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The Medicare Prescription Drug and Modernization Act of 2000
(Breaux-Frist 2000)
Medicare for the 21st Century

IMPROVED MEDICARE MANAGEMENT AND ADMINISTRATION

✓ **Restructures the 1965 Model**
Establishes a new executive branch agency, the Competitive Medicare Agency, outside of the Department of Health and Human Services to oversee Medicare+Choice plans and outpatient prescription drug coverage. Eliminates the inherent conflict of interest of HCFA managing both fee-for-service Medicare and Medicare+Choice plans that compete for the same beneficiaries. Establishes a new mission for Medicare in the 21st century leaving behind the bureaucracy and outdated mindset that continues to plague the program and instead guaranteeing seniors choice, health care security, and improved benefits and delivery of care.

MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFITS PROGRAM

✓ **Establishes Voluntary, Universal Outpatient Prescription Drug Coverage**
Allows all Medicare beneficiaries who are entitled to Part A benefits and enrolled under Part B to elect outpatient prescription drug coverage beginning in 2003. Beneficiaries can receive drug coverage through either a Medicare Prescription Plus Plan, designed for beneficiaries remaining in traditional Medicare, or through a Medicare+Choice Plan.

✓ **Guarantees Medicare Benefits, Standard Coverage for Prescription Drugs, and Protections Against High Out-of-Pocket Drug Costs**
Maintains all current Medicare benefits and offers standard outpatient prescription drug coverage, which includes a $250 deductible, $2,100 in initial coverage and 50% cost-sharing. Provides coverage and security against escalating out-of-pocket drug costs by requiring that all outpatient prescription drug coverage offered to beneficiaries include stop-loss protection of $6,000 so a beneficiary never pays for drugs out of their own pocket beyond this amount. Provides beneficiaries the choice of coverage that best suits their individual needs by allowing the offering of different drug benefit plans, while ensuring the benefit value of standard coverage is maintained along with all stop-loss protections.

✓ **Guarantees Price Discounts off Prescription Drugs**
Requires price discounts negotiated between pharmaceutical companies and insurers to be passed along to beneficiaries through a prescription drug discount card program offered by the plan, to ensure beneficiaries never pay retail prices for prescription drugs at any time.

✓ **Guarantees Affordable Drug Coverage through Universal Premium Subsidies**
Offers all beneficiaries a 25% subsidy toward the premium costs of prescription drug coverage. In addition, all beneficiaries will enjoy the benefits of additional premium reductions as a result of the federal government sharing in the risk of covering high-cost beneficiaries.

✓ **Protects Low-Income Beneficiaries**
Provides subsidies for beneficiaries with incomes below 135% of poverty by offering 100% full coverage of premiums, deductibles and co-pays associated with prescription drug coverage. Beneficiaries between 135% and 150% receive premium subsidies on a sliding scale from as much as 100% to no less than 25%. Since 39% of beneficiaries with incomes below 150% of poverty have no drug coverage under Medicare, this provision alone will provide comprehensive drug coverage for over 5 million seniors and individuals with disabilities.

MEDICARE+CHOICE PROGRAM IMPROVEMENTS

✓ **Improves Benefits and Health Care Delivery under Medicare**
Implements payment reforms for Medicare+Choice plans to preserve and expand choice for seniors and the disabled enrolled in such plans and helps to stabilize plan payments in rural or low payment areas. In 2003, establishes a new competitive system under Medicare+Choice where plans bid for the costs of delivering care and compete based on benefits, price, and quality so that beneficiaries receive the highest-quality, affordable health care. Allows maximum flexibility for plans to reduce current beneficiary Part B premiums and cost-sharing as well as offer new and additional benefits to beneficiaries, including outpatient prescription drug coverage.

BENEFICIARY PROTECTIONS, OUTREACH, AND ENROLLMENT

✓ **Encourages Informed Choice and Maintains Beneficiary Protections**
Establishes Medicare Consumer Coalitions, beneficiary supported organizations, designed to provide beneficiaries timely and accurate information at the federal, state, and local levels with respect to Medicare benefits and options. Ensures beneficiaries are protected through appropriate grievance and appeals processes for all Medicare benefits, including outpatient prescription drug coverage.

MEDICARE SOLVENCY MEASURES

✓ **Establishes Fiscally Responsible Measures of Solvency**
Provides a true and accurate measure of solvency by establishing reporting requirements for the Medicare program as a whole, including both Parts A and B, in determining the financial health of Medicare. Requires reports to Congress by the Medicare Trustees to evaluate general revenue spending in the program, provide historical spending trends, provide 10-year and 50-year projections, and provide information regarding the rate of spending under the program compared to the rate of growth in the gross domestic product.

Medicare Prescription Drug and Modernization Act of 2000
Breaux-Frist 2000
Section by Section Analysis

TITLE I–MEDICARE MANAGEMENT AND ADMINISTRATION

Section 101/Section 2201. Establishment of the Competitive Medicare Agency.

A Medicare Competition and Prescription Drug Program is created under a new title (Title XXII) of the Social Security Act, establishing a new Competitive Medicare Agency (CMA) as an independent, executive branch agency. The new Agency administers Medicare+Choice and the new Medicare Prescription Plus program created under Part B of this title.

The Secretary, Commissioner, and HCFA Administrator must establish an appropriate transition of responsibility to redelegate the administration of Part C, Medicare eligibility and enrollment, and any other parts of Title XVIII, from the Secretary and the HCFA Administrator to the Commissioner of the CMA for purposes of carrying out the responsibilities of Title XXII.

Section 2202. Commissioner, Deputy Commissioner and Other Officers.

The CMA is headed by a Commissioner appointed by the President with the advice and consent of the Senate. The Commissioner serves a term of 6 years and is paid at level I of the Executive Schedule. When the term expires, the Commissioner continues in office until a successor is appointed. Anyone appointed to complete an unexpired term serves only for the remainder of the term. The Commissioner can only be removed from office for neglect of duty or malfeasance in office.

The Commissioner is responsible for coordinating determinations of beneficiary eligibility and enrollment under Title XVIII and administering the Medicare+Choice and Medicare Prescription Plus program under Title XXII. The Commissioner will disseminate comparative information to beneficiaries regarding benefits, cost-sharing obligations, and quality indicators of Medicare+Choice, Medicare fee-for-service, Medicare supplemental policies, and Medicare Prescription Plus plans. Additionally, the Commissioner will establish a beneficiary education program and disseminate information to beneficiaries on appeals rights under these programs.

The Commissioner will negotiate and enforce contracts with Medicare+Choice plans and Medicare Prescription Plus plans. The Commissioner shall also carry out other duties under Part C of Title XVIII, including oversight of demonstration projects and the programs of all-inclusive care for the elderly (PACE), social health maintenance organizations (SHMOs), and Evercare.

The Commissioner of the CMA must submit a report to Congress on the administration of the Medicare+Choice and the Medicare Prescription Plus programs no later than March 31 of each year.

The Commissioner is responsible for the exercise of all powers and discharge of all duties of the CMA. The Commissioner can establish and reorganize units with the Agency, can prescribe rules and regulations under the Administrative Procedures Act, and can delegate authority to his or her subordinates.

A Deputy Commissioner of the CMA is appointed by the President, by and with the consent of the Senate. The Deputy Commissioner serves a 6-year term and is paid at level II of the Executive Schedule. When the Deputy Commissioner's term expires, he or she continues in office until a successor is appointed. Anyone appointed to complete an unexpired term will serve only for the remainder of the term. The Deputy Commissioner performs the duties and exercises the powers delegated to him or her by the Commissioner. The Commissioner and Deputy Commissioner may not be appointed before March 1, 2001.

A Chief Actuary is appointed to serve as the chief actuarial officer for the CMA.

The Commissioner and the Secretary of HHS consult on an ongoing basis to ensure the appropriate coordination of programs administered by the Commissioner under Title XXII and the administration of traditional Medicare by the Secretary of HHS.

Section 2203. Administrative Duties of the Commissioner.

The Commissioner is authorized to hire staff in a flexible manner without regard to civil service laws, but in no case may the rate of compensation exceed Executive Level IV. The Commissioner establishes an Agency budget based on a comprehensive work force plan. Appropriations for administrative expenses are authorized on a biennial basis.

The Secretary ensures that the information and data disclosed to the HCFA Administrator is also disclosed to the CMA Commissioner to in order to carry out his or her duties under Title XXII. The Secretary and Commissioner periodically review and collaborate on the need to exchange additional data as may be necessary to provide to each other as well as states, in order to meet programmatic needs.

Section 2204. Medicare Competition and Prescription Drug Advisory Board.

The Medicare Competition and Prescription Drug Advisory Board is established within the CMA to advise the Commissioner on policies related to the Medicare+Choice program and the Medicare Prescription Plus program under Part B of this title. The Board must submit reports to Congress and the Commissioner regarding the administration of these programs. The reports must be submitted directly to Congress and no officer or agency of the United States may require

that they be submitted to any officer or agency for approval, comments, or review, before being submitted to Congress.

The Board consists of 7 members - 3 appointed by the President; 2 appointed by the President pro tempore of the Senate with the advice of the Chairman and Ranking Minority Member of the Senate Finance Committee; and 2 appointed by the Speaker of the House, with the advice of the Chairman and Ranking Member of the House Ways and Means Committee. Board members serve 6-year terms with initial appointments serving staggered terms as follows: the 3 initial Presidential appointees serve terms of 2, 4 and 6 years; the 2 initial Senate appointees serve terms of 3 and 6 years; the 2 House of Representative appointees serve staggered terms of 4 and 5 years. No Board member may serve more than 8 years.

A member of the Board is designated by the President to serve as Chairperson of the Board for a term of 4 years coincident with the term of the President. The Board meets at the call of the Chairperson but not less than 4 times annually. Both the director and staff of the Board are appointed and paid without regard to civil service provisions except that the rate of pay may not exceed Executive Level IV.

Section 102. Commissioner as Member of the Board of Trustees of the Medicare Trust Funds.

This provision makes the Commissioner of the CMA an ex officio member of the Medicare Board of Trustees.

Section 103. Salary Increase for HCFA Administrator.

This provision raises the salary of the HCFA Administrator to Executive Level III.

Section 161. Requirements for Annual Financial Reporting and Oversight of Medicare.

