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**U.S. House of Representatives
 Committee on Commerce**

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49 Members**Medicare Taskforce Members**

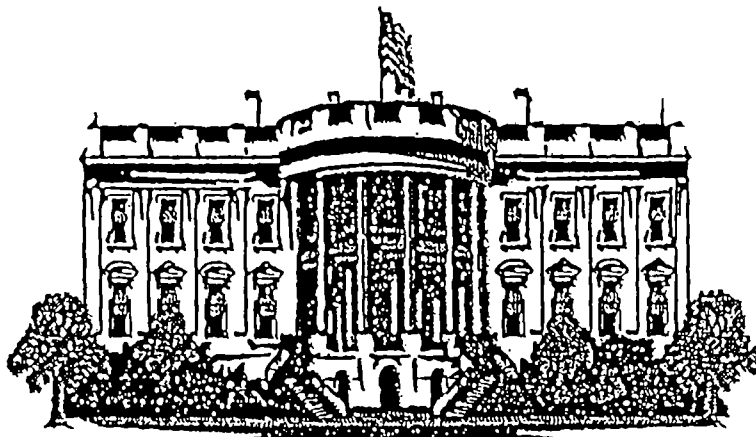
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THE WHITE HOUSE



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Potential Qs for Senate Finance Committee March 10 hearing on Medicare

1. The Republican statement of budget principles released last week asserts they their plan will "lock away every penny of the Social Security Trust Fund surpluses for our nation's elderly [and] set aside more money than the President to strengthen Social Security and Medicare." Shortly thereafter, a Kasich press release (3/5) asserted that "While the president claimed to set aside all of the Social Security surpluses for Social Security, his budget spent more than 40 percent of those surpluses in the first year and nearly \$250 billion over five years." The press release goes on to say "By locking away all of the Social Security surplus, the GOP plan would set aside \$1.8 trillion dollars for reforms to Social Security and even have something left over to address Medicare reforms as necessary." Mr. Lew, is it true that the President's budget spends 40% of the Social Security surpluses in FY2000, and nearly \$250 billion over 5 years?

Answer: In order to be fiscally responsible, we need to look at Social Security and Medicare over the long-term. Both Social Security and Medicare financing are long-term policy issues, and are best analyzed over at least a 15-year time frame. The Administration has proposed a balanced framework to secure the solvency of Social Security and to strengthen Medicare over a 15-year period. During this 15-year period the President's framework would dedicate **more** funds to Social Security than the projected Social Security surpluses. In addition, the President's plan dedicates more than \$700 billion (CBO numbers) from the non-Social Security surpluses to strengthen Medicare by extending the Trust Fund solvency from 2008 to 2020.

2. The President has been making a lot of speeches about a prescription drug benefit for the elderly, but neither we nor CBO could find in your budget any money to finance this proposal. Is the Administration serious about this proposal and, if so, where's the financing?

Answer: The President's framework would extend the Medicare HI Trust Fund's solvency to 2020. But this only accomplishes part of the job. The President has called for bipartisan action to reform the program itself, to achieve long-term actuarial solvency. Part of the savings from these reforms should finance a prescription drug benefit.

3. Mr. Lew, those of us in rural states have been hearing a great deal of concern from our rural hospitals about the President's proposed cuts in Medicare reimbursements. Did the Administration make any attempt to assess the impact of these cuts on rural hospitals? How do you intend to respond to the very real concerns of the rural hospitals?

Answer: We understand that there are very real concerns about the impact of proposed Medicare savings on rural hospitals. We fully intend to work closely with this Committee and other Members of Congress to assess the application of the proposed Medicare savings to particular states.

4. Your plan calls for transferring 15% of the unified surplus to Medicare, but you are not proposing program reforms to increase receipts or reduce Medicare outlays. How can this paper transfer extend the life of the Trust Fund, without reforming the program?

Answer. This is not a paper transfer. The plan is to transfer more than \$700 billion (CBO numbers) -- in the form of government securities -- to the Medicare Trust Fund. These funds would come from the non-Social Security surpluses. These securities are backed by the full faith and credit of the United States; the Federal Treasury has never defaulted on any financial obligations. This transfer will, according to the Medicare actuaries, extend the solvency of the HI Trust Fund to at least 2020. The President does believe that reforms to the Medicare programs are needed to extend the solvency of the Trust Fund for a longer period of time, and looks forward to working with the Congress on a bipartisan basis to come to agreement on appropriate reforms.

5. Senators Kerrey (Nebraska) and Robb may use this opportunity to criticize the use of general revenues for the Medicare HI Trust Fund.

MEDICARE HOSPITAL PAYMENT REDUCTIONS

Question: Recent stories in the *New York Times* reported that the budget will propose \$6 to \$10 billion in hospital cuts over the next five years. Why has the President's budget proposed additional hospital cuts before considering other provider types and before considering the effects of the current BBA reductions on hospitals?

Answer: The budget proposes a 0.9 percent reduction to the anticipated hospital update in FY 2000 which will save \$3.9 billion over the five-year budget window. The budget also proposes to reduce inpatient hospital bad debt payments to hospitals by an additional 10 percent. The budget's payment reductions are justified by recent reports of record-high hospital profits. Recent data confirms that hospitals will earn record-high Medicare inpatient margins of 16 percent and total margins of 6 percent in FY 1999 and maintain these margins through FY 2002. These margins were calculated even after taking into account the BBA reductions. The budget includes these reductions to ensure that Medicare is appropriately paying for inpatient care.

Background: The BBA reduced Medicare spending by \$150 billion over FYs 1998-2002. Almost 40 percent of the reductions came from hospital cuts.

In a recent public meeting, the Medicare Payment Advisory Commission (MedPAC) projected that hospitals will earn record Medicare margins. MedPAC's projections include all of the BBA payment reductions to inpatient payments. MedPAC and industry data show that hospitals have maintained or increased their profitability by increasing efficiency and reducing costs. Although the BBA reduced Medicare payments to hospitals, they have responded to by looking inward and reducing their costs. Analysts believe hospitals have cut costs by reducing administrative overhead, enhancing their purchasing strategies, and improving staff efficiency.

The industry will argue that Medicare inpatient payments should not be reduced because margins in other areas of their business are low (e.g., outpatient). It will also argue that other financial indicators (e.g., debt burden, cash flow) don't necessarily support MedPAC's data. The counter argument is Medicare payments should be reflective of the costs of that particular service. 16 percent inpatient margins suggest that Medicare overpays for inpatient services.

MedPAC will probably not recommend to Congress that the update should be reduced. While staff analysis produced a recommended update range of between 0 percent and current law (0.9 percent), the

Commissioners are likely to recommend the current law update.

Prepared by: Jonathan Blum (x5-7844)

IMPACT OF MEDICARE REDUCTIONS ON RURAL HOSPITALS

Question: Did the Administration consider the impacts of its Medicare reductions on small rural hospitals?

Answer: The Administration recognizes the unique problems faced by rural hospitals and we are committed to ensuring access to care for rural populations. While rural hospitals are typically a critical link in the health care safety net for rural populations, they face higher per-unit costs, have difficulty maintaining threshold occupancy, and have problems recruiting physicians. As you know, we administer a number of important programs that give small rural hospitals special financial treatment. For example, Sole Community Hospitals are paid the higher of the normal prospective payment rate or an established target amount. We believe that this program and others under current law – including the Medicare Dependent Hospital program and the new Critical Access Hospital program – are effective ways to address this very real concern.

As you know, we have an obligation to ensure that Medicare payments are not excessive, and have acted on the premise that the Federal government should share in the dramatic increases in efficiency realized by hospitals over the past few years. Average Medicare inpatient profits are at an all-time high of 16 percent. And while rural hospital inpatient margins have always been somewhat lower, we are pleased to report that they are also at an all-time high, averaging 9.5 percent according to the latest available data.

Nevertheless, we remain quite concerned about the status of rural hospitals. We will closely monitor the effects of our policies, and work with you to ensure that critical access needs of these populations are addressed.

Additional: The budget proposes to reduce Medicare payments for inpatient services in response to recent data that hospital profitability is projected to be at record highs. MedPAC projects that hospitals will earn 16 percent Medicare inpatient margins (and 6 percent total margins) in FY 1999 through at least FY 2002. The Administration has argued that these reductions reflect its fiduciary responsibility to ensure that Medicare payments are fair, adequate and not excessive. There are currently 2,243 rural hospitals (or 44 percent of the total hospitals) participating in the Medicare program.

Prepared by: Jonathan Blum (5-7844)

13% of
Medicare
hospital
operations

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Subject: Re: Hospital Margins 

The modified Q and A is attached and shown below (in case you aren't able to use the attachment).

MEDICARE HOSPITAL PAYMENT REDUCTIONS

Question: Why has the President's budget proposed additional hospital cuts before considering other provider types and before considering the effects of the current BBA reductions on hospitals?

Answer: The budget proposes a 0.9 percent reduction to the anticipated hospital update in FY 2000 which will save \$3.9 billion over the five-year budget window. The budget also proposes to reduce inpatient hospital bad debt payments to hospitals by an additional 10 percent. The budget's payment reductions are justified by recent reports of record-high hospital profits. Recent data confirms that hospitals will earn record-high Medicare inpatient margins of 16 percent and total margins of 6 percent in FY 1999 and maintain these margins through FY 2002. These margins were calculated even after taking into account the BBA reductions. The budget includes these reductions to ensure that Medicare is appropriately paying for inpatient care.

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Background: The BBA reduced Medicare spending by \$150 billion over FYs 1998-2002. Almost 40 percent of the reductions came from hospital cuts.

In their latest recent report, the Medicare Payment Advisory Commission (MedPAC) projected that hospitals will earn record Medicare margins (their projections include all of the BBA payment reductions to inpatient payments), but they did not recommend an additional cut in the update for FY 2000.

MedPAC and industry data show that hospitals have maintained or increased their profitability by increasing efficiency and reducing costs. Although the BBA reduced Medicare payments to hospitals, they have responded by looking inward and reducing their costs. Analysts believe hospitals have cut costs by reducing administrative overhead, enhancing their purchasing strategies, and improving staff efficiency.

The industry argues that Medicare inpatient payments should not be reduced

because margins in other areas of their business are low (e.g., outpatient). It will also argue that other financial indicators (e.g., debt burden, cash flow) don't necessarily support MedPAC's data. The counter argument is Medicare payments should be reflective of the costs of that particular service. 16 percent inpatient margins suggest that Medicare overpays for inpatient services. In addition, MedPAC reports that total hospital margins were 6.4% in 1997, which is the highest level since 1985.

MedPAC's recommendation not to cut the update is inconsistent with their earlier reports. MedPAC's predecessor (the Prospective Payment Assessment Commission or ProPAC) recommended an update freeze in 1997 when they had lower estimates of Medicare margins (7.9% vs. 16%) and total margins (5.6% vs. 6.4%), **and** a higher estimate of the next year's market basket increase (2.8% vs. 2.5%). In addition, the percentage of hospitals with a negative total margin is at an all-time low in the latest MedPAC report (the percent with negative PPS margin is at the lowest level since 1985). The only real differences supporting a higher update this year are Y2k costs and BBA -- **but MedPAC still estimates Medicare margins with the BBA that are more than twice the level when they called for an update freeze.**

Prepared by: Bob Donnelly (x5-7814)



hospqa.new medpac data.

Urban Hospitals

We are concerned about all hospitals but it is important to bear in mind that there are many adjustments currently built into the Medicare payment system to protect hospitals with legitimate differences in costs. For example, Medicare pays hospitals that serve a disproportionate share of the poor higher amounts than other hospitals. Medicare pays teaching hospitals more than other hospitals. Finally Medicare pays extra for "outlier" (extremely expensive) cases.

Of course we will monitor the impacts of our policy.

MEDICARE BAD DEBT REDUCTIONS

Question: The BBA already reduced Medicare bad debt payments. Why has the President's budget proposed additional bad debt reductions?

Answer: The BBA reduced Medicare bad debt payments to hospitals by 45 percent in FY 2000. In addition to deepening the current schedule of hospital bad debt reductions, the budget proposes to extend the bad debt payment reductions to non-hospital providers. Many analysts have argued that Medicare's payment for bad debt creates incentives for providers not to collect their bad debts. These analysts have argued that to modernize Medicare payment policies, Medicare bad debt payment policies should be phased-out of the program. The budget's proposal accelerates the phase-out that was begun by the BBA and moves the program towards private payment methods which don't reimburse providers for bad debts.

Background: Medicare reimburses certain providers for their bad debt expenses which are unpaid patient deductibles and copayments. In order to claim these expenses, the provider must establish that it has made a reasonable effort to collect these bad debts and that there is a very slim likelihood that it will ever be able to collect.

The original policy rationale for Medicare bad debt payments was to prevent providers from cost-shifting their uncollected Medicare patient debts onto their private-payer patients. However, the HHS IG and CBO have argued that bad debt payments should be phased-out. These analysts argue that Medicare reimbursement of bad debt creates incentives for providers not to collect these debts. Beneficiary advocates, on the other hand, may argue that the Medicare bad debt policy protects beneficiaries from overly aggressive collection tactics on the part of providers.

The BBA reduced bad debt payments to hospitals by 25 percent in FY 1998, 40 percent in FY 1999 and 45 percent in FY 2000 and thereafter. Payments to other providers who may claim bad debt expenses (skilled nursing facilities, outpatient rehabilitation facilities, and outpatient physical therapy providers) were not cut.

A similar proposal was considered but dropped by the Senate as an offset for the home health interim payment system (IPS) legislation that was enacted during the FY 1999 Omnibus Appropriations bill.

Prepared by: Jonathan Blum (x5-7844)

PROGRAM INTEGRITY – MEDICARE SAVINGS

Question: Given the BBA cuts and the expected surplus in the budget, why have you proposed additional cuts? What are the fraud and abuse cuts? Aren't these proposals actually provider cuts?

Answer: The Budget proposes five initiatives to correct continued program abuses and increase competition in Medicare. Taken together these provisions will save the Medicare program an estimated \$2.9 billion over the five year period FY 2000-2004. These provisions are not provider cuts – they are policies designed to strengthen the integrity of the Medicare by stopping inappropriate use of benefits, equating Medicare payments with market rates and insuring that Medicare pays only when it is supposed to.

The five initiatives are: 1) clarify Medicare's partial hospitalization benefit, in response to HHS/OIG reports, so that services cannot be provided fraudulently in certain settings (5-year savings: \$205 m); 2) base Medicare payment for drugs on provider acquisition costs rather than on the charge submitted by providers (5-year savings: \$950 m); 3) reduce Medicare Eptoin (a drug administered for renal dialysis) payments by \$1.00 in response to an HHS/OIG report which stated that Medicare overpays by \$1.00 for this drug (5-year savings: \$450 m); 4) require private insurance companies to provide Medicare secondary payer data so Medicare can insure it does not pay primary when other coverage is available (5-year savings: \$640 m); and 5) centers of excellence would insure high quality and low cost by expanding Medicare's ability to pay providers competitively for surgical procedures and enabling them to develop clinical expertise thereby increasing their market share (5-year savings: \$690 m).

Background: Given the slowdown in Medicare spending attributable to both the BBA changes and OACT and CBO technical re-estimates, there may be some reluctance in Congress and elsewhere to attempt further spending reductions. Also, some provider groups will argue that these "program integrity" savings are really nothing more than provider cuts. The Budget proposes two additional initiatives: 1) establish a national limit for prosthetics and orthotics based on the median of state fee schedules (5 year savings: \$580 m) and 2) reducing the laboratory test fee ceiling reimbursement from 74 to 72 percent (5 year savings: \$550 m).

Prepared by: Yvette Shenouda (5-7843)

FINANCING THE MEDICARE BUY-IN

Question: The Budget shows 5 and 10 year costs for the 62 to 64 and displaced worker buy-ins, yet the Administration had reported earlier that these expansions were self financing—can you explain? Do these expansions affect the Part A trust fund and the Part B premium? Will you provide subsidies for low income eligibles?

Answer: The costs of the Administration's Medicare-related program initiatives are all paid for. Any costs of the buy-in proposals are offset by new Medicare fraud, abuse, and overpayment policies.

When all of the Medicare policies are considered together, they have a negligible, but positive, impact on the Part A trust fund. In addition, the Part B premium will actually decrease under the budget. This is because buy-in outlays are not counted toward the Part B premium, yet the Medicare savings contribute to lowering Part B spending and thus the Part B premium.

The 62-64 buy-in policy is self financing in that on average every enrollee will, over their lifetime, completely reimburse Medicare for the costs of their participation in the program before age 65. The "costs" to Medicare come from this short-term subsidy to the enrolled individuals. The buy-in for displaced workers (55-62), on the other hand, does include a partial Medicare subsidy which is not repaid. Without a subsidy the premium would be so high as to make it impractical for all but the very sickest workers to enroll.

We are not considering a low income subsidy for the buy-in policies and would only discuss subsidies if they were completely paid for.

Background: 14.3% of people 55-64 are uninsured (compared to 18.3% of the nonelderly population). The budget targets this population because they are likely to have difficulty finding affordable coverage in the individual market or finding new employment with health benefits. The budget also proposes to allow retirees whose former employer reneges on a commitment to provide health insurance to buy-in to the employer's health plan (through COBRA) by paying a premium.

Buy-in premiums are expected to be high (\$300 to \$400+ a month). HCFA estimates that about 300,000 people will be covered by the buy-in. Most would have had other coverage without the buy-in.

Prepared By: Bob Donnelly (5-7814)

MEDICARE BUY-IN -- EMPLOYER MANDATE? COVERAGE? RETIREMENT?

Question: Is the COBRA policy an employer mandate? Won't this proposal lead employers to curtail their retiree coverage if they know the government will provide an option they don't have to pay for? How many people are covered by the buy-ins and COBRA, and how many are newly insured? How do these policies affect employer insurance coverage and decisions to retire early?

Answer: The COBRA policy is not a mandate on employers. It will apply only to firms that have dropped retiree health benefits by reneging on their promise to provide them. It requires the employee to pay 125% of the costs of active workers. The employer would still bear some cost per person for those using the extended COBRA coverage as the sickest people are likely to buy the new coverage.

The COBRA extension policy will require that firms that have dropped retiree health benefits after reneging on their promise to allow those retirees to buy into the employee group plan until they turn 65. There is no direct government cost from the COBRA policy. Some firms may drop coverage because they know that all their employees will have access to the COBRA policy. Other firms may have less of an incentive to drop their retiree coverage because the employer is still likely to bear some cost per person for those using the extended COBRA coverage as the sickest people are the likeliest to take up the COBRA coverage.

The buy-in proposals will help an estimated 300,000 persons. At full implementation, the 55-62 buy-in will provide coverage to 119,000 previously uninsured workers per year (after five years, 80,000 previously insured displaced workers will be covered per year). At full implementation, the 62-65 buy-in will provide coverage to 200,000 persons (67,000 of whom were previously uninsured). It is unclear how many retirees will lose their coverage in the future and will be eligible for COBRA coverage. The Administration estimates that only 1% of workers with employer-sponsored insurance will retire as a result of the buy-in. The incentive to retire is very low because the buy-in premiums are likely to be higher than the costs of subsidized insurance on the job, and to afford the premium many people would have to continue to work. Also, employers cannot drop workers who would qualify for the buy-in as that violates federal age discrimination law.

Background: The question is answered in full above.

Prepared by: Bob Donnelly (5-7814)

PROTECTING MANAGED CARE OPTIONS FOR MEDICARE BENEFICIARIES

Question: On October 8th the President directed Secretary Shalala to develop strategies to prevent another disruption in Medicare managed care coverage like we have seen this year, with many HMOs not renewing their Medicare contracts and many enrollees forced to change plans or return to fee for service Medicare. How will the policies in this budget prevent another such disruption?

Answer: The budget includes a set of legislative and regulatory changes that will reduce administrative burdens on HMOs and help beneficiaries whose plans have dropped out of Medicare.

The budget proposes to delay the date for HMOs' coverage plan submissions from March to July — allowing the plans to use more up-to-date data in their cost estimates — along with several regulatory changes to reduce plans' administrative workloads (e.g., relaxing rules dealing with coordination of care). Also, HCFA published a notice on January 15th which details plans to phase-in risk adjustment of Medicare+Choice payments. The phase-in responds to plans' concerns that risk adjustment could destabilize their Medicare revenues and should help to limit plan withdrawals.

Background: In addition, the budget would help beneficiaries whose plans leave Medicare by changing Medigap rules to allow beneficiaries whose HMOs leave Medicare to enroll in any available Medigap plan. The budget also proposes allowing enrollees with End Stage Renal Disease (ESRD) to join other Medicare+Choice plans when their HMOs leave Medicare and providing notification by October 15th for enrollees whose plan is leaving Medicare in the next calendar year. HMOs chose not to renew 99 Medicare risk contracts for 1999. These decisions affected over 400,000 enrollees (about 7% of Medicare risk contract enrollment), with about 50,000 left without another managed care plan option.

The Medigap changes, moving the plan data submission to July, and allowing ESRD beneficiaries whose plans leave Medicare to join other Medicare+Choice plans are legislative proposals. The other changes referenced above are regulatory, and are expected to be published in February.

Prepared by: Bob Donnelly (x 5-7814) and Greg White (5-7791)

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Remarks: ☒ URGENT ☐ For your review ☐ Reply ASAP ☐ Please comment

Treasury Comments - Major Issues with Breaux-Thomas

No specific plan for Medicare financing

Need tougher language here that takes Commission and Republicans to task for not helping and probably harming the financial security of the program. Suggest something like:

The plan would reduce finances committed to Medicare from current law. [Reason: under current law, general revenue financing is growing with Part B as a % of program revenues, not just keeping pace with program growth.] Then Congress would be “notified” and asked to have a “debate” when Medicare is close to becoming insolvent – which would be very soon. Together, this is a recipe for obscuring the careful consideration of how Medicare’s long-term financing problems can be addressed - making it harder to avoid ill-considered benefit cuts or other rash changes in the program.

Vague premium support plan

Would emphasize that the additional benefits are likely to benefit the healthiest beneficiaries, who need them the least. Also, desirable competition in the quality of benefits (to benefit all beneficiaries, not just healthy beneficiaries) is one goal of premium support, in addition to price competition. To address this:

...effective price competition – a key goal of premium support – could be replaced by competition to attract the healthiest beneficiaries, through plans offering benefits of little value to the beneficiaries who need them the most.

No meaningful prescription drug benefit

This sounds too much like we wouldn’t support extra subsidies for a drug benefit for the low income. How about:

Providing assistance only to low-income beneficiaries would move Medicare toward a means-tested....

