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United States House of Representatives
Washington, DC 20515

FOR IMMEDIATE RELEASE:
April 12, 2000

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Statement by House Speaker J. Dennis Hastert (R-IL) Regarding the Prescription Drug Plan and a Stronger Medicare

Washington, DC – House Speaker J. Dennis Hastert (R-IL) made the following statement today:

"Today, we unveil a balanced plan to modernize Medicare by providing a voluntary prescription drug benefit to the American people.

"I want to commend Chairman Bliley, Chairman Archer, Chairman Bilirakis and Chairman Thomas, and all the members of the Commerce and Ways and Means Committees who have worked so hard for the last month on the issue of Prescription Drugs.

"This is a serious, responsible proposal, which will help American seniors get better access to prescription drug coverage. I believe that this plan will help lower the costs of prescription drugs for many senior citizens. No American should be forced to choose between putting food on the table and taking life-saving prescription drugs.

"This legislation is necessary because prescription drugs are becoming a more important part of our nation's health care needs. Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again.

"This plan gives our senior citizens flexibility to pick the plan that best fits their needs. It provides protection against high out-of-pocket and unexpected costs. This plan uses the market place, not government regulations, to control the cost of drugs. It protects innovation so we can continue to develop life-saving drugs to battle such diseases as cancer, heart disease and Alzheimer's Disease.

"I pledge to work with the President to modernize our Medicare system with a common-sense prescription drug plan.

"Now, it is my pleasure to introduce Lillie Miller from Alexandria, Virginia. I believe she will benefit under our plan.

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A Prescription Drug Plan for a Stronger Medicare

✓ **Lowers Drug Prices and Expands Access to Prescription Drugs for <u>All</u> Beneficiaries Without Threatening the Patient-Doctor Relationship.**

For the first time, seniors and the disabled won't have to pay full price for prescription drugs. Equally important, patients will have access to the specific drug -- brand or generic -- that their doctor prescribes. The plan addresses this problem by giving Medicare beneficiaries real bargaining power through private health plans to purchase drugs at discount rates. Studies show, including the White House study released April 10th, that insurance-based plans offer policyholders discounts of at least 15 percent on drug prices. Health plans are able to do this through flexibility on cost-sharing, tier pricing, benefit design, formularies, etc.

✓ **Protects Against Higher Drug Prices and Runaway Out-of-Pocket Costs.**

The plan provides coverage and security against escalating out-of-pocket drug costs for <u>every</u> Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' drug costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above $2,000.

✓ **Expands Seniors' Right to Choose the Coverage that Best Suits Their Needs Through a Voluntary and Universally-Offered Benefit.**

Under the plan, beneficiaries may choose from several competing prescription drug plans. The new drug benefit would be <u>100% voluntary</u> while preserving current coverage for seniors who want to keep what they have. If a senior is pleased with his/her current policy, they can choose to stay with their original plan. Instead of limiting the types of drugs health plans can cover, the proposal allows beneficiaries to choose coverage that fits their health needs.

Market-Based Approach. Unlike a one-size-fits-all plan, the proposal adopts a market-oriented benefit that gives seniors real insurance coverage. Because Medicare represents a pool of 40 million potential purchasers, private health plans will design several option packages to best serve individual needs instead of simply one government-defined benefit.

✓ **Rejects Big Government Approach With A Public-Private Partnership That Lowers Premiums.**

The plan targets those seniors and disabled who lack prescription drug coverage by providing 100% federal assistance for low-income seniors who face the greatest obstacles in obtaining drug coverage today – including 100% full reimbursement for premiums. Like the President, the plan also includes reimbursement phase-outs exceeding the poverty line.

Managing Risk and Lowering Premiums. Studies show that a small proportion of seniors consume a majority o prescription drugs, making that segment difficult to insure and driving up costs for everyone. The plan calls for Government to share in insuring the sickest seniors, thereby making risk m ore manageable for private insurers. By Government sharing in the coverage of high risk eniors, premiums would be lowered for every beneficiary.

No Cherry-Picking. overnment and private insurers would share in covering the high cost seniors, creating incen tives in the private market to control costs and prevent adverse selection of only the h althiest beneficiaries.

Other Plans Could Participate. Private employers would be given the option to buy-in to enhance their current lans or begin offering prescription drug coverage to their employees. States that currently o fer prescription drug coverage could choose to enhance their plans with the new federal c verage and not jeopardize the existing coverage their residents currently have. States would also maintain their current assistance for non-drug related premiums and cost-sh ring.

Better Quality. Beca se the proposal is market-oriented, plans will evolve in order to adopt new cutting-edge drug therapies, thereby preventing the need for expensive hospital stays or surgery. The package also fully utilizes innovations of private health plans to ensure seniors are taking the right m dications in the right doses.

✓ **Invests $40 Bi lion to Modernize and Strengthen Medicare.**
The proposal invests 40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside $5.2 billion more than the President's plan. Only because of efforts to strengthen Medicare in 1997, Congress is n ow able to offer this new benefit.

Structural Improvements. The proposal creates an Entity to bring flexibility to the administration of a ph rmaceutical benefit, medical and hospital care and increase choices for seniors.

✓ **Preserves and Protects Medicare to Keep Program Solvent for Future Generations.**
According to the rece tly released Medicare Trustee Report, Medicare will be completely broke by 2023, but th program will begin to run deficits in less than 10 years, by 2010. The plan recognizes the n ed to modernize Medicare with a prescription drug benefit, but also includes structural im rovements to ensure the program's long-term solvency.

✓ **Ensures that Today's Scientific Research and Medical Innovation will Continue to Find Tomorrow's Cures.**
By rejecting Washing on-mandated price controls and a big-government approach, the plan will ensure continued innovation and development of life-saving drug therapies. In recent years, scientific and m edical research resulted in 400 medications to treat the top 3 killers of seniors – heart diseas , cancer and stroke.

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NEWS

FROM THE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 26, 2000

CONTACT: Trent Duffy or Greg Crist
(202) 225-8933

Thomas Reaction to President Clinton's News Conference on a Prescription Drug Benefit for Medicare and Study on Drug Costs

WASHINGTON – Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) today responded to President Clinton's news conference on prescription drug coverage for Medicare beneficiaries and a new study by Families USA that suggests drug prices are rising faster than the rate of inflation.

"This is precisely why our prescription drug plan includes protection for all seniors from runaway out of pocket drug expenses, which is called stop-loss coverage. The President's plan fails to cover seniors' drug costs once they exceed $2,000, which leaves seniors way too vulnerable to escalating drug prices."

"Furthermore, I must clarify that our plan helps all seniors by creating a private-public partnership to help cover the costs of the sickest patients. This in turn, will lower the premiums that all seniors pay for drug benefits, which means more affordable coverage for all seniors -- regardless of income. Our plan is universally offered as an option under Medicare, which is similar to the President's approach. Despite the President's partisan rhetoric, I look forward to working in a bipartisan fashion on building a prescription drug plan for a stronger Medicare that can be signed into law this year. I hope the President's intention is the same."

On April 12th, House Speaker Dennis Hastert (R-IL) and several Members of the Ways and Means and Commerce Committees introduced a comprehensive plan to strengthen Medicare while modernizing the program with a prescription drug benefit for seniors. The market-based plan will offer voluntary prescription drug coverage to every senior while protecting them from exploding prices that threaten their financial security. Contact Tim Scharf in the Ways and Means Press Office at (202) 225-8933 if you would like a summary of the plan. Statements from the AARP and the American Association of Health Plans about the GOP plan follow this release. The brief outline of the plan is as follows:

- Lowers Drug Prices and Expands Access to Prescription Drugs for <u>All</u> Beneficiaries Without Threatening the Patient-Doctor Relationship.
- Protects Against Higher Drug Prices and Runaway Out-of-Pocket Costs.
- Expands Seniors' Right to Choose the Coverage that Best Suits Their Needs Through a Voluntary and Universally-Offered Benefit.
- Rejects Big Government Approach With A Public-Private Partnership That Lowers Premiums.
- Invests $40 Billion to Modernize and Strengthen Medicare.
- Preserves and Protects Medicare to Keep Program Solvent for Future Generations.
- Ensures that Today's Scientific Research and Medical Innovation will Continue to Find Tomorrow's Cures

-AARP and AAHP statements on GOP Prescription Drug Plan Follow-

Statement by AARP Executive Director Horace B. Deets on House Republican Medicare Prescription Drug Proposal, April 12, 2000

"House Republican leaders today outlined a new proposal to help Medicare beneficiaries purchase prescription drug coverage. Many details of this plan are yet to be spelled out, but we are pleased that this proposal moves beyond the prescription drug benefit developed by the Medicare Commission - a proposal that would have provided prescription drug coverage only to low-income older Americans - to providing prescription drug coverage to all older and disabled Americans in Medicare.

As we understand it, the proposal would provide a full subsidy for low-income beneficiaries without jeopardizing Medicare's social insurance foundation. In addition, it has the potential for reducing the premiums that all older Americans would pay for their Medicare prescription drug coverage by providing a government subsidy for those people in Medicare who have extraordinarily high drug costs.

AARP supports a prescription drug benefit in Medicare that would be available to and affordable for all beneficiaries. Many questions must be answered about this proposal before we can judge whether it meets these criteria. Among these questions: Would the level of federal subsidy, which is the same as in the President's proposal, prove adequate to attract the broad risk pool that is needed to make the coverage affordable for the vast majority of beneficiaries? Would this public-private partnership, with its many implementation details, prove workable?

At this early stage, we believe this proposal has merit and should be explored carefully. AARP is prepared to work with the proponents of this idea, as well as with other Members of Congress and the President on a bipartisan basis, to help shape a Medicare prescription drug benefit that will meet the needs of older Americans today and in the future."

Statement of AAHP, in a Letter to Senator William Roth, April 11, 2000

"We believe the most effective way to provide this coverage is through private risk-bearing insurance entities to ensure minimal disruption to current prescription drug coverage. As Congress moves to act to authorize new drug coverage options for Medicare beneficiaries, we believe they should be able to purchase coverage from competing private sector plans that choose to offer such coverage, including existing Medicare+Choice plans, employer-sponsored plans, Medigap plans, and other innovative private insurance entities that would provide this drug benefit."

-30-

DATE: 4/19

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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TO: CHRIS

OFFICE: _____

ROOM: _____

PHONE: _____

FAX: _____

(INCLUDING COVER): 22

REMARKS:

FROM FAMILIES USA

FACT SHEET #'s 6 & 7 WENT TO EVERY MEMBER & SENATOR.

THE REST OF THE PACKAGE WENT TO A SELECT GROUP OF STAFF "FRIENDS"

SINCE OTHER ISSUES ARE MORE BACK BURNER AT THE MOMENT.

Paul S.