The Medicare Board of Trustees is required to submit a report to Congress on the operation and status of the Hospital Insurance and Federal Supplemental Medical Insurance trust funds, as well as the Medicare Prescription Drug Account for all benefits under Title XVIII and Title XXII. The report must include information on the obligations from the general revenues of the Treasury for Medicare benefits; a historical overview of that spending; 10-year and 50-year projections; and overall spending from the general revenues in relation to the rate of GDP. The report is published annually by the Committee on Ways and Means.

TITLE II– MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

Section 201/2221. Establishment of Prescription Drug and Supplemental Benefit Program.

This provision requires the Commissioner to establish a Prescription Drug and Supplemental Benefit Program under Title XXII by which an eligible beneficiary may voluntarily enroll and receive access to covered outpatient prescription drugs and other benefits through enrollment in either a Medicare Prescription Plus plan offered by a private entity or a Medicare+Choice plan. The program is established so that benefits are first provided January 1, 2003. All Title XVIII benefits are guaranteed and are unaffected by the establishment of this program. The costs of providing benefits under this program are paid out of the Medicare Prescription Drug Account established in Section 202.

Section 2222. Election of Prescription Drug Benefits.

This provision requires the Commissioner to establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan) may elect to receive outpatient prescription drug and supplemental benefits offered under this program, consistent with the current process for enrollment under Part B of Medicare.

Eligible beneficiaries may only elect prescription drug coverage under this part during the initial 6-month enrollment period beginning November 1, 2002. In order to be eligible for enrollment, beneficiaries must be entitled to part A of title XVIII and enrolled under part B of Title XVIII as of November 1, 2002.

The Commissioner is required to establish a special enrollment period for certain beneficiaries choosing to maintain their current applicable drug coverage at the time of initial enrollment. In order to be eligible to elect prescription drug benefits outside of the initial enrollment period, a beneficiary must have involuntarily lost their applicable drug coverage. Applicable drug coverage includes: Medicaid prescription drug coverage, including through the Program of All-inclusive Care for the Elderly (PACE), through a social health maintenance organization, or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries; any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan (FEHBP) and a qualified retiree prescription drug plan; coverage under a medicare supplemental policy (Medigap) that provides benefits for prescription drugs; coverage of prescription drugs under a state pharmaceutical assistance program; and coverage of prescription drugs for veterans.

A beneficiary has 63 days to elect prescription drug benefits following the loss of coverage. A beneficiary must submit evidence of the date coverage was lost along with the application for enrollment for benefits under this program.

The Commissioner must conduct a study on the need for rules permitting individuals enrolled under part B of title XVIII but not entitled to benefits under part A to buy into the program, and submit a report and recommendations for legislation to Congress, no later than January 1, 2002.

Section 2223. Enrollment in a Medicare Prescription Plus Plan.

The Commissioner is required to establish a process for an eligible beneficiary to make an annual election to enroll in a Medicare Prescription Plus plan. The process must be consistent with the rules for enrollment and disenrollment with a Medicare+Choice plan, including annual, coordinated election periods, special election periods, and guaranteed issue requirements. A beneficiary enrolled in a Medicare+Choice plan shall receive coverage of prescription drug benefits through the Medicare+Choice plan if such plan provides qualified prescription drug coverage as defined in section 2225. If the Medicare+Choice plan in which the beneficiary is enrolled does not provide such coverage, the beneficiary may receive such coverage through the election of a Medicare Prescription Plus plan.

The Commissioner will develop procedures for the provision of standard prescription drug coverage to each eligible beneficiary that resides in an area where there are no Medicare Prescription Plus plans or Medicare+Choice plans that provide qualified prescription drug coverage.

Section 2224. Beneficiary Information.

The Commissioner will coordinate the dissemination of information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided by Medicare Prescription Plus plans, consistent with information requirements for Medicare+Choice plans.

Section 2225. Outpatient Prescription Drug Benefits.

Qualified prescription drug coverage includes, at a minimum, standard coverage of drugs or the actuarial equivalent of that coverage, including access to negotiated drug prices for beneficiaries, and any additional prescription drug coverage exceeding standard coverage. Standard coverage includes, in 2003, a $250 deductible, 50 percent cost-sharing up to $2,100, and stop-loss protection above $6,000. Benefits will be indexed annually by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries, as determined by the Commissioner for the 12-month period ending in July of the previous year. Plans may offer the actuarial equivalence of the standard package maintaining the $6,000 stop-loss protection.

Under qualified prescription drug coverage offered by a Medicare Prescription Plus plan or a Medicare+Choice organization, the plan must provide beneficiaries with access to negotiated prices for all covered outpatient prescription drugs through a prescription drug discount card program.

Medicare Prescription Plus plans may also include coverage of benefits that are in addition to the benefits available under title XVIII, including coverage of beneficiary cost-sharing for benefits under title XVIII, as long as those cost-sharing benefits are equivalent to the core benefits offered under plan A of the Medigap program. However, a Medicare Prescription Plus plan may only offer additional benefits that exceed qualified prescription drug coverage if that plan also offers qualified prescription drug coverage as an option by itself.

In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Plus plan or the Medicare+Choice plan may use cost control mechanisms that are customarily used in employer-sponsored health care plans, including the use of formularies, tiered copayments, selective contracting with providers of outpatient prescription drugs, and mail order pharmacies.

Section 2226. Beneficiary Protections.

Medicare Prescription Plus plans are required to disclose, in a clear, accurate, and standardized form, information regarding access to covered outpatient drugs, formulary provisions, cost-sharing requirements, and grievance and appeals procedures. In addition, beneficiaries have the right to obtain more detailed plan information, including comparable quality information, at any time upon request. Plans are required to furnish to enrollees a detailed explanation of prescription drug benefits provided. In addition, plans are required to guarantee beneficiaries continue to have access to negotiated price discounts, even when the plan is under no obligation to pay for benefits.

Plans that establish drug formularies are required to include all therapeutic categories and classes of covered outpatient drug. Plans must establish a process for beneficiaries to appeal any denial of a request for benefits based on the application of a formulary. In addition, plans are required to establish quality assurance and utilization management programs, and fraud and abuse controls.

All plans are also required to maintain meaningful procedures for the hearing and resolving of any enrollee grievances; protect the confidentiality and accuracy of all enrollee records; and provide enrollees access to both expedited coverage determinations and a procedure for the reconsideration of any benefit denials, in the same way as such rights are currently provided to beneficiaries in Medicare+Choice.

Plans must charge a uniform premium for individuals enrolled in the plan in the same service area.

2227. Requirements for Eligible Entities.

Provisions in this section require Medicare Prescription Plus plans to be licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which the plan operates. Additionally, this provision requires plans who contract with the Commissioner to provide benefits to assume full financial risk for the provision of these benefits, except as provided in section 2232.

In order to maximize choice and access, the Commissioner is authorized to waive plan licensure requirements for eligible entities in circumstances similar to those allowable for provider-sponsored organizations under Part C of Title XVIII. In such cases, plans are required to meet financial solvency and capital adequacy standards established by the Commissioner.

As is the case under Part C of Title XVIII, the standards established for Medicare Prescription Plus plans supercede any state law or regulation affecting such entities to the extent they are inconsistent with such standards. Specifically, state laws relating to benefit requirements, laws relating to the inclusion or treatment of affiliated providers, and laws related to coverage determinations are preempted. In addition, states are prohibited from imposing premiums or similar taxes on premiums or other funds paid to Medicare Prescription Plus plans.

2228. Submission of Medicare Prescription Plus Plans.

Eligible entities must submit proposals to offer Medicare Prescription Plus plans. These proposals must include a description of the benefits, including any supplemental benefits; the actuarial value of the qualified drug coverage; service area; monthly premiums; actuarial certification of the basis for such premiums; the part of the premium attributable to benefits in excess of standard drug coverage; and the reduction in premiums resulting from reinsurance subsidies.

2229. Approval of Medicare Prescription Plus Plans.

The Commissioner shall approve or disapprove a plan proposal based on the information submitted. The Commissioner has the same authority to negotiate the terms and conditions of the plans as the Director of the Office of Personnel Management has with respect to FEHBP plans.

The Commissioner may not approve a service area if he or she determines that it is designed so as to discriminate based on the health status, economic status, or prior utilization of health care by eligible beneficiaries. The Commissioner must also ensure that the benefit package is not designed to lead to favorable selection of beneficiaries.

Section 2230. Payments to Plans for Approved Medicare Prescription Plus Plan Bids.

The Commissioner pays Medicare Prescription Plus plans the full amount of their premium bid less any plan fees for administrative costs levied under Section 2233. Payments are based upon the method by which Medicare+Choice plans are paid under Section 1853(a) of Title XVIII.

Section 2231. Computation of Beneficiary Share of Premium.

Beneficiaries pay the premium for the plan they select less the following discounts: beneficiaries below 135% FPL, who meet the resource requirements of the Qualified Medicare Beneficiary (QMB) program, receive a full premium subsidy for the qualified prescription drug coverage (or actuarial equivalent). These individuals are entitled to cost-sharing subsidies equal to 95% of the total spending up to the initial coverage limit. Individuals who obtain this subsidized coverage will still be charged nominal copays for each prescription. Beneficiaries who meet the QMB program resource test and have incomes between 135% and 150% FPL are entitled to phased out premium subsidies, ranging from 100% for beneficiaries at 135% FPL to 25% for those at 150% FPL. All beneficiaries above 150% FPL receive a premium discount equal to 25% of the actuarial value of standard drug coverage each year. The premium discount a beneficiary receives is included in the gross income of the beneficiary for that taxable year. The beneficiaries share of any premiums, less subsidies described above, shall be collected in the same manner as beneficiary premiums are collected under Part B.

State Medicaid plans determine whether an individual is eligible for a subsidy and the amount of that subsidy. The CMA Commissioner establishes a process whereby the Commissioner notifies a Medicare Prescription Plus plan or Medicare+Choice plan that an individual is eligible for a cost-sharing subsidy and the amount of such subsidy. The plan reduces the cost-sharing for beneficiaries in accordance with the beneficiaries qualified subsidy amount and is periodically reimbursed by the Commissioner for these cost-sharing reductions.

Section 2232. Additional Prescription Drug Subsidies Through Reinsurance.

To further reduce premiums, mitigate adverse selection, and encourage private plan participation, the Commissioner will provide reinsurance payments towards drug coverage to Medicare Prescription Plus plans, Medicare+Choice plans, and qualified retiree drug plans.

