaginable rate. All these changes promise to streamline care and reduce costs. But even before this approach realizes its full potential, vast savings can be realized just by communicating and utilizing the best available treatments in clinical practice around the country.

The sea changes taking place in medicine are already showing up in changing health trends in the population. Dr. Manton's paper in the *Proceedings of the National Academy of Sciences*, which I left with you, reports that since 1982, there has been an increasing annual decline in chronic disability among people over 65. Since 1989, that annual rate of decline has been at least 1.5%, and may now be as high as 2.2% at the present time, according to unpublished data.

Chronic disability is a good marker for chronic disease and for health care costs, because Medicare enrollees defined as chronically disabled consume 5-7 times more health care dollars than other beneficiaries. Using a mathematical model, Dr. Manton indicates that, if a 1.5% or higher annual decline can be achieved, Medicare can be sustained in financial balance through 2070. He sees the critical ratio not as that of workers to elderly, but of workers to disabled elderly (those who consume the lion's share of funds). If this rate of decline in disability and chronic disease can be achieved, the ratio of disabled elderly to active workers (currently, one disabled senior for every 22 workers) will actually decline and there will be enough savings to Medicare to keep the program solvent throughout the century.

Other studies point toward this conclusion as well, showing that savings to Medicare will far outweigh the costs associated with increased life expectancy, even without taking into account the additional revenues from longer working lives. Achieving a population of people over 65 who are healthy and active has at least two positive social consequences: (1) healthy people require less frequent and less costly health services; (2) healthy seniors may choose to continue in the workforce, thus contributing to Medicare through payroll taxes, benefitting both sides of the support equation.

Dr. Manton concludes in his paper that sustaining the disability decline rate and securing the resulting cost reductions for Medicare depend on accelerating the pace at which federally-funded biomedical research moves forward. Because there has traditionally been a 10-20 year lag-time between discovery and clinical application (although there is evidence that the lag-times are getting shorter), it is critical to increase funding to maximum levels now, if we expect to be prepared for the population crunch on Medicare eligibility beginning in 2011.

As we do this, however, we must also take steps to maximize what we already know, i.e., to close the gap between optimal care and care that is routinely given. For example,

- Misuse of prescription drugs results in avoidable illnesses that cost Medicare up to $16 billion annually.

- Up to 72% of elderly are not vaccinated against pneumonia, and 40% do not receive flu shots, while these illnesses cost Medicare $3 billion a year.

- Strokes attack three million Americans (most of Medicare age) each year at a cost of $30 billion. People receiving new clot-busting drugs in the first hours after a stroke recover more quickly and more fully than others, but use of this new drug is far from universal.

- Beta Blockers taken after a heart attack should be standard treatment to reduce the likelihood of future attacks, but only a fraction of the elderly now receive them.

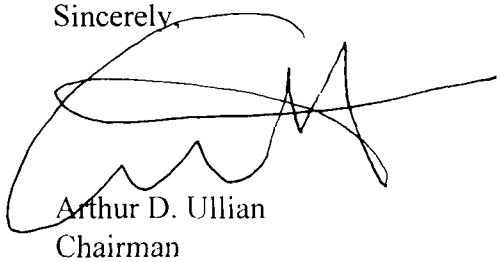
It is hard for me not to view this crisis from a businessman's point of view. Often, we don't have the luxury of looking at a problem academically. We have to consider the most important variables, throw out what doesn't work, and make a decision that moves us toward the best solution. Looking at this problem, it seems clear that investment in innovation — a guiding principle in the private sector — is a quadruple-win solution. It will enable us to control disease and eliminate human suffering sooner. It will increase active life expectancy for the disabled. It will contribute to the financial solvency of Medicare. And it will contribute to a stronger economy.

I urge you to consider a White House initiative that recasts the Medicare debate in terms of making Medicare healthy by making senior citizens healthy. This initiative would recognize the critical link between NIH-supported research, lower Medicare costs and a strong economy. Such an initiative might also include events that would bring together government, the medical community, senior citizens organizations, and others to improve the standard of care for the elderly. And it would encourage the elderly to become proactive participants in improving their own health.

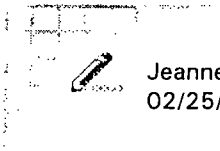
A White House focus on this initiative and on your own strong commitment to expanding biomedical research and improving the health of seniors would be a lasting legacy for your Administration. I would welcome the opportunity to elaborate further on these issues and ideas with you or members of your staff.

With respect and great appreciation for your leadership in this most important endeavor,

Sincerely,



Arthur D. Ullian
Chairman



Jeanne Lambrew
02/25/99 05:00:14 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Draft Workplan

Here's what we discussed as a tentative workplan. Please let me know if something is missing / the timeframe is not right. I think our goal is to have a first round of information ready on Tuesday for a meeting to get some decisions, and another by the end of the week.

1. **BBA extenders:** Mark M. and Bonnie will review to see if there is anything eggregious in them.

Timeframe: Tuesday

2. **FFS modernization:** Mark M. , Bonnie and Barbara will coordinate a process to (a) specify what these policies mean; (2) develop a list of issues (if any) for discussion.

Timeframe: Issues for Tuesday, paper by the end of next week

3. **GME:** Mark M./ Caroline and Barbara, with consultation with Mark McC. This is mostly adding an options section to the paper we did last spring, and soliciting people's opinions.

Timeframe: Tuesday

4. **Cost sharing package:** Rick F.: we would like a distributional analysis of the plan with the 60 visit home health cap and the Medigap reforms.

Timeframe: As soon as possible (medium priority).

5. **Income-related premium:** Mark McC. will develop paper with options on thresholds, phase-outs, administrative issues, etc.

Timeframe: Draft for circulation early next week.

6. **Medicare buy-in:** We will set up a conference call on issues that need estimating on Friday or Monday.

Timeframe: Issues associated with the policy with age eligibility: end of next week
Analysis of: (a) number of people covered in 65-67 buy in without subsidies; (b) ending waiting period for DI for people ages 65-67; and (c) new policy options: As soon as time allows

7. **Drugs:** Need to develop joint background paper ASAP; a meeting to develop options.

Timeframe: Meeting on Tuesday

8. **Premium support issues:** Work will be framed at the conference call scheduled for Friday at 1pm (202/456-5377).

DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED AND USE AMONG MEDICARE BENEFICIARIES

- Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. (Davis et al., 1999).

- Medicare beneficiaries with coverage for drugs used, on average, 20.3 prescriptions per year, compared to 15.3 per year for beneficiaries without coverage. (Davis et al., 1999)

- One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. (Soumerai et al., 1987)

- Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. (Soumerai et al., 1991)

- The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. (Stuart & Grana, 1998)

SPENDING

- 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. (HCFA, 1998)

- Although the elderly comprise 12 percent of the population, they account for over one-third of all prescription drug spending. (Mueller, Schur & O'Connell, 1997)

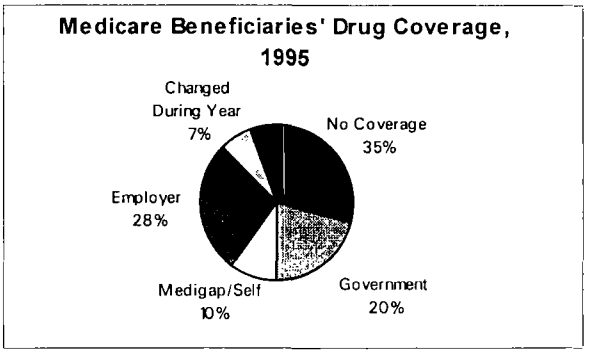
- The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication. (Mueller, Schur & O'Connell, 1997)

- Spending on prescription drugs represents one-third of Medicare fee-for-service beneficiaries' out-of-pocket spending (excluding premiums payments). (AARP, 1998)

- About half of Medicare beneficiaries have prescription drug spending of more than $500 per year; over one in ten have more than $2,000. (HCFA Office of the Actuary, 1999)

INSURANCE 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. (Davis et al, 1999)



- **Retiree health insurance**: The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). (Mercer/Foster Higgins, 1997).

- **Medigap**: 3 of the 10 standard Medigap plans offer prescription drugs. Their benefits includes: a $250 deductible; 50 percent coinsurance; and a cap of $1,250 or $3,000.

  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. (Eppig & Chulis, 1997)

  Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. (Medicare Commission staff analysis)

  Medigap premiums range from $402 to $7,196, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage (Medigap Plan H) to one with virtually identical benefits except for drugs (Medigap Plan D) is well over $1,000 or more than twice as costly ($2,073 v 913 in 1998). (Medicare Commission staff analysis). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

- **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; unpublished HCFA analysis]

BENEFICIARIES WITHOUT ANY INSURANCE COVERAGE

- **Not just a problem for low-income beneficiaries**: Over 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty.

- **Beneficiaries without drug coverage are not much healthier than those with coverage**: Although some argue that beneficiaries without coverage may not need it, 26 percent of beneficiaries without coverage report fair to poor health, compared to 29 percent of beneficiaries with drug coverage. Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs.

- **Older beneficiaries are less likely to have drug coverage**: 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

- **Nearly half of rural beneficiaries have no insurance coverage for drugs**: 46 percent of rural beneficiaries do not have drug coverage

Source: Unpublished analysis of the 1995 Medicare Current Beneficiary Survey

SPENDING BY BENEFICIARIES WITHOUT DRUG COVERAGE

- Even after controlling for health status and income, elderly people with private insurance for drugs had half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent hgiher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. (Rogowski et al., 1997)

- A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs. (Committee on Government Reform and Oversight, 1998)

- A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine. (Families USA, 1995)

SOURCES

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Soumerai SB; Avorn J; Ross-Degnan D; Gormaker S. Payment restrictions for prescription drugs under Medicaid: effects of therapy, cost, and equity. New England Journal of Medicine 317: 550-6.

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Stuart B; Grana J. (1998). Ability to pay and the decision to medicate. Medical Care. 36(2): 202-11.

DRAFT: NEC MEDICARE COMMISSION PRINCIPALS' MEETING

Roosevelt Room; 5:00pm
February 1, 1999

CJ/SL

AGENDA

1/30/99

I. **PRINCIPLES FOR MEDICARE REFORM**

Cut Disc-s

II. **COMPONENTS OF REFORM**

- **Core Components**
- **Controversial Components**
- **Very Controversial Components**

See notes/comments

III. **POLITICAL CONCERNS**

IV. **GUIDANCE**

- **Work with Commission on Good Reform Package**
- **Work Outside of Commission on Good Reform Package**
- **Do Not Propose Good Reform Package/Stick to Principles**
- **Process for POTUS Information / Decisions**

PRINCIPLES TO GUIDE THE MEDICARE COMMISSION RECOMMENDATIONS
DRAFT, 12/1/98
[From Dingell and other Democratic Commission Appointees]

- **Guarantee an adequate, modernized benefits package**: Medicare has provided virtually all elderly, and people with long-term disabilities, critical protection against financial devastation from acute medical illness. Yet, today's Medicare benefits are more similar to private plans in the 1960s rather than the 1990s. For example, while most private plans today offer prescription drug coverage, Medicare does not. As a result, the majority of beneficiaries rely on other types of coverage (e.g., Medigap, employer plans, Medicaid), resulting in inefficiency and high out-of-pocket costs. Any reform proposal should both maintain an entitlement to an adequate set of health benefits and modernize those benefits to lessen the need for secondary health coverage.

- **Encourage and allow Medicare to use competitive practices**: Statutory barriers prevent Medicare from adopting some of the successful payment policies used by private health plans to control health costs. These should be removed to allow Medicare to compete successfully while maintaining its high quality care.