The Future of Medicare: #6

This is one in a series of papers prepared by Families USA that analyze proposals to change the Medicare program. This paper refers to the Medicare Preservation and Improvement Act (S. 1895), sponsored by Senators John Breaux and Bill Frist and based on the Breaux-Thomas proposal, which was debated but not adopted by the National Bipartisan Commission on the Future of Medicare. **April 2000**

Medicare Beneficiaries Need Drug Coverage — Breaux-Frist Proposal Fails the Test

Currently, Medicare's required benefit package excludes outpatient prescription drugs. The Breaux-Frist bill includes an optional outpatient drug benefit (see below).

Medicare Should Cover Prescription Drugs

- Drug therapy is an essential part of modern medicine. It is now the front-line approach for treating and preventing illness. For example, drugs are now reducing deaths from heart disease, the nation's number one killer. A study at the University of Maryland Medical Center found that patients who were prescribed beta-blocker drugs after they recovered from a heart attack were 40 percent less likely to die from a second heart attack over the next two years than patients who did not get the drug.[1]
- In addition to improving quality of care, drug therapy can save money in the long run. For example, drug therapy has replaced surgery as the treatment for serious ulcers. Today's ulcer drug therapy costs about $140 per patient, compared to $28,000 for surgery.[2] Also, the U.S. government's Agency for Health Care Research and Quality estimates that wider use of blood-thinning drugs could prevent 40,000 strokes and save $600 million each year.[3]
- Prescription drug coverage is an integral part of modern health insurance. The Federal Employees Health Benefits Plan and most employer-provided health plans routinely cover drugs.
- National spending on prescription drugs has tripled since 1990 and is expected to double again by 2008.[4]
- Incorporating drug coverage into Medicare's benefit package is the most cost-efficient way to provide drug coverage. The current patchwork system of drug coverage for seniors distorts the market and prevents consumers from making the best choices. Pooling all beneficiaries into one program for drug coverage will achieve the best economies of scale.

Medicare Beneficiaries Are Inadequately Covered, Increasingly Vulnerable

- One-third of all Medicare beneficiaries have a drug benefit as part of their employer-provided retiree coverage. However, the number of firms offering retiree health coverage has declined 25 percent in the last four years.[5]
- Ten percent of Medicare beneficiaries purchase Medicare supplemental insurance—Medigap—to get coverage for prescriptions. Medigap benefits are standardized by federal law and benefits cannot be changed. Three of the standardized policies (H, I, and J) offer some prescription drug

coverage (along with other benefits), but prices for these plans ar increasingly unaffordable. For example, in Miami, Florida, Policy J costs a 65-year-old an averag of $3,428 a year. This policy pays only 50 percent of drug costs (after a $250 deductible) up t a maximum amount of $3,000.[5]

- About 8 percent of beneficiaries get prescription drug coverage fr m an HMO plan, but the value of this coverage has been eroded through increased copayments ar d, in some cases, higher premiums. What is more, in 2000, 82 percent of Medicare HMO drug p ans will cap drug coverage at a level below $2,000.[7] Major cutbacks in drug coverage in 2001 ar predicted.
- Of those who were enrolled in Medicare for the entire year of 199 , slightly more than half had drug benefits throughout the year, while the remainder had either no co erage or coverage for only part of the year.[8]
- Only 56 percent of the most chronically ill beneficiaries had full-ye r coverage,[9] leaving those most likely to need drugs at risk for huge financial burdens.

Breaux-Frist Drug Benefit Is Inadequate

- The Breaux-Frist proposal requires all participating plans—includin traditional Medicare—to offer a high-option plan that covers prescription drugs. However, benefici ries will have to pay 75 percent of the additional cost of the drug benefit unless they have low inc mes (see below). The failure to provide drug coverage for *all* beneficiaries is a serious shortcomi g of the Breaux-Frist proposal.
- The Breaux-Frist proposal requires that the drug benefit in the hig option plan have an actuarial value of $800; no specific benefit design is required. Therefore, p ans could design the drug benefit in a way that attracts healthier beneficiaries by, for example, requi ng a higher deductible and high cost-sharing.
- Under the Breaux-Frist proposal, the government will pay the full c st of the premium for the high option plan for beneficiaries who have incomes below 135 perce of the federal poverty level.[10] However, the government will only pay the full premium for the lo est-cost plans. Low-income beneficiaries who depend on doctors who do not participate in th s low-cost plan, or who need benefits that are not adequately covered by it, may have to forgo rug coverage. Beneficiaries with incomes between 135 and 150 percent of poverty will be eligible or sliding scale subsidies to help defray the additional cost of drug coverage.

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[1] Pharmaceutical Research and Manufacturers of America, *The Value of Pharmaceutica* (Washington, DC: November, 1998).
[2] Ibid.
[3] Agency for Health Care Research and Quality (formerly, Agency for Health Care Polic Research), "Life-Saving Treatments to Prevent Stroke Underused," Press Release, September 7, 1995 (www.ahcpr.gov/news press/stroke.htm).
[4] Henry J. Kaiser Family Foundation, "Medicare and Prescription Drugs," *The Medicare Program*, March 2000.
[5] Democratic Policy Committee, "Medicare Beneficiaries Need Prescription Drug Cover ge," FS-40-Health, January 18, 2000.
[6] Kaiser Foundation, "Medicare and Prescription Drugs."
[7] HCFA, "Medicare+Choice: Changes for the Year 2000," September 1999.
[8] Bruce Stuart, Dennis Shea, and Becky Briesacher, "Prescription Drug Costs for Medic re Beneficiaries: Coverage and Health Status Matter," *Issue Brief*, The Commonwealth Fund, January 2000.
[9] Ibid.
[10] 135 percent of the federal poverty level is $11,273 for an individual or $15,188 for couple.

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The Future of Medicare: #7

This is one in a series of papers prepared by Families USA that analyze proposals to change the Medicare program. This paper refers to the Medicare Preservation and Improvement Act (S. 1895), sponsored by Senators John Breaux and Bill Frist. The Breaux-Frist bill was based on the Breaux-Thomas proposal, which was debated but not adopted by the National Bipartisan Commission on the Future of Medicare.

April 2000

New, Unaccountable Bureaucracy to Run Medicare Under Breaux-Frist

The Breaux-Frist bill calls for the appointment of a new, independent seven-person board to administer the Medicare program. This board, appointed by the President and confirmed by the Senate, will oversee all Medicare plans, including the traditional Medicare program. This proposal raises a number of serious concerns.

The Medicare Board Proposal: An Expensive New Bureaucracy

The Medicare board, as described in the Breaux-Frist bill, will consist of seven very highly paid new government appointees and any staff they choose to hire. Medicare beneficiaries and taxpayers will pay for this new bureaucracy through surcharges on premiums but will have no say in how much money the board collects or how the money is spent. The consequence could be a bloated system that replaces HCFA's low administrative costs with an expensive, top-heavy board that resembles the worst features of private health plans.

Breaux-Frist Gives Control of 11 Percent of the Federal Budget to a Board that Doesn't Answer to Congress or the President

The Breaux-Frist bill gives the new Medicare board a highly unusual degree of independence from both the President and Congress. Members are appointed for staggered seven-year terms and can only be removed for "neglect of duty or malfeasance in office." The board does not report to the President, and he has virtually no authority over it. Because the board will generate its own operating funds by imposing surcharges on Medicare premiums and will not have to rely on appropriations, Congress will have very little authority over it as well. The board could ignore presidential and congressional directives. There is some question about the Constitutionality of this proposal.

The Medicare Board Could Be Subject to Conflicts of Interest

The Breaux-Frist bill fails to require that board appointees and staff members be free of ties to the health plans that do business with Medicare. Most government boards have strong ethical rules that require disclosure of financial interests and limit what people can do after they leave. The absence of such rules will allow the Medicare board to make decisions based on financial self-interest or an eye toward future employment with the health plans. Because the board is not accountable to either the President or Congress, it will be vulnerable to the influence of outside groups. For this reason, the concept of an independent board has been endorsed by the insurance industry but not by Medicare consumer organizations.

The Board's Structure Could Imperil Traditional Medicare

The Breaux-Frist bill converts the Health Care Financing Administration into a new "Division of HCFA-Sponsored Plans," which would be housed in the Department of Health and Human Services (HHS) but would *not* have to report to the Secretary of HHS. The Division of HCFA-Sponsored Plans would be required to submit its health plan – the traditional Medicare program – to the Medicare board for final approval. The Division of HCFA-Sponsored Plans could propose drastic changes in the structure of traditional Medicare without any review by the Secretary or the President and with only fast-track review by Congress. Or the board could reject the Division of HCFA-Sponsored Plans' proposal; if that happened, it appears that neither the board nor the Secretary of HHS would have the authority to resolve the impasse.

The Breaux-Frist Medicare Board and Staff Could Be Subject to Undue Political Influence

The Medicare Board can hire staff "without regard to" current civil service laws and pay scales. The staff of the Medicare board will have responsibility for contracts involving billions of dollars of public money. It is not clear why people in a position of public trust should be hired outside the civil service laws, which were reforms enacted to end rampant political patronage in the government hiring process (the "spoils system") and to insulate government hiring from political influence.

The Medicare Board Proposal Is Not Like Social Security

The other major government program serving older Americans is Social Security, which is operated by an independent agency, the Social Security Administration (SSA). The SSA structure differs from the Breaux-Frist Medicare board in several very significant ways. For example, unlike the Medicare board, SSA reports to the President. Because it requires an annual appropriation for operating funds, SSA is answerable to Congress. And SSA staff are hired under the civil service laws. Although there is also a Social Security *board*, this board is purely advisory and lacks any independent decision-making authority.

Board Proposal Is an Unorthodox Approach to Governance

The restructuring of Medicare proposed by Breaux-Frist is a radical departure from accepted practice in running government programs. The board is unusual in its degree of autonomy from the President and Congress and in its ability to raise its own operating funds. The division of responsibility between the board and the new Division of HCFA-Sponsored Plans is also highly unusual. But giving over 11 percent of the federal budget and the responsibility for administering a major public program to an entity that is autonomous and self-funded is completely without precedent.

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The Future of Medicare

This is one in a series of papers prepared by Families USA that analyze proposals to change the Medicare program. This paper refers to the Medicare reform proposal put forth by President Clinton.

March 2000

Key Features of President Clinton's Medicare Reform Proposal

The Medicare reform proposal introduced by President Clinton on June 29 retains the essential structure of Medicare as it is today – a traditional fee-for-service program and a system of HMOs, both offering a precisely defined benefit package. The proposal extends the life of Medicare with new revenues and savings and modernizes the program while avoiding a radical restructuring of the program.

Here's how it would work:

■ Every beneficiary will have the option of purchasing a prescription drug benefit from Medicare. The new Medicare drug benefit will be phased in beginning in 2002 at a premium of $26 a month, which will cover 50 percent of all drug costs up to $2000. By 2006 the benefit will cover 50 percent of drug costs up to $5,000, for a monthly premium of $51. No deductible is required. A cap on catastrophic expenses is now included in the plan.