In 2003, reinsurance will cover 80% of costs for coverage exceeding $7,050 (the point at which the beneficiary's cost-sharing limit has been reached and the plan's initial coverage limit has been met). In subsequent years, this dollar amount is increased by the percentage increase in average per capita aggregate expenditures for covered drugs for the previous year.

Section 2233. Plan Fees.

The Commissioner may assess Medicare Prescription Plus plans and Medicare+Choice plans that provide prescription drug coverage a fee sufficient to pay the estimated expenses for administering the prescription drug program. These fees are deposited in the Medicare Prescription Drug Account.

Section 2234. Medicare Prescription Drug Account.

A new Medicare Prescription Drug Account is created within the Supplementary Medical Insurance (SMI) Trust Fund. Funds provided under Part B of this title are kept separate from all other funds within SMI. The Commissioner will make payments from the account for low-income subsidies, reinsurance payments, and administrative costs. The Managing Trustee transfers to the Medicaid account amounts attributable to allowable increases in administrative costs associated with identifying and qualifying beneficiaries eligible for low-income subsidies.

Section 2235. Secondary Payer Provisions.

The secondary payer provisions with respect to drug benefits provided under this program are applicable.

Section 2236. Definitions; Treatment of References to Provisions in Medicare+Choice Program.

This section includes definitions of terms and specifies cross references to Part C of Title XVIII that are applicable. It further requires the Secretary of HHS and Commissioner of CMA to submit a legislative proposal for technical changes within 6 months of enactment.

Section 2237. Report on Average Wholesale Price by the General Accounting Office

The General Accounting Office is required to conduct a study to gather information on the current Medicare Part B payment for drugs, biologicals, and related services. The study is required to be done in coordination with similar requirements under the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and is due no later than 6 months after enactment of this bill.

Section 202. Amendments to Federal Supplementary Medical Insurance Trust Fund.

This section provides conforming changes to the SMI Trust Fund.

Section 203. Prescription Drug Coverage under Medicare+Choice.

A Beneficiary may elect outpatient prescription drug coverage through a Medicare+Choice plan. Medicare+Choice plans offering outpatient prescription drug coverage

must offer standard coverage of prescription drug benefits, at a minimum, as outlined in Section 2225. Medicare+Choice plans are required to meet beneficiary protections outlined in Section 2226, including requirements relating to dissemination of information and grievance and appeals. The Commissioner may waive any requirements to the extent that they are determined to be duplicative of requirements otherwise applicable to the plan.

Beneficiary election for drugs through enrollment in Medicare+Choice is coordinated with enrollment for Medicare Prescription Plus plans. Medicare+Choice plans are eligible for reinsurance as established under Section 2232. Beneficiary premium subsidies for outpatient prescription drug coverage apply, as described in Section 2231.

Medicare+Choice organizations must submit a premium for prescription drug benefits that constitutes qualified prescription drug coverage and that is separate from other coverage under the plan; the ratio of the actuarial value of standard coverage to the actuarial value of qualified prescription drug coverage; and a standard premium for outpatient prescription drug benefits. Plans are paid for the delivery of outpatient prescription drug coverage in the same manner as Medicare Prescription Plus plans in section 2230. Medicare+Choice plans may reduce cost-sharing for all prescription drug benefits, and include the reduced cost-sharing as an additional benefit under section 303.

Section 204. Medicaid Amendments.

States are required, as a condition of receiving federal assistance, to make eligibility determinations for premium and cost-sharing assistance for drug coverage and inform the Commissioner of CMA of those beneficiaries who are eligible for such coverage. The federal government assumes 100% of additional administrative costs, over a 5-year period, for making these eligibility determinations.

The federal government will gradually assume 50% of the costs associated with providing dually-eligible Medicaid beneficiaries and certain QMBs qualified prescription drug coverage under Part B of Title XXII. These costs will be assumed by the federal government over a 5-year period and through appropriate revisions in the Medicaid matching payments for each state.

Medicare is the primary payer for prescription drugs for those beneficiaries dually-entitled to drug coverage under Medicaid and Part B of Title XXII. To the extent payments for prescription drugs are not required through either Medicare Prescription Plus plans or Medicare+Choice plans, states are required to maintain Medicaid benefits as a wrap around to benefits, for dually-entitled beneficiaries, under these plans. States are also allowed to require, as a condition for receiving Medicaid drug benefits, that a dually-entitled beneficiary elect drug coverage under Medicare.

Residents of territories are not eligible for low-income subsidies. However, territories

will be able to receive additional funds, beginning at $20 million in 2003, indexed by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to receive these funds, territories are required to formulate a plan on how they would dedicate these funds to assist low-income Medicare beneficiaries in obtaining covered outpatient prescription drugs.

Section 205. Medigap Transition Provisions.

Beneficiaries who have current Medigap prescription drug insurance may maintain such coverage, however, no new (excluding renewals of existing policies) Medigap prescription drug policies may be sold to an individual after January 1, 2003. Beneficiaries who currently have a Medigap prescription drug policy and elect to terminate such policy and enroll in a Medicare Prescription Plus plan are able to enroll in Medigap policies A-G within 63 days of the termination of the Medigap prescription drug policy.

TITLE III–MEDICARE+CHOICE REFORMS

Section 301. Increase in National Per Capital Medicare+Choice Growth Percentage in 2001 and 2002.

This provision eliminates the 0.5% and 0.3% reduction in the annual update factor for minimum payment (floor) counties in 2001 and 2002 respectively.

Section 302. Removing Application of Budget Neutrality in 2002.

This provision eliminates the budget neutrality provision applied to Medicare+Choice payment rates effective for payments in 2002.

Section 303. Competitive Medicare+Choice Program.

This provision establishes a new competitive system for Medicare+Choice plans under the Commissioner of the Competitive Medicare Agency, which creates an environment for plans to compete with the traditional Medicare program based on price, benefits, and quality.

Beginning in 2003, a benchmark amount is determined for each county as the higher of the current payment rate (floor, minimum update, or blend) or 100% of the costs of delivering current Medicare benefits to beneficiaries in that area (county-specific monthly per capita costs), adjusted for demographic factors, risk, and geography as required under current law. All payment factors impacting payment rates shall be published in advance during the same calendar year.

Plans must submit an adjusted bid for the delivery of all current Medicare benefits and any additional benefits and services, to the Commissioner. Plan proposals must include information on the service area and plan type for each plan; the enrollment capacity (if any) in

relation to the plan and area; the monthly plan bid for the provision of benefits; the actuarial value of the reduction in cost-sharing for benefits under Title XVIII and a description of the cost-sharing for these benefits; the actuarial value of any additional benefits and a description of cost-sharing of such benefits; the actuarial value of supplemental benefits; the monthly supplemental premium for such benefits; and any assumptions with respect to the number of enrolled ESRD beneficiaries.

Plans are paid the negotiated adjusted bid in full. 25% of any difference between the plan's adjusted bid and the benchmark will be returned to the Medicare Hospital Insurance Trust Fund, while 75% of the difference will be returned to beneficiaries in the form of either a rebate, reductions in cost-sharing, reductions in premiums (including current Part B premiums), the offering of additional benefits and services (including outpatient prescription drugs), or a combination of any of the above. Any premiums associated with benefits and services exceeding the benchmark amount, including prescription drugs, shall be paid in full by the beneficiary in the same manner as beneficiary premiums are collected under Part B.

Beginning in 2003, the health risk adjuster may not be phased in by more than 20% and will remain at this ratio until such time as the Commissioner establishes a health risk adjuster based on all settings to supersede the current health risk adjuster. Upon the establishment of a new health risk adjuster, such adjuster will be phased in over a period of 10 years.

Beneficiaries with end-stage renal disease are permitted to enroll in a Medicare+Choice plan, pending the establishment of a separate health risk adjuster by the Commissioner which takes into account a beneficiaries' specific health needs based on delivery of care in all settings.

For purposes of determining the county-specific monthly per capita costs, the Commissioner must establish these costs based on the formula for determining average adjusted per capita costs (section 1876 under Title XVIII), excluding indirect and direct graduate medical education costs.

TITLE IV– MEDICARE BENEFICIARY OUTREACH AND EDUCATION.

Section 401. Medicare Consumer Coalitions.

The CMA Commissioner may establish Medicare Consumer Coalitions (MCCs) to help provide information to Medicare beneficiaries. An MCC is defined as a nonprofit organization operated under the direction of a Board of Directors and composed primarily of eligible Medicare beneficiaries. The Commissioner will pay each MCC for the costs of conducting an information program, including the hiring of staff. The Commissioner is responsible for ensuring coordination of federal, state, and local outreach efforts to beneficiaries.

The Commissioner will solicit proposals from MCCs to conduct beneficiary information

campaigns regarding benefits under Medicare Prescription Plus plans, Medicare+Choice plans, and HCFA's fee-for-service plan. The contents of the education campaign may include comparative information on benefits, quality and performance, beneficiary costs, and consumer satisfaction survey in the above plans. The Commissioner will develop standards to ensure that the information provided to beneficiaries is complete, accurate, and uniform. Any information should be submitted to the Commissioner no later than 45 days before the information is scheduled to be sent to beneficiaries. MCCs will consult with HCFA, Medicare+Choice plans, Medicare Prescription Plus plans, and public and private purchasers of health care benefits.

The Commissioner must submit a report to Congress by December 31, 2003, on the performance of the MCCs including an assessment of the effectiveness of their outreach efforts.