- **Manage Medicare so its growth does not exceed that in the private sector**: In the past (with the exception of the mid-1990s), Medicare growth has paralleled that of private sector health spending. However, it faces unprecedented challenges with the aging of the population and rapidly changing health technology. Thus, a goal of any reform proposal should be to modernize Medicare and give it the management tools to ensure that Medicare per capita growth stays in line with private growth.

- **Assure that any costs of reforming Medicare are equitably shared**: No single group -- particularly beneficiaries -- should bear a disproportionate burden of the reduced spending and/or increased financing in a Medicare reform plan. Similarly, Medicare's cross-generational, cross-income sharing of financial burden should be maintained. In any proposal, we should also take into account the increases in beneficiary payments that will occur under current law.

- **Guarantee access to traditional Medicare coverage**: Only about half of Medicare beneficiaries have more than one plan in their area and fully 10 million beneficiaries live in a place (usually rural) with no private managed care option. Additionally, for people with chronic conditions or disabilities, managed care may not be the best health care option. Thus, a viable, modernized, more efficient Medicare fee-for-service program needs to be maintained to assure beneficiaries access to affordable, needed health care services.

- **Ensure that Medicare premiums are affordable**: Nearly two-thirds of elderly households have income under $20,000. Already, these elderly pay about one-third of their incomes on out-of-pocket health care costs. Any proposal should ensure affordability for modest income beneficiaries and guarantee that current low-income protections are maintained or strengthened.

MEDICARE REFORM COMPONENTS

DRAFT: January 30, 1999

BASE COMPONENTS

- **Medicare fee-for-service reforms**
  - Private sector tools for HCFA (e.g., allowing for preferred provider arrangements in fee-for-service, competitive pricing and negotiated pricing authority) [not in estimate]
  - Extensions of the Balanced Budget Act policies through 2007
- **Cost sharing rationalization** (e.g., combining Part A hospital and Part B general deductible; reducing preventive cost sharing and hospital day limits; adding home health copay)
- **Prescription drug benefit**: Benefit with
  - 50 percent premium
  - $250 deductible, typical copays, limit on payments of $1,000 -1,250

CONTROVERSIAL COMPONENTS

- **Premium support** [not in estimate]
- **Income-related premium** (same policy as in Health Security Act: begins at $90,000 for single beneficiaries, $110,000 for couples; does not completely phase out the subsidy)

VERY CONTROVERSIAL COMPONENTS

- Removing direct medical education from Medicare
- Conforming the age eligibility for Medicare with Social Security (without buy-in)

PREMIUM SUPPORT

CONCEPT OF PREMIUM SUPPORT Combines elements of defined benefit and defined contribution to improve Medicare's efficiency.

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.

- **Total premium:** Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.

- **Government payment:** The government contribution toward that premium would be limited (e.g., a percent of the premium and/or as a flat dollar amount).

- **Beneficiary payment:** Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.

- **Savings:** Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

COMMISSION PREMIUM SUPPORT MODEL

- **Beneficiary payment:** This amount depends on the relationship between the plan's premium and the national average premium. (Note: would be geographically adjusted)

    - Below average plans: 12 percent of the premium
    - Above average plans: 12 percent of the national average plus every dollar that the premium is above the national average.

- **Government payment:** 88 percent of the premium up to 88 percent of the national average.

- **Issues:**
    - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.

    - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. This also means that this model will not reduce Medicare costs.

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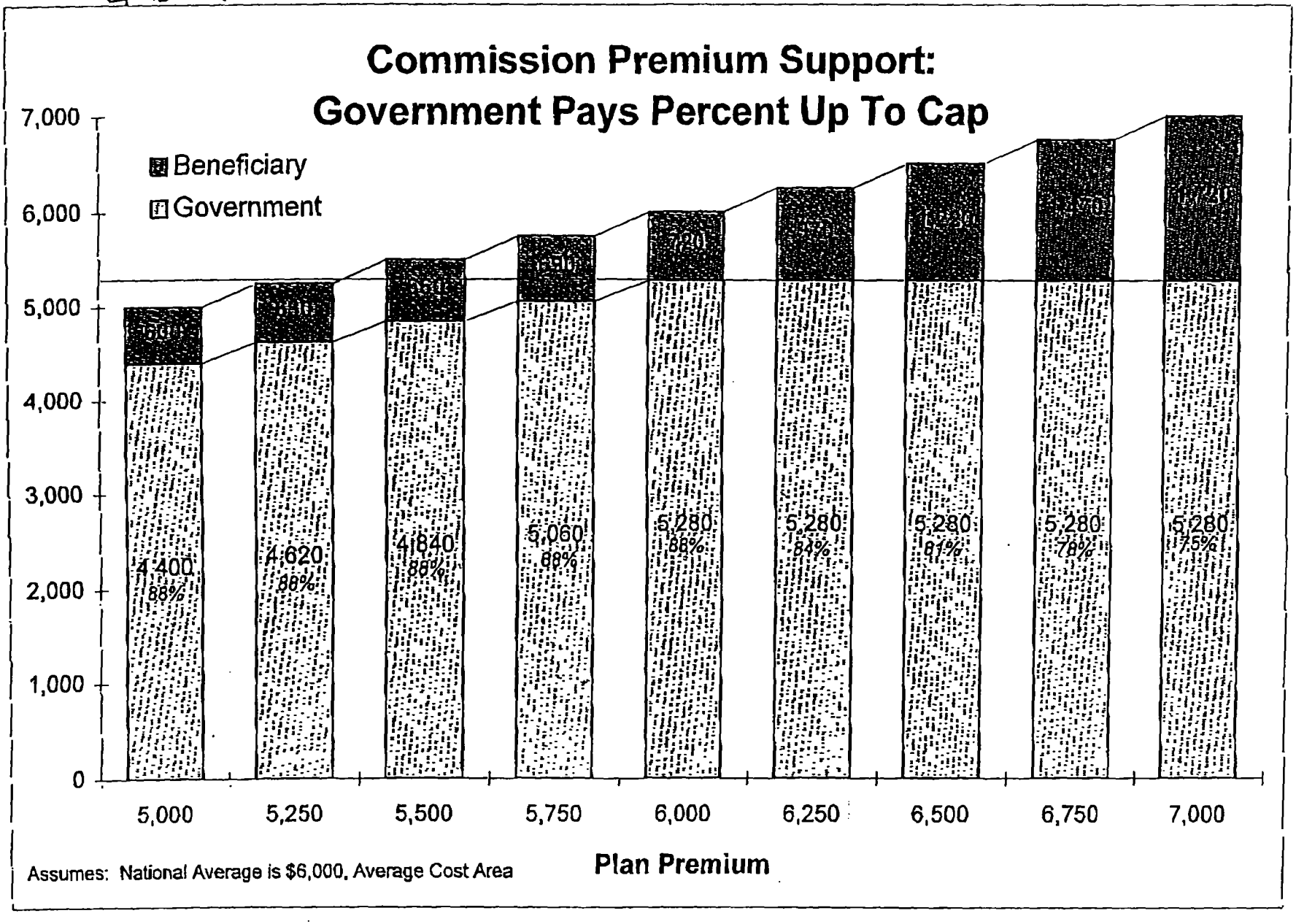

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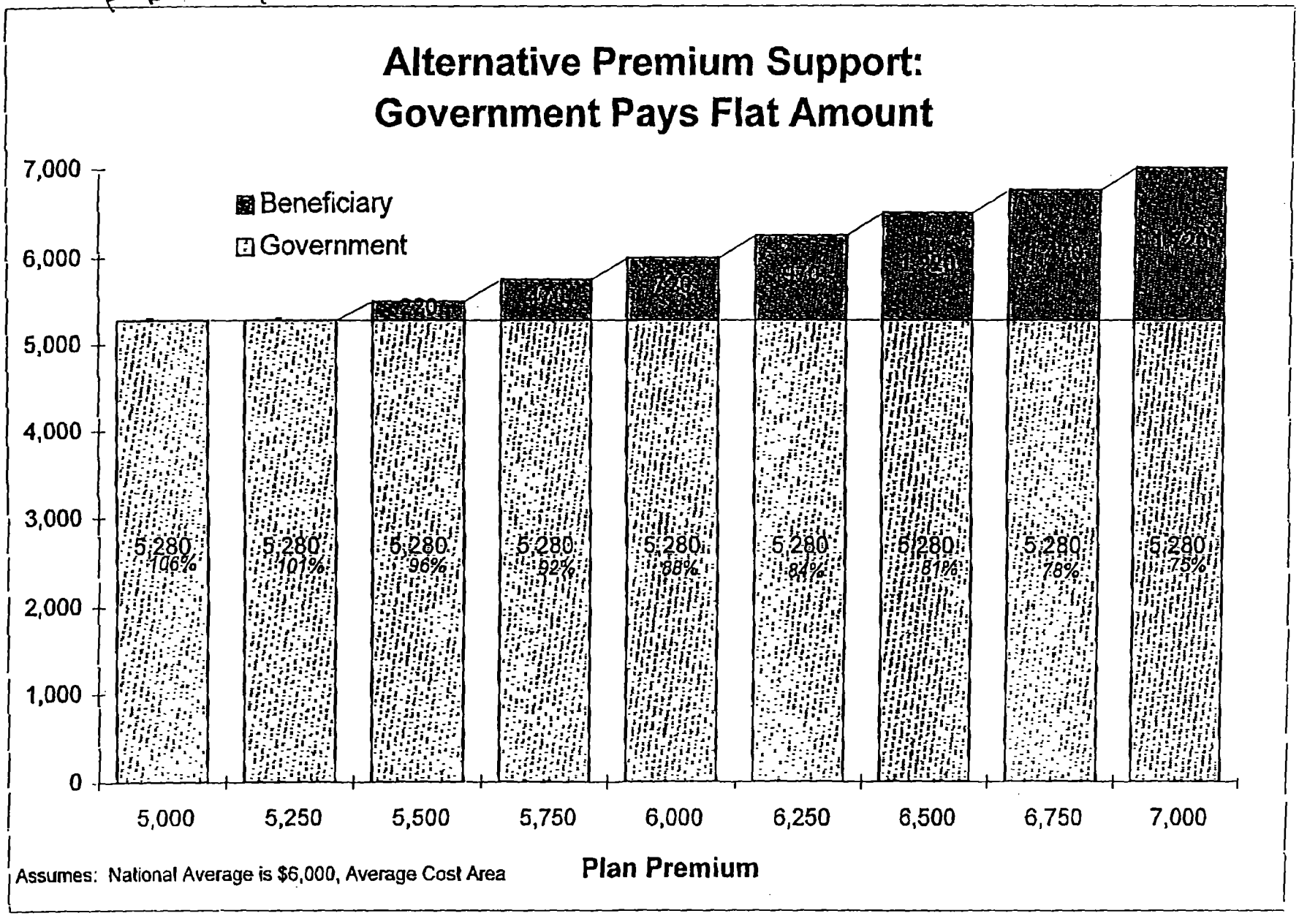

NEC MEDICARE COMMISSION PRINCIPALS MEETING

Roosevelt Room; 4:00pm
January 26, 1999

AGENDA

M6
Need to talk to Chris or Jean before just or put question 6s
1/30/99

I. MEDICARE REFORM: WHAT IS GOOD REFORM

- **Improves Efficiency**
  - -- Medicare fee-for service reforms, like competitive pricing
- **Modernizes and Rationalizes Benefits**
  - -- Meaningful prescription drug benefit for all beneficiaries
  - -- Rationalized cost sharing
- **Adds New Revenues**
  - -- Surplus

II. MEDICARE COMMISSION

- **Where It Is**
  - -- Update
  - -- Premium Support Model
  - -- Other Proposals (age eligibility)
- **How Its Policy Fits with Our Idea of Good Reform**
  - -- Similarities
  - -- Differences