■ Prescription drug premiums and cost-sharing will be paid for low-income beneficiaries with incomes up to 135 percent of the federal poverty level. Those with incomes between 135 and 150 percent of poverty will have their drug premiums paid according to a sliding scale based on income.

■ As they are today, beneficiaries will be guaranteed a precisely defined set of benefits. This benefit package will be guaranteed both in traditional Medicare and in HMOs.

■ Traditional Medicare will be preserved, and beneficiaries will be able to remain in traditional Medicare without paying higher premiums. HMOs will have to offer the same defined benefit package as traditional Medicare. This will force them to compete based on price and quality. They will be unable to design their benefit package so as to cherry-pick the healthiest and least costly beneficiaries. HMOs will be able to offer cheaper plans only if they are more efficient and provide better value for beneficiaries.

■ The Clinton plan eliminates copayments for preventive services such as mammography and prostate cancer screenings. A new 20 percent copayment will be added for laboratory services, and the Part B deductible, now $100, will be indexed to inflation.

■ Laid-off workers between the ages of 55 and 62, and all Americans between the ages of 62 and 65, will be able to buy into the Medicare program. The cost for the former group will be about $400 per month, and the cost for the latter group will be about $300 per month plus a risk-adjusted surcharge beginning at age 65. A tax credit worth 25% of the cost will be available.

■ The proposal provides new revenues for Medicare by dedicating over $400 billion of the budget surplus to the program. The proposal achieves savings by reducing excess provider payments, allowing HCFA to purchase medical services and supplies at more competitive rates, and coordinating care for sicker beneficiaries.

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March 2000

Key Features of S. 1895, the Breaux-Frist Bill

Senators John Breaux (D-LA), Bill Frist (R-TN), Bob Kerrey (D-NE) and Chuck Hagel (R-NE) introduced the "Medicare Preservation and Improvement Act of 1999" at the end of last year. The bill, S.1895, is patterned on the Federal Employee Health Benefits Program, the set of health plans offered to all federal employees. The core of the Breaux-Frist bill came from proposals developed, but not adopted, by the Medicare Commission.

Here's how it would work:

■ A new cap on the amount of general tax dollars that can be used for Medicare is included in the bill. Under current law, 75 percent of expenditures for Part B services are paid by general tax dollars. If these expenditures exceed 40 percent of the total cost of Medicare, the proposed cap would cut off additional funds. This cap eliminates the beneficiary's entitlement to services.

■ Responsibility for the Medicare program is transferred to a board of seven people appointed by the President. The board reports only to Congress and is not accountable to the President after appointment. The board will have oversight of all the plans that offer coverage to Medicare beneficiaries, *including the traditional Medicare plan*. HCFA will give up its role in running Medicare and will no longer carry out such functions as providing information to beneficiaries, collecting data, and conducting quality reviews. HCFA's sole remaining responsibility will be to administer the traditional program as one of the options for beneficiaries.

■ A variety of health plans would be offered to each beneficiary. The federal government would pay part of the premium for each beneficiary; the federal share would be about 88 percent of the average-cost plan. Beneficiaries who want a more expensive plan have to pay all of the additional cost of that plan.

■ Each plan would have to offer the same basic benefits now covered by Medicare. Plans would be able to charge different cost-sharing for different benefits, although the actuarial value of cost-sharing for the basic benefits would have to remain the same.

■ The traditional Medicare program would be one of the choices offered to beneficiaries. In the beginning, traditional Medicare would cost about the same as the average cost plan; however, over time, traditional Medicare would almost certainly become increasingly expensive. Although traditional

Medicare is forced to compete with private plans, the program will not be given any additional tools, such as the ability to purchase in bulk, needed to help it control rising costs and compete effectively.

- All health plans, including the traditional Medicare program, would be required to offer a new "high option" plan that includes a prescription drug benefit worth $1,500 and stop-loss protection for expenses (not counting drug costs) over $2,000. Beneficiaries (except those with low incomes) will have to pay the additional cost of the high option plan, except that they will receive a subsidy equal to 25 percent of the cost of the drug portion of the premium. (This subsidy will be reported to IRS and will be treated as taxable income to the beneficiary.) No beneficiary who chooses a high option plan – whether it is offered by HCFA or by one of the private plans – will be allowed to purchase Medigap insurance to cover their unreimbursed drug costs or the $2,000 in out-of-pocket costs counting towards the $2,000 stop-loss limit.

- Beneficiaries with incomes below 135 percent of poverty will have their premiums paid for the cheapest high option plan offered in their area. Beneficiaries with income between 135 and 150 percent of poverty will be eligible, on a sliding scale basis, for a subsidy towards the cost of the drug portion of the premium for the cheapest high option plan. (This subsidy will be taxable.)

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The Future of Medicare: #1

This is one in a series of papers prepared by Families USA that analyze proposals to change the Medicare program. This paper refers to the Medicare Preservation and Improvement Act (S. 1895), sponsored by Senators John Breaux and Bill Frist. The Breaux-Frist bill was based on the Breaux-Thomas proposal, which was debated but not adopted by the National Bipartisan Commission on the Future of Medicare.

March 2000

The Breaux-Frist Bill: Look Before You Leap

The Breaux-Frist bill calls for radical changes in the Medicare program, essentially privatizing the care of the nation's elderly and disabled. Policymakers should be cautious about embracing this proposal until they have the answers to a number of crucial questions. In particular, they should insist on evidence that a "premium support" or "competitive premium system" model for Medicare, as called for by the Breaux-Frist proposal, will actually work as intended.

Can the Private Market Save Medicare Money?

■ **Over the life of the Medicare program, Medicare has done a better job than the private market in restraining health costs.** Per capita health insurance costs in the private market have increased by an average of 1 percent a year *faster* than those in Medicare during this period.[1] And projections call for private insurance costs over the next decade to increase by an average of 1.5 percentage points each year faster than Medicare.[2] What evidence is there that the private market can now restrain costs better than the Medicare program? If it can't, why should we turn Medicare over to private plans?

■ **The experience with Medicare HMOs so far has found that the presence of private plans actually increases costs to the Medicare program.** This is because Medicare HMOs enroll healthier beneficiaries than traditional Medicare. Under the Breaux-Frist proposal, the Medicare Board is supposed to reject private plans that "are likely to result in" such favorable risk selection, but it is not clear how the board would make this determination. Even if the board manages to weed out and reject the plans that blatantly "cherry pick," plans can be expected to search for subtler ways to target healthier beneficiaries. Unless the board can completely prevent such practices, Medicare HMOs are likely to draw the healthiest beneficiaries and drive up the cost of traditional Medicare, potentially to an unsustainable level. Will the private market meet the needs of beneficiaries if the traditional program becomes unaffordable?

■ **The U.S. General Accounting Office says that Medicare HMOs are overpaid.** The Inspector General found that inflated payment rates to these HMOs will cost taxpayers an estimated $34.3 billion over the next 10 years.[3] Yet Medicare HMOs say they are underpaid, and they have waged an intense battle in Congress to increase their payments. If the Breaux-Frist proposal is

adopted, how can we ensure that health plans won't somehow "ga me" the new bidding process to increase their payments, thus costing Medicare money rather than saving money?

■ **The Inspector General found that Medicare HMOs cl aim administrative costs that vary dramatically, from a low of 3 cents out of ever y premium dollar to a high of 32 cents.** If administrative expenses were limited to 15 percen , the Inspector General estimated that an additional $1 billion would have been available for ad ditional benefits.[4]

The Breaux-Frist Proposal: Too Many Unans wered Questions

■ **Currently, Medicare HMOs enroll primarily the healt hiest beneficiaries.**[5] Where is the evidence that a system of private health plans will provide adeq uate care to the many *un*healthy Medicare beneficiaries—those who have chronic illnesses or disabil ties?

■ To make sure that good health plans are not penalized for attr cting large numbers of unhealthy beneficiaries, the Breaux-Frist bill proposes to adjust paym nts to plans based on the health status of enrollees. Yet the most sophisticated of such "risk adjust rs" currently available compensate for only a portion of the costs incurred by sicker and costlier patients. What is more, **Medicare+Choice plans are resisting even the limited ri k adjustment that the Health Care Financing Administration (HCFA) currently s attempting to implement.** What is the evidence that the embryonic science of risk adjustmen can be rapidly perfected? Why should we believe that health plans will cooperate with risk adjustm ent?

■ **Any savings realized from the Breaux-Frist premium support model will fall far short of the amount necessary to cover the many new b aby boom beneficiaries who will soon join Medicare.** Why should we dismantle a sy tem that works if the new system does not secure the long-term viability of Medicare?

■ The Breaux-Frist bill declares that Medicare shall be deemed i solvent once spending for Part B (outpatient care) exceeds 40 percent of overall program costs. Re ent efforts to curb spending for Part A (hospitalization) by increasing reliance on outpatient care ha ve been successful. As a result, Part B costs as a share of total program costs have been increasi g; it is now estimated that, absent any changes, Part B will exceed 40 percent of total progra costs in 2008. Since Breaux-Frist bars additional spending when this happens, what will be don ? Will benefits be cut off when the 40 percent level is reached? Will plans and/or providers go un aid? Will providers refuse to see patients? How can Medicare beneficiaries count on receiving the c re to which they are entitled?

■ Under Breaux-Frist, Medicare will be run by a new Medicare B ard of seven persons, appointed by the President and confirmed by Congress. This board will be re sponsible for 11 percent of the entire federal budget and will not report to the President but only t Congress. Where is the precedent for turning over operation of a major and expensive public pr gram to an agency outside the Executive Branch? Is Congress really equipped to monitor the day to-day operations of a major program? How will Congress resist intensive lobbying from Medic re HMOs seeking increased payment rates? How will the board be held accountable? What ass urances are there that the board will not be made up of representatives of insurance companies or other special interest group representatives whose livelihoods are affected by Medicare?

■ The Breaux-Frist proposal is based on health plans responding to market conditions, moving into and pulling out of markets to achieve economic efficiencies. If the Breaux-Frist bill is enacted, how will Medicare beneficiaries be assured continuity of care and ongoing relationships with their doctors as health plans come and go?

■ Under Breaux-Frist, Medicare beneficiaries will have to compare different health plans and choose the one that best meets their needs. Although the bill provides funding for nonprofits that will distribute plan information to beneficiaries, how will the millions who are older, chronically ill, or unable to see, hear, or read, be able to review the fine print and make decisions about complicated health plan issues?

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[1] Vladeck, Bruce C., "Perspectives on Medicare Reform," Testimony before the U.S. Senate Committee on Finance, May 16, 1999.
[2] Thorpe, Kenneth E., "Options for Reforming Medicare," Testimony before the U.S. Senate Committee on Finance, May 16, 1999.
[3] Office of Inspector General, *Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates*, U.S. Department of Health and Human Services, December 1999.
[4] Office of Inspector General, *Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent among Managed Care Organizations*, U.S. Department of Health and Human Services, January 2000.
[5] Research by the Medical Payment Advisory Commission, the U.S. General Accounting Office, and others supports this conclusion.