	Outpatient Rx Drugs	Catastrophic protections	Vision/ Dental	Low Cost-Sharing
Typical Employer Plan	✔	✔	✔	✔
FEHBP	✔	✔	✔	✔
Medicare				
BREAUX-FRIST 2000	✔	✔	✔	✔

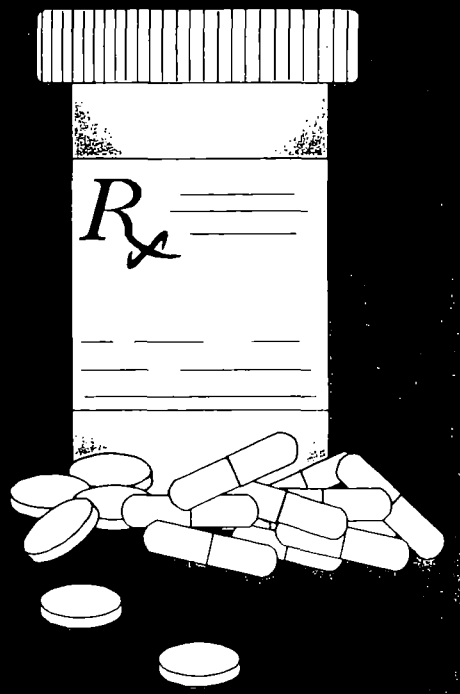
Price of Drug

EXAMPLE:

Retail → **$100**

After Discount Negotiated By Insurer → **$70**

Price Paid by Senior
Under Breaux/Frist 2000
(50% of negotiated price) → **$35**

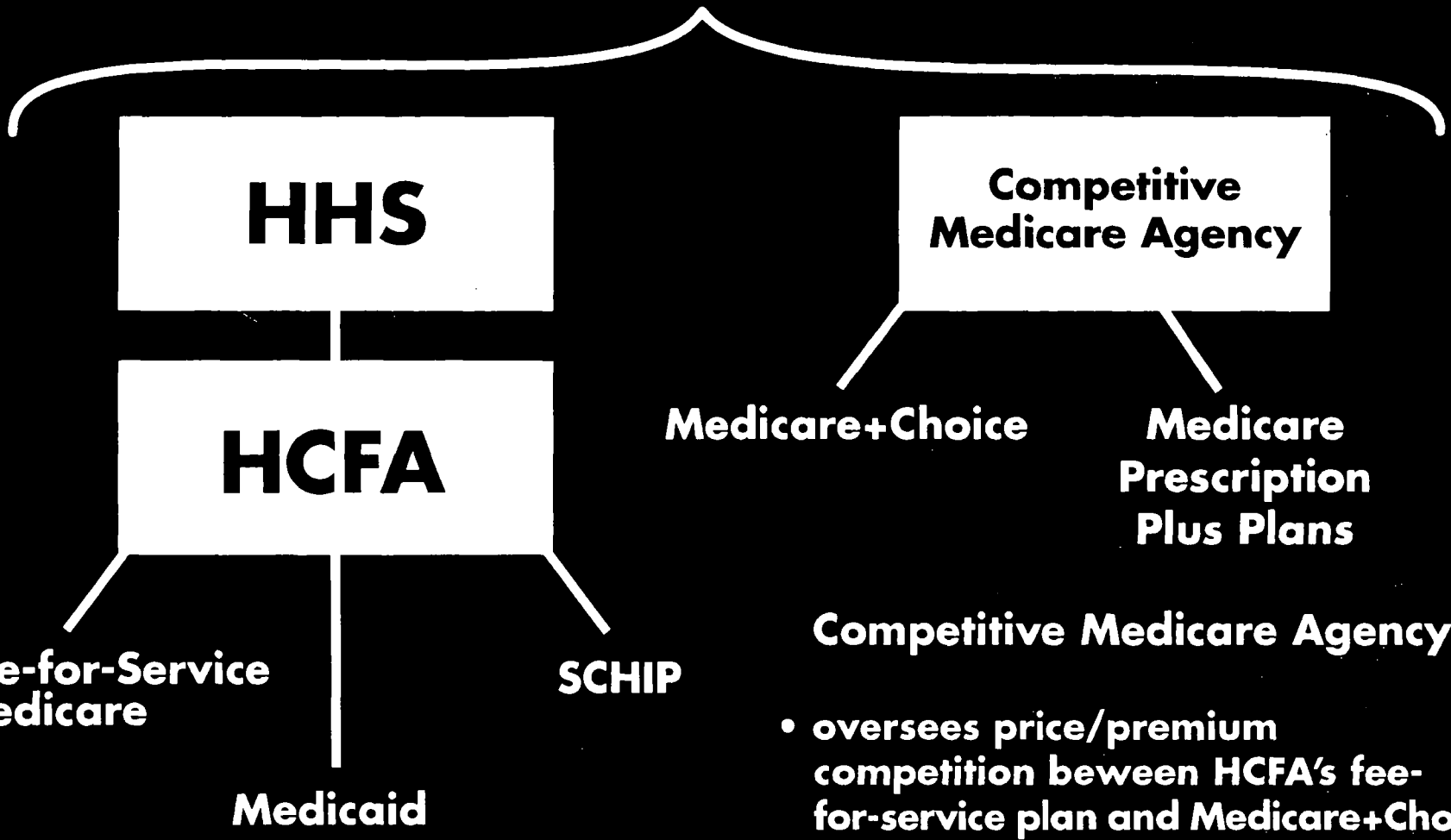


The Medicare Prescription Drug and Modernization Act of 2000

Medicare for the 21st Century

- ✔ Establishes Voluntary, Universal Outpatient Prescription Drug Benefit
- ✔ Guarantees Prescription Drug Price Discounts
- ✔ Provides Full Protections Against High Out-of-Pocket Drug Costs
- ✔ Offers Affordable Coverage through Universal Premium Subsidies and Low-Income Protections
- ✔ Establishes Fiscally Responsible Measures of Solvency
- ✔ Improves the Management and Administration of Medicare

Executive Branch



HCFA would continue to administer fee-for-service and all other non-Medicare functions.

Competitive Medicare Agency:

- oversees price/premium competition beween HCFA's fee-for-service plan and Medicare+Choice
- coordinates beneficiary enrollment
- provides information on all plan choices to beneficiaries

The Medicare Prescription Drug & Modernization Act of 2000

Examples of equivalent drug plan options

STANDARD: • **$250 deductible** • **50% coinsurance up to $2,100 cap** • **$6,000 out-of-pocket maximum**	***Option A:*** • $500 deductible • 30% coinsurance up to $1,500 cap • $6,000 out-of-pocket maximum
Option B: • $0 deductible • 50% coinsurance up to $1,750 cap • $6,000 out-of-pocket maximum	***Option C:*** • $250 deductible • 20% cost sharing up to $1,075 cap • $6,000 out-of-pocket maximum

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

Dan L. Crippen
Director

ADMIN Costs:

June 28, 2000

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Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

Sincerely,

for Dan L. Crippen

Enclosure

cc: Honorable Charles B. Rangel
Ranking Democrat

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 28, 2000

H.R. 4680
Medicare Rx 2000 Act

As ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000

SUMMARY

The Medicare Rx 2000 Act would:

- Establish a prescription drug benefit for Medicare enrollees and a subsidy program for certain low-income participants;
- Establish a new Medicare Benefits Administration (MBA) to oversee the prescription drug benefit and the Medicare+Choice program, and to administer the low-income subsidy program;
- Establish a disease management demonstration project;
- Modify Medicare's coverage and appeals process;
- Adjust payment rates for Medicare+Choice plans; and
- Expand coverage of certain injectable and infusable drugs under Medicare Part B.

The Manager's Amendment would permit the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, cap participation in the disease management project at 30,000, and extend the deadline for Medicare+Choice plans to announce whether they will participate in the program in 2001. The amendment also contains several technical corrections.

H.R. 4680 would affect both direct spending and revenues; therefore, pay-as-you go procedures would apply. CBO estimates that enacting the bill would increase direct spending by $0.4 billion in 2001, by $40 billion over the 2001-2005 period, and by $159 billion over the 2001-2010 period. The prescription drug benefit and the changes in

coverage and payment rates for medical benefits for Medicare enrollees account for nearly all of those increases in direct spending. We estimate that on-budget revenues and off-budget revenues would each decline by less than $50 million a year from 2003 through 2010. The bill also would lead to an increase in the market price of prescription drugs, which would result in:

- Slight increases in direct spending for Medicaid and health benefits for retired federal employees,
- Slight increases in discretionary spending for health programs of several federal agencies, and
- A small decrease in federal tax revenues.

Each of those effects would be less than $50 million in most years.

Subject to appropriation of the necessary amounts, CBO estimates that administering the prescription drug benefit and modifying the coverage and appeals process would cost $0.2 billion in 2001 and $6.5 billion over the 2001-2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments. Other provisions in the bill would result in net savings to state and local governments of approximately $3 billion over the 2001-2005 period and $19 billion over the 2001-2010 period.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4680 is shown in Table 1. The bill would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all federal agencies for employee health benefits. It also would reduce federal revenues by a small amount. The bill would have no effect on outlays or revenues in 2000.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By Fiscal Year, in Billions of Dollars									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare Outlays										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	a	a	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid Outlays										
Change to current-law drug spending	0	0	-2.6	-3.7	-4.1	-4.6	-5.1	-5.7	-6.3	-7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	-0.6	-1.3	-1.2	-0.8	-0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	-2.7	-4.1	-3.9	-3.8	-3.7	-3.9	-4.4	-4.9
Effect of higher drug prices on outlays by federal programs										
Medicaid	0	0	a	a	a	a	a	a	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	a	a	a	a	a	a	a	a
Subtotal, on-budget	0	0	a	a	a	a	a	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	a	a	a	a	a	a	a	a
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	a	a	a	a	a	a	a	a
Social Security payroll taxes (off-budget)	0	0	a	a	a	a	a	a	a	a
Total	0	0	a	a	a	a	a	a	a	-0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	0	0	a	a	a	a	a	a	a	a
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

SOURCE: Congressional Budget Office

NOTES: SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits

a. Costs or savings of less than $50 million.

BASIS OF ESTIMATE

Prescription Drug Benefits

H.R. 4680 would create a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. CBO estimates that the Part D provisions would increase direct spending by $35 billion over the 2001-2005 period and by $142 billion from 2001 through 2010. Of that 10-year total, $81 billion represents outlays for federal reinsurance payments to plans offering qualified prescription drug coverage and $92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by $31 billion in net federal Medicaid savings associated with the new drug program, because part D would replace Medicaid coverage for some individuals. (States would also accrue additional net Medicaid savings totaling $3 billion through 2005 and about $19 billion over the 2001-2010 period.)

CBO estimates that the cost associated with administering the new Part D benefit and other related activities, subject to the appropriation of the necessary amounts, would total $2 billion over the 2001-2005 period and more than $5 billion over the 2001-2010 period.

Two other provisions, which would modify Part B coverage of certain drugs and biologicals and create a disease management demonstration project, would add almost $2 billion over the 10-year period.