Removing direct medical education...

Might also add, to enlist the academic health centers against this proposal, that the plan implicitly places medical financing at greater risk of future cuts:

...Yet the Commission itself proposes to do this, without providing details on how financing for academic health centers would be maintained.

Board could end up being a new bureaucracy

I would be careful about the language here. First, as you note there are legitimate reasons for a Board that is independent from political influence. Second, we are currently proposing such

boards in the context of Social Security reform and our USA proposal, and have argued there that it is possible to design these boards so that they can act in the fiduciary interests of beneficiaries (through independent IG, annual audits, Pres appt and Senate confirmation of board members with staggered terms, etc).

Therefore I would revise as follows:

No assurance that Board will act in beneficiaries' interests.

Although there are legitimate reasons for a new board that is insulated from political pressures, the proposed board appears to be exempt from any government oversight. With its many functions – including a negotiation with each and every plan interested in participating in Medicare – there is no guarantee that the board will act in the fiduciary interests of beneficiaries.



FACSIMILIE TRANSMISSION

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DATE: March 15, 1999

Number of Pages, including this cover sheet: 5

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RESPONSES TO ONLINE NEWS HOUR QUESTIONS

Karen Davis

President

The Commonwealth Fund

March 15, 1999

- **What are the pros and cons of Sen. Breaux's plan?**
 - **Pros**
 - Would achieve significant Medicare savings
 - The Office of the Actuary at the Health Care Financing Administration estimates that it would save \$40 billion 2006, 11 percent of what Medicare expenditures would otherwise have been.
 - Between now and 2030, the plan would save about 11.5 percent of what Medicare otherwise would cost
 - Would encourage more managed care and private insurance plans to participate in Medicare by permitting them greater freedom to set premiums and specify benefits offered
 - **Cons**
 - Would increase costs to beneficiaries
 - Marilyn Moon at the Urban Institute (Commonwealth Fund, March 1999) estimates Medicare beneficiaries would spend \$5000 per person in 2025 (in 1998 dollars) under a similar premium support proposal; while Medicare beneficiaries will be paying substantial amounts even under current law, attention should be on improving benefits not shifting costs to beneficiaries
 - Medicare beneficiaries would spend on average 30 percent of their incomes on health care in 2025
 - Low-income and chronically ill beneficiaries would face even higher costs
 - Most of the savings to the federal budget are simply costs shifted to beneficiaries
 - The Part A deductible (now \$768) and the Part B deductible (\$100) would be replaced with a combined deductible of \$350; MediGap plans would not be permitted, as they are now, to fill in this deductible; beneficiaries – whether hospitalized or not – would thus face higher out-of-pocket costs
 - Home health beneficiaries would be charged a 10 percent coinsurance rate – greatly increasing costs on seriously ill beneficiaries who already bear heavy financial burdens for non-covered Medicare costs
 - A 20 percent coinsurance rate would be charged for all other services except hospital and preventive care
 - The proposal does not improve benefits such as prescription drugs

- There is little evidence to support the theory that a premium support proposal would save health spending by causing managed care plans to charge lower premiums
 - In fact managed care premiums could increase if Medicare no longer set the payment that plans are paid for Medicare-covered services; currently plans can not charge Medicare beneficiaries more than the government pays for covered services; this restriction would be ended under premium support
 - In most states 4 managed care plans now account for over 75 percent of Medicare managed care enrollment – this is unlikely to be sufficient to generate genuine price competition
- The Balanced Budget Act of 1997 expanded the kinds of private plans that can participate in Medicare under a new program called Medicare+Choice
 - We do not yet know if the private market will work even under this program
 - To date few new plans have participated, some managed care plans have pulled out of selected geographic areas
 - The first genuine open enrollment period will not take place until the fall of 1999 – many Medicare beneficiaries are unlikely to understand the choices available and pick plans that work for them
 - Managed care plans have a strong incentive to skimp on services for the chronically ill – new methods of paying managed care plans on a “risk adjusted” basis will not be implemented until the year 2000, and there remains significant doubt whether they will work to prevent discrimination against those with serious health problems
 - New quality standards for managed care plans have not yet been tested; moving more rapidly toward “privatizing” Medicare until these safeguards are in place is not prudent
- **What are the implications of the proposal to raise the age of eligibility for Medicare to age 67?**
 - Unlike Social Security, Medicare beneficiaries can not take Medicare at age 62 by paying a higher premium; President Clinton has proposed such a plan, but this is not included in the Commission Chairman’s proposal
 - The proposal indicates that seniors with delayed eligibility will be permitted to participate in Medicare, but the exact details of what they would be required to pay have not been spelled out
 - An Urban Institute study by Tim Waidman (*Health Affairs*, March/April 1998) indicates that the total number of Medicare beneficiaries would be reduced by 11.3 percent and total annual program costs by 6.2 percent; approximately 500,000 people ages 65 and ages 66 would become uninsured; costs to Medicaid and other governmental programs for coverage of the disabled would increase (32 percent of the total savings to Medicare); costs to employers under retiree health plans would increase (37 percent of the total savings); the remaining 31 percent of

costs would be shifted to the 41 percent of persons who have no supplemental insurance or private Medigap coverage only would

- **Would prescription drugs be covered?**

- Prescription drugs are not included in the Chairman's proposal. Prescription drugs are an important expense to Medicare beneficiaries with serious chronic conditions. The Kaiser/Commonwealth survey of Medicare beneficiaries (Commonwealth Fund, December 1998) found that 11 percent of Medicare beneficiaries spend more than \$100 per month on prescription drugs.
- Medi-Gap plans covering prescription drugs (Plans H, I, J) are often unavailable to seniors with pre-existing conditions; those disabled under age 65 covered by Medicare are not guaranteed an ability to buy Medi-Gap coverage; even when coverage is available, premiums for Medi-Gap coverage with prescription drug benefits are beyond the reach of many Medicare beneficiaries with modest incomes
- Better benefits including prescription drugs are a major reason Medicare beneficiaries enroll in managed care; adding prescription drugs to traditional Medicare would "level the playing field" and make choices a function of quality of care, not just to assure financial protection against major prescription drug expenses

- **What is relationship between federal employee health coverage and Medicare?**

- I'm not sure I understand the question or know the answer. In general if someone is working past age 65, their own employer coverage is the primary payer and Medicare is the secondary payer (the "working aged" provision). If someone is not working and retired, Medicare is the primary payer and the employer retiree coverage is the secondary payer. I assume a retired federal employee covered by Medicare has Medicare as primary payer.
- If the question is about the relationship between the Chairman's proposal and the federal employee health benefit plan (FEHB), FEHB has been cited as the model for premium support. FEHB is a good program and provides good protection to millions of federal employees – active workers and retirees. But over a long period of time, premiums under FEHB have risen at the same rate as Medicare per person costs and private health insurance premiums. Medicare and private health insurance have been equally successful (or unsuccessful) in controlling health care costs over 20 to 30 years. FEHB has experienced some adverse risk selection; that is, sicker people have joined certain plans causing those premiums to spiral upward; benefits are not standardized; even sophisticated federal employees have difficulty understanding the choices available.
- Medicare has an excellent record of achieving low administrative expenses, and offers substantial managed care plan options for those beneficiaries preferring care from those plans. Unlike FEHB, Medicare offers both a public fee-for-service plan options – giving those who wish to remain in traditional Medicare the option.

- Radical restructuring of Medicare to put beneficiaries financially at risk for premiums in excess of Medicare payment to plans may not work for a sicker, older population. Most federal employees are younger and healthy. Since plans have a strong incentive to avoid marketing to sicker, chronically ill patients or providing specialized care designed to meet their needs, they may not have an advantage over traditional Medicare. Yet, if sicker people stay in traditional Medicare and healthier Medicare patients join managed care plans – as has happened to date – the cost of traditional Medicare could spiral and become unaffordable. Marilyn Moon estimates that costs for those choosing traditional Medicare could increase to over \$6,000 per person in 2025 (in 1998 dollars) if adverse risk selection occurs or if private plan premiums go up more slowly than the cost of traditional Medicare.
- **Where does the budget surplus come from?**
 - It is correct that the Social Security trust funds are generating a surplus annually; the Medicare hospital insurance trust fund will be drawn down over the next 10 years and be exhausted by 2008.
 - It is important to remember that the Balanced Budget Act of 1997 made very sharp reductions in Medicare spending. Savings of \$394 billion over the ten year period from 1998-2007 or an average of \$40 billion a year were generated by increasing premiums to beneficiaries and reducing payments to hospitals, home health agencies, physicians, managed care plans, and other health care providers. Premiums for beneficiaries were increased by about \$80 billion over the 10 year period. Today premiums are \$45.50 per month; in 2008 premiums will more than double to \$103 per month.
 - The President has proposed dedicating 15 percent of the 15-year budget surplus – or about \$40 billion a year to the Medicare trust fund. This would restore to the Medicare trust fund approximately the same revenues generated by Medicare savings in the BBA.

Kathleen
Sgambati

603271 ~~4600~~

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****DATE:** 3/22**TO:** Chris Jennings
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Tel: 202/690-7578, Fax: 202/690-5673**TOTAL NUMBER OF PAGES SENT:** 23
(including cover page)**COMMENTS:**

FYI - AP story

Welfare-Medicaid,540

HHS warns states not to delay Medicaid applications

WASHINGTON (AP) As states make it tougher for poor families to get welfare, the federal government is telling officials they must continue to quickly provide and process applications for Medicaid.

The most dramatic problems have come in New York City, where a federal judge ruled that the welfare offices were wrongly delaying applications for Medicaid and food stamps until applicants had looked for work. Federal officials suspect there may be similar, perhaps isolated, problems elsewhere.

Because many states use one application for both cash and Medicaid, sometimes deliberate delays in processing an application for cash can lead to wrongful delays in Medicaid.

Hoping to stem the problem, the Department of Health and Human Services wrote state welfare and Medicaid directors Monday, warning them that they must continue providing Medicaid to people even if they no longer qualify for cash assistance. HHS included a 28-page guide detailing the rules.

Specifically, HHS told states they must provide and process Medicaid applications immediately, no matter what their welfare policies.

"As essential pillar of family self-sufficiency is the ability to obtain and keep health insurance coverage," the guide says.

Food stamp applications raise similar concerns, but that program is administered by the Agriculture Department, so the HHS letter and guide do not address it.

The system used to be much simpler: People who applied and qualified for welfare automatically got Medicaid. But the 1996 welfare overhaul which made it much easier for states to deny welfare to families severed the link between the two programs, assuring that families would still qualify for health insurance even if they no longer received cash.

Advocates for the poor worry that states may be delaying Medicaid unintentionally.

"Many, many states have isolated cases and have some statistical evidence," said Liz Schott of the liberal Center for Budget and Policy Priorities. But she added: "There's no place that is as dramatic or deliberate as New York."

Although it has gotten tougher to get cash, it has gotten easier to qualify for health insurance, at least for children. A new Children's Health Insurance Program, or CHIP, lets states offer Medicaid or other insurance to children living in working poor families not poor enough to qualify for traditional Medicaid.

The HHS guide addresses eligibility for both Medicaid and CHIP. And it addresses families that are diverted from the welfare rolls

when they apply and those who are kicked off welfare for failing to comply with rules.

Thirty states have some sort of "diversion" program, which tries to prevent people from signing up for welfare by requiring an immediate job search or by giving people a lump sum of money to take care of some sort of emergency fixing a car, for instance that will keep them from needing welfare.

"Those are perfectly appropriate tools in cash assistance," said HHS spokeswoman Melissa Skolfield. "The guidebook is simply to be clear that a delay in cash shouldn't mean a delay in enrollment for Medicaid or CHIP."

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WHY WE VOTED NO ON THE BREAUX-THOMAS MEDICARE REFORM PLAN

By Stuart H. Altman and Laura D'Andrea Tyson

After more than a year the National Bipartisan Commission on the Future of Medicare ended one vote short of the supermajority required by law to send a formal recommendation to the President and the Congress. As the two members of the Commission widely reported to be the "swing votes" who ultimately failed to support the Commission's proposal, we believe it is important to explain our decision, a decision which, contrary to speculation inside the Beltway, was guided by policy considerations, not political ones.

Central to the concerns of the Commission—indeed the major reason for its existence—are Medicare's future financing needs. Under current law, the Medicare Trust Fund that finances hospital and other institutional services for Medicare beneficiaries will become bankrupt about 2010, and the growth in other Medicare services will consume an increasing portion of general government revenues, reducing what's left over for all other spending priorities. Many of Medicare's strongest critics imply that its costs are "out of control" either because of gross inefficiencies in government management or because of "excessive" generosity of the Medicare benefits package. But the evidence fails to support either interpretation.

In reality, two main factors drive Medicare's upward trajectory—the aging of the population and the continued rapid growth in health care spending at a faster pace than that of the overall economy. Moreover, if the past is a guide to the future, technological breakthroughs in medicine and the population's understandable appetite for the improvements in health which technology makes possible will continue to fuel the lion's share of projected increases in health care spending. The bottom line is inescapable: Medicare confronts a significant future financing challenge even if it continues to perform about as well as private health care spending on a per capita basis—as has been the case during the first thirty years of its existence. The question is what to do about it—that is, how to share the future costs of Medicare among and between beneficiaries, providers, and taxpayers?

Ultimately, we could not support the Commission's plan because it ducked this central question—in part through overly optimistic assumptions about the savings achievable by enhanced competition in the Medicare program. Even with these assumptions the plan predicted that Medicare's insolvency date would only move forward by four to five years. The plan then called for a public debate about how to fund the program in the future, but made no recommendations.

From the very first meeting, we urged the Commission to focus on what we thought to be its most important responsibility—providing recommendations for Medicare's future financing. Despite our repeated requests, the Commission never considered this issue or the proposal put forth by President Clinton to dedicate 15% of projected surpluses in the federal budget to Medicare over the next fifteen years instead of using such surpluses for other spending programs or tax cuts. This proposal which we supported on policy grounds quickly became the victim of partisan politics. And despite our stated willingness to examine concrete financing alternatives, none were offered.

We also repeatedly stated our desire to include a meaningful prescription drug benefit in the Medicare program as one of the Commission's recommendations, but this too was missing in the final plan. In the absence of such coverage, an inefficient, inequitable, and administratively costly patchwork system has developed for covering the drug needs of the elderly—including Medicaid support for some of the poorest Medicare beneficiaries, increasingly rare employer-provided insurance for some of the richest beneficiaries, and limited supplementary programs offered by private insurers to the dwindling number of Medicare beneficiaries who can afford them. Although the Commission plan included a Medicare drug subsidy for the poorest beneficiaries, it failed to offer any government support toward the purchase of drug coverage by the overwhelming majority of Medicare beneficiaries. We believe that such support is required on both equity and efficiency grounds. Without it, healthier Medicare beneficiaries will continue to forego such coverage, driving up its price and restricting its availability for the very individuals who need it most.

The core proposal of the Commission plan was a gradual but dramatic restructuring of Medicare into a so-called premium support system. In such a system, private plans would be allowed to compete with one another and with the government program in the provision of Medicare services. To foster such competition, the government would offer beneficiaries a choice between participating in the traditional fee for service Medicare program and buying private insurance plans approved to provide the same standard benefits, with the government paying a percentage of the premiums charged by such plans. Competition would be based on differences in price and quality, not on differences in covered services. In this formulation, market competition would gradually replace government price controls as the major mechanism to constrain Medicare costs and encourage greater efficiency in provider and beneficiary decisions.

We have long supported the idea of encouraging market competition to encourage efficiency in health care so we are sympathetic to the premium support approach. But we recognize its limitations and its dangers as well. In particular, the savings from such an approach are almost certainly not as large as those assumed in the Commission plan—market competition may ease Medicare's financing needs, but it will definitely not eliminate them. Nor, as our nation's experience prior to Medicare indicates, will market competition alone assure access to adequate health care benefits for the elderly regardless of differences in their income, health status, or location. Additional safeguards would be required to achieve this goal in a premium support system. For example, the government would have to adjust its premium payments for private plans by region to make sure that beneficiaries were not forced to pay higher prices for the same package of medical services simply because they lived in a high-cost area or because of a lack of competition in their location. (THE PREVIOUS SENTENCE COULD BE CUT IF NECESSARY AND MAY BE SOMEWHAT TECHNICAL) Such essential safeguards were either insufficiently elaborated or missing altogether in the Commission premium-support proposal.

Despite our reservations about the Commission plan, we advocate the goal of improving the efficiency of Medicare through greater competition. We agree with Senator Breaux that the "SOS" or "same-old, same-old" approach of introducing marginal adjustments into Medicare's traditional structure cannot solve the intertwined challenges of inadequacy, inequity, inefficiency and insolvency that confront it. The Commission's failure to reach a supermajority should not be used as an excuse for inaction; instead, building on the Commission's findings, the Congress and the President should work together to develop concrete legislative proposals for significant long-term reform of this critically important government program.

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Laura D'Andrea Tyson

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Here is my attempt to craft some language that might be the basis for a premium support recommendation that could gain support of a majority of Commission members. Comments welcome.

Laura

Tyson Draft of Statement by Medicare Commission

I. Commission Agreement on the Problems Confronting the Medicare Program

A majority of the Commission members agree that the Medicare program has four distinct problems:

Adequacy of benefits: The benefits package for Medicare was designed in 1965 to realize Medicare's basic goal—namely to provide the elderly and later the disabled with health insurance coverage similar in scope, quality and structure to that available to employed persons and their families. Consistent with this goal, the Medicare package was structured as a indemnity, fee for service insurance program covering payment for a specified list of benefits to any licensed provider choosing to provide them. Since 1965, there have been dramatic changes in both the practice of medicine and in the insurance industry, as a result of which there have been growing gaps between Medicare and the insurance programs available to the rest of the population. Employer-sponsored plans and even individual insurance products have rapidly moved from fee for service to capitated structures using closed panels of providers and management of care. Moreover, as a result of changes in the private insurance market, the average benefit packages provided by employers, by other public programs, including Medicaid, and by individual insurance options today include some prescription drug coverage, some catastrophic coverage, and even some preventive coverage, none of which are adequately provided by Medicare. In addition, Medicare deductibles and co-pays for inpatient hospital services are far higher than those for private insurance plans.

A majority of the Commission members agree that the current Medicare benefits package is no longer adequate to cover the health care needs of the elderly in ways that are consistent with the scope, quality and structure of insurance available to the rest of the population.

Inequity: As a result of the gaps in Medicare benefits, beneficiaries are exposed to large out-of-pocket expenses. Such expenses impose a much greater burden on low-income individuals than on high-income individuals. The access of many elderly Americans to necessary medical care is limited by their income, and poorer households are forced to devote a much larger fraction of their income to health spending than are richer ones.

Recognition of the financial burden of the original Medicare system on poorer beneficiaries is the reason behind the development of low-income protection programs of Medicaid--QMBs and SLMBs—to help such individuals cover their Medicare premiums, co-pays and deductibles and to provide limited coverage for prescription drugs. Participation in these programs has been limited to those with incomes below % of poverty, and participation by those eligible has been incomplete and variable across states. Thus, it is not surprising that a recent article in the New England Journal of Medicine found that even with these protections, inadequate coverage for costly drug prescriptions for low-income elderly and disabled remains a serious problem in our health care system. In addition, even with these protections, many low and moderate income participants remain exposed to large out-of-pocket expenses as a result of gaps in Medicare's benefits package.

Inefficiencies: (THIS SECTION IS CURRENTLY WRITTEN IN OUTLINE FORM ONLY—MORE WORK IS NEEDED)

The Medicare system has several features which reduce the incentives for efficiency by both beneficiaries and providers. Basic source of inefficiency—Medicare controls costs by setting prices of services covered in its standard benefits package. Several predictable results of this price-control approach: need to establish and revise huge list of allowable prices to keep up with practice of medicine; tendency of providers to encourage greater utilization of benefits to make up for their controlled prices; no or weak incentives on part of consumers to limit intensity of use; tendency to fraud in documentation of use—provider to be paid if service is performed, so provide evidence of service even when it has not occurred. Evidence of inefficiencies in system—from large regional differences that cannot be explained

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by differences in cost of providing the services—but differences in practice of medicine and intensity of services—more providers, more equipment, more utilization and expense per beneficiary by a factor or four.

Limitations on HCFA flexibility and reform; politics blocks competitive bidding; inability to reduce provider payments, to weed out unscrupulous providers and to restrict provider participation because of political pressures.

A majority of the Commission agrees that the efficiency of the Medicare program can and should be improved and that enhanced competition will foster this goal. At the same time, the majority of the Commission recognizes that the magnitude of the savings from greater efficiency is uncertain and that even under the most optimistic evidence currently available, realistic improvements in program efficiency by themselves will reduce but not eliminate Medicare's future financing difficulties.

Financing Needs and Program Solvency: Under current law, in the year 2000, total Medicare spending will equal \$274 billion or 12% of federal spending and will be paid for by beneficiary premiums (\$25 billion or 10% of the total); payroll taxes (\$130 billion or 53% of the total) and general revenues (\$92 billion or 37% of the total). By 2010, assuming no change in law and an annual growth rate of 7.6% (with demographics accounting for annual growth of about 4%), Medicare spending is projected to rise to \$ billion or 16% of total federal spending. In that year, beneficiary premiums will account for 13%, payroll taxes for 38% and general revenues for 49% of total Medicare spending. Without changes in current law, Medicare spending will continue to rise as a share of total federal spending and general revenues will continue to rise as a share of Medicare's total financing needs through 2030, the year the Commission chose as the ending point for its projections. In 2030, Medicare spending will hit % of total federal spending, and general revenues will account for % of Medicare's total financing needs.

A majority of the Commission agrees that the Medicare program as currently structured faces substantial long-term financing difficulties, indicated by the projected insolvency of the Part A Trust Fund in (year) and by increasing program reliance on general revenues for financing.

II. Commission Agreement on the Concept of a Premium Support Approach for Restructuring Medicare

To the extent that Medicare dollars can be spent more efficiently, it will be easier to address the other problems confronting Medicare—the inadequacy of the Medicare benefits package, inequities in the access of the elderly to necessary medical services based on income, and Medicare's long-term financing needs. Savings from greater efficiency can be used to expand benefits, to increase low-income protections; and to cover projected gaps in Medicare financing. So regardless of differences among Commission members on both the extent of these other problems and the appropriate remedies for them, a majority of the Commission agrees that Medicare should be restructured in ways that will encourage more efficiency both in the HCFA fee for service program and in any other private plans that are allowed to compete with HCFA to provide Medicare services.