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The Future of Medicare: #2

This is one in a series of papers prepared by Families USA that analyz proposals to change the Medicare program. This paper refers to the Medicare Preservation and Imp overment Act (S. 1895), sponsored by Senators John Breaux and Bill Frist. The Breaux-Frist bill was based on the Breaux-Thomas proposal, which was debated but not adopted by the National Bipartis n Commission on the Future of Medicare.

March 2000

Turbulence Ahead for Seniors Under the Breaux-Frist Bill

The Breaux-Frist bill encourages Medicare beneficiaries to choose low-cost HMOs over traditional Medicare. But turning Medicare over to the managed care industry will leave beneficiaries vulnerable to the whims of the marketplace. Medicare HMOs have proven volatile and unreliable, with plans moving in and out of markets in response to economic conditions. Such volatility can be disruptive to seniors, especially if they are receiving ongoing medical treatment. Beneficiaries may no longer have access to the same doctor.

In 1999, 100 health plans left the Medicare market or reduced their service areas – many more pulled out in 2000

- Almost half of the 957 counties that had Medicare managed care plans in 1998 experienced a plan withdrawal in 1999. One in10 of the counties with managed care plans in 1998 was left with no other private plan.

- The plan withdrawals forced 407,000 Medicare beneficiaries across the country to change health plans at the end of 1998. Of these beneficiaries, 61,000 had no other HMO to join. Another 327,000 beneficiaries were faced with plan withdrawals at the end of 1999.[1]

- Plans were more likely to pull out of high-payment areas than low-payment areas, belying the industry argument that payment rates were responsible. According to a 1999 report issued by the government , plans withdrew because of competitive factors, such as the inability to build adequate provider networks or poor market penetration.[2]

Plan withdrawals are expensive and highly disruptive for beneficiaries

- When a Medicare HMO leaves Medicare, the enrollees lose access to that plan's network of doctors. These beneficiaries have no guarantee that their doctors will be in the networks of other HMOs, even if other HMOs are available. Beneficiaries involved in ongoing treatment for cancer or diabetes or other conditions common to the elderly may be forced to change doctors at a critical

time. Involuntary change of providers is disturbing to beneficiaries and is highly disruptive of patient care.

Plan withdrawals are integral to effective markets

■ Markets rely on change—new services and businesses moving in and out of the marketplace in response to economic conditions and competitive factors. This is how businesses increase efficiency and profits. A changing market is essential if the Breaux-Frist bill is to generate even the limited savings it projects.

■ A volatile market may be a good way to sell computers and donuts, but it is a bad way to deliver health care to the nation's elderly and disabled. Medicare beneficiaries, as a whole, are a vulnerable population: many have chronic illnesses and need continuing care. In health care, especially for the elderly and disabled, frequent market upheavals and health plan changes are detrimental to good health.

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[1] Barents Group, LLC, *How Medicare HMO Withdrawals Affect Beneficiary Benefits, Cost and Continuity of Care* Menlo Park, CA: The Henry J. Kaiser Family Foundation, November 1999).

[2] U.S. General Accounting Office, *Medicare Managed Care Plans: Many Factors Contribute to Withdrawals*, GAO/HEHS-99-91 (Washington, D.C.: General Accounting Office, April 1999).

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The Future of Medicare: #3

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March 2000

The Breaux-Frist Proposal Will Jeopardize the Traditional Medicare Program

Although the Breaux-Frist bill claims to maintain the traditional Medicare program for beneficiaries who prefer it or who have no other viable choice, the proposal will undermine the traditional Medicare program and make it so expensive that many beneficiaries will be unable to stay in the program.

Why it's important to preserve traditional Medicare:

- **Some beneficiaries may have little or no choice.** Many beneficiaries, especially those in rural areas, are unlikely to have alternative plans to choose from. They will have access only to traditional Medicare or, if they have access to an alternative plan, that plan may not include the providers they need.

- **Sicker beneficiaries may need traditional Medicare.** Beneficiaries who are sicker may need to remain in the traditional Medicare program because they depend on providers who do not participate in the private plans.

- **Beneficiaries may not want to join an HMO.** Many beneficiaries may choose to remain in traditional Medicare to stay with their existing physicians. Or if they travel, they may elect fee-for-service coverage rather than a local HMO that cannot provide services when they are in another area.

How Breaux-Frist will disadvantage traditional Medicare:

- **Even though the new Medicare Board established by Breaux-Frist is supposed to reject plans with a design that is "likely to result in favorable selection" (that is, enrolling the youngest and healthiest beneficiaries, who cost the least to cover), private plans are nonetheless likely to find ways to "cherry pick."** To the extent that they are successful, the traditional Medicare program will be left with a disproportionate share of the older and sicker beneficiaries, driving up costs. In fact, this already happens in Medicare+Choice, where Medicare HMOs have been found to seek out younger and healthier beneficiaries.[1]

■ **Private plans will be allowed to add benefits** to attract healthier enrollees. They can add benefits that will appeal only to the healthy, such as a discount on health clubs.

■ **Private plans will also use marketing to attract healthier beneficiaries.** A 1997 Kaiser Foundation study found that Medicare HMOs routinely market to younger, healthier beneficiaries by showing them engaged in athletic activities such as skiing, bicycling, and snorkeling.[2]

■ **Traditional Medicare will become the last resort of the costliest Medicare beneficiaries.** A recent study of Medicare HMOs in the years before the advent of Medicare+Choice assessed whether the plans were selectively enrolling healthier beneficiaries and encouraging sicker beneficiaries to disenroll. This study found that Medicare HMO enrollees who got sick disenrolled and rejoined traditional Medicare before they obtained expensive inpatient care, which cost the government some $200 million. Some of these beneficiaries rejoined the HMO when their period of illness passed.[3]

■ **Traditional Medicare will become unaffordable.** As the healthiest beneficiaries leave traditional Medicare to join private plans, Medicare will be left serving the sickest and costliest beneficiaries. This will drive up the premiums for the traditional Medicare program. As premiums increase, more healthy beneficiaries are likely to opt out, further driving up costs. What is more, Marilyn Moon of the Urban Institute estimated that, under a premium support model, out-of-pocket costs for beneficiaries who rely on traditional Medicare could rise to 36.6 percent of median income by the year 2025.[4]

■ **Traditional Medicare will be denied competitive tools.** Under Breaux-Frist, the traditional Medicare program will be forced to compete head-to-head with private insurers but will be denied the tools it needs to compete, such as the ability to purchase in bulk or the ability to contract selectively with providers.

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[1] Research by the Medical Payment Advisory Commission, the U.S. General Accounting Office, and others supports this conclusion.

[2] Ed Malbach, Patricia Newman, et al., *Marketing HMOs to Medicare Beneficiaries: An Analysis of Four Medicare Markets* (Washington, DC: The Henry J. Kaiser Family Foundation, July 1998).

[3] Inspector General, *Review of Inpatient Services Performed on Beneficiaries After Disenrolling from Medicare Managed Care*, A-07-98-01256 (Washington, DC: U.S. Department of Health and Human Services, 1999).

[4] Marilyn Moon, *Restructuring Medicare: Impacts on Beneficiaries* (Washington, DC: The Urban Institute, January 1999).

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The Future of Medicare: #4

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March 2000

The Federal Employees Health Benefits Plan — Not a Model for Medicare

Under the Breaux-Frist bill, Medicare will be transformed into a program resembling the Federal Employee Health Benefits Plan (FEHBP). The remodeled Medicare would operate under a new national board, as the federal Office of Personnel Management (OPM) operates the FEHBP program. Presumably, most beneficiaries would have a choice of the traditional fee-for-service Medicare plan or other managed care plans. Other aspects of the Breaux-Frist proposal—such as the benefit package—would not be the same as the FEHBP.

FEHBP serves a very different population than Medicare:

■ **The population covered by FEHBP is younger and healthier than the Medicare population.** Most Medicare beneficiaries (87 percent) are over the age of 65 and nearly half of those older beneficiaries are 75 and older. By contrast, the average FEHBP enrollee is 45.[1] Three out of ten Medicare beneficiaries are in fair or poor health compared to one out of ten non-elderly Americans.[2]

■ **The healthier FEHBP enrollees are more desirable to insurers.** Medicare beneficiaries are older, sicker, and costlier to cover: the average annual per capita cost of care for Medicare beneficiaries is three times that of the younger, healthier FEHBP enrollees. As a result, fewer plans can be expected to market to the Medicare population and Medicare beneficiaries will not have the range of choices envisioned by supporters of Breaux-Frist.

■ **The federal workers covered by FEHBP are wealthier than Medicare beneficiaries.** The average income for federal workers is over $45,000, while the median income from all sources for Medicare beneficiaries is $19,405.[3] In 1996, 84 percent of Medicare beneficiaries had incomes under $30,000 and 53 percent had incomes under $15,000.[4] The relative wealth of FEHBP enrollees allows them to consider more expensive health plans and

to better afford the high cost of FEHBP's fee-for-service plans, which 70 percent of FEHBP enrollees choose. In addition, many FEHBP enrollees can rely on spousal coverage to supplement or replace FEHBP coverage in areas where choices are limited to expensive fee-for-service plans.

■ **FEHBP enrollees are better equipped to choose from a number of plans:**

Most FEHBP enrollees have ready access through the workplace to information and guidance to help them choose a plan. Although the Breaux-Frist proposal provides for nonprofit organizations ("consumer coalitions") that will make information about health plans available, Medicare beneficiaries—in contrast to federal workers—are individual consumers and are harder to reach with information. Moreover, it is not clear that consumer coalitions will be available to all beneficiaries.

Federal workers have a higher educational level than Medicare beneficiaries. More than seven out of ten non-postal federal employees have at least some college education. By contrast, one of four Medicare beneficiaries did not complete high school and nearly four in ten completed high school but had no further education.[5] Further, at least one out of every five Medicare beneficiaries has Alzheimer's disease or other mental impairments that would make it difficult for them to understand the choices.[6] Only about half of Medicare beneficiares are able to choose a health plan without help from a family member or friend.[7]

FEHBP is not a good model for Medicare:

■ **FEHBP premiums vary dramatically.** The monthly premiums for one person for FEHBP plans range from a low of $56.96 to a high of $180.61.[8] Although geographic differences and variation in benefits contribute to the differences, some FEHBP plans have high premiums because they attract the sickest enrollees. Three plans have dropped out of FEHBP because they were attracting a high concentration of enrollees with health problems, which drove up their premiums.