Coverage of the Part D Program. H.R. 4680 would provide federal reinsurance payments to entities offering qualified prescription drug coverage to Medicare beneficiaries. Eligible entities would include sponsors of prescription drug plans (PDPs), Medicare+Choice organizations, and qualified retiree prescription drug plans—all of which would have to offer qualified drug coverage and comply with other requirements under Part D. Either the specified standard coverage or a benefit design that is at least actuarially equivalent to standard coverage would meet the bill's requirements. Such qualified coverage also would have to include access to negotiated prescription drug prices for all of a beneficiary's purchases of covered drugs.

The bill defines standard coverage for 2003 as a $250 deductible; 50 percent coinsurance—or an actuarially equivalent cost-sharing rate—on the next $2,100 in total drug spending to reach an "initial coverage limit" of $1,050 and an annual limit on out-of-pocket spending of $6,000 (see Table 2). Qualified standard coverage would make the beneficiary responsible for paying 100 percent of drug costs for all drug spending above the $1,050 benefit maximum but below the $6,000 out-of-pocket limit. In other words, in 2003 a beneficiary would begin to pay 100 percent of drug costs after annual drug spending exceeded $2,350 until a total of $7,050 was spent in that year. After annual drug spending exceeded $7,050,

the beneficiary would pay no more for drugs and the plan would pay 100 percent of any additional drug spending in that year. The dollar amounts for the deductible, initial coverage limit, and out-of-pocket limit would be updated annually by the percentage increase in average per capita expenditures for covered outpatient drugs for Medicare beneficiaries.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary[a]	
		Spending in the Interval	Cumulative Spending
$ 0 to 250	100 percent	$ 250	$ 250
$ 250.01 to 2,350	50 percent	1,050	1,300
$ 2,350.01 to 7,050	100 percent	4,700	6,000
Above $ 7,050	0 percent	0	6,000

[a]Assumes beneficiary spends the full amount in the interval.

Alternative coverage designs would qualify under Part D as long as:

- The actuarial value of total coverage is at least equal to the actuarial value of standard coverage,
- The unsubsidized value of coverage (after receiving federal reinsurance payments) is at least actuarially equivalent to the unsubsidized value of standard coverage,
- The benefit design provides for payments by the plan under the initial coverage limit to be at least actuarially equivalent to the amount paid under standard coverage, and
- The limit on out-of-pocket spending is the same as the limit required for the standard package for beneficiaries whose drug spending equals at least $2,350 (in 2003).

H.R. 4680 also would allow third parties (such as Medicaid or employer-sponsored health insurance) to pay a beneficiary's cost-sharing obligation below the out-of-pocket limit and would require that the plan count those third-party contributions toward the beneficiary's out-of-pocket contributions.

The bill would require sponsors of qualifying plans to cover prescription drugs, insulin, and biologicals but would prohibit coverage for a specific list of drugs, such as hair growth products. Drugs currently covered under Medicare Parts A and B would continue to be

products. Drugs currently covered under Medicare Parts A and B would continue to be covered under current law rules.

Qualifying PDPs would assume full financial risk for costs not subject to federal reinsurance subsidies but would be permitted to obtain insurance to cover that risk. The bill would permit insurers to coordinate with other entities to manage the pharmacy benefit. CBO assumes that most insurers would administer the benefit through pharmacy benefit management (PBM) companies.

Administration and Oversight. The bill would create a new agency in the Department of Health and Human Services called the Medicare Benefits Administration (MBA) to administer the new Part D drug benefit, the low-income subsidy program, and the Medicare+Choice program. The plan oversight function currently within the Health Care Financing Administration (HCFA) would be consolidated within the new agency. Premiums set by plans would be subject to rate review and negotiation with the Administrator of the MBA.

H.R. 4680 would require that each Part B beneficiary have access to at least two qualifying plans, at least one of which is a PDP. The MBA could provide financial incentives to existing sponsors to ensure the availability of two plans. If two plans are not available in an area, the MBA would be required to offer a qualifying prescription drug plan. The MBA could establish such a plan on a regional or nationwide basis. CBO assumes that the MBA would offer coverage through its own plan only to beneficiaries who do not have a choice of two qualifying private plans.

Federal Payments for Reinsurance. Sponsors of PDPs, Medicare + Choice organizations, and qualified retiree prescription drug plans who offer qualified drug coverage would be eligible for federal reinsurance payments. Those federal payments would be based on the lesser of the drug costs per enrollee paid by the plan or the amount that would have been paid by the plan if the coverage offered was standard coverage. Such payments by the plans would be considered "allowable drug costs" for the federal reinsurance subsidy. In 2003, the reinsurance schedule for each enrollee would be:

- 30% of allowable drug costs for total drug spending between $1,251 and $1,350;
- 50% of allowable drug costs for total drug spending between $1,351 and $1,450;
- 70% of allowable drug costs for total drug spending between $1,451 and $1,550;
- 90% of allowable drug costs for total drug spending between $1,551 and $2,350,

- 90% of allowable drug costs for total drug spending exceeding $7,050.

The bill also would require the MBA to adjust the subsidy payments so that the total of such subsidy payments for each year is equal to 35 percent of covered outpatient drug payments made by plans based on standard coverage. CBO assumes it would take at least one year to calculate the amount of the adjustment, so those adjustments would be made with a two-year lag.

Plans would charge beneficiaries a premium to cover drug spending that is not subsidized by the federal government plus the plan's cost of administering the benefit and the plan's profit. CBO estimates that plans would charge beneficiaries an annual premium that would average $470 in 2003 and would grow to $809 in 2010.

Enrollment. All Medicare beneficiaries would have a one-time chance to purchase qualified drug coverage from the sponsor of a qualifying plan when they first become eligible for Medicare and during a six-month open enrollment period starting in 2003. During that time, insurers would not be allowed to underwrite their premiums or exclude beneficiaries from coverage based on pre-existing conditions. Rather, the plan would have to charge the same premium to all enrollees in a service area who maintain continuous prescription drug coverage. (Service area is not defined.) Continuous prescription drug coverage refers to prescription drug coverage offered under a PDP, a Medicare+Choice plan, Medicaid, a group health plan, certain Medigap policies, a state pharmaceutical assistance program, or a program of the Department of Veterans Affairs. Beneficiaries would be allowed to change plans each year.

Plans could charge a higher premium to enrollees who did not enroll at the first opportunity or who let coverage lapse for 63 days or longer, except in a few limited circumstances.

Medicare+Choice Drug Benefits. H.R. 4680 would require that all Medicare+Choice plans offering drug benefits meet the qualified prescription drug coverage standards under Part D. However, a Medicare+Choice plan could elect not to offer prescription drug coverage. Medicare+Choice plans that offer qualifying coverage under Part D would be able to charge a separate prescription drug premium and receive federal reinsurance payments.

CBO's Estimating Assumptions for Prescription Drug Benefits

Participation. CBO assumes that Medicare enrollees who have drug coverage under current law that is not federally subsidized would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes that beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit. Of those

who purchase Part B but do not have drug coverage, CBO assumes that 46 percent would purchase a qualified drug plan. In total, CBO estimates that 80 percent of beneficiaries in Part B (equal to 74 percent of all Medicare enrollees) would participate in the drug benefit provided by H.R. 4680.

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CBO also expects states to pay the premiums charged by sponsors of qualified drug plans and the cost-sharing obligations of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid benefits, because that would shift some of the costs for drug coverage for those dual-eligibles from the states to Medicare.

Effectiveness of PBMs. Under H.R. 4680, PBMs would compete against one another for the business of managing the benefit for sponsors of qualifying prescription drug plans. The bill would allow PBMs to use a broad range of current market tools to manage the pharmacy benefits for PDPs, though it would impose certain restrictions on the PBMs' activities.

PBMs would be allowed to negotiate discounts with pharmacies that agree to participate in their networks but would need to guarantee access that is convenient to beneficiaries. PBMs would also be allowed to design restrictive formularies and negotiate rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. However, the bill specifies that the formularies would need to cover all therapeutic classes, which could dilute some of their negotiating power with manufacturers. As long as cost-sharing requirements under a plan are actuarially equivalent to the standard plan for spending under the benefit maximum, the bill would allow PBMs to establish differential copayment requirements that encourage beneficiaries to select lower-priced options, such as generic, preferred formulary, or mail-order drugs.

The appeals process specified under the bill would allow access to off-formulary drugs at a physician's request when the on-formulary drug is considered not as effective as the off-formulary version for the patient or has significant adverse effects for the enrollee. CBO assumes this process would interfere with a PBM's ability to negotiate rebates from manufacturers in certain circumstances. Considering all these factors, CBO estimates that PBMs would be able to reduce spending by an average of about 25 percent from what an uninsured retail purchaser would pay under current law.

Drug Pricing Assumptions and Effects on Other Federal Purchasers. Enrollees whose drug expenses exceed the stop-loss amount would no longer be price-conscious. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 2 percent higher if H.R. 4680 is enacted.

Higher drug prices would also affect spending by other federal programs for prescription drugs. Medicaid, the Federal Employees Health Benefits (FEHB) program, the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the U.S. Coast Guard would all be affected.

CBO estimates that higher drug prices would increase direct spending for Medicaid and for annuitants covered by the FEHB program by less than $50 million over the 2001-2005 period and by $0.3 billion over the 2001-2010 period. Subject to the appropriation of necessary amounts, discretionary spending by federal agencies for active workers covered by the FEHB program, DOD, VA, PHS, and the U.S. Coast Guard would increase by $0.1 billion over the 2001-2010 period. The net impact over the same period for active and retired postal employees would be negligible.

Revenue Impact. As a result of higher drug prices, H.R. 4680 would also lead to a loss of federal income and payroll tax revenues by raising the costs of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the bill would reduce revenues by less than $50 million over the 2001-2005 period and by $0.2 billion from 2001 through 2010. Social Security payroll taxes, which are off-budget, account for $0.1 billion of that 10-year total.

Low-Income Subsidies

A central feature of the bill is the provision of assistance to low-income beneficiaries who participate in Medicare Part D. CBO expects the low-income subsidies, including payments from the SMI trust fund to state Medicaid programs for administrative costs, would increase Medicare spending by $23 billion over the 2001-2005 period and by $92 billion over the 2001-2010 period, amounts that slightly exceed the federal reinsurance payments. Because Medicaid currently pays for a share of prescription drug costs for about 13 percent of Medicare beneficiaries who are dually-eligible for both programs, about a quarter of the bill's Medicare Part D spending (the federal reinsurance payment and the low-income subsidies) would be offset by a decline in the federal share of Medicaid spending. The bill also would increase Medicaid spending for prescription drugs for some new enrollees and the U.S. territories, withhold some funds from states, increase other Medicaid benefits for new enrollees, and provide additional Medicaid payments for administration. CBO estimates those provisions would lead to a decrease in net federal Medicaid spending of $11 billion over the 2001-2005 period and a decrease of $31 billion over the 2001-2010 period.