After hearing from a variety of experts, a majority of the Commission members agree that there are two promising approaches for enhancing the efficiency of the overall Medicare program:

first, giving HCFA both the responsibility and the statutory authority it needs to adopt management innovations developed in private health plans including flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting for preferred providers and disease and case management techniques. In return for granting greater discretion to HCFA in managing FFS Medicare, Congress should hold HCFA to a higher standard of accountability and reporting requirements for cost and quality outcomes;

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and second, allowing private plans to compete with one another and with the FFS Medicare program operated by HCFA for Medicare dollars on the basis of price and quality of service.

Based on these findings, a majority of the Commission members recommend that both of these approaches be adopted. In particular, we recommend that Medicare be restructured to allow beneficiaries to choose between a modernized fee-for service program operated by HCFA and a variety of competing private health care plans. The Medicare program would make a contribution toward the payment of the premium of the plan chosen by each Medicare beneficiary, with the remainder of the premium paid by the beneficiary. This contribution would be calculated as a certain percentage, established by law, of the weighted average of all of the plans, including the HCFA FFS plan, competing for Medicare beneficiaries. The Medicare contribution would not be set in dollar amounts—that is, Medicare would not operate as a defined contribution program—but would be set as a percentage of the weighted average of the costs of all plans certified to compete for Medicare beneficiaries. Increases in these costs over time would result in increases in both Medicare's premium contributions and the premiums paid by Medicare beneficiaries.

Under this formulation, Medicare would continue to operate under an open-ended federal spending commitment, but the risks and burdens of increases in the costs of services covered by Medicare would be automatically shared by a set percentage between Medicare and its beneficiaries. This percentage should be set at a level which provides a government contribution that is sufficiently large to assure that an adequate benefits package is available and affordable to all beneficiaries regardless of income, health status, or geographic location. Over time, both the government's premium contribution and the beneficiaries' premium payment would be expected to increase at about the same pace as the costs of overall health services to the general population.

All plans competing for Medicare beneficiaries would be required to offer at least the same standard defined benefits package as the HCFA fee-for-service plan, and this package would be established by law. In addition, both the HCFA FFS plan and the competing private plans would be required to offer a supplemental defined drugs benefit package, also established by law. The standardization of defined benefits across plans is necessary to encourage plans to compete on price and efficiency, rather than on benefits, and to reduce the likelihood of biased selection whereby less generous plans would compete to attract the healthiest beneficiaries, driving up the price of the plans available to the sickest and neediest ones. The dangers of risk selection are significant as evidenced by the experience of the Federal Employees Health Benefits Plan and Medicare's experience with HMOs; moreover, such dangers are especially strong among the elderly because of dramatic differences in the risk profiles of individuals as they age. The predictable costs of treating Medicare beneficiaries varies greatly—from a few hundred dollars per year for the healthiest beneficiaries to tens of thousands of dollars per year for those with certain chronic conditions. Although in theory effective risk adjustment techniques should be able to control such risk selection problems among plans, such techniques currently exist only in rudimentary form. If and when such techniques develop, it would be possible to allow some limited variation in the standard benefits and prescription drugs packages required by law within specified actuarial ranges. In addition, all plans, including the HCFA fee-for-service plan, could be allowed to offer supplemental packages the purchase of which would not be tied in any way to the purchase of the standard benefits packages required by law and the full price of which would be paid by the Medicare beneficiary.

The approach to restructuring the Medicare system recommended by the majority of Commission members has come to be known as a "premium support" approach in the health care literature, and many of its features bear a strong resemblance to those of the Federal Employees Health Benefit Program. A premium support approach is not a defined contribution approach under which Medicare would provide to each beneficiary a fixed dollar amount that could be used to obtain coverage from approved plans with no mandated benefits package. In contrast, under a premium support approach, each approved plan would be mandated to offer a common standards benefits package and a common prescription drug benefits package, and Medicare would provide to each beneficiary a contribution toward the premium of the approved plans, with the size of the premium reflecting the weighted average of the premiums bid by participating plans, including the HCFA fee for service plan.

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Recent studies by health care experts along with the recent experience of some premium-support type programs, like FEHP, suggest that a premium support approach for Medicare could lead to a reduction in the projected increases in the cost of the Medicare program for both the government and beneficiaries. But it is necessary to be cautious about projecting substantial cost savings from restructuring Medicare into a premium support system. As the last five years have indicated, rapid changes in medical delivery systems and technology make it unwise to predict precisely where health care costs will be in five years, let alone in the more distant future. Although it is certainly reasonable to expect that on average Medicare spending per capita should track private health care spending per capita over the next thirty years as it has during the past thirty years, there is considerable uncertainty about the course of the latter. As a result of the confluence of several factors—including the aging of the population, continued technological progress in health care, and growing per capita incomes (as people become richer their spending on health care tends to increase as a share of their income)—per capita spending on health care for both the elderly and the rest of the population will almost certainly continue to grow considerably more rapidly than the overall economy—a trend which can at best be moderated but not reversed by greater efficiency realized through enhanced competition in both the Medicare system and the rest of the health care system.

Given real uncertainties in future costs, Medicare's restructuring into a premium support system requires that adequate safeguards be included to assure that unexpected developments do not have adverse consequences for beneficiaries, many of whom suffer from low incomes, chronic illnesses, and/or disabilities. Such safeguards must include a government premium rate that is high enough, along with appropriate risk adjusters, geographic adjusters, low-income protections, and strong oversight authority by an independent Medicare Board (described below), to guarantee the availability and affordability of a common standard Medicare benefits package to all beneficiaries regardless of their income or geographic location. Finally, because no safeguards mechanism can be designed to foresee all eventualities, the Medicare Board should be charged with the responsibility of providing annual reports to the Congress and the Administration, comparing Medicare's actual performance with its predicted performance, and making recommendations for changes in the Medicare system, so that it continues to honor this guarantee.

III. Particulars of a Premium Support Approach for Medicare

NOTE: WE HAVE YET TO DETERMINE WHICH OF THESE PARTICULARS HAVE MAJORITY SUPPORT AND WHICH DO NOT—I DO NOT THINK THAT ALL OF THEM WILL HAVE MAJORITY SUPPORT IN OUR FINAL REPORT

The Medicare Board: The proposed restructuring of Medicare to a premium support approach would require the establishment of a new institution—a so-called Medicare Board—charged with several responsibilities including: providing beneficiaries with information about approved plans; computing Medicare and beneficiary premiums to be paid to approved plans based on the weighted average of the bids received from such plans; and approving and negotiating with plans about their service areas and benefits packages design. The Board would operate under strict fiduciary responsibilities and would be required to submit a detailed annual report on its operations to Congress and the Administration. The Board should be designed in such a way that it is composed of health care professionals who serve for limited terms, whose decisions are guided by independent professional considerations and once approved cannot be removed for political reasons.

The Benefits Package: (Saving Medicare Today and Tomorrow Language to be Agreed Upon—Need to Check Consistency with Language above on Drug Benefits)

The Formula for Determining the Premium Contributions of the Government and of Beneficiaries: Under current law, premium payments by Medicare beneficiaries account for about 12% of the total costs of providing the standard Medicare benefits package, with the remaining 88% covered by government revenues. Under a premium support model, the government would pay a specified percentage of the

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weighted average price of the HCFA FFS plan and the private plans authorized to bid to serve the Medicare population, with the remainder paid by the beneficiary. In the premium support approach, actual premium payments of beneficiaries would vary depending on differences between this weighted average price and the price of the plan they selected.

In the particular premium support approach estimated by Commission staff and recommended by members of the Commission, the government would be responsible for 88% of the weighted average bid and average premium payments by beneficiaries would continue to account for about 12% of total program costs. But beneficiaries would pay all of the additional premium for plans whose price exceeded the weighted average price of all plans and would pay no premium for plans whose price fell below the weighted average price of all plans. In this basic Commission model, beneficiary premium rates would not be income-related except for additional government support for beneficiaries under 135% of poverty (see below).

NEED TO ADD DISCUSSION OF PREMIUM FORMULA FOR DRUGS BENEFITS PACKAGE: MY PROPOSAL IS THAT BOTH HCFA FFS AND PRIVATE PLANS BE REQUIRED TO OFFER A STANDARD DRUGS BENEFITS PACKAGE. THERE WOULD BE A PREMIUM BIDDING PROCESS FOR THIS PACKAGE SIMILAR TO THE PREMIUM BIDDING PROCESS FOR THE STANDARD BENEFITS PLAN. THE ONLY DIFFERENCE WOULD BE IN THE CONTRIBUTION RATE FOR GOVERNMENT AND BENEFICIARY. WE COULD NOTE THAT THE COMMISSION MAJORITY COULD NOT AGREE ON THE CONTRIBUTION RATE FOR GOVERNMENT AND EXPLAIN REASONS FOR DISAGREEMENT. STUART AND I WOULD RECOMMEND A SUBSIDY RATE OF AT LEAST 50% FOR TWO REASONS: FIRST, A 50% SUBSIDY RATE WOULD BE SUFFICIENT TO INDUCE THE VAST MAJORITY OF BENEFICIARIES TO ENROLL FOR THE DRUG BENEFIT—AND THIS IS NECESSARY TO AVOID RISK SELECTION PROBLEM—A LOWER SUBSIDY RATE WOULD WORSEN THE RISK POOL OF INDIVIDUALS OPTING FOR DRUG COVERAGE AND MAKE IT LESS EFFICIENT. AND SECOND, AT LEAST A 50% SUBSIDY RATE IS NECESSARY TO REALIZE THE GOAL OF MAKING THE DRUG BENEFIT AFFORDABLE FOR MEDICARE BENEFICIARIES.

DISCUSSION OF DRUG BENEFIT IN HCFA FFS PLAN WOULD ALSO INCLUDE CAVEAT THAT HCFA CONTRACTS WOULD BE BASED ON PRICES AND FORMULARIES AVAILABLE IN THE PRIVATE MARKET, WITHOUT RECOURSE TO PRICE CONTROLS OR REBATES.

Geographic Adjusters to the Formula for the Premium Contribution

THIS DISCUSSION WOULD BEGIN BY NOTING THE VERY LARGE REGIONAL DIFFERENCES IN CURRENT COSTS OF PROVIDING MEDICARE PACKAGE—FOUR TO ONE DIFFERENCES, ONLY THREE-QUARTERS OF WHICH CAN BE DIFFERENCES IN INPUT PRICES, ONE QUARTER OF WHICH IS RESULT OF DIFFERENCES IN INTENSITY OF USE AND PATTERNS OF MEDICAL PRACTICE. SUCH REGIONAL DIFFERENCES ARE ONE REASON WHY PREMIUM SUPPORT MODEL WILL NEED GEOGRAPHIC ADJUSTERS IF MODEL IS BASED ON A NATIONAL BIDDING PROCESS. A SECOND REASON FOR GEOGRAPHIC ADJUSTERS IS REALITY THAT THE EXTENT OF COMPETITION AMONG PROVIDERS IS NOT SAME ACROSS ALL REGIONS—IN PARTICULAR IN SOME RURAL COMMUNITIES THERE MAY BE VERY FEW IF ANY CHOICES AVAILABLE TO BENEFICIARIES OTHER THAN THE HCFA FFS PLAN.

THE MAJORITY OF THE COMMISSION RECOMMENDING PREMIUM SUPPORT AGREES THAT INDIVIDUAL BENEFICIARIES SHOULD NOT HAVE TO PAY MORE FOR THE SAME MEDICARE PACKAGE BASED ON THEIR GEOGRAPHIC LOCATION. IN PARTICULAR BENEFICIARIES SHOULD NOT HAVE TO PAY MORE FOR THE SAME PACKAGE OF SERVICES BECAUSE THEY LIVE IN A HIGH-COST REGION OR BECAUSE OF THE MARKET POWER OF PROVIDERS

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AVAILABLE IN THEIR REGION. THEREFORE, THE PREMIUM SUPPORT MODEL WILL NEED A PROCESS TO ADJUST THE SIZE OF THE GOVERNMENT'S PREMIUM PAYMENTS FOR INDIVIDUAL BENEFICIARIES SO THEY ARE HELD HARMLESS AGAINST HIGHER PRICES IN THEIR REGIONS STEERING FROM THESE TWO FACTORS. THE DEVELOPMENT OF SUCH GEOGRAPHIC ADJUSTERS FOR THE GOVERNMENT'S PREMIUM POSES A SERIOUS TECHNICAL CHALLENGE THAT WILL HAVE TO BE ADDRESSED FOR THE PREMIUM SUPPORT MODEL TO WORK FAIRLY. INITIALLY FOLLOWING THE CURRENT FORMULA FOR REIMBURSING MEDICARE HMOs, ADJUSTERS WHICH OFFSET 100% OF COUNTY-LEVEL VARIATIONS COULD BE SET TO FULLY REFLECT DIFFERENCES IN INPUT PRICES, MARKET POWER AND LEVELS OF CARE IN EACH COUNTY. OVER TIME, THESE ADJUSTERS COULD BE MODIFIED TO ALLOW THAT PORTION OF THE DIFFERENCE IN COUNTY PRICES DUE TO DIFFERENCES IN UTILIZATION AND PRACTICE TO BE SHARED BY THE GOVERNMENT AND THE BENEFICIARY ACCORDING TO THE OVERALL FORMULA FOR DETERMINING THEIR PREMIUM CONTRIBUTIONS.

WHILE SOME REDUCTION IN GEOGRAPHIC VARIATIONS OF MEDICARE PRICES WOULD BE EFFICIENT AND EQUITABLE, THIS WOULD HAVE TO BE PHASED IN GRADUALLY. FOR EXAMPLE THE PREMIUM SUPPORT SYSTEM MIGHT BEGIN WITH 100% ADJUSTMENT OF COUNTY-LEVEL DIFFERENCES IN PRICE MOVING GRADUALLY TO 75% ADJUSTMENT OF SUCH DIFFERENCES ACCORDING TO AN AGREED UPON TIMETABLE.

Special Rural Adjustment Concerns

UNDER A PREMIUM SUPPORT MODEL IT IS POSSIBLE THAT AN INSUFFICIENT NUMBER OF PRIVATE PLANS WILL ENTER SOME RURAL AREAS TO PROVIDE EFFECTIVE COMPETITION FOR HCFA FFS MEDICARE. IF SO, IT IS ALSO POSSIBLE THAT PREMIUMS WILL RISE OR QUALITY WILL FALL AS THE TRADITIONAL PROGRAM USES HIGHER PROFITS IN NONCOMPETITIVE AREAS TO OFFSET LOWER PREMIUMS AND HIGHER COSTS OF CARE IN MORE COMPETITIVE AREAS. GIVING TRADITIONAL MEDICARE FLEXIBLE MODERNIZED MANAGEMENT AUTHORITY AND THE DISCRETION TO SET PREMIUMS IN THESE AREAS COULD CREATE AN UNREGULATED MONOPOLY. THUS IT MAY BE APPROPRIATE TO RESTRICT HCFA'S DISCRETION AND TO CONTINUE TO USE THE CURRENT ADMINISTERED PRICE SYSTEM UNDER CURRENT LAW IN NONCOMPETITIVE RURAL AREAS WITH NO OR FEW PRIVATE OPTIONS. BENEFICIARY PREMIUMS COULD BE BASED ON COSTS INCURRED IN THE ADMINISTERED PRICES SYSTEM, WHICH ARE GENERALLY LOWER IN RURAL AREAS, SO THAT BENEFICIARIES IN THESE AREAS WOULD BE NO WORSE OFF THAN UNDER CURRENT LAW.

Risk Adjusters to the Formula for Premium Contributions

THE PREDICTABLE COSTS OF TREATING MEDICARE BENEFICIARIES VARIES GREATLY ACROSS INDIVIDUALS—FROM A FEW HUNDRED DOLLARS A YEAR FOR THE HEALTHIEST BENEFICIARIES TO TENS OF THOUSANDS OF DOLLARS PER YEAR FOR THOSE WITH CHRONIC CONDITIONS. UNDER THESE CIRCUMSTANCES, PLANS WHICH WERE PAID THE AVERAGE COST OF TREATMENT WOULD HAVE STRONG INCENTIVES TO SHUN SICKER ENROLLEES IN FAVOR OF HEALTHIER ONES. TO THE EXTENT THAT THIS OCCURRED, PLANS THAT MADE IT RELATIVELY EASY TO OBTAIN SERVICES WOULD ATTRACT SICKER BENEFICIARIES AND WOULD HAVE TO CHARGE HIGHER PREMIUM, DRIVING THEIR HEALTHIEST BENEFICIARIES TO LOWER-COST PLANS. IF HIGH-RISK BENEFICIARIES ARE CONCENTRATED IN HIGH-COST PLANS AS A RESULT OF THIS RISK SELECTION PROBLEM, THESE BENEFICIARIES WILL BE FORCED TO PAY INAPPROPRIATELY HIGH PREMIUMS BECAUSE OF THE HIGHER LEVEL OF RISK OF THE POPULATION SERVED BY THOSE PLANS. MOREOVER, THERE WOULD BE NO INCENTIVE FOR PLANS TO PROVIDE HIGH-QUALITY

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CARE TO THE CHRONICALLY ILL OR OTHER BENEFICIARIES SINCE SUCH A PLAN WOULD MERELY ATTRACT MORE OF THEM.

THE MAJORITY OF THE COMMISSION RECOMMENDING PREMIUM SUPPORT APPROACH RECOGNIZES THAT THESE RISK SELECTION PROBLEMS ARE SEVERE AND THAT TO AVOID THEM ADEQUATE RISK ADJUSTMENT IS REQUIRED. A RISK ADJUSTMENT MECHANISM WOULD ADJUST THE GOVERNMENT'S PREMIUM CONTRIBUTION TO PARTICULAR PLANS ON THE BASIS OF THE RISK CHARACTERISTICS OF THE INDIVIDUALS THEY ENROLL, BUT WOULD NOT AFFECT THE BENEFICIARY CONTRIBUTION. SPECIFICALLY, A RISK ADJUSTMENT FACTOR BASED ON BENEFICIARY CHARACTERISTICS WOULD ADJUST THE PREMIUM FOR EACH PLAN BASED ON ITS TYPICAL BENEFICIARY—AND THE GOVERNMENT WOULD PAY THE DIFFERENCE BETWEEN THIS ADJUSTED PREMIUM AND THE BENEFICIARY PREMIUM.

UNFORTUNATELY, WHILE THE PRINCIPLE BEHIND RISK ADJUSTMENT IS WELL UNDERSTOOD, RISK ADJUSTMENT MECHANISMS ARE STILL RUDIMENTARY. MOST EXPERTS, FOR EXAMPLE, AGREE THAT ONLY ABOUT ONE-QUARTER OF HEALTH CARE EXPENDITURES BY A MEDICARE BENEFICIARY ARE PREDICTABLE AT THE TIME OF ENROLLMENT. THUS IT IS UNLIKELY THAT RISK ADJUSTMENT WILL ELIMINATE THE POSSIBILITY OF SIGNIFICANT RISK SELECTION PROBLEMS IN A PREMIUM SUPPORT MODEL IN THE FORESEEABLE FUTURE. HOWEVER, A NUMBER OF OTHER FEATURES OF THE PREMIUM SUPPORT APPROACH COULD BE DESIGNED IN WAYS TO DISCOURAGE RISK SELECTION. THESE INCLUDE: ADHERENCE TO STRONG STANDARDIZATION OF THE BENEFITS PACKAGES OFFERED BY PARTICIPATING PLANS; MAINTENANCE OF A HIGH GOVERNMENT SHARING RATE IN THE OVERALL PREMIUM SO THAT BENEFICIARIES HAVE A WEAKER INCENTIVE TO CHOOSE LOW-COST PLANS; ENCOURAGEMENT OF POINT OF SERVICE OPTIONS THAT ARE ATTRACTIVE TO BOTH CHRONICALLY ILL AND WEALTHY BENEFICIARIES; AND UTILIZATION-BASED RISK ADJUSTMENT TECHNIQUES BY WHICH PREMIUM PAYMENTS ARE ADJUSTED IN PART BASED ON PAST OR CONCURRENT COSTS AND UTILIZATION RATHER THAN DIAGNOSES ALONE.

Tyson Draft: Solvency and Financing Language

As numerous reports from the HCFA Actuaries, the Congressional Budget Office, and independent experts indicate, even under optimistic assumptions about the efficiency gains that might be fostered by a premium support model, Medicare spending like health care spending in the private sector is projected to grow substantially faster than the overall economy. As illustrations of this conclusion, separate estimates by the Commission staff and the HCFA actuaries of the effects of the particular premium support model proposed by Senator Breaux, exclusive of a prescription drug benefit, indicate that even after anticipated efficiency savings, Medicare spending will continue to climb rapidly.

(Need Table showing predicted Medicare spending with Breaux premium support model in 2050, 2010, 2015, 2020, 2025, 2030—not including other proposed changes—want estimate of pure efficiency effect alone—also for comparison need predicted Medicare spending)

A comparison between predicted Medicare spending under Breaux's premium support model without drugs and predicted revenues available to Medicare from both the payroll tax and general revenue transfers under current Medicare law indicates that even a restructured Medicare program faces a substantial and growing financing gap in the near future. Gradually adding the costs of a prescription drug benefit of the type supported by the majority of the Commission members increases the size of this financing gap significantly. (Table needed here—can use a range of drug cost estimates to show the effect of different government subsidy rates.)

The implication of these numbers is that even with a premium support approach Medicare will have to rely increasingly on general revenues. Additional changes in the Medicare program considered by the Commission and supported by some of its members, although not a majority of them, could reduce the financing gap. These changes include: income-relating the premium contribution made by beneficiaries regardless of whether they chose to enroll in HCFA FFS Medicare or one of the authorized private plans; gradually adjusting the age of eligibility for Medicare so it conforms with increases in the age of eligibility for Social Security; and excluding direct graduate medical education charges from Medicare spending. The Commission was unable to reach majority agreement on each of these proposals reflecting the reality that each of them has its own particular disadvantages.

Adjusting the premium contribution by income is a relatively easy formulaic adjustment in a premium support approach, but would be difficult to administer in practice. In addition, although there was agreement among Commission members that high-income beneficiaries could and should pay more for their Medicare coverage, there was disagreement about what level of income would place an elderly family in the "high-income" high-premium category. The lower the level decided upon, the smaller the financing gap confronting Medicare, but the greater the risk that middle rather than high income families would face higher premium contributions, thereby threatening the social insurance nature of Medicare and weakening political support for the program. Finally, a majority of the Commission agreed that any revenues earned from income-relating the Medicare premium should be used to finance an expansion of low-income protections, not to reduce overall Medicare spending, at least for the foreseeable future.