■ **FEHBP shifts costs to sicker enrollees.** Transforming Medicare into a premium support program (or "competitive premium system") modeled after FEHBP will segregate beneficiaries and shift costs to the sick, just as FEHBP already does. In the Washington, D.C. area, for example, an enrollee in FEHBP's Alliance Preferred Provider Organization plan pays more than two-and-a-half times as much in premiums as the plan is worth in benefits to the average enrollee.[9] In Medicare, experience has already shown that HMOs do seek out younger and healthier beneficiaries; expanded participation of private plans in Medicare will almost certainly increase segregation of beneficiaries by health status and further shift costs to the sick.[10] Right now, sicker beneficiaries in traditional Medicare are protected from such cost-shifting because everyone pays the same premium and risks are pooled across all beneficiaries. In FEHBP, sicker enrollees have little choice but to pay the costs that are shifted to the fee-for-service plans.

■ **FEHBP has not achieved any documented savings from efficiency.** Annual per capita growth rates in FEHBP and Medicare were similar during the decade from 1987 to 1997, but in 1998, FEHBP spending exploded while Medicare spending did not increase at all.[11]

FEHBP provides few—and expensive—choices to rural enrollees:

■ **FEHBP fee-for-service plans are costly but participants in rural areas have few alternatives.** For example, West Virginia has only two FEHBP plans available throughout the state (except for plans sponsored by unions or other employee groups)—one fee-for-service plan and one HMO. In rural parts of other states, the expensive Blue Cross/Blue Shield fee-for-service plan is the only plan (except for plans sponsored by employee groups). In the Medicare+Choice program, Medicare HMOs have chosen to operate in only 15 percent of rural counties.

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[1] Committee on Ways and Means, *1998 Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (Washington, DC: House of Representatives, 1998); Office of Workforce Information, *The Fact Book, 1998 Edition* (Washington, DC: U.S. Office of Personnel Management, 1998).

[2] Health Care Financing Administration, *Profile of Medicare Beneficiaries*, 1998.

[3] Office of Workforce Information, op. cit.; Committee on Ways and Means, *1998 Green Book*, op. cit.

[4] Poisal, John, and George Chulis, "Medicare Beneficiaries and Drug Coverage," *Health Affairs*, March/April 2000.

[5] Schoen, Cathy, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland, *Medicare Beneficiaries: A Population at Risk*, The Commonwealth Fund, 1998.

[6] Marilyn Moon, as quoted in the New York Times.

[7] Cathy Schoen et al., op. cit.

[8] Personal communication with Mark Merlis, February 23, 2000.

[9] Mark Merlis, *Medicare Restructuring: The FEHBP Model*, prepared for the Henry J. Kaiser Family Foundation (Washington, DC: Institute for Health Policy Solutions, February 1999).

[10] Research by the Medicare Payment Advisory Commission, the U.S. General Accounting Office, and others supports this conclusion.

[11] Mark Merlis, op. cit.

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The Future of Medicare: #5

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March 2000

The Breaux-Frist Bill Puts Rural Residents at Risk

Rural Medicare beneficiaries will suffer under the Breaux-Frist Medicare reform plan:

- Rural beneficiaries will have little choice of health plans.
- Rural beneficiaries will pay high premiums.
- The Breaux-Frist rural subsidy is inadequate.
- Market changes may disadvantage rural beneficiaries.
- Rural health care providers will be further squeezed.

Why are rural areas unique?

Rural areas are disproportionately elderly and disproportionately poor, so changes in Medicare are likely to have significant impacts on rural people and rural communities. In 1990, 16 percent of the residents in non-metropolitan counties were age 65 and older compared to 12 percent in metropolitan counties.[1] In 1997, 15.9 percent of the population in non-metropolitan areas—and 12.6 percent of those in metropolitan areas—had incomes below poverty.[2]

Why are rural residents at risk?

LACK OF CHOICE: Proponents of premium support (or "competitive premium system") proposals such as Breaux-Frist believe this approach will save money and improve quality through market competition, but rural areas do not have enough competing plans to gain the benefits of competition. Very few HMOs serve rural areas. In 1999, 86 percent of beneficiaries in metropolitan areas had access to a Medicare+Choice plan.[3] By contrast, only 27 percent of rural beneficiaries had access to one or more Medicare HMOs; only 10 percent had access to two or more HMOs. In 13 states, no rural beneficiaries had access to an HMO.[4]

HIGH PREMIUMS: Having little or no choice of health plans, rural residents will have to rely heavily on the traditional Medicare fee-for-service program. But traditional Medicare will become very expensive. In urban and suburban areas, where beneficiaries have a choice of plans, many of the healthier may opt for these private plans. As the healthy beneficiaries

leave, traditional Medicare will be left with the sickest–and costliest– beneficiaries, driving up the cost of the premium. As the premium increases, more urban and suburban seniors will flee to the cheaper plans, further increasing the per capita costs and, thus, the premiums of traditional Medicare.

INADEQUATE RURAL SUBSIDY: Because there is the potential for steep premium increases in traditional Medicare, the Breaux-Frist plan will subsidize the premiums of beneficiaries who live in areas served only by traditional Medicare. However, those rural residents who live in areas served by *even one* other plan–regardless of how good or how expensive that plan is–will receive no such subsidy.

MARKET DISRUPTIONS: The health insurance industry is undergoing constant change–companies merge or acquire other companies, plans move in and out of markets. Recently, for example, some HMOs pulled out of Medicare, leaving many beneficiaries stranded. Rural areas were disproportionately affected: 64 percent of the counties affected by Medicare HMO pullouts were rural counties. These changes may subject rural Medicare beneficiaries, who have few choices of plans, to fluctuating premiums and/or disruption in their health care.

RURAL PROVIDERS HURT: Rural health care providers are disproportionately dependent on Medicare: Medicare payments make up a higher share of income for rural hospitals and rural physicians than for their urban counterparts.[5] If HMOs move aggressively to reduce provider payments, as they will inevitably have to do to realize the cost savings envisioned by the Breaux-Frist bill, rural providers will be hit harder and they will have fewer alternatives to make up the lost income.

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[1] Rural Policy Research Institute, Percent of U.S. Population Age 65 and Older, 1990.
[2] Census Bureau, *Poverty in the United States: 1997*, Table A.
[3] Medicare Payment Advisory Commission, March 1999.
[4] Families USA, *Rural Neglect: Medicare HMOs Ignore Rural Communities*, September 1999.
[5] National Rural Health Association, Testimony Before the Bipartisan Commission on the Future of Medicare, September 8, 1998.

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Drug Benefit Structure Options for Medicare Beneficiaries
August 21, 1998

Administrative Assumptions. To simplify the analyses, assume that the non-managed care benefit options would be administered in as efficient a way as possible. Medicare would establish a process whereby PBMs in each region competitively bid to provide Medicare services. Once a contract is awarded, the winning PBM in each region would be the sole-source benefits manager for a beneficiary in that area.

OPTIONS

I. BENEFIT FOR ALL MEDICARE BENEFICIARIES

Assume:

- Mandatory, not optional, to avoid selection
- Part B benefit; premium not distinguished from other Part B benefits (25 percent)
- Managed care plans would have to offer this benefit as a minimum; rates would not be increased to reflect costs to plans that did not offer this benefit or level of benefits before.
- No change to Medicaid law (i.e., since Medicare is primary over Medicaid, there would be Medicaid savings, but states would have to pay the additional 25 percent premium)
- No recapture of employer payments
- Change in Medigap law to prohibit comparable drug coverage

Benefit Design:

	Annual Deductible	Coinsurance	Out-of-Pocket Limit
a. FEHB Blue Cross/Blue Shield Standard	$50	20%	$1,000*
b. Base Coverage	$250	20%	$1,000
c. Catastrophic plan	$1,000	None	$1,000

* Note: There is no specific drug cap; the general cap is $2,700 for the standard plan

II. BENEFIT FOR LOW-INCOME BENEFICIARIES ONLY

Assume:

- Administered through Medicaid; new optional benefit; no state mandate
- Builds on current eligibility categories for QMB, SLMB and QI programs. No spend-down

Benefit Design:

	Eligibility	Coinsurance	Matching Rate
a. QMB	Income up to 100% Assets at or below 200% of SSI limit	None	FMAP
b. QI	Income up to 185% of poverty Assets at or below 200% of SSI limit	None for those below poverty $1-2 coinsurance per prescription for those above poverty	100 percent

III. BENEFIT FOR BENEFICIARIES IN MANAGED CARE

Assume:

- All participating Medicare managed care plans must offer at least the base benefit from Option I
- No additional premium is allowed
- No change in Medigap or Medicaid

Benefit Design:

	Payment Adjusted	FFS Benefit
a. Required	No	No
b. Required plus adjustment	Yes	No
c. Requirement plus FFS Catastrophic	No	Yes: Catastrophic coverage option

MEMORANDUM October 23, 1998

FROM: Sally T. Burner
Office of the Actuary
Health Care Financing Administration

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

This memorandum presents the estimated financial effects in fiscal years 2000-2009 under eight alternative proposals to add coverage of prescription drugs to the Medicare program.

Table 1, attached, summarizes the key provisions of the proposals. The proposals differ primarily by (i) which beneficiaries would be eligible for the new coverage (all, low-income only, or managed care enrollees only); (ii) whether Medicare capitation payments to managed care plans would be increased to reflect the mandatory drug coverage; and (iii) by beneficiary cost-sharing requirements (principally low, medium, or high deductible).

In all cases, the drug benefits would be covered under the Supplementary Medical Insurance program ("Part B" of Medicare) and their cost to Medicare would be included in the determination of the monthly SMI premium.[1] Accordingly, 25 percent of the additional Medicare expenditures under these proposals would be financed through higher premiums, and the remaining 75 percent through increased revenue transfers from the general fund of the Treasury. (Option 2.b also involves a "maintenance of effort" payment by the States, as noted below.) This summary of the provisions represents our understanding of the proposals and may be subject to change if we have misinterpreted the specifications or if the proposals are developed further.

The following table shows the estimated total increase in Medicare benefit expenditures during the first 5 and first 10 years under each of the proposals. The 10-year "gross" cost (before reflecting additional premium revenue and reduced Medicaid outlays) generally ranges from $141 billion for the proposals affecting low-income beneficiaries only to $523 billion to cover all beneficiaries with a $50 drug deductible (but no increase in capitation payments). An exception is option 3.a, which would mandate coverage of prescription drugs for Medicare+Choice enrollees only but which would not increase capitation payments; we estimate that this option would result in a negligible savings. Medicare administrative expenses would increase under these proposals but we have not estimated this additional cost.

---

[1] For options 2.a and 2.b, providing drug coverage to low-income beneficiaries only, we continued to assume that the cost to Medicare would be included in the premium determination, with the result that 25 percent of such costs would be met through premium payments by all beneficiaries. Similarly, option 3.b, mandating drug coverage for managed care enrollees only and adjusting capitation payments accordingly, is assumed to result in an increase in SMI premiums for all beneficiaries. An alternative would be to institute a separate drug-related monthly premium for only those beneficiaries eligible for drug coverage.