Medicare spending on low-income subsidies. Under the bill, Medicare would subsidize spending for premiums and cost sharing under Part D for certain low-income Medicare beneficiaries (except those residing in the U.S. territories). Subsidies would be 100 percent

federally financed. Beneficiaries with incomes below 135 percent of the poverty level and with limited assets would receive a premium subsidy equal to the premium for standard coverage (or its actuarial equivalent). They would also receive a subsidy for cost sharing up to 95 percent of the maximum amount permitted under the initial coverage limit (in 2003, that would be 95 percent of $1,300, or $1,235). Individuals with incomes between 135 and 150 percent of the poverty level would receive smaller premium subsidies determined using a sliding scale, but would not be eligible for subsidies for cost sharing.

Participation in the subsidy program would grow over time as beneficiaries become aware of and apply for those subsidies, though some low-income Medicare beneficiaries who would participate in Part D and who would be eligible for subsidy assistance would choose not to participate in the subsidy program. CBO expects that about 8 million Medicare beneficiaries, or one quarter of the enrollees in Part D, would receive subsidy assistance by 2007. Most of those subsidy recipients currently receive full or partial medical assistance under Medicaid. We estimate that Medicare payments for low-income subsidies would total $23 billion over the 2001-2005 period and $90 billion over the 2001-2010 period.

The bill would require that state Medicaid programs perform eligibility determinations for the subsidies (see below for more detail) and would offer states a higher federal match rate than the average rate of 50 percent to perform those services. Although the Medicaid program would initially incur the costs of administration, Medicare's Supplementary Medical Insurance (SMI) Trust Fund would ultimately transfer funds to Medicaid to cover some of Medicaid's new administrative costs. CBO estimates that Medicare spending for those administrative costs would total $0.2 billion over the 2001-2005 period and $1.4 billion over the 2001-2010 period.

Changes in Medicaid drug spending. In 2007, about 5.5 million low-income Medicare beneficiaries are expected to be eligible for full benefits under Medicaid, which covers prescription drugs for most beneficiaries. Under the bill, the Medicare Part D benefit would become the primary payor for prescription drugs for those beneficiaries. Cost-sharing assistance provided by Medicare to full dual-eligibles under 135 percent of poverty also would replace Medicaid assistance. Thus, savings would accrue to the Medicaid program, and would be shared with the states at the regular federal match rate (57 percent, on average). Medicaid would continue to pay for prescription drug spending not covered by the new Part D benefit and for some cost-sharing subsidies, including spending in the gap between the initial coverage limit and the annual out-of-pocket limit.

CBO anticipates that state Medicaid programs would pay premiums and cost-sharing amounts for full dual-eligibles who are not eligible for subsidy assistance to enroll them in the new drug benefit program. The bill would not allow full dual-eligibles over 135 percent of poverty access to Part D subsidy assistance (except for some dual-eligibles under 150

percent of poverty who might be eligible for premium subsidies). Those beneficiaries would be worse off under the new drug benefit than under current law if Medicaid did not pay for prescription drug spending beyond the scope of the Part D benefit. Although the bill is silent on the question of whether states would be permitted to enroll and subsidize dual-eligibles above the subsidy thresholds, CBO assumes that they would be allowed to do so and would be reimbursed at the regular federal match rate for Medicaid.

Medicaid's savings would be partially offset by new drug spending. Because CBO expects that the new drug program would increase participation of full dual-eligibles in the Medicaid program, Medicaid would be required to pay for their prescription drug spending not covered by the Part D benefit or Medicare subsidies. Finally, federal Medicaid spending in the U.S. territories would increase by additional amounts provided in the bill for prescription drug assistance to low-income Medicare beneficiaries. CBO estimates that net federal Medicaid spending for prescription drugs would decline by $10 billion over the 2001-2005 period and by $39 billion over the 2001-2010 period.

Reduction in federal payments to states. The bill would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2006. The amount of the reduction would be based on the amount of low-income subsidies that Part D of Medicare would pay for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 80 percent in 2003 to 20 percent in 2006.

CBO anticipates that the reduction would be difficult to administer because it is likely that states would demand that the federal government document its spending on subsidy payments before withholding funds. CBO's estimate therefore assumes a six-month lag between the time that low-income subsidies are paid and the time that any reductions in federal Medicaid payments are made. CBO also anticipates that potential conflicts between states and the federal government over the amount of the withholding could result in HCFA making less than the full amount of the reduction specified in the bill. Overall, CBO estimates that those reductions would lower federal Medicaid outlays by $3 billion over the 2001-2005 period and by $4 billion over the 2001-2010 period.

Impact on other Medicaid benefits. In addition to its regular benefits, Medicaid pays for some or all of the premiums and out-of-pocket expenses incurred by certain Medicare beneficiaries with low incomes and limited resources. Medicaid covers Medicare premiums and cost sharing for beneficiaries with incomes below the poverty level, and the Part B premium for beneficiaries with incomes between 100 and 120 percent of the poverty level. However, many of the Medicare beneficiaries who are eligible for this Medicaid assistance are not enrolled in Medicaid; some may not be aware of their eligibility, while others may prefer to avoid the hassle of Medicaid's enrollment process and pay Medicare cost sharing

program and may choose not to participate.

CBO believes that the attractiveness of assistance for a prescription drug benefit would boost the number of low-income Medicare beneficiaries enrolled in Medicaid by about 1.5 million by 2006 (a 20 percent increase). The bill would require state Medicaid programs to determine the eligibility of Medicare beneficiaries for the low-income subsidies under Part D of Medicare. Some beneficiaries, while applying for those subsidies in a local Medicaid office, would learn that they are eligible for additional assistance under Medicaid and would enroll. CBO estimates that provision would increase federal Medicaid spending by $2 billion over the 2001-2005 period and by $10 billion over the 2001-2010 period.

Administrative Costs for Medicaid. The bill would affect Medicaid spending for administrative costs in a number of ways. As noted above, state Medicaid programs would be required to determine the eligibility of Medicare beneficiaries for low-income subsidies under Part D. The federal Medicaid matching rate for costs related to those determinations would rise from 60 percent in 2003 to 100 percent after 2006. (The current match rate for most administrative costs is 50 percent.) CBO assumes that states would reclassify some of their regular administrative expenses as Part D administrative costs to take advantage of the higher match rate. As noted above, Medicare (SMI) would transfer funds to Medicaid to cover the portion of Medicaid's administrative costs reimbursed above the regular federal match rate.

The bill would also necessitate increased spending on administration as more low-income Medicare beneficiaries enroll in Medicaid, but would yield savings as states would have reduced responsibility for handling prescription drug claims for full-dual eligibles. CBO estimates that net federal Medicaid outlays for administration would increase by $0.7 billion over the 2001-2005 period and $1.6 billion over the 2001-2010 period.

Disease Management Project

H.R. 4680 would direct the Administrator of the MBA to conduct a three-year demonstration project to evaluate the impact of disease management services on the costs and health outcomes of Medicare Part B beneficiaries with certain illnesses. Eligible beneficiaries would have to have advanced-stage congestive heart failure, diabetes, or coronary heart disease and would be required to secure the approval of their physicians in order to participate.

Participants would be entitled to additional prescription drug benefits paid through the enrolling disease management organization (DMO). More specifically, the organization would pay for a beneficiary's premium, deductible, and cost-sharing under Part D plus any

amounts not covered by the plan because of the initial coverage limit. The organization would pay for all prescription drug costs for participants who are not enrolled under Part D. CBO expects that offering such highly desirable drug benefits would create strong demand for disease management services among chronically ill beneficiaries.

Given the nature of the contractual agreements outlined in the bill, however, whether disease management organizations would enter into contracts under those conditions is uncertain. Much of that uncertainty involves the interpretation of how the fee would be negotiated between DMOs and the Administrator. The bill would require that the fee paid to DMOs be negotiated in a manner that would guarantee a "net reduction in expenditures under the Medicare program" for participating beneficiaries. However, accurately estimating the benchmark spending against which the savings or costs would be measured would be extremely difficult, particularly because the bill would delay the implementation of improved risk adjustment factors. As a result, CBO believes that there is no assurance that the demonstration project could be implemented so as to reduce Medicare expenditures and that, on the contrary, it would increase costs to the Medicare program overall.

Moreover, the extent to which DMOs would be willing to be participate in the project is unclear. CBO assumes that it is unlikely that DMOs would assume full risk for any additional costs associated with the expanded drug benefit unless those costs are reflected in the negotiated fee. Under the bill, DMOs are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, or D. If DMOs must guarantee a "net reduction in expenditures under the Medicare program," with those expenditures defined to include additional premium and cost-sharing assistance paid under the project, CBO assumes that all DMOs would decline to participate. However, if those drug benefit payments are included in the negotiated fee, CBO assumes DMOs would enter into those agreements.

Without any legislative restrictions on the number of qualifying beneficiaries allowed to join the demonstration project, CBO would assume that up to 300,000 of them would enroll, if DMOs decided to participate and offer those benefits. Assuming an equal probability that regulations implementing the project would include or exclude payments for drug benefits from the negotiated fee, CBO estimates that such enrollment in the demonstration project would increase federal spending by about $1.1 billion over the 2001-2005 period. However, because the Manager's Amendment to the bill would limit participation to 30,000 enrollees, CBO estimates that the demonstration project would increase net federal spending by $0.3 billion over 2001-2005 period and by $0.4 billion over the 2001-2010 period.

Medicare Coverage and Appeals Process

H.R. 4680 would modify the curren: appeals process for the Medicare fee-for-service program to make it similar to the appeals process under the Medicare+Choice program. The bill would allow Medicare beneficiaries the right to an initial determination of coverage before services are provided. The bill would provide for external contractors to independently handle reconsiderations for denied services, impose time limits for the appeals processes, provide rules for the review of local and national coverage decisions, authorize continuing education for reviewers and adjudicators, limit beneficiaries' liability, and eliminate the Secretary's ability to overturn or modify the decisions of the Provider Reimbursement Review Board with regard to appeals by Part A providers. CBO estimates those provisions would increase direct spending by about $50 million in 2001, $0.7 billion between 2001 and 2005, and $3 billion from 2001 through 2010. Assuming appropriation of the necessary amounts, CBO assumes that the appeals and coverage provisions would increase discretionary spending by $44 million in 2001 and by $1.1 billion over the 2001-2010 period.