Raising the age of eligibility to conform with the age of eligibility for Social Security could reduce Medicare spending significantly in the future but it carries a real risk of leaving many older Americans without health insurance. Almost 1 in 8 Americans aged 62-64 today have no health insurance, and the number of uninsured Americans is growing most rapidly in the 55-65 age cohort. Lack of insurance coverage in the United States is a serious policy problem: raising the age of eligibility for Medicare would aggravate this problem unless this policy were accompanied by a fair buy-in program for those who were no longer eligible for Medicare.

Carving out funding for Direct Medical Education (DME) from the Medicare program would reduce projected spending. But this approach begs the question of how to guarantee teaching hospitals with the support they need not only to provide education and research in medicine but also to cover the cost of their treatment of difficult medical cases and uninsured patients.

Finally, even if all three of these approaches to reducing Medicare spending were adopted, Commission staff estimates of the Breaux premium support plan indicate that a substantial financing gap for Medicare would remain. Substantial additional funds from general revenues would be required, over and above those currently projected under current Medicare law, to guarantee the premium contribution rates for beneficiaries proposed in the Breaux plan (as noted above these rates are:—on average beneficiaries pay 12% of the premium costs for a standard benefits package, pay no premium for plans the cost of which is less than 85% of the national weighted average, and pay all additional amounts for plans the cost of which is greater than this average.) Without the infusion of such funds, either the shares of the total premium paid by beneficiaries would have to be increased or other changes in the proposed Breaux plan would have to be made to reduce Medicare's financing gap. Moreover, the inclusion of a drug benefit of the type recommended by the majority of the Commission would require an even larger infusion of general funds, a larger increase in premiums paid by beneficiaries, or some other offsetting change in the premium support plan.

Even among the majority of Commission members who recommend a premium support approach, there is disagreement on the best way to address Medicare's projected financing gap.

Two members of this majority support the idea that the Part A Trust Fund of the current Medicare program be replaced by a Unified Medicare Trust Fund consisting of the current Part A payroll tax plus the general revenues committed to Medicare under current law. This proposal recognizes that although the Part A Trust Fund concept would no longer make sense in a premium support approach, some kind of trust fund accounting is probably the most comprehensible way to illustrate Medicare's huge future liabilities. A Unified Trust Fund approach, like a Part A Trust Fund approach, reveals that under current law Medicare would become insolvent as early as (date). To address this impending insolvency problem while allowing for a gradual transition to a premium support approach that includes an affordable prescription drug package, these two members of the majority support the President's proposal to commit 15% of the projected surpluses in the general fund to Medicare over the next years. Because the interest earned on the surplus funds committed to Medicare would accrue to Medicare over time, the total cost of covering Medicare's projected financing gaps in this way would be considerably less than the total cost of covering the same gaps at the time they developed through general revenues.

The remaining members of the majority of the Commission who recommend a premium support approach recommend that Medicare solvency be assessed by examining the increasing shift of Medicare program costs to the general fund and the changing ratios of total Medicare financing borne by the general fund, by beneficiaries, and by the payroll tax. According to this proposal, when general revenues exceed 50% of total program outlays without further Congressional approval, there should be a public debate and decision about the financing of the Medicare program focused on potential adjustments in the payroll tax, beneficiary premiums, and the percentage of general funds to be allocated to Medicare.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

March 2, 1999

MEMORANDUM FOR THURGOOD MARSHALL, JR. *Handwritten: Hordy*

Attached is letter to the President expressing deep concern regarding the direction of the recent Medicare Commission discussions as Senator Breaux and Representative Thomas continue to court support for their proposal.

Handwritten: Mary Beth Donahue
Mary Beth Donahue

Attachments



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 1999

MEMORANDUM FOR THE PRESIDENT

I am writing because of my deep concern about the direction of the recent Medicare Commission discussions as Senator Breaux and Representative Thomas continue to court support for their proposal. While I believe the Administration has and should continue to vigorously articulate specific recommendations for strengthening and modernizing Medicare, we should be extremely cautious about accepting the vague "premium support" model developed by the Commission without fully exploring the significant policy issues it raises. In my view, it would also be a tactical mistake to cede political leverage by validating a premium support approach in advance of the upcoming congressional debate.

Despite the very hard work of your appointees, your staff, and the other Democrats involved with the Commission, I think that we must conclude that the Commission has failed in its primary task, which was to engage the policy community and the public in an open process that could develop reasonably broad, bipartisan agreement on how to address the long-term financing issues facing Medicare. Instead, the work of the Commission has focused largely on recasting and dressing up the Republican's 1995 Medicare reform goal of privatizing Medicare under the guise of "premium support." While the Democrats (helped considerably by your budget proposal) have remained willing to engage on the primary mission of the Commission – long-term financial solvency – little progress has been made in this area. Indeed, at the last Commission meeting, Republicans sought to recast the solvency debate in terms of the "rate of program growth" rather than trust fund solvency – a fairly transparent attempt to dismiss your strong argument for dedicating a portion of the surplus to extend the life of the Medicare Part A trust fund.

As the Commission winds up its work, we are left with a vague proposal that enjoys no public credibility, that fails to address the long-term financing problem of Medicare, that fails to address the critical need for an outpatient prescription drug benefit, and that fails to achieve any true bipartisan consensus on the appropriate future direction for Medicare. These problems are fundamental. Even if some last minute maneuvering brings about some coverage for prescription drugs or some use of the surplus, it seems doubtful that, after a thorough review, the "deal" would long survive the Commission's end.

In addition, we have extraordinarily few details on many of the major elements of the proposal, leaving the door open for the Republican leadership and Commission members to later selectively invoke the Commission's endorsement for items they decide to include in their legislative proposals. Another serious problem is that we only last week received an objective analysis (from the HCFA actuary) of the financial impacts of the proposal, and we have yet to receive any information on the distributional consequences (the winners and losers). I do not see how we or the congressional Democrats can move forward on a bipartisan basis when there is no

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firm meeting of the minds about what this proposal is intended to do, who it affects, how it would be structured, and who would pay for it.

Although the proposal put forth by Senator Breaux and Representative Thomas lacks specificity in many areas, the information that has been provided raises significant policy concerns. These include:

- **A substantial portion of the savings from the proposal result from raising beneficiary costs.** The estimates from the HCFA actuary indicate that roughly 45 percent of the savings from the Breaux/Thomas proposal come from increasing costs to beneficiaries, including specific proposals that would increase cost sharing (particularly for home health care), delay program eligibility to age 67, and create a new income-related premium (although these savings may be spent on new low-income protections). The income-related premium would begin at \$24,000 for single beneficiaries and \$30,000 for couples, a threshold so low that it essentially changes the social insurance nature of the program. In contrast, the income related premium proposed in the Health Security Act began at \$90,000 for single beneficiaries and \$110,000 for couples. The change in the eligibility age will increase the number of uninsured Americans, whether or not a buy-in proposal is included in the package. I do not believe that these proposals, as currently specified, are good for Medicare or will be acceptable to most congressional Democrats.
- **The proposal places the traditional fee-for-service Medicare program and the beneficiaries that it serves at risk.** While the Breaux/Thomas proposal contains some improvements for fee-for-service Medicare, including the new authorities that you have regularly requested to make HCFA a more prudent purchaser, the premium support program that is being considered would increase costs for those beneficiaries who elect to stay in fee-for-service or who have no choice of plans (e.g., millions of beneficiaries in rural areas). According to the HCFA actuary, fee-for-service premiums will increase by roughly 18 to 30 percent under premium support, with somewhat lower increases, 10 to 20 percent, if BBA extenders are enacted at the same time. Such increases may force lower income beneficiaries into private plans; beneficiaries in rural areas with no private plan choices will be forced to pay much higher premiums.
- **The proposal does not guarantee that all beneficiaries will receive the Medicare defined benefits.** Although the Democrats on the Commission have repeatedly stated that the benefit package for private plans should be defined so that it includes all existing Medicare benefits, the proposal appears to allow a proposed Medicare Board to approve benefit variations. Without a defined benefit package, aggressive risk selection activities by private plans could lead to greater adverse selection against the fee-for-service program. Without perfect risk adjustment, which we do not have, fee-for-service costs and premiums will increase.

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- **Premium support, which is the most contentious element of the proposal, neither addresses Medicare's long-term financing problem nor produces sufficient savings to justify its adoption at this time.** According to the estimates of the HCFA actuaries, the inclusion of premium support will reduce Medicare spending in 2030 by just 2.5 to 3.1 percent. Over the 30-year period, premium support would provide only a little more savings than would be gained from the combination of the proposed fee-for-service modernizations and extending the BBA savings policies for about 5 years. While any method of improving the efficiency of Medicare should be seriously explored – and premium support has some positive attributes – it is clear that premium support has little impact on the long-term financial problems faced by the program.

As stated above, while we know something about the savings that may come about from premium support, we still do not have distributional analyses of who wins and who loses under different premium support approaches. Given the political controversy that premium support engenders, combined with its adverse impacts on beneficiaries without other choices, it would be premature for us to give any indication that premium support might be appropriate for Medicare.

We also need to be mindful that the premium support concept remains a moving target, despite the attempts of Senator Breaux and Representative Thomas to provide some direction. For example, at the last Commission meeting, three of the advocates of premium support suggested that their support was based primarily on the ability of private plans under premium support to provide substantial additional benefits to beneficiaries. However, the premium support specifications released by Senator Breaux either eliminate or substantially restrict (two options) the ability of private plans to offer additional benefits. Some members of the Commission and most of the public are not yet aware of this fact, and many potential supporters may have second thoughts when they understand the new direction. Again, I think that there is need for extreme caution in our public pronouncements until the details are written down and well understood by all of the relevant parties.

- **The proposal does not include a critically needed outpatient pharmaceutical benefit for all beneficiaries.** As you well know, prescription drug therapies are increasingly important to improving the health and well-being of our citizens, particularly those with chronic health conditions. Medicare simply cannot operate efficiently unless providers and health plans can use all of the tools available to improve the health of the elderly and the disabled.

Unfortunately, Senator Breaux and Representative Thomas have not agreed to support inclusion of a prescription drug benefit that would be available to all Medicare beneficiaries, instead suggesting a combination of different approaches for different segments of the Medicare population. Their stated reason for opposing a Medicare outpatient pharmaceutical benefit is a concern about substituting for existing prescription

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drug coverage, but much of this concern is misdirected. A substantial portion of existing spending is either in public programs (i.e., Medicaid) or government subsidized (i.e., employer-provided retiree benefits, Medicare+Choice plans). Further, all of the trends indicate that employers will be providing fewer retiree health care benefits in the future.

Another concern raised by some Commission members is that a Medicare pharmaceutical benefit would give HCFA too much power over the prices that the elderly pay for prescription drugs. I view this argument as saying that we should be putting the profit needs of the pharmaceutical industry above the needs of beneficiaries to have access adequate health care. We must assure that beneficiaries are provided an affordable prescription drug benefit and that HCFA and private plans have sufficient authority to procure needed drugs at the best possible prices for beneficiaries and taxpayers.

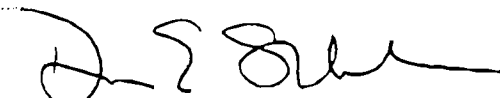
- **The new Medicare Board that would be created under the proposal would bifurcate federal responsibility for Medicare and significantly reduce executive branch influence over Medicare policy and spending.** The Breaux/Thomas proposal to create a new Medicare Board would result in a split of administrative responsibility for Medicare, with the new Board overseeing private plans, and HCFA continuing to have responsibility for fee-for-service Medicare. This split of responsibility would eliminate the single point of accountability for Medicare that we have today, and would make it much more difficult for the President and the Executive Branch to coordinate overall Medicare policy in a way that focuses on the needs of all beneficiaries. It also could diffuse our successful anti-fraud efforts, particularly the aggressive initiatives undertaken by the HHS Inspector General, by separating accountability over program finances. Such a change is not prudent given the important role that Medicare plays in the lives of millions of Americans as well as its significant impact on the federal budget.
- **Current beneficiaries may experience significant disruptions.** We also need to be cautious about the extent to which we cause large disruptions for current beneficiaries. Last year, when a large number of managed care plans left the program, there was a considerable backlash from beneficiaries who experienced changes in plans, benefits and providers. Significantly greater changes for beneficiaries are likely under the Breaux/Thomas proposal. For example, the proposal would significantly limit the extent to which private plans could offer additional benefits to beneficiaries, which would mean that most current beneficiaries in Medicare+Choice plans would lose many of the benefits that they have today. In addition, market shake-ups and plan withdrawals could well be more frequent and more extreme under premium support, particularly in the early years before the system stabilizes. These issues have received no attention by the Commission.

In raising these serious concerns, I am also reminded that the Administration has a vision for addressing Medicare's financial problems and for strengthening and modernizing the benefits and program operations. As your budget proposal demonstrates, the Administration, working with congressional Democrats and interested Republicans, can begin to address Medicare's

problems without undermining the financial security of present and future beneficiaries. A thoughtful approach that includes dedication of a portion of the surplus to Medicare, the authority for HCFA to use more competitive purchasing practices, a responsible income-related premium aimed at truly higher income beneficiaries, an affordable prescription drug benefit, more rational cost sharing, and an extension of BBA savings proposals would be a package that could receive substantial support. These policies have been discussed before and are fairly well understood by the public and the Congress, and, unlike premium support, would not be considered radical change to the program.

We have an opportunity this year to make real improvements in Medicare that both secure the financing of the program for years and enhance the health care protection that we offer the elderly and disabled. But as we continue to put forth our vision for change, I believe that we need to be careful not to provide political cover to an untested, radical restructuring proposal that may be taken up in Congress this year. In my opinion, providing Administration validation of premium support would diminish our ability to control the details through the legislative process, potentially handing us a take-or-leave-it proposal for Medicare restructuring imbedded in a broader legislative vehicle at the end of this session. As we move forward, we need to protect the program from those whose ultimate goal is simply to privatize rather than improve Medicare.

The Commission process has been a trying one for all of us, and everyone who supports this program appreciates the effort that you personally and your appointees and staff have made to try and make the process a success. I hope that we can shift those energies now toward developing a proposal that is consistent with the values that underlie this program and which can garner broad public support and bipartisan support in Congress.



Donna E. Shalala

FAX TRANSMISSION

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To: Dan M.
Mark Miller
Mark McClellan

To: Jeanne Lambrew
Gary Claxton

Date: February 21, 1999

Fax #:

Pages: 8, including this cover sheet.

From: Richard S. Foster

Subject: Medicare Legislative Packages

COMMENTS:

The pseudo-Jeanne package with the three income related premium options.

~~CONFIDENTIAL~~

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: 34R DATE: 04/05/12
2012-0463-5

Package 4—Jeanne Lambrew's illustrative Medicare legislative package¹

Category	Provision	Comment
Fee-for-service:		
Cost sharing	Combined A & B deductible of \$350 (indexed to CPI) 0% coinsurance on inpatient and preventive care; 10% coinsurance on 1st 60 post-deductible HHA visits; present law OPD coinsurance; 20% coinsurance on all other services	
Modernization	Standard BCV package	
Admin. Budget package	All (known) provisions of Administrations FY2000 Budget legislative package	
BBA extenders	Current Jeanne Lambrew package: 2007 / no M+C / no DSH	
Medical education	Remove DME funding from Medicare; no IME provision	
DSH	No provision	
Medigap reforms	Prohibit coverage of Medicare deductible(s)	
Premium support:		
Administration	No specification	
Benefit packages	Standard package of covered services for all plans, equal to revised FFS benefit package, including drugs Flexibility allowed in beneficiary cost-sharing requirements Plans cannot include cost of supplemental benefits in premium bids	NOT USED: Est's reflect Sen. Breaux's Board-administered benefit variation
Premium allocation	Gov't FFS plan must bid nationally; others may bid nationally or regionally Partial geographic adjustment of payments; full risk adjustment Beneficiary/government premium allocation not clear yet	NOT USED: Est's reflect Sen. Breaux's "alternative" formula
Income related premium	Option (1): Single bene's: 15% at \$90,000 - 40% at \$100,000+ Bene couples: 15% at \$115,000 - 40% at \$125,000+ Option (2): Single bene's: 15% at \$60,000 - 40% at \$110,000+ Bene couples: 15% at \$90,000 - 40% at \$150,000+ Option (3): Single bene's: 15% at \$50,000 - 40% at \$100,000+ Bene couples: 15% at \$75,000 - 40% at \$150,000+ Initial threshold indexed by CPI, w/ same slope thereafter	"HSA level" "BBA level" "Senate level"
FFS and PS:		
Eligibility age	Increase age of eligibility following OASDI schedule	
Voluntary coverage	Same provision as President's Budget but applies to 62-66	May not be feasible
Drug coverage	Optional for FFS bene's, w/ one-time-opportunity only; required for private plans \$250 deductible \$7/\$15 copayments per generic/brand name script Maximum benefit per beneficiary of \$1,500 All parameters indexed to general inflation 50% of drug benefit cost to be included in bene premium determination	Not feasible; treat as mandatory for all
Budget surplus revenue	President's Budget proposal	

¹ As described in 2-15-99 e-mail note and clarified and modified by Jeanne Lambrew on 2-17-99 and 2-19-99.

Estimated costs (+) or savings (–) under Jeanne Lambrew's illustrative Medicare legislative package
(Calendar year estimates; amounts in billions)

—Option (1): Income related premium thresholds = \$90,000 / \$100,000 singles, \$115,000 / \$125,000 couples—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders.....	\$0.0	\$0.0	-\$0.4	-\$2.4	-\$4.3	-\$6.5	-\$8.9	-\$11.0	-\$11.3	-\$12.2	-\$13.2	-\$14.3	-\$15.5	-\$16.8	-\$18.2	-\$19.7	-\$21.3
Cost sharing changes.....	-0.3	-0.3	-0.2	-0.1	0.0	0.1	0.2	0.3	0.5	0.7	0.9	1.1	1.4	1.7	2.1	2.5	3.0
Modernization proposals.....	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME.....	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact.....	2.3	-3.6	-3.8	-4.8	-5.9	-6.2	-6.7	-7.3	-7.9	-8.5	-9.3	-10.1	-11.0	-12.0	-13.1	-14.1	-15.3
Income-related premium.....	-2.6	-3.0	-3.2	-3.5	-3.9	-4.3	-4.7	-5.2	-5.7	-6.3	-7.0	-7.7	-8.5	-9.4	-10.3	-11.4	-12.5
Premium support subtotal..	-0.4	-6.6	-7.0	-8.3	-9.8	-10.5	-11.4	-12.4	-13.6	-14.8	-16.3	-17.9	-19.6	-21.4	-23.4	-25.5	-27.8
Drug coverage:																	
Expenditure impact.....	0.0	20.0	21.5	23.2	25.1	27.1	29.2	31.5	34.1	36.9	40.1	43.5	47.2	51.1	55.1	59.2	63.5
Premium impact.....	0.0	-10.4	-11.2	-12.1	-13.0	-14.0	-15.1	-16.3	-17.6	-19.0	-20.5	-22.1	-24.0	-26.0	-28.0	-30.0	-32.2
Drug coverage subtotal.....	0.0	9.6	10.3	11.1	12.1	13.1	14.1	15.2	16.5	17.9	19.6	21.4	23.2	25.1	27.1	29.2	31.3
Change in age of eligibility.....	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
Admin. Budget proposals.....	-1.3	-1.5	-1.6	-1.7	-1.9	-2.0	-2.1	-2.3	-2.5	-2.7	-2.9	-3.2	-3.6	-3.9	-4.2	-4.6	-5.0
"Budget surplus" revenues.....	-17.6	-19.6	-27.2	-26.0	-29.5	-32.6	-40.0	-45.4	-50.0	-55.7	-60.9	-65.9	-70.2	-73.7	-75.5	0.0	0.0
Medigap regulation changes..	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions.....	0.0	0.1	0.1	0.2	0.3	0.5	0.6	0.7	0.8	1.0	1.0	1.0	1.2	1.3	1.4	1.4	1.5
Total savings.....	-25.8	-24.8	-32.8	-35.1	-42.1	-48.1	-59.0	-68.1	-74.8	-83.6	-90.2	-96.9	-104.8	-111.9	-115.8	-43.2	-46.1
Total present law expend's.....	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's.....	-10.3%	-9.4%	-11.8%	-11.8%	-13.1%	-13.9%	-15.8%	-16.9%	-17.1%	-17.6%	-17.5%	-17.2%	-17.1%	-16.8%	-16.0%	-5.5%	-5.4%

Notes: 1. Refer to specification summaries for description of provisions. NB: Premium support formula is not Jeanne's "rebate" specification; pending further review of Jeanne's specifications, estimates are shown instead for Commission staff's "alternative formula" (see Jeff Lemieux February 17, 1999 memorandum and CBO February 1999 summary).