Proposal	Estimated total increase in Medicare benefit expenditures, in billions	
	2000-2004	2000-2009
Option 1.a	$191	$523
Option 1.b	162	455
Option 1.c	116	350
Options 2.a and 2.b	51	141
Option 3.a	([1])	([1])
Option 3.b	63	188
Option 3.c	117	354

[1] Savings of less than $50 million.

The "net" cost to Medicare, after reflecting additional premium income (but not additional administrative expenses), is shown in table 2 (attached). In addition, the estimated net reductions in Medicaid outlays are shown, reflecting (i) somewhat higher outlays for Medicare premiums and coinsurance, but (ii) significantly lower outlays for prescription drugs. Under option 2.b, State Medicaid programs would be required to rebate to the Medicare program an amount equal to their prior drug spending on behalf of dual beneficiaries.[2] With the exception of options 2.a and 2.b, and again excluding the impact on Medicare and Medicaid administrative costs, the net budget impact of these proposals is generally estimated at a little over 70 percent of the gross increase in Medicare benefit expenditures shown in the table above.

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

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

Sally T. Burner

Sally T. Burner, A.S.A.
Special Assistant to the Chief Actuary

[2] For purposes of estimating this transfer, we have assumed that it would be established for all years at an amount equal to the estimated Medicaid spending on prescription drugs in fiscal year 2000. We have also assumed that a Federal requirement for State revenues would be found constitutional, although this outcome seems far from certain.

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

Table 1—Su ary of key prov ions of alternative proposals to add coverage of prescription dr gs to Medicare

Proposal	Eligibility	Adjust managed care payments?	Deductible	Coinsurance	Maximum out-of-pocket cost
Option 1.a	All beneficiaries	No	$50	20%	$1,000
Option 1.b	All beneficiaries	No	$250	20%	$1,000
Option 1.c	All beneficiaries	No	$1,000	None	$1,000
Options 2.a and 2.b[1]	Low-income beneficiaries only:				
	Dual & QMB[2]	No	None	None	n.a.
	SLMB & QI[3]	No	None	$2 per script	n.a.
Option 3.a	Managed care enrollees only	No	$250	20%	$1,000
Option 3.b	Managed care enrollees only	Yes	$250	20%	$1,000
Option 3.c	All beneficiaries:				
	Managed care	No	$250	20%	$1,000
	Fee-for-service	n.a.	$1,000	None	$1,000

[1] Under option 2.b, States would be required to rebate to the Medicare program an amount equal to their prior drug spending on behalf of dual beneficiaries. Option 1.a would not require this "maintenance of effort" payment.

[2] Income and assets meeting existing standards for either full or QMB Medicaid eligibility.

[3] Income and assets meeting existing standards for either SLMB, QI1, or QI2 Medicaid eligibility.

Note: For each option, the prescription drug coverage would be classified as a benefit under the Supplementary Medical Insurance program, and its cost would be included in the determination of the monthly SMI premium. Eligibility for the Medicare benefit under option 2 would be determined through the Medicaid program, using the existing income and asset criteria for Medicaid eligibility. For all proposals with drug deductibles, the amount of the deductible would not be indexed in future years. An effective date of January 1, 2000 was assumed for each proposal.

Office of the Actuary
Health Care Financing Admin.
October 23, 1998

Table 2—Esti ited Medicare and Federal Medicaid costs (+) or sav gs (-) under alternative prop ls to add coverage of prescription drugs to Medicare

(In billio)

Proposal	Fiscal year										Total,	Total,
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
Option 1.a												
Medicare expenditures	$20.6	$37.1	$40.4	$44.3	$48.6	$53.5	$59.1	$65.5	$72.8	$80.8	$191.1	$522.7
Medicare premiums	-4.9	-8.7	-9.5	-10.4	-11.4	-12.5	-13.8	-15.3	-16.9	-18.8	-44.9	-122.2
Net Medicare impact	15.7	28.4	30.9	33.9	37.2	41.0	45.3	50.3	55.8	62.0	146.2	400.6
Fed. Medicaid expenditures	-1.2	-1.4	-1.5	-1.7	-1.9	-2.1	-2.4	-2.7	-3.1	-3.4	-7.7	-21.4
Net budget impact	14.6	27.0	29.4	32.2	35.3	38.9	42.9	47.5	52.8	58.5	138.5	379.1
Option 1.b												
Medicare expenditures	17.0	30.9	34.1	37.7	41.8	46.5	51.8	57.9	64.7	72.3	161.6	454.8
Medicare premiums	-4.0	-7.2	-7.9	-8.7	-9.7	-10.8	-12.0	-13.4	-14.9	-16.7	-37.5	-105.2
Net Medicare impact	13.1	23.7	26.2	29.0	32.2	35.8	39.8	44.5	49.8	55.6	124.1	349.7
Fed. Medicaid expenditures	-1.1	-1.3	-1.4	-1.6	-1.8	-2.1	-2.4	-2.7	-3.0	-3.4	-7.3	-20.8
Net budget impact	11.9	22.5	24.7	27.4	30.3	33.7	37.5	41.9	46.8	52.2	116.9	328.8
Option 1.c												
Medicare expenditures	11.4	21.2	24.1	27.5	31.4	35.7	40.6	46.1	52.4	59.2	115.6	349.6
Medicare premiums	-2.5	-4.7	-5.4	-6.2	-7.0	-8.0	-9.1	-10.4	-11.8	-13.4	-25.9	-78.7
Net Medicare impact	8.8	16.5	18.7	21.4	24.3	27.6	31.4	35.7	40.5	45.8	89.7	270.8
Fed. Medicaid expenditures	-1.0	-1.0	-1.2	-1.4	-1.6	-1.9	-2.2	-2.6	-3.0	-3.4	-6.3	-19.3
Net budget impact	7.9	15.4	17.5	19.9	22.7	25.7	29.2	33.2	37.6	42.4	83.4	251.5
Option 2.a												
Medicare expenditures	5.5	9.9	10.8	11.9	13.1	14.4	16.0	17.7	19.6	21.7	51.2	140.6
Medicare premiums	-1.4	-2.5	-2.7	-3.0	-3.3	-3.6	-4.0	-4.4	-4.9	-5.4	-12.8	-35.2
Net Medicare impact	4.1	7.4	8.1	8.9	9.8	10.8	12.0	13.3	14.7	16.3	38.4	105.5
Fed. Medicaid expenditures	-2.1	-3.1	-3.4	-3.7	-4.0	-4.5	-4.9	-5.5	-6.0	-6.7	-16.3	-43.9
Net budget impact	2.0	4.3	4.8	5.2	5.8	6.4	7.1	7.8	8.7	9.6	22.1	61.6
Option 2.b												
Medicare expenditures	5.5	9.9	10.8	11.9	13.1	14.4	16.0	17.7	19.6	21.7	51.2	140.6
Medicare premiums	-1.0	-2.0	-2.2	-2.5	-2.8	-3.1	-3.5	-3.9	-4.4	-4.9	-10.4	-30.2
MOE transfer	-1.5	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-2.0	-9.7	-20.0
Net Medicare impact	2.9	5.9	6.6	7.4	8.3	9.3	10.4	11.7	13.2	14.8	31.1	90.5
Fed. Medicaid expenditures	-2.1	-3.1	-3.4	-3.7	-4.0	-4.5	-4.9	-5.5	-6.0	-6.7	-16.3	-43.9
Net budget impact	0.8	2.8	3.2	3.7	4.2	4.8	5.5	6.3	7.1	8.1	14.8	46.6
Option 3.a												
Medicare expenditures	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Medicare premiums	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Net Medicare impact	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Fed. Medicaid expenditures	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Net budget impact	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Option 3.b												
Medicare expenditures	6.2	11.7	13.2	15.0	17.1	19.4	21.9	24.6	27.6	30.8	63.3	187.5
Medicare premiums	-1.6	-2.9	-3.3	-3.8	-4.3	-4.8	-5.5	-6.1	-6.9	-7.7	-15.8	-46.9
Net Medicare impact	4.7	8.8	9.9	11.3	12.8	14.5	16.4	18.4	20.7	23.1	47.4	140.7
Fed. Medicaid expenditures	0.2	0.3	0.3	0.4	0.4	0.5	0.6	0.6	0.7	0.8	1.6	4.7
Net budget impact	4.8	9.1	10.2	11.6	13.2	15.0	17.0	19.1	21.4	23.9	49.0	145.4
Option 3.c												
Medicare expenditures	11.5	21.5	24.5	27.9	31.8	36.2	41.1	46.8	53.1	60.1	117.2	354.4
Medicare premiums	-2.6	-4.8	-5.5	-6.3	-7.2	-8.2	-9.3	-10.6	-12.0	-13.6	-26.3	-79.9
Net Medicare impact	9.0	16.7	19.0	21.6	24.6	28.0	31.8	36.2	41.1	46.4	90.9	274.5
Fed. Medicaid expenditures	-1.0	-1.0	-1.2	-1.4	-1.6	-1.9	-2.2	-2.5	-2.9	-3.4	-6.2	-19.2
Net budget impact	8.0	15.6	17.8	20.2	23.0	26.1	29.6	33.7	38.1	43.1	84.6	255.3

[1] Cost or savings of less than $50 million.

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

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

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

w/o drug benefit, per capita 484 ; $6000/ USPCC year.

Office of the Actuary
Health Care Financing Admin.
October 23, 1998

The National Bipartisan Commission on the Future of Medicare
Ph: 202-252-3380
Fax: 202-252-3397

Fax

To: Medicare Commission Members' Staff **From:** Bobby Jindal

Attn: **Pages:** 6, including the cover sheet

CC: **Date:** November 9, 1998

Re: Staff Meeting on Nov. 10th at 10:00AM **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

Attached are the following documents for your review prior to the staff meeting, which is scheduled to be held tomorrow morning, Tuesday, Nov. 10th at 10:00 a.m. in H-137, Capitol.

Let me know if you have any questions, thanks.

Agenda for November 10 Staff Meeting

1. Discussion of Analysis of Sample Medicare Benefit and Medigap Changes

   Staff has been analyzing various proposals discussed by Members or witnesses during recent Commission and task force meetings. These have included combining and changing the Part A and Part B deductible, adding stop loss and prescription drug coverage, and adding coinsurance to different services. Members have also discussed the impact of first-dollar supplemental coverage on Medicare utilization and costs. Staff has worked with CBO to generate initial order of magnitude estimates to illustrate the potential impact of some of these proposals. Anne Mutti and Jeff Lemieux have already presented analyses of three proposals (raising the eligibility age, means-testing Part B premiums, and extending BBA provisions).

2. Discussion of Premium Support Concept and Different Formulas Used by FEHBP and other Models

   Staff has been analyzing various aspects of a premium support model discussed by Members or witnesses during recent Commission and task force meetings. Mike O'Grady presented a paper outlining key questions to be considered. Staff has additional information on constructing premium formulas and determining the government's contribution (e.g., national versus local calculations).

3. Next Steps

   Staff will continue working on additional Medicare/Medigap changes, combinations of proposals, and scoring of sample premium support scenarios.