III. POLITICAL CONCERNS

- **Democrats**
  - -- Too much like a voucher
  - -- Too risky
- **Republicans**
  - -- Prescription Drugs Concern
  - -- How to Use the Surplus
- **Breaux** [need for "success"; willingness to have one Administration appointee]

IV. GUIDANCE

- **Work with Commission on Good Reform Package**
- **Work Outside of Commission on Good Reform Package**
- **Do Not Propose Good Reform Package/Stick to Principles**

COMPONENT	BREAUX'S PLAN	ALTERNATIVE
Administration	Board that: Decides service areas Negotiates benefits, premiums Sets standards Provides information	Board that: [??] Decides service areas Updates the basic benefits Monitors standards Provides information
Benefits	Basic: Includes core benefits Total package at least equal to FFS Drugs: Private plans: May design and offer a drug and other benefits and receive gov't subsidy if total premium is below national average FFS: No benefit [placeholder] Cost Sharing: Private plans: No Standards FFS: $350 combined deductible 20% coinsurance for most services 10% for home health None for preventive, hospital care	Basic: Equal to today's benefits Drugs: Private plans & FFS: Offer at least a benefit with a [$250 deductible, 5% coinsurance, and $1,000 cap on benefits] Cost Sharing: Private plans: At least FFS FFS: $350 combined deductible 20% coinsurance for most services 10% for home health ? None for preventive, hospital care
Government Contribution	Fixed percent of the premium (including extra benefits) up to a dollar limit (fixed percent of the national average premium)	Fixed percent of the median premium (that includes a standard set of benefits) in a region
Beneficiary Contribution	In general: FFS: Difference between the national average Medicare spending and the gov't contribution Private plans: Difference plan premium and gov't contribution Income-related premium: No premium below 100% of poverty Phases up as income rises	In general: FFS: Difference between the regional average Medicare spending and the gov't contribution Private plans: Difference plan premium and gov't contribution Income-related premium: No premium below 135% of poverty ?
Fee-For-Service Reforms	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO BBA extenders
Age Eligibility Increase	Raise to conform with Social Security Allow some type of Medicare buy-in	?
Graduate Medical Education	Move direct medical education out of Medicare; Consider removing IME, DSH	?
Financing	No specific options	Surplus

COMMISSION PREMIUM SUPPORT MODEL

The proposed premium support model would work as follows:

1. **Medicare and private health plans set their premiums.** For Medicare, this premium is the national average spending on beneficiaries in its fee-for-service program. For private plans, the premium is its estimate of how much it needs for (a) benefits equivalent to those in Medicare fee-for-service; and (b) any supplemental benefits it decides to offer.

   Issue: No plan has an incentive to bid below average. This is because they can get government payments for extra benefits up to the national average. And since the Medicare benefits package is so inadequate, the majority of beneficiaries would opt for an average cost plan with subsidized benefits rather than a plan with a lower premium. Thus, it is hard to imagine how this structure will produce Medicare savings.

   Moreover, Medicare will subsidize extra benefits for some but not all beneficiaries. Beneficiaries who live in low-cost areas, or who have access to plans that are more efficient than the national average premium, may get a higher Medicare contribution for extra benefits. However, beneficiaries who live in high cost areas or who do not have access to private plans do not get the same government assistance.

2. **Beneficiary contribution is set.** Beneficiaries would pay 12 percent of the Medicare or private plan premium for plans with premiums at or below the national average premium. For plans with above-average premiums, the beneficiary would pay 12 percent of the national average plus every additional dollar of the premium that is above the national average.

   Low-income beneficiaries would pay nothing, and high-income beneficiaries would pay more than 12 percent [specifics not included].

   Issues: This proposal suggests that all beneficiaries in high-cost areas, where private plan premiums are above the national average, will pay more than 12 percent to participate in private plans. This creates a strong disincentive for beneficiaries to join private plans. It is also hard assess whether the low-income protections are sufficient in this proposal.

3. **Government contribution is set.** The government payment would be set in three steps. First, the premium would be geographically adjusted. The geographic adjuster would reflect part (not all) of the variation in Medicare costs compared to the national average. Second, the beneficiary payment would be subtracted. Third, the payment would be adjusted for the beneficiary's health (risk).

   Issues: Plan in high-cost areas would be hit twice under this proposal. First, only part of their higher costs are reflected in the payment -- they are underpaid in order to reduce some of today's large geographic variation. Second, beneficiaries would pay more for private plans since they pay for every dollar that the premium is above the national average.

Premium Support Alternative (Reischauer)

- **Benefits**. Benefits would be standardized and raised, including lower cost sharing and a decent prescription drug benefit. This new standard benefits package would be generous enough that few people would want to purchase Medigap.

  All plans, including FFS Medicare, would have to offer the standard benefits. Only limited variation would be allowed (e.g., plans could vary drug cost sharing, management of benefit).

  Plans could offer supplemental benefits on top of the new standard package, but such benefit plans would be subject to several restrictions: plans could not offer benefits only to people enrolled in their base plan; they must build into the premium the cost of utilization and that amount would be transferred to the base plan in which the beneficiary is enrolled.

- **Setting the total premium.** Plans (including FFS) would bid on the standard package for the average enrollee in the region. Regions would be defined based on beneficiary density and provider networks. FFS would be included in this bidding process; its bid would be analogous to the AAPCC (based on its local costs).

- **Government contribution**: There would be some bidding rule: for example, the government contribution would be based on the median bid (including FFS in the bidding). This amount would be increased if there was not sufficient capacity in plans with bids below the amount. The beneficiary's Part B-like premium and improved benefits premium (see below) would be subtracted from the median bid. This is the government contribution. The government contribution would be risk adjusted.

- **Beneficiary premiums**. There would be two basic parts of the beneficiary premium:

  - Part B-like premium: National amount, made equal to the Part B premium

  - Improved benefit premium: Region's average actuarial value of the added benefits (standard benefits minus current Medicare benefits).

  For plans whose bid is above the median, the beneficiary would also pay 100 percent of the difference between the bid and the median.

  For plans whose bid is below the median, the beneficiary either would have their improved benefits premium reduced or the plan would be required to offer the beneficiary extra benefits equal to the value of the difference between the median and the bid.

  There would be low-income protections (e.g., beneficiaries with incomes below 150 percent of poverty would not have to pay the Part B-like or improved benefit premium).

NEW REVENUES AND THE SURPLUS

NEED FOR NEW REVENUE

- **Massive cuts would be needed.** For the Hospital Insurance (HI) Trust Fund to be solvent only through 2022, it would take an 18 percent reduction in baseline spending in each year (all else held constant). To give an example of what that means, in 2000, this would amount to about $26 billion -- more than Medicare pays for all of outpatient services or home health care.

- **Growth would have to be slowed to below general inflation.** Even if Medicare per capita cost growth were constrained to general inflation in every year -- unprecedented in health care and less than half projected private spending growth rate -- the Trust Fund would only be extended to 2016.

EFFECTS OF THE SURPLUS

- **Reserving remainder of the surplus for Medicare.** The President's plan would include a provision that automatically sends to the Medicare Trust Fund a set dollar amount from the surplus annually for the next 15 years. These funds would be prohibited from being used for any other purpose, thus preventing the Trust Fund from being raided for other priorities.

- **Part of a broader Medicare reform initiative.** The President strongly urged the Medicare Commission and the Congress to include his proposal as part of a broader reform initiative. Medicare reform is about more than solvency -- it should also improve Medicare's efficiency, equity, and adequacy in terms of benefits. Medicare has fewer management tools and less ability to use competition than private health plans. Moreover, its benefits are outdated. Unlike virtually every employer health plan, Medicare does not pay for prescription drugs, for example. Thus, structural reforms as well as funds are needed to strengthen Medicare.

- **Ensuring that Medicare is financed for the next two decades.** Even in the absence of broader reforms, the President's plan would ensure that Medicare can continue to provide its critical health services. His proposal would double the life expectancy of the Medicare Trust Fund to 2020, making its outlook better than it has been in the last quarter of a century.

ADVANTAGES OF THE SURPLUS

- **Baby boom generation created the surplus -- and will need it when they retire.** In fact, the same generation -- the baby boomers -- that has helped create this surplus is going to need it when they retire and are covered by Medicare. By taking this action, the President is ending the need in the foreseeable future to look for new revenues from younger generations.

- **More progressive than a payroll tax increase.** The payroll tax, which is the main source of financing for the Medicare Trust Fund, is not progressive. It imposes a constant tax rate on earnings and does not tax other types of income at all, such as income from stocks. The budget surplus is primarily funded by the income tax. This is not a "flat tax" – it imposes somewhat higher tax rates on those with higher incomes, who have more ability to pay. Thus, even without further Medicare reforms, the proposed commitment of the surplus will make Medicare more progressive right away.

- **Enhances the likelihood of a reform package**. To meet the goals of Medicare reform, a proposal must: (1) make Medicare more efficient; (2) modernize and rationalize its benefits; and (3) add new revenues. This proposal to add new revenues improves the prospects for a bipartisan reform plan.

THE NEED FOR PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

- **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 dollars spent on health care will be on prescription 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 four years, the percent of large firms offering employer-sponsored coverage for Medicare eligibles dropped about 20 percent.

- **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.

January 7, 1998

TO: Gene

FROM: Jeanne and Chris

SUBJECT: Medicare Commission Update

The Medicare Commission has a March 1 reporting deadline, so that Chairman Breaux and Congressman Thomas are assuming final votes on the Commission's recommendations within the next six weeks. Given the composition of the Commission, the Presidential appointees (particularly Laura Tyson and Stuart Altman) are needed to validate and support the Commission's work. Senator Breaux and his staff are also increasingly seeking technical and policy guidance directly from us. Because of the relevance of this issue to current budget and Social Security deliberations, this memo includes an update the Commission work to date and tradeoffs of potential options.

MEDICARE'S PROBLEM

As a result of our administrative actions (e.g., our aggressive anti-fraud and waste efforts), the 1993 Medicare/budget reforms, and the unprecedented changes to the Medicare program included in the Balanced Budget Act of 1997, the life of the Trust Fund has been extended to 2008. The program's per capita growth rate is now actually growing slower than that of the private sector. Moreover, because estimates of program growth rates are now lower than originally projected and the robust economy is producing much higher Medicare payroll revenues than had been expected, the next Trustees' report is likely to push out the exhaustion date even further.

Despite these successes, Medicare's long-run problem remains. As Senator Breaux and Senator Frist have repeatedly pointed out, the Medicare program faces even larger and more immediate problems than does Social Security. While Social Security's Trust Fund expires in 2032, Medicare's Trust Fund is exhausted in 2008. Actual spending will overtake Social Security by about 2030; and Medicare's growth as a percent of GDP is projected to be three times as high as that of Social Security. While the hope has been -- and always will be -- that the major breakthroughs in disease prevention, treatment and cures will significantly constrain costs, few credible actuaries currently subscribe to this point of view.

Medicare as % of GDP [illegible] Health → in answer to [illegible] can we say that [illegible] health as % of GDP [illegible] reduces private spending?

Not only is Medicare's problem larger, it is more difficult to solve. Most economists and health policy analysts agree that it is unreasonable to consider a spending growth target that is below that of the private sector. Yet, to extend the trust fund by 2016 -- only 8 years -- would require spending growth per beneficiary of 3 percent which is about general inflation, which has historically been unsustainable for any public or private health program. This simple fact shows that spending reductions alone cannot significantly extend the trust fund; new beneficiary contributions or revenue are required.

This problem is compounded by Medicare's benefit shortcomings. One of the few things that all Commission members agree on is that Medicare has considerable gaps in coverage. Because it has no catastrophic coverage, has an irrational and frequently inequitable cost sharing structure (e.g., a $768 hospital deductible), and does not cover outpatient prescription drugs, the benefit package is actually 80 percent less valuable than most typical large firms -- including FEHBP. The lack of prescription drug coverage is particularly problematic, since it is affecting the ability of physicians to adequately treat Medicare beneficiaries as medicine increasingly relies on pharmacological advances.