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

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

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

Estimated costs (+) or savings (–) under Jeanne Lambrew's illustrative Medicare legislative package
(Calendar year estimates; amounts in billions)

—Option (1): Income related premium thresholds = \$90,000 / \$100,000 singles, \$115,000 / \$125,000 couples—

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total savings, nominal dollars			Total savings, % of PL expend's		
														2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-22.9	-24.6	-26.3	-28.2	-30.3	-32.7	-35.0	-37.5	-40.0	-42.8	-45.7	-48.8	-52.0	-55.3	-7	-57	-698	-0.5%	-1.7%	-2.4%
3.5	4.0	4.7	5.3	6.1	6.9	7.8	8.8	9.9	11.1	12.4	13.8	15.4	17.0	-1	1	140	-0.1%	0.0%	0.5%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-16.6	-17.7	-19.0	-20.4	-21.9	-23.5	-25.2	-27.1	-29.0	-31.0	-33.2	-35.5	-37.8	-40.3	-16	-52	-515	-1.1%	-1.5%	-1.8%
-13.7	-14.9	-16.1	-17.5	-19.0	-20.7	-22.6	-24.7	-26.9	-29.4	-32.1	-35.0	-38.3	-41.8	-16	-42	-462	-1.1%	-1.2%	-1.6%
-30.2	-32.6	-35.2	-37.9	-40.9	-44.2	-47.8	-51.8	-55.9	-60.4	-65.2	-70.5	-76.1	-82.1	-32	-95	-977	-2.3%	-2.8%	-3.4%
68.1	72.9	77.9	83.3	89.1	95.4	101.9	108.3	115.4	122.9	130.6	138.5	146.5	154.5	90	249	2,114	6.4%	7.2%	7.2%
-34.5	-36.9	-39.5	-42.2	-45.1	-48.3	-51.7	-55.2	-58.9	-62.7	-66.7	-70.8	-74.9	-79.0	-47	-129	-1,078	-3.3%	-3.7%	-3.7%
33.6	36.0	38.4	41.1	44.0	47.1	50.2	53.1	56.5	60.2	63.9	67.7	71.6	75.5	43	120	1,036	3.1%	3.5%	3.6%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
-5.4	-5.8	-6.3	-6.7	-7.3	-7.8	-8.4	-9.0	-9.6	-10.3	-11.0	-11.7	-12.5	-13.3	-8	-20	-172	-0.6%	-0.6%	-0.6%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-120	-344	-690	-8.5%	-10.0%	-2.4%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
1.6	1.7	1.8	1.9	2.2	2.4	2.6	2.7	2.9	3.0	3.2	3.4	3.5	3.7	1	4	50	0.1%	0.1%	0.2%
-49.5	-52.9	-56.6	-60.4	-67.4	-74.8	-80.4	-86.9	-93.4	-100.3	-108.0	-116.4	-125.0	-134.5	-161	-494	-2,310	-11.4%	-14.3%	-7.9%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-5.4%	-5.4%	-5.4%	-5.3%	-5.5%	-5.7%	-5.7%	-5.8%	-5.8%	-5.8%	-5.9%	-5.9%	-5.9%	-6.0%	—	—	—	—	—	—

Estimated costs (+) or savings (–) under Jeanne Lambrew's illustrative Medicare legislative package

(Calendar year estimates; amounts in billions)

—Option (2): Income related premium thresholds = \$60,000 / \$110,000 singles, \$90,000 / \$150,000 couples—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders.....	\$0.0	\$0.0	-\$0.4	-\$2.4	-\$4.3	-\$6.5	-\$8.9	-\$11.0	-\$11.3	-\$12.2	-\$13.2	-\$14.3	-\$15.5	-\$16.8	-\$18.2	-\$19.7	-\$21.3
Cost sharing changes.....	-0.3	-0.3	-0.2	-0.1	0.0	0.1	0.2	0.3	0.5	0.7	0.9	1.1	1.4	1.7	2.1	2.5	3.0
Modernization proposals.....	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME.....	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact.....	2.3	-3.6	-3.8	-4.8	-5.9	-6.2	-6.7	-7.3	-7.9	-8.5	-9.3	-10.1	-11.0	-12.0	-13.1	-14.1	-15.3
Income-related premium.....	-2.9	-3.3	-3.6	-3.9	-4.3	-4.7	-5.2	-5.7	-6.2	-6.9	-7.6	-8.4	-9.3	-10.2	-11.2	-12.2	-13.4
Premium support subtotal..	-0.7	-6.9	-7.4	-8.7	-10.2	-10.9	-11.9	-12.9	-14.1	-15.4	-16.9	-18.5	-20.3	-22.2	-24.2	-26.4	-28.7
Drug coverage:																	
Expenditure impact.....	0.0	20.0	21.5	23.2	25.1	27.1	29.2	31.5	34.1	36.9	40.1	43.5	47.2	51.1	55.1	59.2	63.5
Premium impact.....	0.0	-10.4	-11.2	-12.1	-13.0	-14.0	-15.1	-16.3	-17.6	-19.0	-20.5	-22.1	-24.0	-26.0	-28.0	-30.0	-32.2
Drug coverage subtotal.....	0.0	9.6	10.3	11.1	12.1	13.1	14.1	15.2	16.5	17.9	19.6	21.4	23.2	25.1	27.1	29.2	31.3
Change in age of eligibility.....	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
Admin. Budget proposals.....	-1.3	-1.5	-1.6	-1.7	-1.9	-2.0	-2.1	-2.3	-2.5	-2.7	-2.9	-3.2	-3.6	-3.9	-4.2	-4.6	-5.0
"Budget surplus" revenues.....	-17.6	-19.6	-27.2	-26.0	-29.5	-32.6	-40.0	-45.4	-50.0	-55.7	-60.9	-65.9	-70.2	-73.7	-75.5	0.0	0.0
Medigap regulation changes..	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions.....	0.0	0.1	0.1	0.2	0.3	0.5	0.6	0.7	0.8	1.0	1.0	1.0	1.2	1.3	1.4	1.4	1.5
Total savings.....	-26.2	-25.2	-33.2	-35.5	-42.5	-48.5	-59.5	-68.6	-75.3	-84.2	-90.9	-97.6	-105.5	-112.7	-116.7	-44.1	-47.0
Total present law expend's.....	251	264	279	297	321	346	373	404	438	475	518	562	613	668	725	786	850
Savings as % of expend's.....	-10.4%	-9.6%	-11.9%	-11.9%	-13.3%	-14.0%	-16.0%	-17.0%	-17.2%	-17.8%	-17.6%	-17.4%	-17.2%	-16.9%	-16.1%	-5.6%	-5.5%

Notes: 1. Refer to specification summaries for description of provisions. NB: Premium support formula is not Jeanne's "rebate" specification; pending further review of Jeanne's specifications, estimates are shown instead for Commission staff's "alternative formula" (see Jeff Lemieux February 17, 1999 memorandum and CBO February 1999 summary).

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

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

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

Estimated costs (+) or savings (–) under Joint and separate Lambrew's illustrative health care legislative package
(Calendar year estimates; amounts in billions)

—Option (2): Income related premium thresholds = \$60,000 / \$110,000 singles, \$90,000 / \$150,000 couples—

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total savings, nominal dollars			Total savings, % of PL expenditures		
														2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-\$22.9	-\$24.6	-\$26.3	-\$28.2	-\$30.3	-\$32.7	-\$35.0	-\$37.5	-\$40.0	-\$42.8	-\$45.7	-\$48.8	-\$52.0	-\$55.3	-\$7	-\$57	-\$698	-0.5%	-1.7%	-2.4%
3.5	4.0	4.7	5.3	6.1	6.9	7.8	8.8	9.9	11.1	12.4	13.8	15.4	17.0	-1	1	140	-0.1%	0.0%	0.5%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-16.6	-17.7	-19.0	-20.4	-21.9	-23.5	-25.2	-27.1	-29.0	-31.0	-33.2	-35.5	-37.8	-40.3	-16	-52	-515	-1.1%	-1.5%	-1.8%
-14.6	-15.9	-17.2	-18.6	-20.2	-21.9	-23.8	-26.0	-28.2	-30.7	-33.4	-36.4	-39.7	-43.3	-18	-47	-489	-1.3%	-1.4%	-1.7%
-31.2	-33.6	-36.2	-39.0	-42.1	-45.4	-49.0	-53.0	-57.2	-61.7	-66.6	-71.9	-77.5	-83.5	-34	-99	-1,005	-2.4%	-2.9%	-3.4%
68.1	72.9	77.9	83.3	89.1	95.4	101.9	108.3	115.4	122.9	130.6	138.5	146.5	154.5	90	249	2,114	6.4%	7.2%	7.2%
-34.5	-36.9	-39.5	-42.2	-45.1	-48.3	-51.7	-55.2	-58.9	-62.7	-66.7	-70.8	-74.9	-79.0	-47	-129	-1,078	-3.3%	-3.7%	-3.7%
33.6	36.0	38.4	41.1	44.0	47.1	50.2	53.1	56.5	60.2	63.9	67.7	71.6	75.5	43	120	1,036	3.1%	3.5%	3.6%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
-5.4	-5.8	-6.3	-6.7	-7.3	-7.8	-8.4	-9.0	-9.6	-10.3	-11.0	-11.7	-12.5	-13.3	-8	-20	-172	-0.6%	-0.6%	-0.6%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-120	-344	-690	-8.5%	-10.0%	-2.4%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
1.6	1.7	1.8	1.9	2.2	2.4	2.6	2.7	2.9	3.0	3.2	3.4	3.5	3.7	1	4	50	0.1%	0.1%	0.2%
-50.4	-53.9	-57.6	-61.5	-68.5	-75.9	-81.6	-88.2	-94.7	-101.6	-109.4	-117.8	-126.4	-135.9	-163	-499	-2,337	-11.5%	-14.5%	-8.0%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-5.5%	-5.5%	-5.5%	-5.4%	-5.6%	-5.8%	-5.8%	-5.9%	-5.9%	-5.9%	-5.9%	-6.0%	-6.0%	-6.1%	—	—	—	—	—	—

Estimated costs (+) or savings (-) under Jeanne Lambrew's illustrative Medicare legislative package
(Calendar year estimates; amounts in billions)

—Option (3): Income related premium thresholds = \$50,000 / \$100,000 singles, \$75,000 / \$150,000 couples—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
BBA extenders.....	\$0.0	\$0.0	-\$0.4	-\$2.4	-\$4.3	-\$6.5	-\$8.9	-\$11.0	-\$11.3	-\$12.2	-\$13.2	-\$14.3	-\$15.5	-\$16.8	-\$18.2	-\$19.7	-\$21.3
Cost sharing changes.....	-0.3	-0.3	-0.2	-0.1	0.0	0.1	0.2	0.3	0.5	0.7	0.9	1.1	1.4	1.7	2.1	2.5	3.0
Modernization proposals.....	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-3.1	-3.3	-3.6	-3.8	-4.1	-4.5	-4.8
Removal of DME.....	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-5.9	-6.2	-6.5	-6.7	-7.0	-7.4	-7.7
Premium support:																	
Net expenditure impact.....	2.3	-3.6	-3.8	-4.8	-5.9	-6.2	-6.7	-7.3	-7.9	-8.5	-9.3	-10.1	-11.0	-12.0	-13.1	-14.1	-15.3
Income-related premium.....	-3.7	-4.2	-4.5	-4.9	-5.3	-5.8	-6.3	-6.9	-7.6	-8.3	-9.2	-10.1	-11.0	-12.0	-13.2	-14.4	-15.6
Premium support subtotal.....	-1.4	-7.8	-8.3	-9.7	-11.2	-12.0	-13.1	-14.2	-15.5	-16.9	-18.5	-20.2	-22.1	-24.1	-26.2	-28.5	-30.9
Drug coverage:																	
Expenditure impact.....	0.0	20.0	21.5	23.2	25.1	27.1	29.2	31.5	34.1	36.9	40.1	43.5	47.2	51.1	55.1	59.2	63.5
Premium impact.....	0.0	-10.4	-11.2	-12.1	-13.0	-14.0	-15.1	-16.3	-17.6	-19.0	-20.5	-22.1	-24.0	-26.0	-28.0	-30.0	-32.2
Drug coverage subtotal.....	0.0	9.6	10.3	11.1	12.1	13.1	14.1	15.2	16.5	17.9	19.6	21.4	23.2	25.1	27.1	29.2	31.3
Change in age of eligibility.....	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-8.0	-8.3	-10.2	-12.1	-12.2	-12.9	-13.5
Admin. Budget proposals.....	-1.3	-1.5	-1.6	-1.7	-1.9	-2.0	-2.1	-2.3	-2.5	-2.7	-2.9	-3.2	-3.6	-3.9	-4.2	-4.6	-5.0
"Budget surplus" revenues.....	-17.6	-19.6	-27.2	-26.0	-29.5	-32.6	-40.0	-45.4	-50.0	-55.7	-60.9	-65.9	-70.2	-73.7	-75.5	0.0	0.0
Medigap regulation changes.....	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-1.6	-1.7	-1.7	-1.8
Interactions.....	0.0	0.1	0.1	0.2	0.3	0.5	0.6	0.7	0.8	1.0	1.0	1.0	1.2	1.3	1.4	1.4	1.5
Total savings.....	-26.9	-26.0	-34.1	-36.5	-43.5	-49.7	-60.7	-69.8	-76.7	-85.7	-92.4	-99.3	-107.3	-114.6	-118.7	-46.2	-49.3
Total present law expend's.....	251	264	279	297	321	346	373	404	438	475	516	562	613	668	725	786	850
Savings as % of expend's.....	-10.8%	-9.9%	-12.3%	-12.3%	-13.6%	-14.4%	-16.3%	-17.3%	-17.5%	-18.1%	-17.9%	-17.7%	-17.5%	-17.2%	-16.4%	-5.9%	-5.8%

Notes: 1. Refer to specification summaries for description of provisions. NB: Premium support formula is not Jeanne's "rebate" specification; pending further review of Jeanne's specifications, estimates are shown instead for Commission staff's "alternative formula" (see Jeff Lemieux February 17, 1999 memorandum and CBO February 1999 summary).

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

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

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

Estimated costs (+) or savings (-) under Jeanne Lambrew's Illustrative Medicare legislative package

(Calendar year estimates; amounts in billions)

—Option (3): Income related premium thresholds = \$50,000 / \$100,000 singles, \$75,000 / \$150,000 couples—

2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Total savings, nominal dollars			Total savings, % of PL expend's		
														2000-04	2000-09	2000-30	2000-04	2000-09	2000-30
-22.9	-24.6	-26.3	-28.2	-30.3	-32.7	-35.0	-37.5	-40.0	-42.8	-45.7	-48.8	-52.0	-55.3	-7	-57	-698	-0.5%	-1.7%	-2.4%
3.5	4.0	4.7	5.3	6.1	6.9	7.8	8.8	9.9	11.1	12.4	13.8	15.4	17.0	-1	1	140	-0.1%	0.0%	0.5%
-5.2	-5.6	-6.0	-6.4	-6.9	-7.5	-8.1	-8.7	-9.4	-10.2	-11.0	-11.9	-12.8	-13.8	-9	-22	-173	-0.7%	-0.6%	-0.6%
-8.0	-8.4	-8.8	-9.2	-9.6	-9.9	-10.7	-11.4	-12.2	-13.1	-14.0	-15.0	-15.9	-17.0	-20	-46	-257	-1.4%	-1.3%	-0.9%
-16.6	-17.7	-19.0	-20.4	-21.9	-23.5	-25.2	-27.1	-29.0	-31.0	-33.2	-35.5	-37.8	-40.3	-16	-52	-515	-1.1%	-1.5%	-1.8%
-17.0	-18.3	-19.8	-21.3	-23.0	-24.8	-26.8	-29.1	-31.5	-34.1	-36.9	-40.0	-43.4	-47.1	-23	-58	-556	-1.8%	-1.7%	-1.9%
-33.8	-36.1	-38.8	-41.7	-44.9	-48.3	-52.1	-56.2	-60.5	-65.1	-70.1	-75.5	-81.2	-87.3	-38	-110	-1,072	-2.7%	-3.2%	-3.7%
68.1	72.9	77.9	83.3	89.1	95.4	101.9	108.3	115.4	122.9	130.6	138.5	146.5	154.5	90	249	2,114	6.4%	7.2%	7.2%
-34.5	-36.9	-39.5	-42.2	-45.1	-48.3	-51.7	-55.2	-58.9	-62.7	-66.7	-70.8	-74.9	-79.0	-47	-129	-1,078	-3.3%	-3.7%	-3.7%
33.6	36.0	38.4	41.1	44.0	47.1	50.2	53.1	56.5	60.2	63.9	67.7	71.6	75.5	43	120	1,036	3.1%	3.5%	3.6%
-14.4	-15.6	-16.8	-18.1	-22.3	-26.5	-28.4	-30.5	-32.6	-34.9	-37.4	-40.1	-42.8	-45.7	-2	-25	-509	-0.1%	-0.7%	-1.7%
-5.4	-5.8	-6.3	-6.7	-7.3	-7.8	-8.4	-9.0	-9.6	-10.3	-11.0	-11.7	-12.5	-13.3	-8	-20	-172	-0.6%	-0.6%	-0.6%
0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-120	-344	-690	-8.5%	-10.0%	-2.4%
-1.9	-2.0	-2.1	-2.2	-2.4	-2.5	-2.6	-2.7	-2.9	-3.0	-3.2	-3.3	-3.4	-3.6	-5	-11	-60	-0.4%	-0.3%	-0.2%
1.6	1.7	1.8	1.9	2.2	2.4	2.6	2.7	2.9	3.0	3.2	3.4	3.5	3.7	1	4	50	0.1%	0.1%	0.2%
-52.8	-56.4	-60.2	-64.2	-71.3	-78.8	-84.6	-91.3	-98.0	-105.0	-112.9	-121.4	-130.1	-139.7	-167	-510	-2,404	-11.8%	-14.8%	-8.2%
920	986	1,057	1,133	1,216	1,307	1,402	1,503	1,609	1,722	1,843	1,970	2,101	2,237	—	—	—	—	—	—
-5.7%	-5.7%	-5.7%	-5.7%	-5.9%	-6.0%	-6.0%	-6.1%	-6.1%	-6.1%	-6.1%	-6.2%	-6.2%	-6.2%	—	—	—	—	—	—

TOTAL F.08

	Final State Food Stamp Proposal	Recommended Food Stamp Adjustment	Final State Medicaid Proposal	Recommended Medicaid Determination	Total Final State Submission	Total Proposed Determination
1a	\$1.37	\$1.37	\$1.37	\$1.37	\$2.74	\$2.74
	\$0.00	\$1.05	\$0.00	\$1.05	\$0.00	\$2.10
Arizona	\$5.68	\$5.68	\$5.68	\$5.68	\$11.36	\$11.36
Arkansas	\$1.61	\$1.61	\$1.61	\$1.61	\$3.22	\$3.22
California	\$58.85	\$58.85	\$68.80	\$68.80	\$127.65	\$127.65
Colorado	\$0.79	\$2.77	\$0.00	\$2.77	\$0.79	\$5.54
Connecticut	\$0.91	\$2.73	\$4.75	\$4.37	\$5.66	\$7.10
Delaware	\$0.00	\$1.00	\$0.00	\$1.00	\$0.00	\$2.00
Florida	\$1.41	\$14.41	\$27.40	\$14.41	\$28.81	\$28.82
Georgia	\$0.00	\$0.00	\$0.00	\$12.82	\$0.00	\$12.82
Hawaii	\$0.00	\$0.00	\$0.00	\$0.99	\$0.00	\$0.99
Idaho	\$0.00	\$1.50	\$0.00	\$1.50	\$0.00	\$3.00
Illinois	\$9.50	\$9.16	\$10.99	\$14.39	\$20.49	\$23.55
Indiana	\$0.95	\$1.11	\$3.25	\$4.61	\$4.20	\$5.72
Iowa	\$0.98	\$0.98	\$0.00	\$0.00	\$0.98	\$0.98
Kansas	\$0.99	\$1.60	\$0.99	\$1.60	\$1.98	\$3.20
Kentucky	\$0.00	\$4.30	\$0.00	\$4.30	\$0.00	\$8.60
Louisiana	\$0.00	\$1.10	\$0.00	\$1.10	\$0.00	\$2.20
Maine	\$0.60	\$0.60	\$0.76	\$0.76	\$1.36	\$1.36
Maryland	\$1.19	\$1.19	\$5.38	\$5.38	\$6.57	\$6.57
Massachusetts	\$2.58	\$2.08	\$6.90	\$9.84	\$9.48	\$11.92
Michigan	\$0.16	\$4.78	\$10.12	\$11.06	\$10.28	\$15.84
Minnesota	\$1.22	\$2.38	\$1.53	\$2.24	\$2.75	\$4.62
Mississippi	\$0.98	\$2.10	\$0.00	\$2.10	\$0.98	\$4.20
Missouri	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Montana	\$0.16	\$0.65	\$0.29	\$0.65	\$0.45	\$1.30
Nebraska	\$0.00	\$0.55	\$0.00	\$0.55	\$0.00	\$1.10
Nevada	\$0.00	\$1.78	\$0.00	\$1.78	\$0.00	\$3.56
New Hampshire	\$0.76	\$0.88	\$0.76	\$0.88	\$1.52	\$1.76
New Jersey	\$8.67	\$9.13	\$13.02	\$14.61	\$21.69	\$23.74
New Mexico	\$0.00	\$1.42	\$0.00	\$1.42	\$0.00	\$2.84
New York	\$55.60	\$63.33	\$46.74	\$53.79	\$102.34	\$117.12
N Carolina	\$0.00	\$0.00	\$5.38	\$12.99	\$5.38	\$12.99
N Dakota	\$0.31	\$0.31	\$0.64	\$0.64	\$0.95	\$0.95
Ohio	\$0.21	\$5.84	\$0.33	\$5.84	\$0.54	\$11.68
Oklahoma	\$0.00	\$4.12	\$0.00	\$4.12	\$0.00	\$8.24
Oregon	\$2.48	\$5.37	\$1.03	\$5.37	\$3.51	\$10.74
Pennsylvania	\$0.10	\$0.10	\$0.00	\$0.00	\$0.10	\$0.10
Rhode Island	\$0.00	\$0.09	\$0.00	\$1.37	\$0.00	\$1.46
S Carolina	\$0.45	\$1.78	\$0.43	\$1.72	\$0.88	\$3.50
S Dakota	\$0.18	\$0.18	\$0.67	\$0.67	\$0.85	\$0.85
Tennessee	\$2.26	\$2.26	\$2.51	\$2.51	\$4.77	\$4.77
Texas	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Utah	\$1.14	\$1.14	\$1.14	\$1.14	\$2.28	\$2.28
Vermont	\$0.00	\$0.44	\$0.00	\$0.44	\$0.00	\$0.88
Virginia	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Washington	\$2.28	\$2.28	\$6.24	\$6.24	\$8.52	\$8.52
West Virginia	\$0.00	\$0.57	\$0.00	\$0.57	\$0.00	\$1.14
Wisconsin	\$0.00	\$0.00	\$6.96	\$6.96	\$6.96	\$6.96
Wyoming	\$0.38	\$0.39	\$0.38	\$0.39	\$0.76	\$0.78
Total	\$0.63	\$1.62	\$0.63	\$1.62	\$1.26	\$3.24
Total	\$165.38	\$226.58	\$236.68	\$300.02	\$402.06	\$526.60



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

Dan L. Crippen
Director

February 18, 1999

The Honorable John B. Breaux
United States Senate
Washington, D.C. 20510

Dear Senator:

I am pleased to respond to your letter of February 4. We do not have specifics on many aspects of your proposal, so our response may be less precise than you or others would prefer. However, I hope that what we say is at least helpful and that we can continue to assist you as you refine your proposal. I believe that the most important piece of the analysis at this stage is to get the questions right and begin to suggest how your proposal might change the Medicare program.

Summary

Under current law, health plans in the Medicare program compete on the basis of covered benefits and quality of service, not on price. Your proposal would foster greater competition among plans and greater choice for beneficiaries. We believe increased competition will reduce costs. As the attached paper indicates, the details that remain to be specified would determine the ultimate effectiveness of the proposal in slowing the growth of Medicare's costs. But the general direction of the proposal is clearly promising.