DRAFT

Analyses of Sample Medicare Benefit and Medigap Changes

Note: These policies have been mentioned by Commission members or public witnesses. This list of sample changes is for discussion purposes only, and does not imply Commission endorsement.

(This chart is based upon CBO estimates. These estimates are highly preliminary. They have not been internally reviewed by CBO and therefore are subject to change. They are intended to provide a sense of magnitude only. The estimates reflect the impact on net Medicare expenditures. Because combining policies may result in interactions, the policy estimates may not be exactly additive.)

Sample Policies mentioned by Commissioners or witnesses (not endorsed by the Commission)	**5-year estimate (2000-2004) (in billions)**	**9-year estimate (2000-2009) (in billions)**	**2008 estimate (in billions)**	**Change in Part B monthly premium (2000)**	**Change in Medigap monthly premium (2000)**
Combined Deductible at $380 in year 2000. Indexed.[1]	$5	$6	$0	-$3.00	$3.00[2]
$500 Combined Deductible in 2000. Indexed	-$11	-$28	-$5	-$4.00	$10.00
$1,000 Combined Deductible in 2000. Indexed.	-$65	-$147	-$23	-$8.00	$35.00
$4,000 Stop Loss in 2000. Indexed.	$35	$78	$12	$2.00	-$7.00
Home Health 20% Coinsurance	-$32	-$70	-$11	-$1.00	$11.00

[1] Under the combined deductible options, the deductible would be applicable to all services and indexed to Medicare growth rate.

[2] Medigap estimates are based upon plans that only cover Medicare cost-sharing at an estimated monthly premium of $80.

Sample Policies mentioned by Commissioners or witnesses (not endorsed by the Commission)	5-year estimate (2000-2004) (in billions)	9-year estimate (2000-2009) (in billions)	2008 estimate (in billions)	Change in Part B monthly premium (2000)	Change in Medigap monthly premium (2000)
Hospital Coinsurance of 20 percent effective at beginning of stay	-$138	-$294	-$43	$0.00	$44.00
No Limit on Hospital Day Coverage	Not available yet; expected to be a small cost				
Prescription Drug Coverage[3]	$119	$267	$42	$15.00	Not available yet
Change Medigap Coverage to 50 percent of cost-sharing above the deductible	-$36	-$78	-$12	-$1.00	-$59.00

[3] Prescription drug benefit is in Part B with a $250 deductible, $2,000 stop-loss, 20 percent coinsurance; beneficiaries pay 25 percent of cost in premium. Assumes a discount of 9 percent off nominal charges.

Figure 1 - Hypothetical Premium Support Using the FEHBP Formula

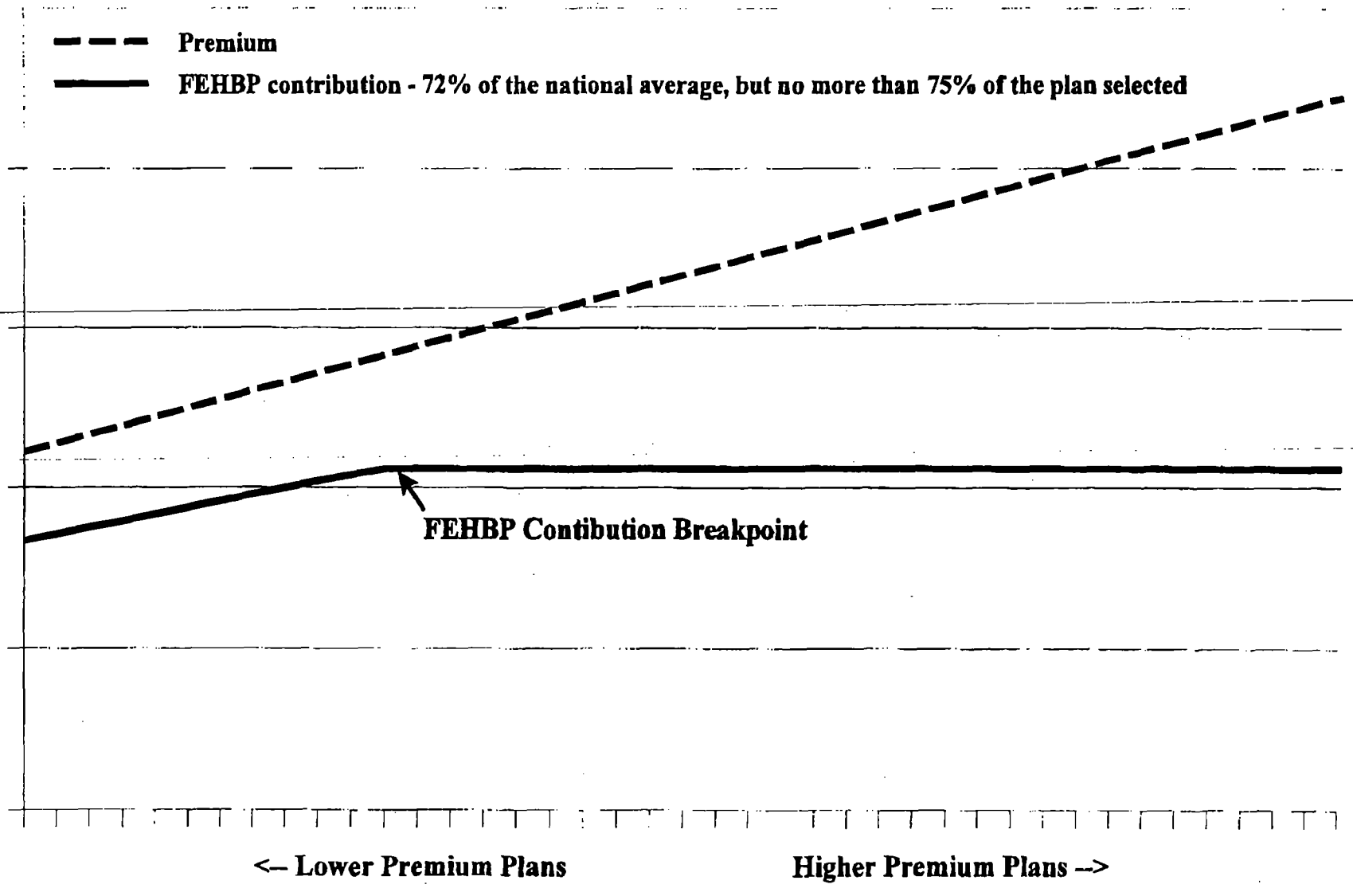
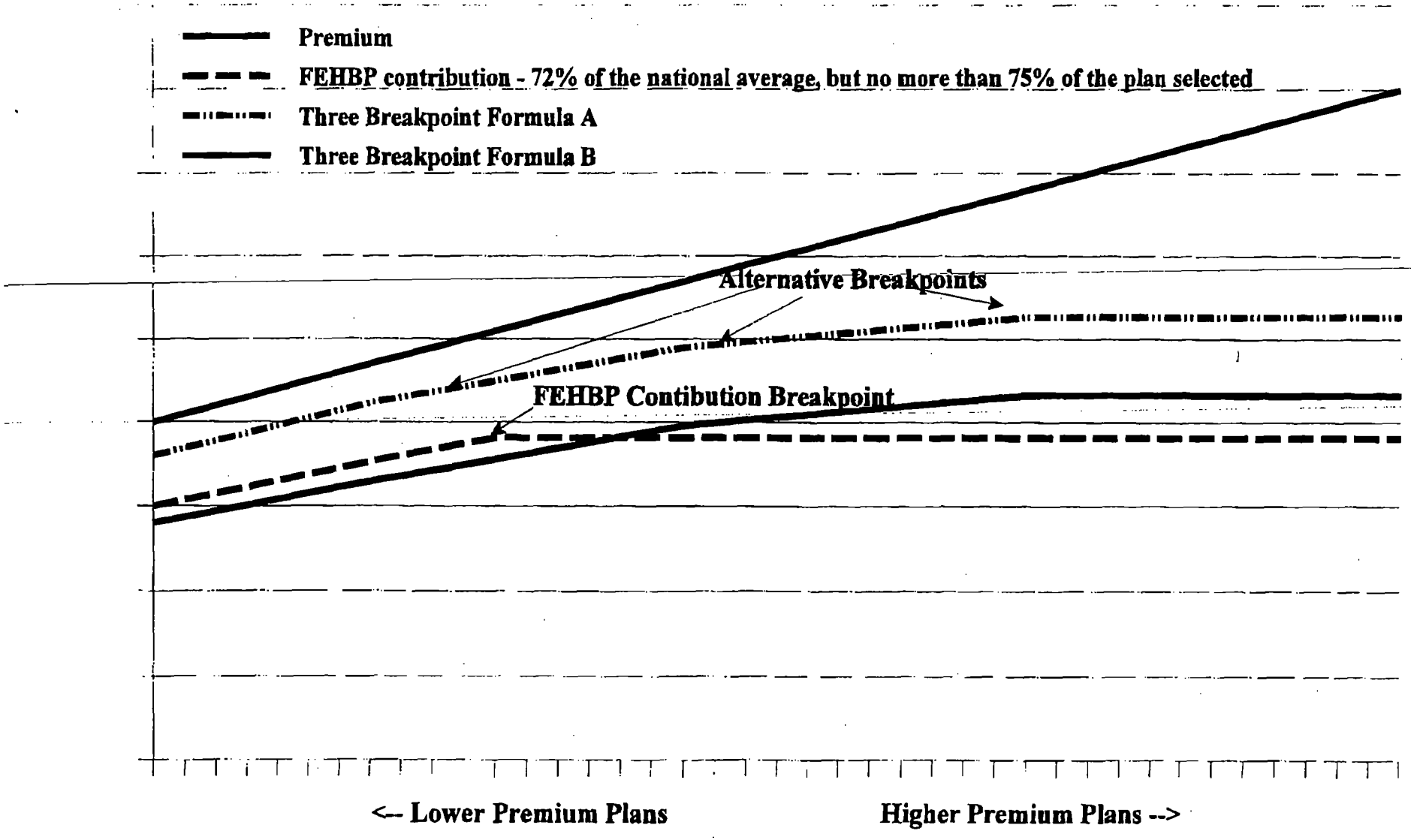


Figure 2 -Hypothetical Premium Support Using a Three Breakpoint Formula



MEDICARE DRUG BENEFITS 10/29

8 different options
differ by eligibility

3rd set primarily for managed care, these would increase capitation payments; maximum OOP of 1000

SMI premium cost carries thru into premium, but it gets weird when you don't have everyone covered; ↑ for all but not everyone gets the benefit.

assuming that:
① drug ben. we proscribe
② substandard benefit
③ no benefit

not assuming that payment is on what they're getting now.

used MCBS file (what we think bennie pd)
discount factor 13%

drug-drug interaction
expenses — properly managed drug benefit to prevent hospitalizations.
Danny - private mkt.