MEDICARE COMMISSION STAFF WORK / REPUBLICAN ISSUES

This Commission has been focusing on one major reform idea: "premium support". Premium support is a term coined by Reischauer and Aaron to described a combined defined contribution and defined benefits model. In practice, this means that beneficiaries would still be entitled to a minimum set of benefits, but the government payment for those benefits would be limited in some way. At its August meeting, the Commission heard a number of approaches to premium support, differing dramatically depending on how the government contribution and minimum benefits are set.

At its December 2 meeting, the Commission staff presented a single, FEHBP-like model. Under this proposal, the government's payment for Medicare coverage would be set as a percent of the premiums offered by health plans. Beneficiaries would pay the difference between the premiums and the government contribution. The percent that the government pays decreases as the premium rises, and once the government contribution reaches a certain dollar amount, it stops increasing altogether. Private plans would offer benefits at least equal to the actuarial value of current Medicare plus certain core benefits (like CHIP). They could also offer any supplemental benefit that they chose, and include its cost in its premiums. Thus, the government would pay for a percent of the supplemental benefits as well as the basic benefits. In contrast, Medicare fee-for-service would not include supplemental benefits. Its premium would be set nationally and beneficiaries would pay a percent of its premium in the same way that they pay for private plans.

Clearly, this plan reflects many of the Republican priorities. First, it lacks a clearly defined, uniform minimum benefits package. The concept of an actuarial value makes sense when the starting point is a benefits package that is rich like FEHBP or state employees' health plans. However, Medicare is currently below the twentieth percentile of actuarial value of private employer plans. There is not any room to substitute one benefit for another. More importantly, there are serious questions about whether Medicare beneficiaries -- a third of whom have some type of cognitive impairment -- can make informed choices of plans when their benefits are allowed to vary.

Second, the proposal offers a significant subsidy for supplemental benefits but only for people in private plans. Thus, if a plan can offer the basic benefits for a premium below the fee-for-service premium, it include extra benefits in its premium so beneficiaries would have a choice of fee-for-service without benefits or private plans with extra benefits at the same premium. This gives private plans the advantage of competing with fee-for-service on benefits as well as price. It also has the effect of probably making this model cost, rather than save, money. Our analysts and outside people like Reischauer and Moon agree that the structure of this specific proposal is flawed and will likely raise Medicare costs.

In addition to this premium support proposal, the Commission staff has presented options like: rationalizing Medicare cost sharing (single deductible, high copayments for certain services, a cap on out-of-pocket expenses); prohibiting Medigap from covering deductibles (in an attempt to reduce overutilization); raising the age eligibility of Medicare from 65 to 67; and carving out Medicare graduate medical education (GME) and disproportionate share hospital (DSH) payments from Medicare. There is also a strong push to have an independent agency, some "Medicare Board." administer this system. This comes at a time when we expect that HCFA is the new target for the Republicans in the same way that the IRS was several years ago. There has been debate and discussion on these issues, but most people are focusing on the benefits and premium support issues.

Want to discuss

DEMOCRATS' POSITION

Despite clear problems with the specific options for premium support laid out by the Commission, our appointees and Democratic appointees have not given up on the idea of premium support for two reasons. First, all of them truly want to improve Medicare's efficiency and extend the life of the trust fund. Second, they see this Commission as an opportunity to improve Medicare's benefits, and if a reasonable premium support proposal is the vehicle, are willing to consider it. However, there has been great concern about (a) whether premium support can be made consistent with Democrats' priorities; and (b) the use of any endorsement of premium support by Republicans. Senator Kennedy, for one, worries that there is no returning from an endorsement of ~~premium support, and that we can fund drugs elsewhere.~~

Need to see what consensus or principles compel for premium support

Recognizing these concerns, we worked with Mr. Dingell and Congressional Democrats just before the December meeting on a set of principles to guide Medicare reform. They serve two purposes. First, they are the bottom line of what needs to be in premium support for Democrats to endorse it. Second, if it looks like there can be no consensus in the Commission, they can be part of an exit strategy -- showing that Democrats are for real reform consistent with these principals, but Republicans want a reckless plan. They were discussed at the December 3 meeting, and again at yesterday's Democrats-only meeting. Senate Breaux promised that his mark will include policies reflecting them, and we agreed to work with him on what those policies would be. The following is a discussion of the principles and the policies behind them.

Guarantee an adequate, modernized benefits package. All Democratic appointees agree that benefits not only should be guaranteed, but should be clearly defined -- not just a dollar amount. There is an openness to considering the Republicans' idea of a board separate from Medicare to update Medicare coverage policy periodically (this could help accommodate the Republicans' interest in eliminating HCFA altogether). However, this has to be done carefully, since any

support in this direction could undermine HCFA in this upcoming Congress.

More importantly, there is bipartisan support for improving Medicare's cost sharing. There is general agreement that this should be done in a budget neutral way -- Democrats are quick to point to facts about how much higher Medicare cost sharing is than typical private plans today. There also is not a great interest in reducing the cost sharing burden as a whole, since most would prefer that any funds available to improve Medicare should go toward adding a prescription drug benefit. As such, both the Commission and internal Administration staff are looking at (a) replacing the $780 hospital deductible and $100 Part B deductible with a single, Part A and B deductible (about $350 if budget neutral); and (b) eliminating the payment limit on hospital days (currently, Medicare stops paying for hospital care after day xx) and cost sharing for preventive services funded by adding coinsurance to home health, lab services and certain other services. The deductible change should help lessen the need for Medigap -- which too many beneficiaries pay too much for today.

Probably the most important improvement to Medicare would be adding a prescription drug benefit. Not surprisingly, its expense remains a major challenge. A comprehensive, Part B benefit (with a 75 percent government subsidy) would cost about $160 billion over five years according to HCFA actuaries' preliminary estimates. In light of this, we are examining low cost alternatives, like making it an optional or partly-subsidized part of Medicare. For example, a benefit with a $100 deductible, copays (e.g., $7 per generic drug, $15 per brand name drug) and a maximum payment limit of $1,000 -- typical of what is offered in Medicare managed care today -- would cost $50 to 60 billion over 5 with a 75 percent premium subsidy, $30 to 40 billion with a 50 percent premium (about $20 per month). Although there is some disagreement on whether a capped benefit is worth it, some experts think that past experience suggests that it is better to help a lot of people a little than a few people a lot.

It is important to point out the difference between this approach to benefits and that of the Commission. The Commission's December plan allowed improvements in private plans but not Medicare fee-for-service, creating a powerful incentive for beneficiaries to choose managed care. It also, as Laura Tyson pointed out, creates a huge potential for risk selection as plans will only cover the drugs in areas with high payment or healthy beneficiaries. Most Democrats -- Breaux included -- agree that drugs need to be available in both FFS and managed care.

Encourage and allow Medicare to use competitive practices: The Republicans have been reluctant to improve the efficiency of the current Medicare FFS, in part because it makes it a more attractive, affordable option for beneficiaries. There is also a philosophical distrust and dislike of HCFA, so giving it greater flexibility is anathema. However, it has been a priority for Democrats. Bruce Vladeck has been working with HHS on a list of ideas that would make Medicare FFS more competitive. Interestingly, there are few new ideas -- most have been in your past budgets. We are also reviewing options for extending policies in the BBA, in hopes of coming up with a sizable amount of savings since there is some skepticism about the savings in a premium support / competitive model. This package is also important in principle -- we may be able to save more in FFS reforms than in poorly designed premium support models.

Manage Medicare so its growth does not exceed that in the private sector. This principle is less to ensure that certain policies are in place than to prevent bad policies from being included. Our

recommended way to prevent excessive spending cuts is using the private sector per capita cost growth as a target.

Assure that any costs of reforming Medicare are equitably shared: This, too, is a defensive rather than proactive principle. Because Medicare's spending growth per beneficiary tends to parallel private growth under current law, new beneficiary payments and/or revenues will surely be needed for reform. This principle is intended to assure that beneficiaries are not the only source of funding -- that others need to share in the cost of reform as well.

Guarantee access to traditional Medicare coverage: In some of the more conservative premium support proposals, the option to remain in HFCA-run Medicare FFS is removed. Since a large proportion of beneficiaries today do not have access to private Medicare managed care, this could present real access problems. This principle aims to assure that all beneficiaries -- especially those in rural areas -- have the option of traditional Medicare. It also implicitly implies that such coverage must be affordable. The 1995 Republican budget, for example, included Medicare reforms that would make it increasing expensive to remain in FFS. A level playing field between FFS and private plans is essential to Medicare reform.

Ensure that Medicare premiums are affordable. This principle, at a minimum, means that Medicare beneficiaries who are protected by Medicaid today maintain those protections. Some have advocated for additional protections; (e.g., cost sharing protections up to 150 percent of poverty). Other think that if there is considerably more cost sharing under the reform proposal, we need to rethink how these protections are structured.

MEDICARE COMMISSION, JANUARY 22, 1999

1/27/99

DRAFT REFORM PLAN. Senator Breaux released a "draft working document" on Medicare on January 21. It includes:

- **Premium support**: A combination of a defined contribution / defined benefit approach.
  - ***FEHBP-like model***: Medicare would pay a percent of the whatever the plan's premium is up to a cap (the national average premium) for benefits at least actuarially equivalent to those in current Medicare.
  - ***Alternative: Competitive pricing / Reischauer-like model***: Medicare and private plans would bid on an identical set of benefits. The government contribution would be set at the median premium. People pay more for plans above the median premium, nothing for plans below.
- **Reforms similar to Senate Finance Committee's 1997 BBA:**
  - ***Raises Medicare's age eligibility***: Conforms to Social Security, suggests a Medicare buy-in proposal could be included.
  - ***Income-related premium***
  - ***Home health co-payment***
- **Replaces most of HCFA with a separate "Medicare Board", reforms graduate medical education**

IMPLICATIONS

- **Democratic principles**: Does not conform with Democrats' principles that include:
  - Equal, defined benefits for fee-for-service and managed care
  - Prescription drug benefit -- in a section called "areas that need resolution"
- **May not save much money:** FEHBP model probably does not save much money,
  - Alternative approach would probably save money, but not fully developed
  - Provider payment reductions -- in a section called "areas that need resolution"
- **Timing:** Next public meeting: January 26; Final report is due on March 1

QUESTIONS

- What is an acceptable outcome for the Commission
  - What should our role be in achieving that outcome (both with respect to Senator Breaux and Democratic appointees)

- If a compromise looks unlikely, how do we want to position the Administration

U.S. House of Representatives
Committee on Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515–6115

DEMOCRATIC STAFF

FAX COVER SHEET

DATE: _____

TO: GARY CAXTON

FROM: JEANNE LAMBREW

FAX NUMBER: _____

NUMBER OF PAGES:
(Including Cover) 6

COMMENTS:
FROM SRS. GROUPS.

(If there are problems with this transmission,
please phone 202-225-3641, Democratic Staff, 2322 RHOB.)

LEADERSHIP COUNCIL
----------*of*----------
AGING ORGANIZATIONS

The Honorable John Breaux
Chairman, National Bipartisan Commission on
the Future of Medicare
516 Hart Senate Office Building
Washington, D.C 20510

February 10, 1999

Dear Chairman Breaux.

The undersigned members of the Leadership Council of Aging Organizations (LCAO), a coalition of 42 national groups representing over 50 million older Americans, appreciate the Commission's efforts to craft a Medicare proposal that can receive bipartisan support. At the outset, we want you to know that we strongly support earmarking a minimum of 15 percent of the projected budget surplus to the Medicare program, as President Clinton has proposed. We urge the Commission to include this proposal in its formal recommendations.