Reducing Medicare's costs should not be the only goal of reform. Costs could be reduced—without necessarily ensuring Medicare's long-term financial stability—by cutting payments to providers, reducing access to services, or making other changes that are likely to reduce the welfare of Medicare beneficiaries. An effective reform would introduce strong new incentives for efficiency. Other important goals of reform include ensuring an acceptable level of quality and access to services and allowing maximum flexibility for beneficiaries to choose a plan that meets their needs. Needless to say, proposals must also be feasible to implement. Designing a proposal that meets all of those goals is clearly a tall order!

The Honorable John B. Breaux
February 18, 1999
Page Two

Your proposal attempts to address those issues. Its ultimate success will depend on the details of its design and on the interaction of a restructured Medicare program with other programs.

The Congressional Budget Office (CBO) does not have the ability to assess alternative policies with any precision once we move past the 10-year budget window. Like the Medicare trustees, we have projections only over the long term—projections that make assumptions about general changes in policy. By contrast, long-term analyses require a baseline free of unreasonable assumptions about the course of spending without major policy interventions.

Discussion

Although we cannot provide a cost estimate of your proposal, we can offer a preliminary analysis that is perhaps less satisfying but potentially more informative. We suggest a few principles by which to assess the potential for changes in policy to reform Medicare. Those principles are certainly related yet different enough to justify their separate consideration.

First, we believe that introducing competition into the Medicare program could help to reduce costs in both the short and the long run. A premium support system that resulted in effective price competition among plans would most likely lower Medicare costs.

Second, Medicare reforms should also enhance efficiency—the productive use of medical resources. If beneficiaries face choices among health plans, they tend to recognize more readily the trade-offs those choices entail. Allowing greater choice results in a more effective use of health care resources. Another issue related to efficiency is the considerable excess capacity that exists in the U.S. system for delivering health care. In 1997, for example, about 40 percent of all hospital beds went unoccupied on an average day, even though the number of beds had declined by 20,000 from the year before. Similarly, there is some evidence of an oversupply of physicians, at least in particular markets. Your proposal could help to reduce some of the costs associated with the inefficient use of health resources.

Third, reforms that improved efficiency could maintain the quality of health care while reducing its costs. The goal of any change in policy should be to at least maintain the system's quality, if not improve it. Unfortunately, there is little agreement about how to measure the quality of health care, particularly for the

elderly. What is clear is that improving quality is not synonymous with increasing expenditures.

Your proposal would maintain the government's large contribution toward the care of Medicare beneficiaries. That contribution level is well in excess of the level in health insurance programs for federal employees, such as the Federal Employees Health Benefits Program (FEHBP). Expanding pharmaceutical coverage in private plans—to the extent the costs do not squeeze out other, more effective treatment—could improve the quality of care. Again, the specific design aspects of the reform proposal will have a critical bearing on the actual outcome of the policy.

Fourth, allowing beneficiaries to choose among multiple plans will help to modernize the Medicare program and allow the elderly to select benefits that are more closely aligned with their needs. As the commission knows, most Medicare beneficiaries are still enrolled in the traditional program formulated 35 years ago, which has significant gaps in coverage compared with the typical employer-sponsored plan of today.

Finally, it is obvious but true that any reform proposal must actually work—that is, it must create a system of rules under which the intended effects can actually occur. Of course, there are practical limits on how burdensome and intrusive such a system might be. Your proposal is modeled in part on the FEHBP, which could provide useful guidance for implementation. However, a restructured Medicare program would be considerably more complex than the FEHBP. The additional responsibilities of the proposed Medicare Board, the potential expansion of the number of competing plans, and the large number of Medicare beneficiaries make the implementation of reform a formidable challenge.

Medicare's many interactions with current programs will affect the ultimate success of any reform, and two of those interactions merit particular mention. Most fee-for-service enrollees have supplemental insurance coverage through medigap policies, employer-sponsored insurance, or Medicaid. That additional coverage increases Medicare spending by encouraging greater use of services. To the extent reforms mitigate that incentive, Medicare spending could be reduced. In addition, restructuring Medicare would establish a new, complex relationship between the Medicare and Medicaid programs. That relationship could have important implications for federal costs and the quality of care for dually eligible beneficiaries.

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February 18, 1999
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Estimating Issues

Reforming programs such as Social Security and Medicare is challenging for many reasons, not least because of the need to assess the long-term effects of any change. Although the solvency of Medicare's Hospital Insurance Trust Fund has been the focus of much policy debate, we know that it is not an accurate measure of the fiscal health of the program.

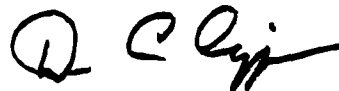
We also know that the Medicare trustees' long-term projections of spending include assumptions about future, unspecified changes in behavior and policy. The trustees essentially assume that Medicare's increasing claim on the economy and the federal budget—following Herb Stein's dictum—"cannot go on forever" and that something will happen to slow the growth in spending.

They are clearly right in that assumption, but by itself, the assumption provides little help in assessing the impact of various policies. Indeed, it may well be your policy proposal that will produce their outcome. However, it is simply not legitimate to "score" or compare any proposal with the trustees' projections. For long-run comparisons, a baseline is needed that is free of unreasonable assumptions about the course of spending without major policy interventions.

Senator, I am sure this is both more and less than what you expected as a response. Issues of health care are unusually complex, but we can also get lost in the complexity and in the elegance of our analysis. I think it is important to keep in mind a set of principles for reform and to try to assess the desirability of any plan relative to those principles. We certainly have not cornered the market on defining such principles, or assessing the impacts, but I hope this response provides a useful template for further consideration.

If you have any question about CBO's analysis, please call me. If your staff has any questions, they may call Joseph Antos or Linda Bilheimer at 226-2666.

Sincerely,



Dan L. Crippen
Director

c: The Honorable William M. Thomas

Enclosure

A PRELIMINARY REVIEW OF THE PREMIUM SUPPORT MODEL
AS A FOUNDATION FOR MEDICARE REFORM

Congressional Budget Office
February 1999

OVERVIEW

The aging of the baby boomers will place unprecedented demands on the Medicare program. Between 2010 and 2030, the elderly population will grow at an annual rate of almost 3 percent, rising from 39 million to 69 million. Medicare costs are likely to grow considerably faster than program enrollment because costs per beneficiary are also likely to increase rapidly. To reduce the growing share of the nation's resources that the Medicare program would otherwise absorb, major policy changes are necessary to slow the rise in costs per beneficiary.

The Bipartisan Commission on Medicare Reform is considering a premium support model as a basis for restructuring the Medicare program. That approach, which adopts some of the attributes of the Federal Employees Health Benefits Program (FEHBP), is intended to produce greater competition among health plans serving the Medicare population and greater choice for beneficiaries. A premium support system that resulted in effective price competition among health plans would have the potential to lower Medicare's costs.

BACKGROUND

Under current law, Medicare beneficiaries may enroll in the traditional fee-for-service plan or in private health plans that serve Medicare beneficiaries in the Medicare+Choice (M+C) market. The large majority of enrollees have chosen to remain in the fee-for-service program, but the Congressional Budget Office (CBO) projects that the percentage of beneficiaries in private plans will double over the next 10 years, rising from 15 percent in 1999 to 31 percent in 2009. By contrast, more than 85 percent of workers with employer-sponsored health coverage are currently in some form of managed care plan.

Most beneficiaries in the traditional program have some form of supplemental coverage to pay for their deductibles and copayments. Almost one-third of those beneficiaries pay for private medigap insurance; a similar proportion obtains supplemental coverage as a retirement benefit from former employers. Supplemental coverage raises Medicare's costs because beneficiaries who do not face cost-sharing requirements use more of the services covered by the program. Medigap premiums are rising rapidly, however, and employers are becoming less willing to provide coverage for retirees. Those factors will contribute to growth in the proportion of beneficiaries enrolling in managed care plans that have low cost-sharing requirements and provide additional benefits, such as prescription drug coverage.

Before enactment of the Balanced Budget Act of 1997 (BBA), Medicare's payments to health plans were based on average fee-for-service costs in each county.

That system resulted in wide variations in payments to plans and considerable volatility in payments from year to year. It also meant that plans had incentives to compete on the basis of the benefits they covered rather than on price.

The BBA introduced Medicare+Choice with the intent of reducing payment variation and volatility. In each county, the payment that health plans now receive is the highest of:

- A blend of the local rate and a price-adjusted national average rate;
- A floor amount; or
- A rate 2 percent higher than the previous year's rate for that county.

The annual growth in the components of the blended rate and in the floor amount is determined by the projected growth in per capita spending in the fee-for-service sector, less a statutory reduction for 1998 through 2002. Other payment changes in the BBA will also lower payments to health plans. Thus, before the act, Medicare paid plans about 95 percent of per capita costs in the fee-for-service sector, but that rate will drop to about 90 percent when the BBA provisions are fully phased in. Nonetheless, the rate of increase in payments to plans remains tied to growth in per capita spending in the fee-for-service sector. More fundamentally, the payments that plans receive are still unrelated to their performance.

Program rules foster competition among M+C plans on the basis of expanding benefits rather than lowering premiums. If an M+C plan makes profits that are higher than the Medicare rules allow, the excess must be returned to enrollees as additional benefits. Plans may not offer rebates to enrollees. (Excess profits could be returned in the form of a rebate to the federal government, but all plans prefer to offer additional benefits because of the obvious marketing advantage.) Beneficiaries pay a premium (in addition to the Medicare Part B premium, which all beneficiaries pay) only if the cost of the plan that they select is higher than Medicare's payment. However, only a minority of health plans currently charge an extra premium.

THE PROPOSAL

The premium support approach would tie the government's contribution for each health plan, including traditional Medicare, to the national weighted average premium. Beneficiaries selecting lower-cost plans would have a larger share of their premium subsidized by Medicare than those selecting higher-cost plans, and the core benefits offered by plans could vary only within a limited range. Two options are

under consideration; they differ only in the schedule of federal premium contributions.

This preliminary assessment of the proposal is based on the following assumptions, which CBO staff developed after discussions with commission staff and receipt of a letter dated February 4, 1999, from Senator Breaux.

- Medicare would offer beneficiaries a choice of enrolling in a private health plan or a government-run fee-for-service program. The traditional program would receive capitation payments like any other participating plan, and the federal government would refrain from bailing it out even if the program ran into financial difficulties. Moreover, the federal government would regulate the Medicare market without giving preference to the traditional program, thus ensuring a level playing field for all plans.
- In order to survive in a competitive environment, the fee-for-service program would be allowed to compete aggressively with private plans. Traditional Medicare would adopt the same tools that private plans use to manage costs. Cost-cutting or revenue-raising strategies might include:
 - Authority to negotiate prices with providers;
 - Exclusive contracting;
 - Restricted provider panels;
 - Increases in premiums and cost-sharing requirements; and
 - Reductions in covered benefits.
- The government's contribution would depend on the premium charged by each health plan but would be capped. The maximum premium contribution paid by the government would equal about 88 percent of the national average.
- Under Option I of the proposal, beneficiaries would pay:
 - 10 percent of the total premium for plans with premiums set at 90 percent of the national average or below.
 - Approximately 33 percent of the additional costs for plans with premiums that were between 90 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average.)

- 100 percent of the additional costs for plans with premiums that were above the national average.

(Option II is discussed later in this attachment.)

- Under both options, the premium contributions made by beneficiaries would depend solely on the plan that they chose. People choosing the same plan in different parts of the country would make the same contribution, regardless of the local cost differences. By the same token, plans seeking to serve a particular market would quote a premium to Medicare that reflected their charges for a national average population.
- A newly created Medicare Board would oversee the program. It would have greater responsibilities than the Office of Personnel Management (OPM) exercises in its oversight of the FEHBP.
 - The board would negotiate with the private plans regarding their core benefits and the premiums they charged for those benefits. The government's contribution would be based on the national weighted average of those premiums and the premium charged by the traditional fee-for-service program. The board would ensure that the actuarial value of the core benefits varied by no more than 10 percent among plans.
 - For the purpose of calculating the government's contribution, private plans could include prescription drugs among their core benefits. The costs of dental, vision, and hearing benefits would not be included in the calculation, even though many M+C plans now offer those benefits as an integral part of their coverage. The traditional fee-for-service plan would not offer a drug benefit.
 - The board would adjust payment amounts to plans to reflect the costs of doing business in different geographic locations. Whether that adjustment would incorporate some of the cost differences that result from differences in the use of health services is unclear. But the proposal's intent is for per capita payments to vary less among plans than they do today.
 - Payments to health plans would be adjusted for risk as well, but the proposal does not specify the form of risk adjustment. CBO has assumed the same course for risk adjustment as

under current law. That is, risk adjustment would initially reflect use of inpatient hospital services, and a broader system that incorporated the use of other services would be developed at some time in the future.

KEY ISSUES REQUIRING CLARIFICATION

Those assumptions, and other design elements not listed above, would determine the effectiveness of the commission's premium support approach in slowing the growth of Medicare spending. Changing any key element of the proposal could have a profound impact on program costs. Some of the more important aspects of the proposal that need further clarification include:

- *The terms on which the traditional fee-for-service program would compete with private plans.* Would the traditional program have to survive on the capitation payments it received, without the possibility of receiving additional federal subsidies were losses to occur? Would it be able to use all of the management tools that private plans employ, including the ability to contract with providers on a selective basis?
- *The authority and capability of the Medicare Board, which would play a critical role in controlling spending growth in both the short and long terms.* To what extent would the board oversee the traditional fee-for-service program? Would the board retain Medicare's existing authority to set rates and limit payments? What authority would it have to negotiate premiums with plans? How would it adjust rates for risk and geographic factors? (Effective risk adjustment would be important for the stability of a competitive Medicare market.)
- *How plans' premiums and the federal contribution would be determined.* Would the contribution be tied strictly to the premium charged for core benefits, or would there be circumstances under which plans could receive a contribution for noncore benefits as well?

In addition, it has been suggested that the premium support proposal might include a provision that would require higher-income beneficiaries to make larger premium contributions. The specifications that CBO analysts discussed with commission staff did not include a provision for means-tested premiums, and that issue is not discussed in this attachment. However, such a provision could have a significant effect on Medicare costs under a premium support system.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE SHORT TERM

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

The interaction between beneficiaries' choices of health plans and decisions by plans about what benefits to offer and what premiums to charge would affect program costs in complex ways. Many beneficiaries would make decisions that would leave government costs unchanged. For example, beneficiaries who did not change plans would not generally increase government costs. (They could cost Medicare more, however, if their plans were not already receiving the maximum government contribution and chose to raise their premiums.) In addition, as is similar to the situation in M+C today, some beneficiaries enrolled in traditional Medicare who purchased medigap policies might find a competing plan that would be an attractive alternative. Switching to a private plan might lower their own costs because they would no longer be paying a separate medigap premium, but it would not necessarily change federal costs.

Some plans might seek to expand their enrollment by enhancing their benefits while still remaining competitive in terms of price. Some M+C plans, for example, have costs below those of the fee-for-service program and charge no additional premiums. Those plans could upgrade their benefits, raise their premiums to the level of the national average, and still compete with the fee-for-service plan. Plans currently offering benefits that cost between 90 percent and 100 percent of the national average, for instance, might find that opportunity quite attractive. Their enrollees would pay only 33 cents for every dollar of increased benefits, up to the national average. Such increases would boost the national average premium in the short term.

To capitalize on the demand for lower-cost coverage, other plans might decide to reduce their benefits and market themselves as low-cost alternatives. It is reasonable to assume that some beneficiaries would move from traditional Medicare—whose premiums would be close to the national weighted average in the short term—to a more preferable plan with premiums below the national average. Government costs would fall for beneficiaries who chose less expensive health plans only if they selected plans that would receive a lower government contribution than their current plan.

The ongoing shift from the traditional fee-for-service sector to managed care that is occurring under current law could accelerate under a premium support system. With premium support, costs in the fee-for-service program would largely determine the national average premium for several years, that is, until the majority of beneficiaries were enrolled in competing plans. If people moved from traditional Medicare into lower-cost plans—those with premiums below the national weighted average—the average premium would fall. That outcome would lower the government's total contribution for premiums. In addition, the traditional program would become an increasingly costly option for beneficiaries unless it could lower its premiums as well.

The adjustments that the Medicare Board made to premiums to reflect geographic differences in health care costs could also affect the government's costs. If the adjustments reflected only differences in input costs and did not incorporate the effects of differences in service utilization, plans operating in high-cost markets might face significantly lower payments than they currently receive and might have to reduce their benefits. Conversely, plans in low-cost markets would gain from such adjustments and have more flexibility to enhance their benefits and raise their premiums. How local plans might change their benefits is uncertain, as is the resulting net effect of those changes on the national average premium.

The premium adjustments would also influence the number of plans electing to participate in different markets. The adjustments would, at best, only approximate the underlying cost differentials among geographic areas. Consequently, as they do today, plans would seek out markets in which their projected per capita costs would be significantly lower than the adjusted per capita payment—and avoid markets in which the converse was the case.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE LONG TERM

If the Medicare program became more competitive, with a much higher percentage of beneficiaries enrolled in private plans that competed on the basis of price and quality, the future growth of program spending would be more closely tied to trends in private health care markets. A major incentive for restructuring Medicare is to generate the same competitive forces within the program that the private sector experienced in the mid-1990s. Between 1993 and 1996, the growth of employer-sponsored health insurance premiums slowed dramatically as a result of the shift to managed care and increasing competition among health plans. By contrast, Medicare spending per enrollee continued to rise rapidly.

Whether recent experience in the private sector reflects longer-term spending trends is uncertain, however. Over the past year, premiums for employer-sponsored insurance have once again begun to grow more rapidly, as health plans that had held down premiums to capture a larger market share have sought to improve their profit margins. As a result, controversy has arisen about the long-term effects of managed care on prices and costs in the private health care market and whether slower cost growth associated with the shift to managed care is a one-time phenomenon.

Analysts generally agree that part of the recent slowdown in private health insurance premiums did, indeed, reflect a one-time change in the level of premiums, as employers switched their employees from higher-cost to lower-cost plans. But most analysts do not anticipate a return to the double-digit rates of growth in premiums that occurred before 1993. Both employers and health plans now function in a much more competitive health care environment than existed 10 years ago. Purchasers are likely to continue to be aggressive in pressuring plans to hold down premium growth, and plans will continue to seek innovative ways to control costs while constraining payments to providers. Moreover, persistent excess capacity in the health care system will continue to give plans leverage with providers.

If, however, the current trend toward consolidation among health plans continues, so that only a few plans operate in any market, the incentives for price competition among plans may be reduced. (The number of plans operating in a market does not necessarily predict how competitive that market will be.) But whether consolidation will continue in the long term or whether new patterns of market organization may emerge is still uncertain.

As in the private sector, analysts do not anticipate a return to double-digit growth in Medicare's per capita costs over the next decade. CBO projects that per capita spending growth in the program will be slower, on average, over the next 10 years than in the 1990s. But that projection primarily reflects payment policies affecting the traditional fee-for-service program. After 2010, the program will begin to experience the extraordinary demographic pressures associated with the retirement of the baby boomers. Addressing that boost in demand will require growth in per capita spending that is slower than the growth that will occur under current policies.

Whether a more competitive approach slowed Medicare spending in the long term would depend in part on the competitive environment that existed more generally in health care markets. It would also depend on how aggressive the Medicare Board was in its negotiations with health plans and whether the board would be allowed to negotiate with the traditional fee-for-service program.

THE ROLE OF THE BOARD

Commission staff compare the Medicare Board's role to that of OPM in overseeing the FEHBP. But if the board had limited authority to negotiate with the traditional program, its task could be much more difficult than OPM's because the traditional program would be the market leader—at least in the early years of the program. OPM exerts considerable control over the national plans that offer services under the FEHBP, especially Blue Cross and Blue Shield, which is the market leader and accounts for more than 40 percent of federal enrollment. Within the FEHBP, the national plans are the major competition for local health plans, just as the fee-for-service program is the major competition for private health plans under Medicare.

OPM seems to use its market power in modest ways to extract favorable terms from local health plans. The plans are required to provide OPM with detailed information on their premiums, and how they were developed, for the two employer groups that are closest in size to their federal employees' group. OPM uses the lower of those two rates to establish the premium for the FEHBP. Whether the Medicare Board would be able to fully exploit its considerably greater market power is uncertain.

How effective the board was in limiting the expansion of covered benefits would be of critical importance for long-term spending growth. The rate of growth of the national average premium would be a function, in part, of the services that plans included in their premiums for core benefits. There would be tremendous pressure to continue to expand those benefits as a result of the rapid development of medical technology. That pressure exists today but is likely to increase in the future, especially considering that many future medical breakthroughs will probably be targeted toward the elderly market.

Under the proposal, the board's authority with respect to prescription drugs would apparently be limited, which could have a sizable effect on program costs. The proposal would allow private plans to include the costs of prescription drugs in their premiums for core benefits. Thus, a new service with rapidly rising costs would be built into the base for determining the government's contribution, potentially causing Medicare's long-term costs to grow more rapidly as well. Initially, the effects on the national average premium would be small because most beneficiaries are in the traditional program, which would not offer drug coverage. But over time, the effect could be compounded if more beneficiaries shifted to private plans that offered drug coverage, which in turn could cause prescription drugs to become an increasingly important component of the national average premium.

Pressure by beneficiaries to expand covered benefits is also likely to grow over the next decade and beyond, regardless of any policy actions taken to reform

Medicare. When the baby boomers retire, they are going to be wealthier, on average, than previous generations of retirees. They are therefore likely to be more willing to pay for plans charging higher premiums if those plans offer richer benefits or are judged to be of higher quality. Under a premium support model, many of those plans would also have higher federal contributions. If the demand for new benefits was strong and was backed up by beneficiaries' willingness to pay for them, the board's ability to limit "benefit creep" could be compromised.

THE ALTERNATIVE OPTION

The commission has developed a second option for consideration that differs from the first only in having a different structure of government subsidies for Medicare. Beneficiaries would pay:

- Nothing for plans with premiums that were below 85 percent of the national weighted average premium.
- Approximately 75 percent of the additional costs for plans with premiums that were between 85 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average premium.)
- 100 percent of the additional costs for plans with premiums that were above the national average.

The steepness of the schedule could discourage benefit creep somewhat because beneficiaries would pay a larger share of the costs of additional benefits than they would under Option I. But given the high percentage of the premium that the government would pay—regardless of the plan a beneficiary chose—it is unclear whether small changes in beneficiaries' contributions would have much effect on their choice of health plans. The schedule might also encourage plans to establish premiums that were about 85 percent of the national average. Because such plans would probably have "lean" benefits, however, it is unclear whether they would capture a significant share of the market.