1:1 affect for Δ in out of pocket.

mostly copay oriented
now cap
spending is lower in HMO world

most plans have copays, not deductibles

get costs down by:

index deductible

max out of pocket costs switch to max plan payment.

PBM → lowering costs

you can either control mgmt, price

means tested

managed care

universal.

you can means test the deductible.

3c - only if Dept pushes other option that they'd like to see.

none of these are State options.

3b index premium $
max out o pocket costs
what's the effect.
Cost would grow at 9.5%
over 10 years (3:1).

Call mon @3

* mtg late next wk to discuss
send new list of options for drug benefit*

GARY
DAN
MARK
CHARMIAN
PHIL

mtg HCFA & PBM

FAX COVER SHEET

To: Donna Adler

Telephone: _____

FAX: _____

From: Julie Gilgen

Message: _____

_____

_____

_____

_____

No. of pages (including cover sheet): 5

Beneficiary Protections

Current beneficiary protections provided to Medicare+Choice beneficiaries would also apply to enrollees in prescription drug plans. These protections include guaranteed issue, nondiscrimination, community rating, prohibitions against pre-existing condition exclusions, and grievance and appeals mechanisms. Prescription drug plans would be required to disclose in clear, accurate and standardized form its premiums, deductibles, co-payments and access to covered out-patient drugs. Additional and more detailed information must be provided upon request.

Plans must assure convenient access to pharmacies. If plans develop formularies, they must use pharmaceutical and therapeutic committees that include physicians and pharmacists. Beneficiaries could appeal for coverage of a medically necessary, non-formulary drug if the prescribing physician determines that the formulary drug is not effective or has significant adverse side effects.

Plans must have quality assurance measures in place to reduce medical errors and adverse drug interactions. Plans must have drug utilization programs, programs to control fraud and abuse and medical management therapy programs to provide beneficiary education and counseling of the proper uses of their prescription medicines.

Beneficiaries would have access to negotiated discounts, even beyond initial benefit caps. All beneficiaries, regardless of where they live, would have the choice of at least two plans, one of which must be a prescription drug plan for Fee-For-Service beneficiaries.

Subsidies for Low Income Beneficiaries

Beneficiaries with incomes below 135% of poverty would receive a full subsidy for the premium of the least costly plan in their area and full cost-sharing subsidy for all costs except nominal co-pays. Beneficiaries with incomes between 135% of poverty and 150% of poverty would receive sliding scale premium subsidies and full cost-sharing subsidies. These Medicare beneficiaries would be treated as seniors first, and low-income second. Therefore, Medicare would become primary for dual eligible beneficiaries. States could offer coverage beyond the Medicare benefit.

Subsidies for All Medicare Beneficiaries Through Reinsurance for Sickest Beneficiaries

Plans that offer qualified prescription drug coverage will be entitled to receive reinsurance payments from Medicare for high cost patients. A plan with a typical patient profile will receive a 25%-30% effective subsidy, thereby encouraging lower risk people to enroll and making insurance more affordable for all beneficiaries. Plans with higher numbers of sick patients will receive additional assistance. This largely solves the adverse selection concern and also acts as an automatic retrospective risk adjuster based on real costs.

The reinsurance will apply in phased-in attachment points. There will be a gradual schedule of increased government assistance as patients' costs rise. As such, Medicare will provide more assistance to those patients with higher costs. In no case will the plans be absolved of all risk because it is important for them to retain incentives to negotiate high cost drugs and effectively manage high cost patients.

To encourage retiree plans to retain and expand their prescription drug coverage, qualified employer plans could avail themselves of these reinsurance subsidies.

Title II Medicare Oversight and Management Administration

A new agency, to be called the Medicare Oversight and Management Administration (MOMA), would be established within the Department of Health and Human Services (DHHS) to administer the prescription drug benefit and the Medicare+Choice program. Additionally, the MOMA would disseminate information about the Medicare program to beneficiaries through the mail, Internet, and through the toll-free telephone number. The MOMA Administrator would submit an annual report to Congress and the President on the prescription drug benefit and the Medicare+Choice program.

The Administrator and the Deputy Administrator of the MOMA would be appointed by the President for a five-year term with the approval of the Senate. The Administrator would be able to hire personnel without regard to Civil Service hiring procedures under an alternative salary scale, but ethics in government restrictions, conflict of interest provisions, and post-employment lobbying limitations would apply.

Medicare Policy Board

A Medicare Policy Board (MPB) would be established within the MOMA in the DHHS. The MPB would advise and make recommendations to the MOMA Administrator and would submit reports containing legislative or administrative changes to the President and to Congress. The topics of study could include beneficiary education and enrollment, and competitive bidding. The reports would be published in the Federal Register. The MOMA Administrator would be required to submit an analysis of the recommendations to the President and to Congress within a certain time period. The MPB would consist of seven individuals, appointed for a fixed term by the President, the House of Representatives and the Senate. The MPB would have a Director and an independent staff and the capability to conduct research and analyses under its own budget authority.

Title III Oversight of Financial Sustainability of the Medicare Program

Today, Medicare solvency only measures the fiscal outlook of part of Medicare – the Part A Hospital Insurance Trust Fund, which is funded through the payroll tax. This trust fund can easily be gamed, such as when the home health program was transferred from Part A to Part B, which is funded from the General Fund and beneficiary premiums.

Since the addition of a Medicare drug benefit would have a zero impact on Medicare's current measure of solvency, it is appropriate to develop a new process to examine the overall sustainability of the program in this legislation.

The Board of Trustees of Medicare would be required to report annually to Congress the total amounts obligated from the General Fund to Medicare. The report must also show what percentage of Medicare's finances are derived from the General Fund each year and into the future. House and Senate committees of jurisdiction would be required to hold hearings on the report.

Title IV Establishing International Equity in the Financing of Pharmaceutical Research and Development Costs

Presently, Americans, and seniors in particular, are shouldering a disproportionate burden for the research and development costs of the pharmaceutical industry. This is because many countries have enacted price controls and, in effect, only pay the marginal costs of manufacturing the drugs.

Under the bill, the US Trade Representative in consultation with the Secretary of Health and Human Services shall enter into negotiations with G-8 countries and NAFTA signatories to eliminate price controls and the unfair trade practices that result from the application of such controls. The purpose of the negotiations would be to ensure that other countries pay their fair share of the pharmaceutical research. If in a year after enactment the negotiations have not achieved their intended objectives, the USTR could recommend to Congress the most effective measures to eliminate the disparity including imposing measures under Section 301 of the Trade Act of 1974.

Title V Medicare+Choice Payment Reforms

To strengthen and stabilize the Medicare+Choice program, payments rates for plans would be adjusted. This would be accomplished by removing budget neutrality and increasing the "floor" payment rate to attract Medicare+Choice plans to rural areas. Plans would be able to apply to the MOMA, through the presentation of cost and other relevant data, to negotiate for increases in rates up to a limit.

Title VI Recouping Government Investments in the Research and Development of Prescription Drugs

The pharmaceutical industry has greatly benefited from research performed with taxpayer dollars through National of Institute of Health (NIH) grantees. While NIH grantees must report to NIH new inventions and plans for licensing those inventions to outside entities, grantees do not have to report the number of new drugs developed by outside entities or the royalties collected from the sale of such drugs.

The bill would require grantees to report to NIH on: 1) the drugs licensed to outside companies; 2) the stage of development at which the drug was licensed for marketing; and 3) the royalties collected by the grantee from the sale of those drugs.

(Considering options for recouping these taxpayer provided funds.)

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Facsimile Cover Sheet

To: Christopher Jennings
Company: White House
Phone: 202.456.5560
Fax: 202.456.5557

From: Alissa Fox
Company: BCBSA
Phone: 202-626-8618
Fax: 202-626-4833

Date: April, 28, 2000
Pages including this cover page: 3

Comments:

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

1310 G Street, N.W.
Washington, D.C. 20005
Telephone 202.626.4780
Fax 202.626.4853

April 24, 2000

The Honorable William V. Roth Jr.
U.S. Senate
104 Hart Senate Office Bldg.
Washington, DC 20510

Dear Senator Roth:

As you consider ways of making prescription drug coverage more affordable and accessible to Medicare beneficiaries, the Blue Cross and Blue Shield Association (BCBSA) urges you to not rely on the so-called "stand-alone" option. **Private stand-alone prescription drug coverage will not work.** To pass legislation providing access to such coverage would constitute an empty promise to Medicare beneficiaries.

Together, Blue Cross and Blue Shield Plans form the country's largest provider of Medigap coverage. It is exceedingly unlikely that any of our Plans would offer a stand-alone prescription drug policy in their service areas. The reason is affordability. The absolute cost and annual rate of increase in the cost of prescription drugs would make a drug-only benefit package so expensive that only those who expect to have very high use of the benefit would initially buy a policy. The package would not appeal to the majority of seniors that has relatively low drug costs. Plans would experience tremendous adverse selection, which would escalate premiums.

Without a large pool of relatively healthy seniors subsidizing a much smaller pool of high-cost prescription drug users, premiums would be exorbitant. Moreover, with drug spending projected to *double* over the next five years, large annual price increases would result in "healthier" enrollees dropping their policy each year, which in turn would lead to even higher prices for those who remained. This downward spiral in enrollment would leave many seniors without coverage and very disillusioned – and would make insurers loathe to offer such a policy.

Even a system of federal subsidy would not resolve the underlying failures of a stand-alone prescription drug benefit. A private stand-alone policy would still be subject to considerable selection and to the rapidly rising cost of drugs. In addition, a subsidy would entail a number of difficult operational issues: How is the subsidy to be targeted and delivered? Who would administer the subsidy? Would the subsidy be tied to the premium charged, which will vary greatly by geographic and age factors, or would it be a set dollar amount? And, would the real value of the subsidy stay constant over time?

A private stand-alone drug insurance policy is a recipe for failure. Instead, BCBSA supports comprehensive reform of the Medicare program to assure the program will remain financially stable and secure. In the context of overall reform that adequately finances current benefits, BCBSA believes Congress should provide prescription drug benefits as an integral part of Medicare coverage.

If comprehensive reform of the Medicare program is not feasible this year, an effective interim step would be to provide federal funding to states for the provision of targeted assistance to those seniors who have the greatest need. Several states have already implemented effective pharmacy assistance programs. Federal funding would allow these states to expand their programs and allow the remaining states to implement similar programs. Such an interim program would be effective in meeting the goal of making prescription drug coverage more affordable and accessible to seniors. This is not the case for private prescription drug coverage.

Congress should also act this year to stabilize the Medicare+Choice program, which provides an option for prescription drug coverage to millions of Medicare beneficiaries.

We appreciate the opportunities you have given BCBSA to provide input into this important debate and we stand ready to assist the committee in the development of an effective solution.

Thank you for your time and attention.

Sincerely,

Mary Nell Lehnhard
Senior Vice President

Cc: William E. Kirk, III, Blue Cross and Blue Shield of Delaware