As Medicare moves forward into the next century, we must not abandon the essential elements that have served beneficiaries well for the past 30 years:

- a program to which everyone contributes and from which everyone benefits;
- a structure based on shared risk, spread across a broad population; and
- a package of defined benefits supported by funding that reflects the costs of those benefits in the community.

You may recall that last August we sent you and other Commission members a set of ten Medicare reform principles that would guide us in our efforts to move the program into the 21st Century. Specifically, we believe that Medicare reform must:

1. Continue to guarantee universal eligibility and broad-based financing for needed benefits.
2. Guarantee an adequate, defined package of benefits and improve coverage for preventive care and prescription drugs.
3. Assure that Medicare payments will keep pace with the growth in benefit costs, without using artificial budget inflators or caps on spending.
4. Assure financial viability by providing sufficient revenues to meet growing needs, improving cost effectiveness and efficiency in service delivery, and strengthening efforts against waste, fraud and abuse.
5. Ensure the affordability of beneficiary contributions and improve protections for low-income beneficiaries.
6. Retain an affordable traditional fee-for-service option that shares risks across a broad population, accompanied by an affordable Medigap program that requires community rating and open enrollment for all beneficiaries.
7. Treat and coordinate the full range of the total health needs of beneficiaries, including those with chronic health conditions.

8. Include strong quality assurance mechanisms, beneficiary financial protections and the consumer-friendly information beneficiaries need to make well-informed choices.
9. Reject proposals that would increase the number of persons without health insurance.
10. Ensure that other health costs are shared appropriately among all payers and do not place a disproportionate burden on Medicare.

The Draft Working Document you have put forward is inconsistent with many of these principles and we, therefore, are not able to support the proposal at this time. In an area as complex and important as Medicare reform, "the devil is in the details" and we are unable to tell from the document the degree to which the proposal would assure program viability in the future and might do significant harm to present and future Medicare beneficiaries. For example, we are particularly anxious to see precise cost and premium estimates for the proposal through 2030. We hope that you will respond directly to our concerns, as well as answer these questions in the course of the Commission's public deliberations. We cannot consider supporting a Medicare reform proposal without specific answers to the following questions:

- It appears that your proposal would erode the current Medicare program guarantees to beneficiaries. Would beneficiaries continue to be entitled to at least the same package of specific benefits they are currently assured, regardless of which plan they choose? Could plans or the new Medicare Board change beneficiary cost sharing, for example, by requiring high deductibles, without congressional approval? Could plans or the Board arbitrarily limit the number of physician or home health visits beneficiaries may receive per year, without congressional approval? Would the Medicare Board have authority to increase the level of benefits plans must provide, which could have significant federal budget implications, without congressional approval?

  We are also concerned, as we believe you are, that variations in benefit packages across plans will lead to undesirable adverse selection. We remind you that, according to the Physician Payment Review Commission, "In recent years, FEHBP administrators have aggressively limited the variation in benefit packages to facilitate consumer comparison of plans and limit some of the risk selection among plans" [1997 PPRC Annual Report to Congress, page 184] Dr Robert Reischauer testified before the Senate Finance Committee on May 21, 1998 that "Subtle differences in benefit packages, if they were allowed, could be used by plans to attract healthier participants in a restructured Medicare program"

- The Draft Working Document states that "The Government's contribution will be based on a percentage of the national weighted average premium." Currently, beneficiaries in the traditional fee-for-service (FFS) program are guaranteed that their Part B premiums will not exceed 25 percent of Part B program costs, under any circumstances. During the Commission's recent deliberations you stated that, under a combined Part A and B program, beneficiaries would pay 12 percent of program costs. Under your proposal, what would the average Medicare beneficiary in the FFS program pay this year for premiums relative to current law? What would this FFS premium comparison look like in 2010 and 2020? If FFS costs in a particular geographic market are greater that those in competing managed care plans, couldn't FFS beneficiaries over time end up paying significantly more that 12 percent? Isn't it likely that this would be the case in low cost rural areas, where the cost of a national FFS plan would likely be much higher than local private plan costs? Wouldn't this result in forcing many beneficiaries in rural areas into managed care plans?

- The Commission's authorizing legislation specifically charges the Commission to "make recommendations on the impact of chronic disease and disability trends." However, no mention whatsoever is made about addressing chronic or long-term care needs in the Draft Working Document. We are dismayed that your proposal did not consider the growing needs of the chronically ill and the inadequate coverage they receive under the present Medicare program. What proposals are you considering, if any, to fulfill this charge and reform Medicare to better address the rapidly growing needs of beneficiaries with chronic health conditions?

- The Commission's authorizing legislation also charges the Commission to "make recommendations to restore the solvency" of Medicare Part A and restore the "financial integrity" of Part B. How would you define "solvency" and "financial integrity" under your proposed combined Part A and Part B program? Under your proposal, how far into the future would Medicare be solvent?

- We have serious concerns about the powers and authority given to the new Medicare Board under the Draft Working Document and the diffusion of responsibility between the Board and HCFA. Upon what model is this new Board based, recognizing that under the FEHBP the Office of Personnel Management is a government agency? Would the Board be responsible for maintaining Medicare's central eligibility and enrollment files? Would the Board be authorized to make changes in the current Medicare provider Conditions of Participation? What enforcement authority would the Board be given if a plan or provider failed to meet financial or quality standards or did not provide the guaranteed set of benefits? To what entity would the Board be financially and politically accountable? What role would Congress and HCFA have in determining risk and geographic payment adjustments? What role would the Board have in determining and enforcing appeals and other due process requirements for plans?

- The Draft Working Document proposes that Medicare's eligibility age be increased to match Social Security. If Medicare's eligibility age is raised to age 67, how many older Americans will be thrown into the ranks of the uninsured? Would Medicare beneficiaries be able to receive reduced benefits at age 62, as are available under Social Security? We assume that, in conjunction with your proposal to raise the eligibility age, you are also considering some form of buy-in for beneficiaries under age 67. What would be the price of the premiums? What provisions would you include to ensure that lower income beneficiaries could afford such a buy-in? How many older Americans would become uninsured even if a buy-in were included? What are the estimated budget savings from this proposal?

- As you know, in the past, many of us have been concerned that income-related premiums could eventually erode popular support for Medicare and cause higher income beneficiaries to disenroll from Medicare Part B. Under your proposal, would enrollment in the combined Part A and B program be voluntary or mandatory? At what income thresholds would beneficiaries begin to pay higher premiums? Would these thresholds be indexed each year? What are the estimated budget savings for income relating premiums? Would private plans be given information on beneficiaries' incomes in order to determine premiums? How would income levels be determined? Would these excess premiums be charged through the tax system? How would this be administered?

- Would there continue to be a guarantee that the government contribution would increase over time at the rate of inflation in the Medicare program?

- The Draft Working Document states that "Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental cost of choosing more expensive plans." Earlier Commission documents suggested that this cutoff might occur at 130 percent of the national weighted average premium. Would your proposal cut off the government contribution at only 100 percent of the national weighted average premium? Wouldn't this result in a two-tiered system in which only wealthy beneficiaries could afford an enhanced benefit package? Under your proposal, what, in fact, would the cutoff point be? What would this do in high cost areas? Would payments to plans be adjusted downward in high cost areas? If so, by how much?

- Under current law, beneficiaries with incomes up to 135 percent of poverty do not have to pay Medicare Part B premiums. Many of us believe that levels of protection should be raised to 150 percent of poverty. During the Commission's last meeting, it was suggested that, under your proposal, QMBs and SLMBs (with incomes up to 120 percent of poverty) would not have to pay premiums. Are you proposing to reduce current premium protections from 135 percent to 120 percent of poverty? How would QI-1 and QI-2 beneficiaries be treated? At what level of income would beneficiaries be protected against cost sharing? Would Medicare or Medicaid be responsible for low-income protections? What steps would be taken to increase abysmally low participation rates in these programs?

- The Draft Working Document proposes a new 10 percent home health copayment. How would you ensure that home health users, the vast majority of whom are lower income widows over age 75, would be able to afford needed services? Those in greatest need would be forced to pay the most. Unless cost sharing protections are raised well above 100 percent of poverty, a significant number of these older Americans will be forced to go without needed home health care, resulting in a loss of independence, greater need for medications, premature institutionalization and higher total health system costs.

- Are you proposing a combined $350 deductible in which beneficiaries would be prohibited by law from purchasing first dollar Medigap coverage? Would beneficiaries be subject to criminal prosecution and imprisonment if they chose to purchase such private insurance coverage? At what levels of income would low-income beneficiaries not be forced to pay this deductible? What are the estimated budget savings from this proposal? Do you share our concern that many lower income beneficiaries would forego needed care, jeopardizing their health, and end up costing Medicare more in the end?

- In earlier Commission documents, it was suggested that restructured cost sharing would pay for stop-loss protections, similar to those available today under many private insurance plans. Are you still proposing that Medicare guarantee beneficiaries some form of stop-loss protection?

- What is your recommendation for assuring that all Medicare beneficiaries have access to meaningful prescription drug coverage? Would any improved preventive benefits be included in the core package?

- For those enrolled in private plans, would plans be responsible for collecting the entire premium directly from the beneficiary? What would happen if a beneficiary did not pay his/her premium?

- The Draft Working Document proposes that Disproportionate Share Hospital (DSH) and Direct Medical Education (DME) payments be carved out of Medicare and financed through an appropriations program. What assurances can be made that these programs would be funded adequately? Wouldn't subjecting these programs to the appropriations process increase the risk that funding would be cut significantly?

We are very concerned that the proposals included under the Draft Working Document could undermine current Medicare guarantees and be detrimental to the health and well-being of present and future Medicare beneficiaries. We look forward to receiving responses to our questions and working on a bipartisan basis with you, your staff and other Commission members to address our serious concerns.

Sincerely,

Steve Protulis, Chair

Alzheimer's Association
American Association for International Aging
American Association of Homes and Services for the Aging
American Society on Aging
Asociacion Nacional Pro Personas Mayores
Association for Gerontology and Human Development in
Historically Black Colleges and Universities
Association of Jewish Aging Services
B'nai B'rith Center for Senior Housing and Services
Families USA
The Gerontological Society of America
Gray Panthers
National Academy of Elder Law Attorneys
National Association for Home Care
National Association of Area Agencies on Aging
National Association of Retired Federal Employees
National Association of State Units on Aging
National Caucus and Center on Black Aged, Inc.
National Committee to Preserve Social Security and Medicare
National Hispanic Council on Aging
National Osteoporosis Foundation
National Senior Citizens Law Center
Older Women's League
United Auto Workers Retired and Older Workers Department

cc. Members of the Bipartisan Commission on the Future of Medicare

FAX TRANSMISSION

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AB
KF

To: Bridgett Taylor **Date:** January 29, 1999

Fax #: 202 - 225 - 5288 **Pages:** 3, including this cover sheet.

From: Rick Foster

Subject: Mr. Dingell's Drug Proposals

COMMENTS:

We've started working on your request on behalf of Rep. Dingell and are making good progress. There are a few questions we'd like to pose on the operation of the proposals. In a couple of cases, we've assumed answers but let us know if these aren't correct.

1. For all the options, would Medicare+Choice plans be required to include drug coverage at least equal to the proposed coverage as part of their benefit package? [We've assumed "yes."]

2. Would Medicare payments to Medicare+Choice plans be adjusted to reflect 95% of the increase in average fee-for-service Medicare costs under the proposal? [We've assumed "yes."]

   In practice, incidentally, the interaction between a voluntary drug option and Medicare+Choice gets tricky. We would probably have to use different payment rates to plans, depending on whether or not the enrollee had opted for drug coverage. This isn't an issue for our cost estimates, however, just something to think about for design purposes.