MEASUREMENT AND BASELINE ISSUES

Estimates of the long-term effects on costs of any proposal to restructure the Medicare program depend critically on the baseline against which the proposal is measured. Ideally, such a baseline would assume that current policies would continue without the introduction of significant program reforms. It is reasonable to

assume that over the long term, without restructuring the Medicare program, the government would continue to adjust its administered prices, as it has in the past, in an attempt to slow the growth in outlays.

CBO does not currently have a baseline that extends beyond a 10-year window. The Medicare trustees make long-term projections for the program that might be considered for such a purpose, but those projections assume that growth in per capita spending will decline to the rate of growth of hourly wages by 2020. Such a reduction in the rate of growth is unlikely to occur in the absence of policy actions that go significantly beyond the adjustment of administered prices.



HOUSE BUDGET COMMITTEE

DEMOCRATIC CAUCUS

Congressman John M. Spratt, Jr., Ranking Minority Member
222 O'Neill House Office Building, Washington, DC 20515 • 202-226-7200

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

Dan L. Crippen
Director

February 18, 1999

The Honorable John B. Breaux
United States Senate
Washington, D.C. 20510

Dear Senator:

I am pleased to respond to your letter of February 4. We do not have specifics on many aspects of your proposal, so our response may be less precise than you or others would prefer. However, I hope that what we say is at least helpful and that we can continue to assist you as you refine your proposal. I believe that the most important piece of the analysis at this stage is to get the questions right and begin to suggest how your proposal might change the Medicare program.

Summary

Under current law, health plans in the Medicare program compete on the basis of covered benefits and quality of service, not on price. Your proposal would foster greater competition among plans and greater choice for beneficiaries. We believe increased competition will reduce costs. As the attached paper indicates, the details that remain to be specified would determine the ultimate effectiveness of the proposal in slowing the growth of Medicare's costs. But the general direction of the proposal is clearly promising.

Reducing Medicare's costs should not be the only goal of reform. Costs could be reduced—without necessarily ensuring Medicare's long-term financial stability—by cutting payments to providers, reducing access to services, or making other changes that are likely to reduce the welfare of Medicare beneficiaries. An effective reform would introduce strong new incentives for efficiency. Other important goals of reform include ensuring an acceptable level of quality and access to services and allowing maximum flexibility for beneficiaries to choose a plan that meets their needs. Needless to say, proposals must also be feasible to implement. Designing a proposal that meets all of those goals is clearly a tall order!

The Honorable John B. Breaux
February 18, 1999
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Your proposal attempts to address those issues. Its ultimate success will depend on the details of its design and on the interaction of a restructured Medicare program with other programs.

The Congressional Budget Office (CBO) does not have the ability to assess alternative policies with any precision once we move past the 10-year budget window. Like the Medicare trustees, we have projections only over the long term—projections that make assumptions about general changes in policy. By contrast, long-term analyses require a baseline free of unreasonable assumptions about the course of spending without major policy interventions.

Discussion

Although we cannot provide a cost estimate of your proposal, we can offer a preliminary analysis that is perhaps less satisfying but potentially more informative. We suggest a few principles by which to assess the potential for changes in policy to reform Medicare. Those principles are certainly related yet different enough to justify their separate consideration.

First, we believe that introducing competition into the Medicare program could help to reduce costs in both the short and the long run. A premium support system that resulted in effective price competition among plans would most likely lower Medicare costs.

Second, Medicare reforms should also enhance efficiency—the productive use of medical resources. If beneficiaries face choices among health plans, they tend to recognize more readily the trade-offs those choices entail. Allowing greater choice results in a more effective use of health care resources. Another issue related to efficiency is the considerable excess capacity that exists in the U.S. system for delivering health care. In 1997, for example, about 40 percent of all hospital beds went unoccupied on an average day, even though the number of beds had declined by 20,000 from the year before. Similarly, there is some evidence of an oversupply of physicians, at least in particular markets. Your proposal could help to reduce some of the costs associated with the inefficient use of health resources.

Third, reforms that improved efficiency could maintain the quality of health care while reducing its costs. The goal of any change in policy should be to at least maintain the system's quality, if not improve it. Unfortunately, there is little agreement about how to measure the quality of health care, particularly for the

elderly. What is clear is that improving quality is not synonymous with increasing expenditures.

Your proposal would maintain the government's large contribution toward the care of Medicare beneficiaries. That contribution level is well in excess of the level in health insurance programs for federal employees, such as the Federal Employees Health Benefits Program (FEHBP). Expanding pharmaceutical coverage in private plans—to the extent the costs do not squeeze out other, more effective treatment—could improve the quality of care. Again, the specific design aspects of the reform proposal will have a critical bearing on the actual outcome of the policy.

Fourth, allowing beneficiaries to choose among multiple plans will help to modernize the Medicare program and allow the elderly to select benefits that are more closely aligned with their needs. As the commission knows, most Medicare beneficiaries are still enrolled in the traditional program formulated 35 years ago, which has significant gaps in coverage compared with the typical employer-sponsored plan of today.

Finally, it is obvious but true that any reform proposal must actually work—that is, it must create a system of rules under which the intended effects can actually occur. Of course, there are practical limits on how burdensome and intrusive such a system might be. Your proposal is modeled in part on the FEHBP, which could provide useful guidance for implementation. However, a restructured Medicare program would be considerably more complex than the FEHBP. The additional responsibilities of the proposed Medicare Board, the potential expansion of the number of competing plans, and the large number of Medicare beneficiaries make the implementation of reform a formidable challenge.

Medicare's many interactions with current programs will affect the ultimate success of any reform, and two of those interactions merit particular mention. Most fee-for-service enrollees have supplemental insurance coverage through medigap policies, employer-sponsored insurance, or Medicaid. That additional coverage increases Medicare spending by encouraging greater use of services. To the extent reforms mitigate that incentive, Medicare spending could be reduced. In addition, restructuring Medicare would establish a new, complex relationship between the Medicare and Medicaid programs. That relationship could have important implications for federal costs and the quality of care for dually eligible beneficiaries.

The Honorable John B. Breaux
February 18, 1999
Page Four

Estimating Issues

Reforming programs such as Social Security and Medicare is challenging for many reasons, not least because of the need to assess the long-term effects of any change. Although the solvency of Medicare's Hospital Insurance Trust Fund has been the focus of much policy debate, we know that it is not an accurate measure of the fiscal health of the program.

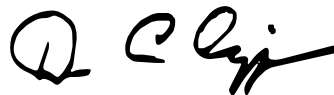
We also know that the Medicare trustees' long-term projections of spending include assumptions about future, unspecified changes in behavior and policy. The trustees essentially assume that Medicare's increasing claim on the economy and the federal budget—following Herb Stein's dictum—"cannot go on forever" and that something will happen to slow the growth in spending.

They are clearly right in that assumption, but by itself, the assumption provides little help in assessing the impact of various policies. Indeed, it may well be your policy proposal that will produce their outcome. However, it is simply not legitimate to "score" or compare any proposal with the trustees' projections. For long-run comparisons, a baseline is needed that is free of unreasonable assumptions about the course of spending without major policy interventions.

Senator, I am sure this is both more and less than what you expected as a response. Issues of health care are unusually complex, but we can also get lost in the complexity and in the elegance of our analysis. I think it is important to keep in mind a set of principles for reform and to try to assess the desirability of any plan relative to those principles. We certainly have not cornered the market on defining such principles, or assessing the impacts, but I hope this response provides a useful template for further consideration.

If you have any question about CBO's analysis, please call me. If your staff has any questions, they may call Joseph Antos or Linda Bilheimer at 226-2666.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Crippen", with a stylized flourish at the end.

Dan L. Crippen
Director

c: The Honorable William M. Thomas

Enclosure

**A PRELIMINARY REVIEW OF THE PREMIUM SUPPORT MODEL
AS A FOUNDATION FOR MEDICARE REFORM**

**Congressional Budget Office
February 1999**

OVERVIEW

The aging of the baby boomers will place unprecedented demands on the Medicare program. Between 2010 and 2030, the elderly population will grow at an annual rate of almost 3 percent, rising from 39 million to 69 million. Medicare costs are likely to grow considerably faster than program enrollment because costs per beneficiary are also likely to increase rapidly. To reduce the growing share of the nation's resources that the Medicare program would otherwise absorb, major policy changes are necessary to slow the rise in costs per beneficiary.

The Bipartisan Commission on Medicare Reform is considering a premium support model as a basis for restructuring the Medicare program. That approach, which adopts some of the attributes of the Federal Employees Health Benefits Program (FEHBP), is intended to produce greater competition among health plans serving the Medicare population and greater choice for beneficiaries. A premium support system that resulted in effective price competition among health plans would have the potential to lower Medicare's costs.

BACKGROUND

Under current law, Medicare beneficiaries may enroll in the traditional fee-for-service plan or in private health plans that serve Medicare beneficiaries in the Medicare+Choice (M+C) market. The large majority of enrollees have chosen to remain in the fee-for-service program, but the Congressional Budget Office (CBO) projects that the percentage of beneficiaries in private plans will double over the next 10 years, rising from 15 percent in 1999 to 31 percent in 2009. By contrast, more than 85 percent of workers with employer-sponsored health coverage are currently in some form of managed care plan.

Most beneficiaries in the traditional program have some form of supplemental coverage to pay for their deductibles and copayments. Almost one-third of those beneficiaries pay for private medigap insurance; a similar proportion obtains supplemental coverage as a retirement benefit from former employers. Supplemental coverage raises Medicare's costs because beneficiaries who do not face cost-sharing requirements use more of the services covered by the program. Medigap premiums are rising rapidly, however, and employers are becoming less willing to provide coverage for retirees. Those factors will contribute to growth in the proportion of beneficiaries enrolling in managed care plans that have low cost-sharing requirements and provide additional benefits, such as prescription drug coverage.

Before enactment of the Balanced Budget Act of 1997 (BBA), Medicare's payments to health plans were based on average fee-for-service costs in each county.

That system resulted in wide variations in payments to plans and considerable volatility in payments from year to year. It also meant that plans had incentives to compete on the basis of the benefits they covered rather than on price.

The BBA introduced Medicare+Choice with the intent of reducing payment variation and volatility. In each county, the payment that health plans now receive is the highest of:

- A blend of the local rate and a price-adjusted national average rate;
- A floor amount; or
- A rate 2 percent higher than the previous year's rate for that county.

The annual growth in the components of the blended rate and in the floor amount is determined by the projected growth in per capita spending in the fee-for-service sector, less a statutory reduction for 1998 through 2002. Other payment changes in the BBA will also lower payments to health plans. Thus, before the act, Medicare paid plans about 95 percent of per capita costs in the fee-for-service sector, but that rate will drop to about 90 percent when the BBA provisions are fully phased in. Nonetheless, the rate of increase in payments to plans remains tied to growth in per capita spending in the fee-for-service sector. More fundamentally, the payments that plans receive are still unrelated to their performance.

Program rules foster competition among M+C plans on the basis of expanding benefits rather than lowering premiums. If an M+C plan makes profits that are higher than the Medicare rules allow, the excess must be returned to enrollees as additional benefits. Plans may not offer rebates to enrollees. (Excess profits could be returned in the form of a rebate to the federal government, but all plans prefer to offer additional benefits because of the obvious marketing advantage.) Beneficiaries pay a premium (in addition to the Medicare Part B premium, which all beneficiaries pay) only if the cost of the plan that they select is higher than Medicare's payment. However, only a minority of health plans currently charge an extra premium.

THE PROPOSAL

The premium support approach would tie the government's contribution for each health plan, including traditional Medicare, to the national weighted average premium. Beneficiaries selecting lower-cost plans would have a larger share of their premium subsidized by Medicare than those selecting higher-cost plans, and the core benefits offered by plans could vary only within a limited range. Two options are

under consideration; they differ only in the schedule of federal premium contributions.

This preliminary assessment of the proposal is based on the following assumptions, which CBO staff developed after discussions with commission staff and receipt of a letter dated February 4, 1999, from Senator Breaux.

- Medicare would offer beneficiaries a choice of enrolling in a private health plan or a government-run fee-for-service program. The traditional program would receive capitation payments like any other participating plan, and the federal government would refrain from bailing it out even if the program ran into financial difficulties. Moreover, the federal government would regulate the Medicare market without giving preference to the traditional program, thus ensuring a level playing field for all plans.
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In addition, it has been suggested that the premium support proposal might include a provision that would require higher-income beneficiaries to make larger premium contributions. The specifications that CBO analysts discussed with commission staff did not include a provision for means-tested premiums, and that issue is not discussed in this attachment. However, such a provision could have a significant effect on Medicare costs under a premium support system.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE SHORT TERM

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

The interaction between beneficiaries' choices of health plans and decisions by plans about what benefits to offer and what premiums to charge would affect program costs in complex ways. Many beneficiaries would make decisions that would leave government costs unchanged. For example, beneficiaries who did not change plans would not generally increase government costs. (They could cost Medicare more, however, if their plans were not already receiving the maximum government contribution and chose to raise their premiums.) In addition, as is similar to the situation in M+C today, some beneficiaries enrolled in traditional Medicare who purchased medigap policies might find a competing plan that would be an attractive alternative. Switching to a private plan might lower their own costs because they would no longer be paying a separate medigap premium, but it would not necessarily change federal costs.

Some plans might seek to expand their enrollment by enhancing their benefits while still remaining competitive in terms of price. Some M+C plans, for example, have costs below those of the fee-for-service program and charge no additional premiums. Those plans could upgrade their benefits, raise their premiums to the level of the national average, and still compete with the fee-for-service plan. Plans currently offering benefits that cost between 90 percent and 100 percent of the national average, for instance, might find that opportunity quite attractive. Their enrollees would pay only 33 cents for every dollar of increased benefits, up to the national average. Such increases would boost the national average premium in the short term.

To capitalize on the demand for lower-cost coverage, other plans might decide to reduce their benefits and market themselves as low-cost alternatives. It is reasonable to assume that some beneficiaries would move from traditional Medicare—whose premiums would be close to the national weighted average in the short term—to a more preferable plan with premiums below the national average. Government costs would fall for beneficiaries who chose less expensive health plans only if they selected plans that would receive a lower government contribution than their current plan.

The ongoing shift from the traditional fee-for-service sector to managed care that is occurring under current law could accelerate under a premium support system. With premium support, costs in the fee-for-service program would largely determine the national average premium for several years, that is, until the majority of beneficiaries were enrolled in competing plans. If people moved from traditional Medicare into lower-cost plans—those with premiums below the national weighted average—the average premium would fall. That outcome would lower the government's total contribution for premiums. In addition, the traditional program would become an increasingly costly option for beneficiaries unless it could lower its premiums as well.

The adjustments that the Medicare Board made to premiums to reflect geographic differences in health care costs could also affect the government's costs. If the adjustments reflected only differences in input costs and did not incorporate the effects of differences in service utilization, plans operating in high-cost markets might face significantly lower payments than they currently receive and might have to reduce their benefits. Conversely, plans in low-cost markets would gain from such adjustments and have more flexibility to enhance their benefits and raise their premiums. How local plans might change their benefits is uncertain, as is the resulting net effect of those changes on the national average premium.

The premium adjustments would also influence the number of plans electing to participate in different markets. The adjustments would, at best, only approximate the underlying cost differentials among geographic areas. Consequently, as they do today, plans would seek out markets in which their projected per capita costs would be significantly lower than the adjusted per capita payment—and avoid markets in which the converse was the case.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE LONG TERM

If the Medicare program became more competitive, with a much higher percentage of beneficiaries enrolled in private plans that competed on the basis of price and quality, the future growth of program spending would be more closely tied to trends in private health care markets. A major incentive for restructuring Medicare is to generate the same competitive forces within the program that the private sector experienced in the mid-1990s. Between 1993 and 1996, the growth of employer-sponsored health insurance premiums slowed dramatically as a result of the shift to managed care and increasing competition among health plans. By contrast, Medicare spending per enrollee continued to rise rapidly.

Whether recent experience in the private sector reflects longer-term spending trends is uncertain, however. Over the past year, premiums for employer-sponsored insurance have once again begun to grow more rapidly, as health plans that had held down premiums to capture a larger market share have sought to improve their profit margins. As a result, controversy has arisen about the long-term effects of managed care on prices and costs in the private health care market and whether slower cost growth associated with the shift to managed care is a one-time phenomenon.

Analysts generally agree that part of the recent slowdown in private health insurance premiums did, indeed, reflect a one-time change in the level of premiums, as employers switched their employees from higher-cost to lower-cost plans. But most analysts do not anticipate a return to the double-digit rates of growth in premiums that occurred before 1993. Both employers and health plans now function in a much more competitive health care environment than existed 10 years ago. Purchasers are likely to continue to be aggressive in pressuring plans to hold down premium growth, and plans will continue to seek innovative ways to control costs while constraining payments to providers. Moreover, persistent excess capacity in the health care system will continue to give plans leverage with providers.

If, however, the current trend toward consolidation among health plans continues, so that only a few plans operate in any market, the incentives for price competition among plans may be reduced. (The number of plans operating in a market does not necessarily predict how competitive that market will be.) But whether consolidation will continue in the long term or whether new patterns of market organization may emerge is still uncertain.

As in the private sector, analysts do not anticipate a return to double-digit growth in Medicare's per capita costs over the next decade. CBO projects that per capita spending growth in the program will be slower, on average, over the next 10 years than in the 1990s. But that projection primarily reflects payment policies affecting the traditional fee-for-service program. After 2010, the program will begin to experience the extraordinary demographic pressures associated with the retirement of the baby boomers. Addressing that boost in demand will require growth in per capita spending that is slower than the growth that will occur under current policies.

Whether a more competitive approach slowed Medicare spending in the long term would depend in part on the competitive environment that existed more generally in health care markets. It would also depend on how aggressive the Medicare Board was in its negotiations with health plans and whether the board would be allowed to negotiate with the traditional fee-for-service program.

THE ROLE OF THE BOARD

Commission staff compare the Medicare Board's role to that of OPM in overseeing the FEHBP. But if the board had limited authority to negotiate with the traditional program, its task could be much more difficult than OPM's because the traditional program would be the market leader—at least in the early years of the program. OPM exerts considerable control over the national plans that offer services under the FEHBP, especially Blue Cross and Blue Shield, which is the market leader and accounts for more than 40 percent of federal enrollment. Within the FEHBP, the national plans are the major competition for local health plans, just as the fee-for-service program is the major competition for private health plans under Medicare.

OPM seems to use its market power in modest ways to extract favorable terms from local health plans. The plans are required to provide OPM with detailed information on their premiums, and how they were developed, for the two employer groups that are closest in size to their federal employees' group. OPM uses the lower of those two rates to establish the premium for the FEHBP. Whether the Medicare Board would be able to fully exploit its considerably greater market power is uncertain.

How effective the board was in limiting the expansion of covered benefits would be of critical importance for long-term spending growth. The rate of growth of the national average premium would be a function, in part, of the services that plans included in their premiums for core benefits. There would be tremendous pressure to continue to expand those benefits as a result of the rapid development of medical technology. That pressure exists today but is likely to increase in the future, especially considering that many future medical breakthroughs will probably be targeted toward the elderly market.

Under the proposal, the board's authority with respect to prescription drugs would apparently be limited, which could have a sizable effect on program costs. The proposal would allow private plans to include the costs of prescription drugs in their premiums for core benefits. Thus, a new service with rapidly rising costs would be built into the base for determining the government's contribution, potentially causing Medicare's long-term costs to grow more rapidly as well. Initially, the effects on the national average premium would be small because most beneficiaries are in the traditional program, which would not offer drug coverage. But over time, the effect could be compounded if more beneficiaries shifted to private plans that offered drug coverage, which in turn could cause prescription drugs to become an increasingly important component of the national average premium.

Pressure by beneficiaries to expand covered benefits is also likely to grow over the next decade and beyond, regardless of any policy actions taken to reform

Medicare. When the baby boomers retire, they are going to be wealthier, on average, than previous generations of retirees. They are therefore likely to be more willing to pay for plans charging higher premiums if those plans offer richer benefits or are judged to be of higher quality. Under a premium support model, many of those plans would also have higher federal contributions. If the demand for new benefits was strong and was backed up by beneficiaries' willingness to pay for them, the board's ability to limit "benefit creep" could be compromised.

THE ALTERNATIVE OPTION

The commission has developed a second option for consideration that differs from the first only in having a different structure of government subsidies for Medicare. Beneficiaries would pay:

- Nothing for plans with premiums that were below 85 percent of the national weighted average premium.
- Approximately 75 percent of the additional costs for plans with premiums that were between 85 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average premium.)
- 100 percent of the additional costs for plans with premiums that were above the national average.

The steepness of the schedule could discourage benefit creep somewhat because beneficiaries would pay a larger share of the costs of additional benefits than they would under Option I. But given the high percentage of the premium that the government would pay—regardless of the plan a beneficiary chose—it is unclear whether small changes in beneficiaries' contributions would have much effect on their choice of health plans. The schedule might also encourage plans to establish premiums that were about 85 percent of the national average. Because such plans would probably have "lean" benefits, however, it is unclear whether they would capture a significant share of the market.

MEASUREMENT AND BASELINE ISSUES

Estimates of the long-term effects on costs of any proposal to restructure the Medicare program depend critically on the baseline against which the proposal is measured. Ideally, such a baseline would assume that current policies would continue without the introduction of significant program reforms. It is reasonable to

assume that over the long term, without restructuring the Medicare program, the government would continue to adjust its administered prices, as it has in the past, in an attempt to slow the growth in outlays.

CBO does not currently have a baseline that extends beyond a 10-year window. The Medicare trustees make long-term projections for the program that might be considered for such a purpose, but those projections assume that growth in per capita spending will decline to the rate of growth of hourly wages by 2020. Such a reduction in the rate of growth is unlikely to occur in the absence of policy actions that go significantly beyond the adjustment of administered prices.

February 17, 1999

Dear Commission Member:

Enclosed please find an estimate prepared by Medicare Commission staff of the premium support proposal I put forward to the Commission last month. HCFA is working with Medicare Commission staff to refine the details of my proposal and provide its analysis of it. I also expect an analysis from CBO regarding the effects of a premium support model.

After the many constructive questions and comments I received on the proposal in our last commission meeting, in correspondence since then, and in numerous personal conversations, I have modified my original proposal and requested additional analyses from HCFA and CBO. Rather than delay the release of their analysis of my original proposal, or delay the further development of the Commission proposal, I decided to proceed on both tracks.