Medicare+Choice Reforms

Under current law, payment rates for Medicare+Choice plans are defined according to plan members' county of residence, and are then adjusted for each beneficiary's demographic and risk characteristics. The geographic payment rates are the highest of three different rates: a minimum floor rate; a blend of the county-specific rates existing before the Balanced Budget Act of 1997 and the national average rate, adjusted for local costs; or the previous year's rate increased by 2 percent. The floor and county-specific rates are updated each calendar year by the expected rate of increase in per-capita Medicare costs, minus specified percentage reductions from that rate of increase over the 1998-2002 period. The updated county rates are used to calculate a new national average and hence the new blended rates. The share of the national average rate in the blend will increase until reaching 50 percent local and 50 percent national rates some time after 2002. Finally, a "budget neutrality adjustment" is applied to the blended rates to ensure that the expected Medicare+Choice payments are the same as if all payments were completely based on local rates. That adjustment may either increase or lower the counties' rates depending upon interactions with other factors in the payment system.

The bill would eliminate the reductions from the national per capita growth rate for 2001 and 2002. In 2002, the bill would increase the floor payment rate from an estimated $432 to $450 and would allow plans to choose to be paid a 50:50 blend of local and national rates beginning in 2002. Between 2002 and 2005, the bill would establish a minimum update of 2.5 percent instead of 2 percent for counties served by one or fewer plans. The bill would

eliminate the budget neutrality adjustment beginning in 2003, and in 2004, would allow plans to negotiate a rate of payment with HCFA regardless of the county-specific rate, as long as the negotiated rate does not exceed the national average per-capita cost and does not increase more than the expected rate of increase for private insurance, minus the cost of prescription drugs. Finally, the bill would phase in implementation of improved methods of adjusting payments to reflect differences in health status, with full implementation delayed until 2013. CBO estimates that those provisions would increase Medicare outlays by $4 billion over the 2001-2005 period and by $13 billion over the 2001-2010 period.

Coverage of Drugs and Biologicals under Part B

The bill would expand the Part B outpatient drug benefit to include coverage of certain drug products that are not usually self-administered by the patient but are administered incident to a physician's service. CBO estimates that this provision would increase federal spending by $0.7 billion over the 2001-2005 period and by $1.3 billion over the 2001-2010 period.

SPENDING SUBJECT TO APPROPRIATION

The bill would establish the Medicare Benefits Administration to oversee the prescription drug benefit and to assume certain responsibilities of the Health Care Financing Administration. Subject to appropriation of the necessary amounts, CBO estimates those activities would increase federal spending by $0.2 billion in 2001 and by $5.4 billion over the 2001-2005 period. With the administrative costs of the coverage and appeals provision and the effect on federal purchasers of higher prices for prescription drugs (both described above), CBO estimates that enacting H.R. 4680 would increase discretionary spending by a total of $6.6 billion over the 10-year period, assuming appropriation of the necessary amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	390	1,550	9,180	12,800	15,960	18,360	21,080	23,780	26,450	29,440
Changes in receipts	0	0	0	-2	-5	-10	-10	-15	-20	-25	-35

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs). This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs could result in a shift of premium payments away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues to states. CBO cannot estimate the magnitude of those losses because we have no basis for predicting the size of such shifts or the degree to which such plans would have been taxable in the absence of the preemption.

The bill includes a number of preemptions that would be intergovernmental mandates as defined by UMRA, but those preemptions would impose no costs on state, local, or tribal governments. Among the preemptions are protections from civil or criminal liability for certain federal contractors, waivers of state licensing requirements, and preemption of laws establishing minimum coverage requirements.

Other Impacts

CBO estimates that the bill would reduce state Medicaid spending by about $3 billion over the 2001-2005 period and by $19 billion over the 2001-2010 period. A number of factors would contribute to that reduction. State Medicaid programs would benefit as coverage responsibility for dual-eligibles shifts from Medicaid to PDPs for prescription drug coverage and to Medicare for cost-sharing subsidies. However, some savings would be offset by prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. As a result CBO estimates that net state spending for prescription drug coverage would decline by $8 billion over the 2001-2005 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state revenues by $3 billion over the same period. Additionally, increased Medicaid enrollment and other changes are expected to increase state spending by

$1.6 billion over the 2001-2005 period.

As a condition of approval for their Medicaid plans, states would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare and would be required to transmit that information to the MBA. However, states have the ability to alter their programmatic and financial responsibilities for Medicaid to accommodate this additional determination requirement; consequently, this requirement would not be an intergovernmental mandate as defined in UMRA. Additional costs would total approximately $0.3 billion over the 2001-2005 period. Costs would decrease over time because the matching rate from the federal government would increase annually until 2007 when it would reach 100 percent.

State and local governments that provide health insurance to their employees or retired employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in the costs of their health plans. Because CBO cannot predict how states would restructure the prescription drug component of their health plans, we cannot estimate the amount of such savings.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On June 21, 2000, CBO produced a preliminary analysis of H.R. 4680, as modified in discussions with staff. That analysis concluded the bill would increase direct spending by $38.6 billion over the 2001-2005 period and by $155 billion over the 2001-2010 period. The current estimate is $1.4 billion higher over the first five years and $4 billion higher over the 10-year period. Two revisions in the committee-approved bill—the addition of the disease management project, and an increase in the updates to rates paid to Medicare+Choice plans in 2001 and 2002—increased the estimate by $1.5 billion for the 2001-2005 period and by $3.4 billion for the 2001-2010 period. The remaining differences are due to numerous refinements of estimating assumptions and to differences between specifications discussed with staff and the legislative language in the reported bill and subsequently modified by the

Manager's Amendment dated June 28, 2000.

This estimate includes one significant change in the display of the estimated cost of administering the low-income subsidy. The previous estimate combined the transfer from SMI to Medicaid for administering the low-income subsidy and the administrative spending that is funded through Medicaid. The current estimate displays those components separately.

The estimated impact on revenues is unchanged. The estimate of spending subject to appropriation was incomplete in the previous analysis.

ESTIMATE PREPARED BY:

Federal Costs: Charles Betley, Tom Bradley, Julia Christensen, Jeanne De Sa, Eric Rollins, and Christopher Topoleski (226-9010); and Sandra Christensen, Karuna Patel, and Judith Wagner (226-2666).

Impact on State, Local, and Tribal Governments: Leo Lex (225-3220)

Impact on the Private Sector: Bruce Vavrichek (226-2676)

ESTIMATE APPROVED BY:

Robert A. Sunshine
Assistant Director for Budget Analysis

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

Dan L. Crippen
Director

ADMIN Costs:

June 28, 2000

Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

Sincerely,

for Dan L. Crippen

Enclosure

cc: Honorable Charles B. Rangel
Ranking Democrat

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 28, 2000

H.R. 4680
Medicare Rx 2000 Act

As ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000

SUMMARY

The Medicare Rx 2000 Act would:

- Establish a prescription drug benefit for Medicare enrollees and a subsidy program for certain low-income participants;
- Establish a new Medicare Benefits Administration (MBA) to oversee the prescription drug benefit and the Medicare+Choice program, and to administer the low-income subsidy program;
- Establish a disease management demonstration project;
- Modify Medicare's coverage and appeals process;
- Adjust payment rates for Medicare+Choice plans; and
- Expand coverage of certain injectable and infusable drugs under Medicare Part B.

The Manager's Amendment would permit the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, cap participation in the disease management project at 30,000, and extend the deadline for Medicare+Choice plans to announce whether they will participate in the program in 2001. The amendment also contains several technical corrections.

H.R. 4680 would affect both direct spending and revenues; therefore, pay-as-you go procedures would apply. CBO estimates that enacting the bill would increase direct spending by $0.4 billion in 2001, by $40 billion over the 2001-2005 period, and by $159 billion over the 2001-2010 period. The prescription drug benefit and the changes in

coverage and payment rates for medical benefits for Medicare enrollees account for nearly all of those increases in direct spending. We estimate that on-budget revenues and off-budget revenues would each decline by less than $50 million a year from 2003 through 2010. The bill also would lead to an increase in the market price of prescription drugs, which would result in:

- Slight increases in direct spending for Medicaid and health benefits for retired federal employees,
- Slight increases in discretionary spending for health programs of several federal agencies, and
- A small decrease in federal tax revenues.

Each of those effects would be less than $50 million in most years.

Subject to appropriation of the necessary amounts, CBO estimates that administering the prescription drug benefit and modifying the coverage and appeals process would cost $0.2 billion in 2001 and $6.5 billion over the 2001-2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments. Other provisions in the bill would result in net savings to state and local governments of approximately $3 billion over the 2001-2005 period and $19 billion over the 2001-2010 period.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4680 is shown in Table 1. The bill would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all federal agencies for employee health benefits. It also would reduce federal revenues by a small amount. The bill would have no effect on outlays or revenues in 2000.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By Fiscal Year, in Billions of Dollars									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare Outlays										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	a	a	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid Outlays										
Change to current-law drug spending	0	0	-2.6	-3.7	-4.1	-4.6	-5.1	-5.7	-6.3	-7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	-0.6	-1.3	-1.2	-0.8	-0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	-2.7	-4.1	-3.9	-3.8	-3.7	-3.9	-4.4	-4.9
Effect of higher drug prices on outlays by federal programs										
Medicaid	0	0	a	a	a	a	a	a	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	a	a	a	a	a	a	a	a
Subtotal, on-budget	0	0	a	a	a	a	a	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	a	a	a	a	a	a	a	a
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	a	a	a	a	a	a	a	a
Social Security payroll taxes (off-budget)	0	0	a	a	a	a	a	a	a	a
Total	0	0	a	a	a	a	a	a	a	-0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	0	0	a	a	a	a	a	a	a	a
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

SOURCE: Congressional Budget Office

NOTES: SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits

a Costs or savings of less than $50 million.