3. Would the maximum out-of-pocket limits or benefit limits be indexed to CPI also? [We've assumed "yes."]

4. On option 4, what are the rest of the cost-sharing requirements for fee-for-service beneficiaries? Also, there's a tricky interaction between the combined deductible and the drug benefit. The attached note from Greg Savord summarizes the issues.

Please let us know if you have any questions about these issues. We'll continue working on the first 3 options in the meantime.

Some Thoughts on Option 4 of Representative Dingell's January 19, 1999 Prescription Drug Proposals

The prescription drug benefit under option 4 is included in the $350 combined deductible. After the deductible, the beneficiary would pay $7 (generic) or $15 (branded) per prescription fill. The maximum program benefit would be $1,000.

So far, I have two questions.

- How is the coinsurance applied when the remaining deductible covers part of a prescription fill?
- How is the deductible allocated between prescription drugs and other services? Beneficiary and program payments vary with different allocations of the deductible.

The following example illustrates different ways of allocating the deductible. The example assumes that if any remaining deductible is applied to a prescription fill, the copay is not applied to that prescription fill. The example also assumes that the average prescription copay is $10.

Gregory Savord

Example

$350 Combined Deductible
20% Non-Rx Coinsurance
$10 Rx Copay per fill
$1,000 Maximum Drug Benefit

$75 Average Rx Cost per fill
3 Rx fills
$500 Non-Rx Costs

Non-Rx			Rx					Combined		
Deductible	Coinsurance	Medicare Pays	No. Fills subject to deductible	Deductible	Copay	Medicare Pays	Excess OOP	Bene Pays	Medicare Pays	Total Costs
Deductible applied to non-Rx first										
$350	$30	$120	0	$0	$30	$195	$0	$410	$315	$725
Deductible applied to Rx first										
$125	$75	$300	3	$225	$0	$0	$0	$425	$300	$725

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To:	Bridgett Taylor	Date:	February 7, 1999
Fax #:	202-225-5288	Pages:	5, including this cover sheet.
From:	Rick Foster 410-786-6374 410-786-1295 (fax) rfoster1@hcfa.gov		

Subject: Mr. Dingell's Drug Estimates

COMMENTS:

The attached memorandum from Greg Savord shows the estimated financial impact of the first three drug proposals that you requested on behalf of Mr. Dingell on January 22. Since we haven't heard back from you on the specification questions we posed on January 29, we've gone ahead using the assumptions that we'd indicated for the first three. The fourth option involved a more comprehensive question and we've postponed estimating it pending further word.

At this time, we haven't provided these estimates to anyone else other than you. I understand that you have shared this request with Jeanne Lambrew and others in the Administration. With your permission, we would like to provide copies of this memorandum to them. Also, if permissible, we would like to share the results with Bobby Jindal for possible use with the Commission at large. Please let us know your preferences in both cases, and whether you have any questions about these estimates. Thanks.

MEMORANDUM February 3, 1999

FROM: Gregory J. Savord
Office of the Actuary
Health Care Financing Administration

SUBJECT: Estimated Short-Range Financial Effects of Three Alternative Proposals to Cover Prescription Drugs Under Medicare

This memorandum presents the estimated financial effects in fiscal years 2001-2010 under three alternative proposals to add coverage of prescription drugs to the Medicare program.

Table 1, attached, summarizes the key provisions of the proposals. The proposals differ primarily by (i) deductible level; (ii) coinsurance rate; and (iii) maximum out-of-pocket limit or a maximum Medicare benefit.

In all cases, the drug benefits would be covered under the Supplementary Medical Insurance program ("Part B" of Medicare) and their cost to Medicare would be included in the determination of the monthly SMI premium. In contrast to current law in which approximately 25 percent of SMI cost is financed through premiums, 50 percent of the additional Medicare expenditures under these proposals would be financed through higher premiums, and the remaining 50 percent through increased revenue transfers from the general fund of the Treasury. Capitation payments to Medicare+Choice plans would be increased by a percentage[1] of the average fee-for-service cost of the drug coverages. This summary of the provisions represents our understanding of the proposals and may be subject to change if we have misinterpreted the specifications or if the proposals are developed further.[2]

The following table shows the estimated total increase in Medicare benefit expenditures during the first 5 and first 10 years under each of the proposals. The 10-year "gross" cost (before reflecting additional premium revenue and reduced Medicaid outlays) generally ranges from about $220 billion for the proposals with benefit limits to about $530 billion for the proposal with an out-of-pocket maximum. Medicare administrative expenses would increase under these proposals but we have not estimated this additional cost.

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[1]The percentage would be the current law ratio of Medicare+Choice per capita rates to fee-for-service per capita costs.

[2]We have assumed that the drug coverage would be *mandatory*, rather than the originally specified voluntary option for beneficiaries. In practice, we estimate that virtually all beneficiaries, if given an optional, one-time opportunity to elect drug coverage with a 50-percent Federal subsidy, would choose to enroll. Thus, the estimated financial impact for voluntary coverage options, otherwise equivalent to those shown in this memorandum, would not differ significantly from these estimates.

Proposal	Estimated total increase in Medicare benefit expenditures, in billions	
	2001-2005	2001-2010
Option 1	$188	$528
Option 2	84	216
Option 3	88	222

The "net" cost to Medicare, after reflecting additional premium income (but not additional administrative expenses), is shown in table 2 (attached). In addition, the estimated net reductions in Federal Medicaid outlays are shown, reflecting (i) somewhat higher outlays for Medicare premiums and coinsurance, but (ii) significantly lower outlays for prescription drugs. Excluding the impact on Medicare and Medicaid administrative costs, the net budget impact of these proposals is generally estimated at about 50 percent of the gross increase in Medicare benefit expenditures shown in the table above.

These estimates are based on the intermediate set of economic and demographic assumptions from the 1998 OASDI and Medicare Trustees Reports and assume the same growth trends estimated for overall prescription drug costs, as reported in our most recent projection of national health expenditures.[3] Data on individual drug expenditures were drawn from the 1995 Cost and Use file of the Medicare Current Beneficiary Survey, and adjusted for survey underreporting and the induced utilization estimated to result from reduced out-of-pocket costs under the various proposals.

As with any proposal to introduce a new medical benefit, these estimates are subject to substantial uncertainty. Actual future costs could differ significantly from these estimates.

Gregory Savord

Gregory J. Savord, F.S.A.
Special Assistant to the Chief Actuary

[3] See Sheila Smith *et. al.*, "The Next Ten Years of Health Spending: What Does The Future Hold?" *Health Affairs*, Vol. 17 No. 5 (September/October 1998).

Table 1—Summary of key provisions of alternative proposals to add coverage of prescription drugs to Medicare

Proposal	Deductible	Coinsurance	Maximum out-of-pocket cost	Maximum Benefit	Beneficiary Premium
Option 1. Comprehensive benefit	$250	20%	$1,000	None	50%
Option 2. High deductible, capped drug benefit	$500	10%	None	$1,250	50%
Option 3. Medium deductible, capped drug benefit	$250	10%	None	$1,000	50%

Note: For each option, the prescription drug coverage would be classified as a benefit under the Supplementary Medical Insurance program, and its cost would be included in the determination of the monthly SMI premium. The incremental SMI premium would be 50% of aged per capita drug benefits. The drug deductible, out-of-pocket limit, and benefit payment limit would be indexed to inflation in future years. An effective date of January 1, 2001 was assumed for each proposal.

Office of the Actuary
Health Care Financing Admin.
February 3, 1999

Table 2.—Estimated Medicare and Federal Medicaid costs (+) or savings (-) under alternative proposals to add coverage of prescription drugs to Medicare

(In billions)

Proposal	Fiscal year										Total,	Total,
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001-05	2001-10
Option 1.												
Medicare expenditures	$19.6	$35.8	$39.5	$43.9	$48.8	$54.3	$60.5	$67.4	$74.9	$83.5	$187.7	$528.4
Medicare premiums	-12.0	-17.2	-19.0	-21.1	-23.3	-25.8	-28.7	-31.8	-35.3	-39.0	-92.6	-253.3
Net Medicare impact	7.6	18.6	20.5	22.8	25.5	28.5	31.9	35.6	39.7	44.5	95.1	275.1
Fed. Medicaid expenditures	-0.1	-0.7	-0.7	-0.8	-0.9	-1.1	-1.2	-1.4	-1.6	-1.8	-3.3	-10.2
Net budget impact	7.6	17.9	19.7	22.0	24.6	27.4	30.7	34.2	38.1	42.7	91.8	264.9
Option 2.												
Medicare expenditures	$9.4	$16.8	$18.0	$19.4	$20.9	$22.5	$24.3	$26.2	$28.2	$30.4	84.5	216.1
Medicare premiums	-6.1	-8.6	-9.2	-9.9	-10.6	-11.4	-12.3	-13.2	-14.2	-15.3	-44.4	-110.8
Net Medicare impact	3.3	8.3	8.8	9.5	10.3	11.1	12.0	12.9	14.0	15.2	40.2	105.3
Fed. Medicaid expenditures	-0.1	-0.4	-0.4	-0.5	-0.5	-0.6	-0.7	-0.7	-0.9	-1.0	-1.9	-5.7
Net budget impact	3.3	7.9	8.4	9.0	9.7	10.5	11.3	12.2	13.1	14.2	38.3	99.6
Option 3.												
Medicare expenditures	$10.0	$17.8	$18.9	$20.2	$21.6	$23.1	$24.7	$26.5	$28.4	$30.4	88.5	221.5
Medicare premiums	-6.5	-9.1	-9.7	-10.3	-11.0	-11.8	-12.6	-13.4	-14.4	-15.4	-46.7	-114.3
Net Medicare impact	3.5	8.7	9.2	9.8	10.5	11.3	12.1	13.0	14.0	15.1	41.7	107.2
Fed. Medicaid expenditures	(1)	-0.4	-0.4	-0.4	-0.5	-0.5	-0.6	-0.7	-0.8	-0.9	-1.7	-5.1
Net budget impact	2.5	8.3	8.8	9.4	10.0	10.7	11.5	12.3	13.2	14.2	39.1	101.1

[1] Savings of less than $50 million

Notes: 1. Estimates are based on the intermediate set of assumptions from the 1998 Trustees Reports and data from the Medicare Current Beneficiary survey (1995 Cost and Use File).

2. Estimates shown exclude changes in Medicare and Medicaid administrative expenses.

3. See table 1 and accompanying memorandum for summary of proposals.

Office of the Actuary
Health Care Financing Admin.
February 3, 1999

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To: Reed Et al

UNITED STATES SENATOR JOHN BREAUX

Facsimile Transmission

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FROM: Senator John Breaux

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LOUISIANA

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United States Senate

WASHINGTON, DC 20510-1803

February 9, 1999

The Honorable John Dingell
U.S. House of Representatives
2328 Rayburn House Office Building
Washington, DC 20515

Dear John:

Thank you for your letter regarding the draft proposal I presented to the Medicare Commission. I appreciate your concerns about the FEHBP/premium support approach I outlined at our last meeting.

I am preparing a more detailed analysis of my plan in response to your letter. Please be assured that I am committed to a premium support system that guarantees our nation's elderly a core set of defined benefits. I am also committed to an administrative structure that would allow Medicare benefits to improve over time. To this end, I believe the following features of my premium support proposal meet the principles you have set out:

- All private plans and the government fee-for-service plan must provide at least a minimum defined set of core services. A Medicare Board would oversee plan design to minimize variation and to ensure the benefits package is structured in a way that does not lead to risk segmentation.

- HCFA will be given new tools to enable it to operate more competitively and more efficiently.

- Seniors will continue to have access to Medicare's traditional fee-for-service program. Enhanced management tools at HCFA and meaningful low-income subsidies should ensure that fee-for-service remains an affordable, viable option for all seniors.