The modified proposal under review includes coverage of prescription drugs in the benefit package under premium support. It also includes changes to current law such as extenders of certain provisions of the 1997 Balanced Budget Act, Medigap reform to discourage first-dollar coverage of Medicare cost-sharing and certain HCFA modernization authorities. The results of these analyses will also be forthcoming shortly.

A number of events have conspired to slow down our progress toward our March 1 deadline. While I remain committed to meeting that deadline, a Commission agreement is our top priority and I realize this may take additional time. Therefore, I intend to proceed as follows:

1. Release of a Medicare Commission staff analysis of my original proposal (attached). Analyses by HCFA and CBO should be available shortly;
2. Continued modification of this proposal to reflect any and all comments that can be thoughtfully incorporated into a premium support model or for the transition period that moving to such a model would require;

3. A meeting on February 24 to fully discuss the analysis of my original proposal, and the refinements and improvements I am making to that proposal. I will endeavor to have as much analysis of this modified proposal as time will allow;

4. One or more meetings immediately thereafter to conclude the Commission work and provide our report to the Congress, the President and the American people.

The Commission was given a very difficult set of challenges to address. Our job as the National Bipartisan Commission on the Future of Medicare is in fact *the future of Medicare*, to work in a bipartisan fashion to preserve and improve the entitlement upon which millions of beneficiaries and their families rely, and to do so in a fiscally responsible manner. I believe the Commission should do its best to come up with a proposal that will accomplish this. I want to thank each one of you for your help in guiding our course toward recommendations that will alter the Medicare debate and set the course for future legislation.

Sincerely,

JOHN BREAUX
United States Senator

To: Medicare Commission

2/17/1999

From: Jeff Lemieux

I have attached an updated estimate of Senator Breaux's proposal in response to requests from several Commissioners. Conforming to the decisions of the Modeling Task Force, the estimate is focused on the long term, and uses many different measures to gauge the impact of the proposal.

Highlights:

- Using an extension of CBO's projections of health spending as a basis for the estimate, the proposal would gradually slow the growth of Medicare spending. Although the growth in outlays would be slowed by a modest 1 percent a year on average, the savings would compound to significant amounts in the long run. By 2030, annual Medicare spending would be \$475-\$850 billion less under Senator Breaux's proposal than under current law. (Absent changes in the law, the Modeling task force projected that Medicare spending would reach \$2.2 to \$2.9 trillion in 2030.)
- Under the proposal, Medicare would grow from 12 percent of the federal budget in 2000 to 21-29 percent in 2030. (Under current law, Medicare is projected to grow to 28-38 percent of the budget.) Due to rapid growth in the number of beneficiaries, and because per-beneficiary spending under the proposal would grow faster than per-capita GDP, Medicare spending would rise from 2.7 percent of the economy in 2000 to approximately 4.6-6.3 percent in 2030. (Under current law, Medicare spending would rise to 6.3-8.5 percent of GDP).
- Although beneficiaries' premiums would vary based on the plan selected, average premiums would remain at 12 percent of program costs. Because the proposal would slow the growth of program costs, beneficiary premiums would be 15-25 percent less than those expected under current law on average. If the government-run fee-for-service plan used the management tools available under Senator Breaux's proposal to slow the growth of its costs, premiums would be lower in the fee-for-service plan than under current law.
- Because the savings would accumulate slowly over time, Senator Breaux's proposal would not significantly extend the insolvency date of the Part A fund. The proposal does not lend itself to continuing the distinction between Parts A and B, however, and although the estimates attempt to compute results for the Part A fund, those results are especially uncertain. (Recently enacted and proposed transfers between Parts A and Part B of Medicare and from the general Treasury to Part A have weakened the analytic usefulness of the Part A fund's finances. The Modeling Task Force concentrated on broader measures, such as those above.)

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

Data Update:

- Medicare spending grew very slowly in fiscal year 1998, and Medicare spending will probably grow slowly in 1999 as well. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.
- New Medicare estimates from CBO show slightly lower Medicare spending and slowed enrollment in private plans in the short run. Because the reasons for those changes are probably temporary, neither change would significantly affect the 30-year projections used in the estimate of Senator Breaux's plan. The estimate does discuss the sensitivity of the results to lower projected enrollment in private plans.
- With Medicare contributing significant, if temporary, controls on its costs, the growth of national health spending will probably continue its remarkably slow pace in 1998 and 1999.

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Preliminary Staff Estimate: Senator Breaux's Medicare Proposal

2/16/99

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

The results are presented in two ways: a traditional estimate, which assumes that Medicare's fee-for-service plan would grow precisely as in baseline, and a nontraditional estimate, which assumes that the additional administrative flexibility granted the Health Care Financing Administration (HCFA) under Senator Breaux's plan in combination with modest continuing, but unspecified, cost controls approved by Congress would hold down the growth of the fee-for-service plan's costs. The traditional estimate assumes, in effect, that the fee-for-service plan would do nothing to compete with private plans; the nontraditional estimate assumes that the fee-for-service plan would control its costs to some extent. The nontraditional estimate may be more realistic for the Commission's deliberations. Under the Trustees Intermediate baseline, which already assumes a substantial slowdown in Medicare spending, however, the nontraditional estimate produces an especially optimistic outlook. The estimates also test the sensitivity of the results to a lowered projection of the number of beneficiaries enrolled in private plans.

Introduction: Major Estimating Issues

There are two key issues in estimating future Medicare spending under a premium support system: transition costs or savings, and long-term savings. The premium support system proposed by Senator Breaux is designed to minimize any disruption to the program, and transition costs or savings are expected to be small.

Transition Costs or Savings in Premium Support

Staff estimates have been empirical in nature; they have taken into account the current offerings and premiums of private plans in Medicare and assumed that those plans would continue their current offerings and premiums as a premium support system was implemented. Under that assumption, Senator Breaux's plan for premium support would have a small transition cost.

A more theoretical approach might lead to additional transition costs or savings. The behavior of plans and beneficiaries could differ depending on whether the premium support system used the original FEHB-style premium formula proposed by Senator Breaux or an alternative premium formula, which would allow beneficiaries to pay no premiums at all for plans whose premiums were less than about 85

percent of the national average. The additional transition costs or savings would be due to beneficiaries choosing plans priced higher or lower than those currently offered based on the incentives imbedded in the premium support formula. Under the more theoretical approach, the FEHB-style plan could lead to more generous offerings by plans and higher transition costs for Medicare. The alternative premium formula would boost incentives for lower-cost plans, creating transition savings for Medicare. In either case, Senator Breaux's plan would require the Board to dampen movements in plans' offerings to minimize any transition costs or savings.

The basis of the estimate section below contains a discussion of the empirical and theoretical approaches to estimating transition costs. The best estimate would probably contain elements of both approaches. The 30-year results, however, are virtually unaffected by whatever transition costs or savings are used in the estimates. The most important parameter in the long-run estimates is by far the estimated savings from price competition under premium support.

Long-Run Savings from Price Competition in Premium Support

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

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

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

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

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2/16/99

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long run.

HCFA's projections of health spending, by contrast, assume that the growth of premiums for private plans will equal that of the fee-for-service program, even under the assumption that current law is not changed.¹ HCFA projects that both Medicare spending and private insurance premiums will return to an 8 percent annual growth rate. Those projections have been criticized for assuming that the power of purchasers and health plans to achieve savings compared to fee-for-service is over.² That assumption is critical in determining the potential for a competitive system, like premium support, to reduce the growth in Medicare spending.

Description of the Proposal

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

Premiums: Two Alternative Schedules

Medicare premiums would be based on a national schedule similar to that used in the FEHB system. In this estimate, the schedule would be based on either of the following sets of rules:

FEHB-Style Formula presented by Senator Breaux

- For plans whose premiums were less than 90 percent of the national weighted average, the government's contribution would be 90 percent of the premium (and the beneficiary's share would be 10 percent).
- For premiums between 90 percent and 100 percent of the national weighted average, the government's share would increase by \$2 for every additional \$1 the beneficiary paid.
- For premiums above 100 percent of the national weighted average, the government's share would be capped.

(Under this formula an enrollee's share of the premium for an average plan would be about 12 percent.)

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

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

Alternative Formula

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

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

Schedules 1 and 2 (attached) summarize the government and enrollee shares of plan premiums as they increase through a hypothetical range. Schedule 1 corresponds to the FEHB-Style Formula, and Schedule 2 corresponds to the Alternative Formula. For both schedules, the national weighted average premium was assumed to be about \$5,710, and the national premium for the government-run fee-for-service plan was about \$5,685. (Those figures are meant to be illustrative, not estimates of future premiums. For reference, the Medicare Part B premium is projected to be about 12 percent of total Medicare program costs when the Balanced Budget Act of 1997 is fully implemented.)

High-income people would pay additional premiums. Extra premiums of 15 percent of a plan's costs would be charged to beneficiaries whose incomes placed them above 500 percent of poverty. For beneficiaries with incomes between 300 and 500 percent of poverty, additional premiums would be charged based on a sliding scale (see Schedule 3).

Low-income beneficiaries would be eligible for premium and cost-sharing assistance via Medicaid as under current law. For the purposes of this estimate, extra premiums received from high-income people would be reserved to provide extra assistance to low-income beneficiaries. That assistance could take many forms, including support for prescription drug coverage, efforts to expand participation in assistance currently offered, and extending assistance to near poor. The estimate assumes that a trust fund separate from Medicare would be established to receive the high-income premiums and pay out received funds as extra assistance to low-income beneficiaries. The high-income premium and low-income assistance therefore has no net effect on the federal budget and no effect on Medicare spending and premiums.

The Medicare Board

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

premiums are collected under current law.

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

Specifically, the Medicare Board would ensure that all plans covered at least those benefit items covered by the fee-for-service plan, and that plans covered those items to an extent comparable to the fee-for-service plan. To encourage innovations by plans and broad competition among various types of plans, plans would be given the flexibility to propose benefit design options. The Board would approve any proposed changes. The Board also would be required to exclude certain benefits for dental, vision, and hearing services from the computation of the national average premium, and the Board would be allowed to exclude other such peripheral benefits at its discretion. Furthermore, the Board would keep benefits within a certain range of value. This estimate assumes that the variation of benefit value would not exceed 10 percent.

Risk adjusters for plans would include

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

The geographic payment adjuster would include elements of historical Medicare costs and the cost of providing health services in areas. This estimate assumes that the areas would be defined as Metropolitan Statistical Areas with one additional area for non-metropolitan areas of each state. The geographic adjustment factors would be approximately budget-neutral; the magnitude of the geographic adjusters would be a policy decision. This estimate assumes that the geographic adjuster would have approximately 75 percent of the variation currently embedded in Medicare's AAPCC payment

adjusters.³ That would prevent private plan enrollees in high- or low-cost areas from facing disruptively large premium changes when the premium support system was implemented.

Raising the Normal Age of Eligibility to that of Social Security

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

Modernizing the Government-Run Fee-For-Service Plan

Senator Breaux's proposal would make it easier for the fee-for-service plan to compete by authorizing the use of management tools currently available to private plans. Those tools would include enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting, and preferred provider arrangements.

In addition, the proposal would modify the benefit package for the fee-for-service plan. For example, the proposal would create a combined deductible of approximately \$350 (in 1999 dollars) to replace the Part B deductible and the per-episode hospital deductibles and limits in the current Part A package, and coinsurance of 10 percent would be extended to home health care.

Medigap Reform

Senator Breaux's plan envisions reform of the Medigap market. Among other things, the proposal mentions limiting the effect of first-dollar coverage.

Carving Out Direct Medical Education

The proposal would end Medicare payments for direct medical education, instead funding those activities elsewhere in the budget. The proposal also recommends reviewing payments for indirect medical education and revisiting Medicare payments to Disproportionate Share Hospitals (DSH) to

³

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

ensure that DSH payments are reasonable and appropriate. For the purposes of this estimate, payments for indirect medical education and DSH were assumed to be unchanged.

Financing

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

Minor and Conforming Changes

The premium support system would not be compatible with the Part A-only coverage available under current law. Also, the option for Part B-only coverage under current law would have to be folded into Medicaid or some other program. To accommodate persons eligible for Medicare because of End-Stage Renal Disease (ESRD), a special payment adjuster, risk pool, or other arrangement would have to be made. Alternatively, ESRD coverage could be separated from the premium support system and maintained as under current law.⁴ In this estimate, no savings were assumed for the ESRD population.

Basis of the Estimate

Under current law, the growth of Medicare spending will be determined by the growth of spending in the fee-for-service program. That is because Medicare law links the growth of Medicare's payments to private plans to the growth in spending under the fee-for-service program.⁵ Under Senator Breaux's proposal for a premium support system, however, the growth of Medicare spending would be determined by the average growth in premiums for all plans—private plans as well as the government-run fee-for-service plan, weighted by the enrollment in those plans.

Under a premium support system, federal outlays and beneficiaries' out-of-pocket costs would ultimately depend on the sensitivity of beneficiaries to price differences among plans. In the FEHB program for federal workers and retirees, that sensitivity operates in two ways. First, plans set their

⁴ This is certainly not an exhaustive list of technical issues that would have to be considered to form a legislative package from this sort of proposal.

⁵ Changes in the way Medicare pays private plans made by the Balanced Budget Act of 1997 will temporarily break the connection between the growth of fee-for-service spending and the growth of payments to private plans.

premiums knowing that high premiums may cause enrollees to switch to less expensive plans and, second, some enrollees actually switch every year. Enrollee switching behavior is easy to measure. The following table shows the weighted average growth in premiums in FEHB before and after the annual open season, when enrollees select plans.⁶

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

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

The following estimate is based on projections of Medicare spending, premiums for private insurance, and the share of Medicare beneficiaries enrolled in private plans from CBO.⁷ CBO's baseline for Medicare spending has been extended to 2030 by the Commission using two alternatives: the Trustees Intermediate baseline, which assumes that the growth of Medicare spending will slow after 2010, and the No Slowdown baseline, which assumes no such slowing. The Commission is using both scenarios as current-law baselines—projections of Medicare spending that would occur if Medicare laws were not changed.

This estimate uses CBO's projection for the growth of private health insurance premiums as a guide to the likely growth of premiums for private plans under a premium support system for Medicare. In general, CBO assumes that private premiums will grow considerably more rapidly in the future than

⁶ Pre-open season premiums are weighted by the previous year's enrollment patterns—that measures what the growth of premiums would have been if no workers or retirees switched plans. The post-open season measure weights the growth of premiums using actual enrollment decisions—that is the amount by which government payments grow in the FEHB system.

⁷ As with previous estimates prepared through the Modeling task force, this estimate uses CBO's January 1998 economic and health baselines. Although those baselines changed in January 1999, the changes do not imply significant changes to the 30-year projections used by the Commission.

they have in the last 5 or 6 years. Specifically, CBO projects that private premiums will grow faster than the economy as a whole in the coming years, but will grow more slowly than current-law Medicare spending, at least after the major impact of the Balanced Budget Act has ended.⁸

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

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

Transition Issues: Two Premium Formulas

Because the additional premiums that some private plans in Medicare currently charge would be folded into the premium support system, the implementation of the system would initially raise Medicare's costs. Based on current premiums of private plans in Medicare, that aspect of the transition to a premium support system would add 1.5 percent to Medicare spending.

Under the FEHB-style premium formula, plans would have an incentive to offer richer benefits and correspondingly higher premiums than they currently offer and charge. However, the Medicare Board would prohibit benefits for certain peripheral items such as vision care, hearing aids, or dental care from affecting the government's costs. Senator Breaux's plan would also require the Board to carefully scrutinize proposed benefit changes to be sure that all plans offered packages of similar generosity. Under the alternative formula, transition savings could occur for a similar, though opposite, reason. In either case, because the estimates are dominated by the long-run competitive savings, the transitional costs or savings have a minimal impact on the estimate.

Modernizing the Fee-For-Service Plan and Reforming Medigap

Based on preliminary estimates from CBO, implementing a combined deductible of \$350 (in 1999 dollars) indexed to the growth of spending in the fee-for-service plan would be approximately budget

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

neutral. If Part A and Part B remained separate, the combined deductible would raise Part A costs by about 4 percent and reduce Part B costs by the same percentage. Although some Medigap reforms could significantly reduce the fee-for-service plan's costs, this estimate assumes that those reforms did not limit first-dollar coverage sufficiently to lower Medicare's costs. Instituting a 10 percent coinsurance for home health services would lower Medicare costs by about 1 percent in Part A and 1.5 percent in Part B.

Traditionally, CBO would not recognize savings from granting HCFA additional authority or flexibility to manage the fee-for-service plan in a more cost effective way. That is because there is no guarantee that HCFA would exercise the new powers, or that those powers would effectively reduce Medicare costs. The traditional estimate below is therefore closest to budget estimates from CBO.

Such traditions may not be helpful for this Commission, however. Senator Breaux's premium support proposal is designed to pressure the fee-for-service plan to stay competitive with private plans. Whether or not the fee-for-service plan competed via HCFA's new administrative tools or through direct Congressional action, it seems reasonable to assume that spending for the plan would be slowed at least somewhat. The so-called nontraditional estimate makes that assumption. The nontraditional estimate under the Trustees Intermediate baseline, which already assumes a slowdown in the growth of Medicare spending, is therefore considerably more optimistic than traditional CBO estimates.

Traditional Estimate. The traditional estimate assumes that the additional powers and flexibility granted HCFA to run the fee-for-service plan would not affect the fee-for-service plan's premium. The estimate assumes either that HCFA did not use those tools or else the tools did not work to slow the growth of spending in the fee-for-service plan. As a result, the fee-for-service plan would gradually lose competitiveness and, by 2030, the estimate assumes that 75 percent of beneficiaries were enrolled in private plans. (That is considerably more than CBO's long-term baseline.) The summary estimate is shown in Table 1; the detailed tables developed by the Modeling task force are shown in Tables 2-5. In this case, a modest sustained reduction in the growth of Medicare spending compounds to significant savings for the program in the long run.

Nontraditional Estimate. The nontraditional estimate assumes that the additional powers granted HCFA are used to the extent that the growth of Medicare spending in the fee-for-service plan fell by just over one-half of one percent a year. (Alternatively, one could assume that HCFA's powers were combined with Congressional action to slow the growth of costs by that amount.) For comparison, the magnitude of the assumed reduction in the growth of fee-for-service spending from HCFA or Congressional initiatives is similar to the slowing that would be achieved by extending certain provisions of the Balanced Budget Act of 1997.⁹ Importantly, extending some moderation in the growth of fees

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For example,

- PPS Hospital update at market basket - 1.7 percent;
- PPS Capital 2.1 percent reduction

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

With a more competitive fee-for-service plan, the estimate assumes that by 2030 only 50 percent of beneficiaries were in private plans. (That is the same as CBO's long-term baseline.) The nontraditional estimate may be more realistic for the purposes of this Commission. The summary estimate for the nontraditional estimate is shown in Table 6; the detailed tables developed by the Modeling task force are shown in Tables 7-10.

Impact on Health Plans and Beneficiaries

In the short run, the FEHB-style premium schedule is intended to be roughly budget neutral if plans initially made similar offerings to those expected under current law and beneficiaries initially made similar choices to those they otherwise would have made. The impact on plans would be straightforward—fundamentally, plans would receive their premium.¹⁰ The impact on beneficiaries would be relatively modest—either premium formula would require that fee-for-service beneficiaries pay a premium similar to the Part B premium under current law.¹¹ If the geographic adjuster was less variable than the AAPCC adjusters used under current law, enrollees in private plans in very high-cost areas could face increases in their overall premium obligations; private plan enrollees in low-cost areas could see reductions in their premiums.

In any given year, beneficiaries would choose from plans available to them based on the incentives in

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

¹⁰ Government payments would be adjusted as specified above.

¹¹ The premium schedule is calibrated to the Part B premiums that would be applicable after the transfer of most home health spending from Part A to Part B in the fee-for-service program. By the time a premium support system was implemented, the transfer would be largely complete.

the premium schedule—higher cost plans would cost them more and lower cost plans would cost them less. Beneficiaries in certain rural areas could have additional choices of plans to the extent that national or regional private plans were developed.

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

Under the traditional estimate, in which fee-for-service spending is unaffected by changes in HCFA's management tools or Congressional action, the fee-for-service plan would gradually lose competitiveness with private plans and its premium would rise. Eventually, the premium for the fee-for-service plan would exceed its projected value under baseline (see Tables 11 and 12).¹²

Under the nontraditional estimate, in which the fee-for-service plan is assumed to compete with private plans, premiums in fee-for-service rise more slowly and remain below those projected in baseline (see Table 13 and 14).

Under either scenario, the average premium paid by beneficiaries would be lower than the premium projected under current law. The fee-for-service plan could do more to slow the growth of its costs and reduce its premiums with Congressional approval. That could set up a virtuous cycle of competition with private plans.

Sensitivity of the Estimate to Lower Projection of Number of Enrollees in Private Plans

The number of enrollees moving to private plans in Medicare has fallen in the last 3 or 4 months. Because of the recent, and largely unexpected, uncertainty about Medicare's payments and rules for private plans, CBO has reduced its projection of the number of enrollees in private plans over the next several years, and possibly will reduce its projection for the long run as well. To show the order of magnitude, CBO had previously projected that enrollment in private risk plans would approach 40 percent by 2010. CBO's current projections imply that enrollment would be about 33 percent in that year. (CBO did not extend its current projections of enrollment trends to 2030.)

The traditional estimate above assumes that private plans will be more willing to serve Medicare beneficiaries under a premium support system and that, over time, if costs under the government-run plan were not moderated, more beneficiaries would choose those plans. Starting from a lower base,

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The premium support system pegs the average enrollee premium at 12 percent of Medicare spending; Part B premiums under baseline are projected to reach 14 percent of Medicare spending as the baby-boomers, who will be heavy users of Part B services at first, retire in large numbers.

however, could reduce the estimated savings by 10-20 percent using the traditional estimating method. Under the nontraditional estimate, it would matter less to the long-run savings how many beneficiaries were enrolled in private plans. Starting from a lower based could reduce the estimated savings by 5-10 percent using that method.

Impact on Other Programs

Medicaid spending would not necessarily be changed by the implementation of an FEHB-style system. Medicaid programs supporting Medicare premiums and/or cost-sharing could be adapted to mimic the FEHB-style system. To the extent that the growth of Medicare costs and premiums was slowed, the growth of Medicaid spending for Medicare premiums would be slowed as well. The cost estimate does not include savings from the Medicaid program.

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