- With seniors spending an average of $2,000 every year for out-of-pocket health care expenses and with Medicare's Part B premium scheduled to double by 2007, the current affordability of Medicare is at issue. This model allows for a blend of existing government protections and market-based competition to control costs more effectively than under current law.

As I said during our last Commission meeting, I support a premium support model because I believe it offers the best chance to provide our nation's seniors with an affordable, high quality health care delivery system in the 21st Century. I do not believe the 1965 model that Medicare currently is based on can meet the solvency, adequacy, efficiency and equity standards the Commission has discussed. Nor do I believe the current program can continue to meet the Democratic principles you outlined without fundamental reform.

Right now Medicare entitles beneficiaries to a health plan that pays for only 53 percent of their total health care costs. Rather than defending a program that only meets half of seniors' health care needs, I am looking for ways to better adapt Medicare to seniors health care needs in the next century. Many health policy analysts, including Bob Reischauer and David Kendall, as well as a majority of Commission members have indicated that premium support would be the best model for reform.

I look forward to the opportunity to work together to determine the best way to design a premium support model for Medicare that affirms the social contract we made to our seniors. To this end, I request that you provide me with specific suggestions about the design features you would include in a premium support system, particularly with respect to designing the benefits package and a prescription drug benefit.

Last week in his speech to the AARP, President Clinton stressed the importance of achieving bipartisan Medicare reform and I welcome your specific input that would help us move this process forward and reach that goal. I believe we can achieve consensus on recommendations that will prepare Medicare's delivery system for the baby boom generation while preserving the intergenerational commitment to a quality health care system for older Americans.

Finally, it is my intention to schedule a meeting of Democratic members prior to the next full Commission meeting, both pending the trial schedule in the Senate.

Sincerely,

JOHN BREAUX
United States Senator

SENATOR JOHN BREAUX
LOUISIANA

Jennings
Podesta

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WASHING

C Jennings
Podesta

To: POTUS

FROM: Breaux 2-10-99

Re: Medicare Commission

Enclosed is: (1) D-C/PPI paper on Premium Support proposal
(2.) 2 page Summary of Draft
(3.) More Detailed description of Working Document

Daschal suggested that the three of us should meet on this - Chris Jennings has been kept informed - Your 3 appointees are key to what we do - Whatever you think I should do now please let me know - Thanks.

John

(1.)

For Immediate Release:
Robin Swanson

Contact Information:
(202) 547-0001

BREAUX PROPOSAL TO RESCUE MEDICARE AIMS SQUARELY AT POLITICAL CENTER

Without Reform, Medicare Will Go Bankrupt in 2008, Before First Baby Boomer Retires

WASHINGTON, D.C. -- As the National Bipartisan Commission on the Future of Medicare nears a vote on Senator John Breaux's (D- LA) Medicare reform proposal, the Progressive Policy Institute urges President Clinton to support the initiative and push for a bipartisan consensus in order to avoid Medicare's certain bankruptcy by 2008.

In "Medicare Breakthrough: Senator Breaux's Reform Proposal," PPI Senior Health Care Analyst David Kendall highlights the key components essential to maintaining the solvency of the Medicare program. "Medicare needs a fundamental overhaul for more than fiscal reasons: its benefits are frozen in time," says Kendall.

"Democrats on the Commission who have raised concerns about the Breaux proposal have to make a choice: either improve the Breaux proposal or come up with their own plan," said Kendall commenting on a recent letter to Senator Breaux from all the Democratic members of the commission except Senator Robert Kerrey (D - NE), who supports many elements of the Breaux proposal.

According to the PPI report, the Breaux proposal draws together a wide variety of reforms that harness competitive forces to restrain health care costs while ensuring seniors basic entitlement coverage.

PPI highlights three key elements in the Breaux Proposal that would:

1. Establish a new purchasing system for Medicare modeled on the Federal Employees Health Benefits Program (FEHBP).
2. Target benefits by income, including prescription drugs.
3. Raise the retirement age to be consistent with social security.

- MORE -

Medicare Breakthrough - Add one

The FEHBP proposal, currently used by almost 10 million federal workers, retirees, and their families, combines a unique blend of government financing and market competition while giving consumers a broad choice of health plans with competitively low prices. Breaux also has proposed a Medicare Board in order to set the ground rules for competition between traditional Medicare and private plans for this initiative.

Another key provision in the Breaux proposal requires higher income beneficiaries to pay more for Medicare coverage, in addition to paying more for high-cost plans. This ensures that low-income beneficiaries would have drug coverage while allowing the consumer to select coverage through a menu of private, competing pharmacy benefit managers in exchange for higher deductibles or premiums.

Finally, by raising the Medicare retirement age consistent with Social Security (from age 65 to 67), the proposal addresses the reality of America's aging population, while providing for the disabled and uninsured.

For more information on the report or to speak David Kendall, please call the Communications Department at (202) 547-0001 or visit our web site at www.dlcppi.org.

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PPI
PROGRESSIVE POLICY INSTITUTE

Backgrounder
February 1999

Medicare Breakthrough

Senator Breaux's Reform Proposal

David B. Kendall

While Social Security is at the top of the nation's agenda, Medicare poses a more daunting challenge. Unlike Social Security, Medicare will go bankrupt in 2008—*before* the first baby boomer retires. Without reform, Medicare spending will triple from 2.4 percent to 7.1 percent of gross domestic product and will exceed even Social Security spending by 2030.

Medicare needs a fundamental overhaul for more than fiscal reasons: its benefits are frozen in time. Its 1965 benefit structure does not include prescription drug coverage that is now common among private health plans. And Medicare's eligibility age remains fixed at age 65 while Social Security's eligibility is slowly increasing to age 67.

Rising to this enormous challenge, Senator John Breaux (D-LA), chairman of the National Bipartisan Commission on the Future of Medicare, has offered a breakthough proposal to the commission. This proposal draws together a wide variety of reforms that would: 1) establish a new purchasing system for Medicare modeled on the Federal Employees Health Benefits Program (FEHBP); 2) target benefits by income including prescription drugs; and 3) raise the retirement age to be consistent with Social Security.

Senator Breaux's proposal aims squarely at the political center, and it follows the "third way" principle of achieving public goals through market means. While it would harness competitive forces to restrain health care costs, it does not go as far as a voucher system that would leave seniors without an entitlement to basic coverage, as Republicans proposed in 1995. It also challenges the assumption of many Democrats that a tax increase is the only appropriate solution to Medicare's fiscal problems. The Breaux plan would help ensure that the baby boomer generation does not take more out of Medicare than it adds to it.

The Medicare commission consists of Chairman Breaux plus 16 members who were appointed by the President and leaders of both political parties in Congress. At this writing, the Breaux proposal has 10 likely votes and needs one more for a super-majority, which is required by statute to prevent a party-line vote. The remaining vote or votes need to come from the four presidential appointees who have not yet declared their position on the Breaux proposal. The Progressive Policy Institute (PPI) urges President Clinton to seize this opportunity to push for a bipartisan agreement that uses the Breaux approach as the basic blueprint for Medicare reform. This backgrounder briefly describes the key features of the Breaux proposal, which are fully described in two previous PPI reports: *Three Principles to Guide the Medicare Debate* and *A New Deal for Medicare and Medicaid: Building a Buyer's Market for Health Care.*

The FEHBP Model

Nearly 10 million federal workers, retirees, and their families—including members of Congress— have a broad choice of health plans with lower prices than most other health care systems in the country. FEHBP also guarantees that the government's contribution will keep pace with health care costs over time. This unique blend of government financing and market competition makes it a good model for Medicare reform.

In fact, Medicare has already begun to evolve toward the FEHBP model. The Medicare+Choice program enacted in 1997 greatly expanded the range of private plan choices available to beneficiaries. The final step is to bring Medicare's traditional fee-for-service plan into head-to-head competition with private plans.

Under the Breaux proposal, traditional Medicare and private plans would submit their premium prices for a core set of benefits annually so that beneficiaries could make side-by-side comparisons. The government would provide "premium support," a financial contribution that would enable beneficiaries to choose among competing health plans. If beneficiaries chose a low or average cost plan, their premium support would be 88 percent of the premium. Those beneficiaries would pay the same amount as they now pay for Medicare Part B, which covers doctors' bills (currently $45 a month). Beneficiaries would pay more than 12 percent of their plan's premium only if they chose a higher cost plan.

No one knows whether traditional Medicare or private plans would provide the best value in the long run. Competition is necessary, however, to create the incentive for all types of plans to restrain costs and improve quality. Nonetheless, the Breaux proposal guarantees that coverage for the core benefits will always be affordable. In addition, traditional Medicare would be freed from the political micromanagement that today constrains its operations by dictating prices and contract rules. Finally, Senator Breaux has proposed a Medicare Board that would set the ground rules for competition between traditional Medicare and private plans.

Benefits Targeted by Income

The Breaux proposal would require higher income beneficiaries to pay more for Medicare coverage in addition to paying more for high cost plans. This reform is not only a progressive alternative to across-the-board benefit cuts, it also blazes a new path for expanding benefits such as prescription drugs.

In the State of the Union address, President Clinton's call for a prescription drug benefit helped raise public awareness about the one-third of Medicare beneficiaries who lack any drug coverage and the millions more who have inadequate coverage. But a broad guarantee of drug coverage could increase Medicare's costs by 10-to-20 percent annually and dramatically exacerbate Medicare's long term financial problems.

Upper income beneficiaries can certainly afford to pay for drug coverage themselves and do so today. The Breaux proposal ensures that all low income beneficiaries would have drug coverage as well. For middle class seniors, the details of a drug benefit have not been worked out, but the government should make sure drug coverage is broadly available without becoming the primary source of financing.

Since most managed care plans would likely offer drug coverage as they do today, beneficiaries remaining in traditional Medicare would need the most help with access to coverage. Traditional Medicare could offer a drug benefit in a non-traditional way. Beneficiaries could select coverage through a menu of private, competing pharmacy benefit managers in exchange for higher deductibles or premiums.

A Retirement Age Consistent with Social Security

Beyond rising health care costs and political pressures to expand benefits, Medicare's social contract is coming undone for the fortunate reason that people are living longer. Medicare (and Social Security) were founded on the principle that the young support the old so that generation after generation has support in their old age. But Medicare's promise of ever-expanding benefits is not sustainable fiscally, politically, or morally.

The double whammy of a greater number of older Americans who will live longer than ever before has already prompted an extension of Social Security's age of eligibility for full benefits from 65 to 67 over a 21-year period. Breaux's proposal would copy that change to Medicare.

An open question is how to prevent the ranks of the uninsured from rising due to an increase in the eligibility age, either because some people age 65 to 67 cannot work due to disability, or if they do work their employer does not provide insurance. Medicare's program for the disabled would help, and its eligibility rules might need to be loosened further. More importantly, workers without job-based coverage regardless of their age should receive a tax credit when they purchase their own coverage. This idea is winning support from members of Congress as diverse as Representative Jim McDermott (D-WA) and Representative Richard Armey (R-TX).

Long Term Solvency

Medicare's fiscal problem is so large that no single solution will solve it. The Breaux proposal will go a long way, but more steps will be needed in the future. That is why the President's proposal to reserve 15 percent of the surplus for Medicare is so important.

The danger, however, is that infusing new funds into Medicare will create unjustified complacency about the need for reform. Or worse, it could create the illusion that a vast reservoir of funding exists for new benefits. The President can readily avert these problems by endorsing the Breaux proposal. Such action could turn out to be decisive in preparing Medicare for the challenges of the 21st century.

David B. Kendall is senior analyst for health policy at the Progressive Policy Institute. Kerry Dobbins, research assistant, provided background material for this report.

For further information about PPI publications, please call the publications department at 800-546-0027, write the Progressive Policy Institute, 600 Pennsylvania Ave., Suite 400, Washington, DC, 20003, or visit PPI's web site at: http://www.dlcppi.org.

(2)

SUMMARY OF BREAUX WORKING DRAFT

This proposal models Medicare on the Federal Employees Health Benefits Program (FEHBP). The premium support system based on an FEHBP model would allow for a blend of existing government protections and market-based competition.

PREMIUM SUPPORT

MEDICARE BOARD

- A Medicare Board would be created to oversee and negotiate with private plans and the government run fee-for-service plan, approve plan service areas, ensure quality standards, approve benefit packages, minimize adverse selection and provide information to beneficiaries.

BENEFITS PACKAGE

- Medicare beneficiaries could stay in the government-run fee-for-service plan or enroll in a private plan. Regardless of the plan chosen, beneficiaries would be entitled to a core set of Medicare benefits defined by statute, including access to a prescription drug benefit.
- Private plans would be required to offer the same benefits offered in the government-run fee-for-service plan. Plans would have some flexibility on design details, subject to final approval by the Medicare Board.
- Plans could offer additional benefits beyond the core package but the board would be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan should be reformed to modernize cost-sharing. For example: a combined Parts A and B deductible of $350; 20% coinsurance for everything except hospital stays and preventative care; 10% coinsurance for home health.

GOVERNMENT CONTRIBUTION

- The government contribution would be based on a percentage of the national weighted average under a national bidding system. Absent an income-related system, beneficiaries would pay 12% towards the premium for plans at the national weighted average. This is roughly equivalent to the share of Medicare costs currently represented by the Part B premium.
- Beneficiaries would pay the incremental costs of choosing more expensive plans. Both the beneficiary and government contribution toward the cost of

DRAFT WORKING DOCUMENT
Medicare Commission

January 22, 1999 (9:30am) c://breaux/wpwin/mark.2

This document is guided by the statute creating the National Bipartisan Commission on the Future of Medicare and is a product of what the Chairman learned through the process of the Commission's meetings and work over the past year.

As directed by statute, the Commission must address Medicare's financial instability and make recommendations addressing the solvency crisis facing the program. Once Medicare is on firmer fiscal footing, our first priority should be to modernize and rationalize Medicare's benefit package. Using a portion of any budget surplus that materializes to shore up Medicare can help, but it won't solve the problem. Premium or tax increases should not be considered until the Commission addresses the government's ability to meet its commitment to fund Medicare's current benefit package.

One of our early witnesses, Robert Reischauer, expressed the problems facing the Medicare program in terms of the four "i's": insolvency, inadequacy, inefficiency and inequity. In terms of its solvency, there are many indicators of Medicare spending and its projected impact on the budget. For example, Medicare will grow from 12 percent of the federal budget to 28 percent in 2030 under our most optimistic baseline. Medicare's Hospital Insurance (HI) trust fund, which is funded primarily with payroll taxes, will be insolvent beginning in 2008.

The program is inadequate insofar as its benefits package does not reflect modern notions of comprehensive health care coverage and isn't comparable in scope, quality and structure to the health benefits generally available to employed persons and their dependents. The system of government-administered pricing causes inefficiencies in the way health care services are delivered to seniors and providers have little incentive to provide the most cost-effective care. Lastly, the current program is inequitable in that there is no geographically uniform or constant set of benefits. If a beneficiary lives in southern California or Florida, Medicare will pay for prescription drugs or dental benefits if the person joins an HMO. If a beneficiary lives in rural Nebraska, he or she gets nothing approaching such benefits. Additionally, Medicare only covers approximately half of the health care costs of beneficiaries and one survey indicates that the actuarial value of Medicare's benefit package is in the 20th percentile of those of most private employers.

The proposal outlined below, which is based on a premium support model, aims to modernize Medicare's benefit design and correct the four "i's". It will allow beneficiaries to combine in an integrated and comprehensive form all sources of support for their health care coverage while ensuring that Medicare is more efficient and more responsive to beneficiaries needs. It also guarantees low-income protections so that all beneficiaries have meaningful access to quality health care, including the traditional Medicare fee-for-service plan.

These recommendations should be a blueprint for Congress to enact comprehensive legislation to fundamentally restructure Medicare over the next several years. Our nation's health care delivery system is constantly evolving and given the uncertainty of long-term health care spending projections and the advances in medical technology, Medicare will have to be revisited at regular intervals.

SUMMARY

- This proposal would model Medicare on a system patterned after the Federal Employees Health Benefits Program (FEHBP). It would allow for a blend of existing government protections and market-based competition. It would also guarantee financial protection for low-income beneficiaries.
- Medicare's fee-for-service program will operate as part of this new system and HCFA will be given the tools it needs to modernize and compete accordingly.
- This proposal will reform the Medigap program to make it more efficient and to try to minimize the adverse effects of first dollar coverage.
- The eligibility age for Medicare will increase to conform with the eligibility age increase scheduled for Social Security. A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.

I. PREMIUM SUPPORT

A. Administrative Structure

- A Medicare Board will be established to oversee and negotiate with private plans and the government run fee-for-service plan and to approve plan service areas. The board will have authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries.

B. Benefits Package

- Plans participating in Medicare would be required to offer a standardized core benefit package defined in statute (e.g., hospital, surgical, inpatient, etc.).

Participating plans would have some flexibility on design details (i.e. cost-sharing, copays) but the Medicare Board would have final approval. Private plans participating in premium support will be required to offer benefits at least equivalent to the package offered in the government-run fee-for-service plan.

- Plans can offer additional benefits beyond the core package. Much like the negotiations process between plans and OPM in FEHBP, benefits will be updated through the annual negotiations process between plans and the board. The board will be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan will be revamped by modernizing cost-sharing and by combining the Parts A and B deductibles. One example of a modernized cost-sharing structure would be to have a combined deductible of $350, charging 20% coinsurance for everything except hospital and preventive care and charging 10% coinsurance for home health.

C. Calculating Medicare's Premium

The government-run fee-for-service plan will bid nationally based on its actual and projected claims costs. Other plans can choose to bid nationally, regionally or in local areas. The Board would oversee the designation of service areas to ensure access in areas that would otherwise have limited plan availability.

- Under an FEHBP system, total Medicare premiums for plans in a given area will be based on a national schedule similar to that used in the FEHBP system. The overall cost of plans will be based directly on their bids and the negotiations process with the Medicare Board.

a) Government's Contribution

- The government's contribution will be based on a percentage of the national weighted average premium. Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental costs of choosing more expensive plans. The government's contribution as it is made to the plan that the beneficiary chooses will be adjusted for health risk and other factors.

b) Beneficiary's Contribution

- The beneficiary's contribution will be based on the cost of the plan chosen with beneficiaries paying a minimum percentage of the premiums based on their income. The government contribution will stop increasing and beneficiaries will pay the full incremental costs for plans above a certain threshold (e.g., 100% of the cost of average plan). Both the beneficiary and government contribution toward the cost of the average plan will rise and fall in the same proportion as the cost of that plan changes from year to year.
- Higher-income Medicare beneficiaries should be required to pay a larger share

of their Medicare premiums than moderate and low-income beneficiaries. Income-related premiums will apply to both private plans and the government-run fee-for-service option.

- Premium support subsidies should be sufficient to ensure that low-income beneficiaries have access to necessary health services and have a meaningful choice of plan options. The revenue generated by income-relating the premium for upper-income beneficiaries will be primarily dedicated to subsidizing premiums for low-income beneficiaries.

II. MODERNIZING MEDICARE FEE-FOR-SERVICE

- The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries. In accordance with Congressional and Board oversight and approval, the government-run plan will have flexibility to modify its payments rates and its arrangements with contractors as well as offering benefit enhancements if they are financially feasible in a competitive environment.
- The government-run fee-for-service plan will have a premium just like the private plans participating in a premium support system. To enable the government-run fee-for-service plan to compete with private plans in a premium support system, HCFA would be given management tools adopted by the private sector. These reforms include things such as enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

III. MEDIGAP REFORM

- In order to keep fee-for-service costs affordable, Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost.

IV. MISCELLANEOUS

- Medicare's eligibility age will be gradually increased to match the Social Security retirement age. It is also recommended that Social Security and Medicare be reformed in conjunction with each other because of the interrelated effects of these programs on the retirement security of older Americans.
- A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.
- Graduate Medical Education: Payments for Direct Medical Education (DME) would be carved out of the Medicare program--financed and distributed

independent of a premium support system. The Chairman assumes that federal support for DME would continue through either a mandatory or discretionary appropriations program. Since the funding source would shift from the HI payroll tax to general revenue, the Chairman believes that it is appropriate to include institutions not currently eligible for Medicare GME support that conduct approved residency programs, such as free-standing children's hospitals. Similarly, the long-term solution for indirect medical education (IME) may involve a carve-out from Medicare. For now, however, the Chairman believes that the Medicare program should continue to pay for differences in costs between teaching and non-teaching hospitals through the indirect medical education (IME) adjustment. However, the Chairman recognizes that the level of the Medicare IME adjustment may need to be aligned gradually over several years with what analyses show is the actual statistical difference between teaching and non-teaching hospital costs. The Chairman believes that Disproportionate-Share Hospital (DSH) payments and other subsidies within the Medicare program should be revisited to ensure that Medicare's support is reasonable and appropriate. The Chairman notes that these subsidies could be carved out of the Medicare program and financed through a mandatory or discretionary appropriation program. However, the Chairman recognizes that any changes in federal support should continue to recognize the additional costs to hospitals of treating large numbers of low-income individuals.

V. REVENUE AND FINANCING

- The primary source of income to the Hospital Insurance (HI) trust fund is the payroll tax. The 2.9 percent tax on all earned income accounts for 88.3 percent of the total $121.1 billion in income in 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.
- The Supplementary Medical Insurance (SMI) trust fund is financed from premiums paid by the users of Part B and from general revenues. When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Premiums over time dropped to 25% of program costs because Part B costs increased much faster than the inflation computation that was used to compute the upward premium adjustment.
- Under current law, the proportion of financing sources are expected to change over time, with the portion represented by payroll taxes decreasing and the portion represented by general revenue increasing. By 2030, premiums and payroll taxes are expected to fund only 31-35 percent of Medicare's

expenditures compared to 63 percent in 1997. In 2030, 64-70 percent of Medicare will be funded through general revenue (or other funding) as compared to approximately *37* percent in 1997.

- The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms will result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and will enhance our ability to stand by our commitment to today's and future beneficiaries. Even if projected budget surpluses materialize, without these changes, significantly greater revenues and/or beneficiary sacrifices will be required in the future and beneficiaries will not receive the greatest value for the total health dollars spent on their behalf.

VI. AREAS THAT NEED RESOLUTION

- DRUGS--open issue--the Chairman is exploring several options for including a prescription drug coverage.

- Changes to provider payments

VII. ALTERNATIVE DESIGN OPTIONS

The following are examples of elements of a premium support system that could be changed to arrive at a different model than the one described above.

- National vs. Regional Bidding: Under a national bidding structure, a geographic adjuster is necessary to create a fair and equitable system. A geographic adjuster would also address the fact that Medicare spending varies by a factor of more than three across regions with seemingly similar populations and with no demonstrable differences in health outcomes. Under a national schedule, national plans such as the government-run fee-for-service could compete in a straightforward and fair way. Beneficiaries in national plans would pay the same amount regardless of where they lived. Under a regional bidding system, a geographic adjuster would not be required but some provision would have to be made to allow fair competition between local and national plans such as fee-for-service and to prevent regional inequities in beneficiary premiums.
- Benefits Package: Plans would be required to offer and compete on a core benefits package. Unlike the model described above, additional benefits could only be offered in a supplemental plan that would have to be sold and marketed separately from the core package. This would ensure that plans compete on the basis of cost and quality, not on the basis of the benefits offered.