BASIS OF ESTIMATE

Prescription Drug Benefits

H.R. 4680 would create a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. CBO estimates that the Part D provisions would increase direct spending by $35 billion over the 2001-2005 period and by $142 billion from 2001 through 2010. Of that 10-year total, $81 billion represents outlays for federal reinsurance payments to plans offering qualified prescription drug coverage and $92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by $31 billion in net federal Medicaid savings associated with the new drug program, because part D would replace Medicaid coverage for some individuals. (States would also accrue additional net Medicaid savings totaling $3 billion through 2005 and about $19 billion over the 2001-2010 period.)

CBO estimates that the cost associated with administering the new Part D benefit and other related activities, subject to the appropriation of the necessary amounts, would total $2 billion over the 2001-2005 period and more than $5 billion over the 2001-2010 period.

Two other provisions, which would modify Part B coverage of certain drugs and biologicals and create a disease management demonstration project, would add almost $2 billion over the 10-year period.

Coverage of the Part D Program. H.R. 4680 would provide federal reinsurance payments to entities offering qualified prescription drug coverage to Medicare beneficiaries. Eligible entities would include sponsors of prescription drug plans (PDPs), Medicare+Choice organizations, and qualified retiree prescription drug plans—all of which would have to offer qualified drug coverage and comply with other requirements under Part D. Either the specified standard coverage or a benefit design that is at least actuarially equivalent to standard coverage would meet the bill's requirements. Such qualified coverage also would have to include access to negotiated prescription drug prices for all of a beneficiary's purchases of covered drugs.

The bill defines standard coverage for 2003 as a $250 deductible; 50 percent coinsurance—or an actuarially equivalent cost-sharing rate—on the next $2,100 in total drug spending to reach an "initial coverage limit" of $1,050, and an annual limit on out-of-pocket spending of $6,000 (see Table 2). Qualified standard coverage would make the beneficiary responsible for paying 100 percent of drug costs for all drug spending above the $1,050 benefit maximum but below the $6,000 out-of-pocket limit. In other words, in 2003 a beneficiary would begin to pay 100 percent of drug costs after annual drug spending exceeded $2,350 until a total of $7,050 was spent in that year. After annual drug spending exceeded $7,050,

the beneficiary would pay no more for drugs and the plan would pay 100 percent of any additional drug spending in that year. The dollar amounts for the deductible, initial coverage limit, and out-of-pocket limit would be updated annually by the percentage increase in average per capita expenditures for covered outpatient drugs for Medicare beneficiaries.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary[a]	
		Spending in the Interval	Cumulative Spending
$ 0 to 250	100 percent	$ 250	$ 250
$ 250.01 to 2,350	50 percent	1,050	1,300
$ 2,350.01 to 7,050	100 percent	4,700	6,000
Above $ 7,050	0 percent	0	6,000

[a]Assumes beneficiary spends the full amount in the interval.

Alternative coverage designs would qualify under Part D as long as:

- The actuarial value of total coverage is at least equal to the actuarial value of standard coverage,
- The unsubsidized value of coverage (after receiving federal reinsurance payments) is at least actuarially equivalent to the unsubsidized value of standard coverage,
- The benefit design provides for payments by the plan under the initial coverage limit to be at least actuarially equivalent to the amount paid under standard coverage, and
- The limit on out-of-pocket spending is the same as the limit required for the standard package for beneficiaries whose drug spending equals at least $2,350 (in 2003).

H.R. 4680 also would allow third parties (such as Medicaid or employer-sponsored health insurance) to pay a beneficiary's cost-sharing obligation below the out-of-pocket limit and would require that the plan count those third-party contributions toward the beneficiary's out-of-pocket contributions.

The bill would require sponsors of qualifying plans to cover prescription drugs, insulin, and biologicals but would prohibit coverage for a specific list of drugs, such as hair growth products. Drugs currently covered under Medicare Parts A and B would continue to be

products. Drugs currently covered under Medicare Parts A and B would continue to be covered under current law rules.

Qualifying PDPs would assume full financial risk for costs not subject to federal reinsurance subsidies but would be permitted to obtain insurance to cover that risk. The bill would permit insurers to coordinate with other entities to manage the pharmacy benefit. CBO assumes that most insurers would administer the benefit through pharmacy benefit management (PBM) companies.

Administration and Oversight. The bill would create a new agency in the Department of Health and Human Services called the Medicare Benefits Administration (MBA) to administer the new Part D drug benefit, the low-income subsidy program, and the Medicare+Choice program. The plan oversight function currently within the Health Care Financing Administration (HCFA) would be consolidated within the new agency. Premiums set by plans would be subject to rate review and negotiation with the Administrator of the MBA.

H.R. 4680 would require that each Part B beneficiary have access to at least two qualifying plans, at least one of which is a PDP. The MBA could provide financial incentives to existing sponsors to ensure the availability of two plans. If two plans are not available in an area, the MBA would be required to offer a qualifying prescription drug plan. The MBA could establish such a plan on a regional or nationwide basis. CBO assumes that the MBA would offer coverage through its own plan only to beneficiaries who do not have a choice of two qualifying private plans.

Federal Payments for Reinsurance. Sponsors of PDPs, Medicare + Choice organizations, and qualified retiree prescription drug plans who offer qualified drug coverage would be eligible for federal reinsurance payments. Those federal payments would be based on the lesser of the drug costs per enrollee paid by the plan or the amount that would have been paid by the plan if the coverage offered was standard coverage. Such payments by the plans would be considered "allowable drug costs" for the federal reinsurance subsidy. In 2003, the reinsurance schedule for each enrollee would be:

- 30% of allowable drug costs for total drug spending between $1,251 and $1,350;
- 50% of allowable drug costs for total drug spending between $1,351 and $1,450;
- 70% of allowable drug costs for total drug spending between $1,451 and $1,550;
- 90% of allowable drug costs for total drug spending between $1,551 and $2,350,

- 90% of allowable drug costs for total drug spending exceeding $7,050.

The bill also would require the MBA to adjust the subsidy payments so that the total of such subsidy payments for each year is equal to 35 percent of covered outpatient drug payments made by plans based on standard coverage. CBO assumes it would take at least one year to calculate the amount of the adjustment, so those adjustments would be made with a two-year lag.

Plans would charge beneficiaries a premium to cover drug spending that is not subsidized by the federal government plus the plan's cost of administering the benefit and the plan's profit. CBO estimates that plans would charge beneficiaries an annual premium that would average $470 in 2003 and would grow to $809 in 2010.

Enrollment. All Medicare beneficiaries would have a one-time chance to purchase qualified drug coverage from the sponsor of a qualifying plan when they first become eligible for Medicare and during a six-month open enrollment period starting in 2003. During that time, insurers would not be allowed to underwrite their premiums or exclude beneficiaries from coverage based on pre-existing conditions. Rather, the plan would have to charge the same premium to all enrollees in a service area who maintain continuous prescription drug coverage. (Service area is not defined.) Continuous prescription drug coverage refers to prescription drug coverage offered under a PDP, a Medicare+Choice plan, Medicaid, a group health plan, certain Medigap policies, a state pharmaceutical assistance program, or a program of the Department of Veterans Affairs. Beneficiaries would be allowed to change plans each year.

Plans could charge a higher premium to enrollees who did not enroll at the first opportunity or who let coverage lapse for 63 days or longer, except in a few limited circumstances.

Medicare+Choice Drug Benefits. H.R. 4680 would require that all Medicare+Choice plans offering drug benefits meet the qualified prescription drug coverage standards under Part D. However, a Medicare+Choice plan could elect not to offer prescription drug coverage. Medicare+Choice plans that offer qualifying coverage under Part D would be able to charge a separate prescription drug premium and receive federal reinsurance payments.

CBO's Estimating Assumptions for Prescription Drug Benefits

Participation. CBO assumes that Medicare enrollees who have drug coverage under current law that is not federally subsidized would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes that beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit. Of those

who purchase Part B but do not have drug coverage, CBO assumes that 46 percent would purchase a qualified drug plan. In total, CBO estimates that 80 percent of beneficiaries in Part B (equal to 74 percent of all Medicare enrollees) would participate in the drug benefit provided by H.R. 4680.

10 M PEOPLE

CBO also expects states to pay the premiums charged by sponsors of qualified drug plans and the cost-sharing obligations of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid benefits, because that would shift some of the costs for drug coverage for those dual-eligibles from the states to Medicare.

Effectiveness of PBMs. Under H.R. 4680, PBMs would compete against one another for the business of managing the benefit for sponsors of qualifying prescription drug plans. The bill would allow PBMs to use a broad range of current market tools to manage the pharmacy benefits for PDPs, though it would impose certain restrictions on the PBMs' activities.

PBMs would be allowed to negotiate discounts with pharmacies that agree to participate in their networks but would need to guarantee access that is convenient to beneficiaries. PBMs would also be allowed to design restrictive formularies and negotiate rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. However, the bill specifies that the formularies would need to cover all therapeutic classes, which could dilute some of their negotiating power with manufacturers. As long as cost-sharing requirements under a plan are actuarially equivalent to the standard plan for spending under the benefit maximum, the bill would allow PBMs to establish differential copayment requirements that encourage beneficiaries to select lower-priced options, such as generic, preferred formulary, or mail-order drugs.

The appeals process specified under the bill would allow access to off-formulary drugs at a physician's request when the on-formulary drug is considered not as effective as the off-formulary version for the patient or has significant adverse effects for the enrollee. CBO assumes this process would interfere with a PBM's ability to negotiate rebates from manufacturers in certain circumstances. Considering all these factors, CBO estimates that PBMs would be able to reduce spending by an average of about 25 percent from what an uninsured retail purchaser would pay under current law.

Drug Pricing Assumptions and Effects on Other Federal Purchasers. Enrollees whose drug expenses exceed the stop-loss amount would no longer be price-conscious. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 2 percent higher if H.R. 4680 is enacted.

Higher drug prices would also affect spending by other federal programs for prescription drugs. Medicaid, the Federal Employees Health Benefits (FEHB) program, the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the U.S. Coast Guard would all be affected.

CBO estimates that higher drug prices would increase direct spending for Medicaid and for annuitants covered by the FEHB program by less than $50 million over the 2001-2005 period and by $0.3 billion over the 2001-2010 period. Subject to the appropriation of necessary amounts, discretionary spending by federal agencies for active workers covered by the FEHB program, DOD, VA, PHS, and the U.S. Coast Guard would increase by $0.1 billion over the 2001-2010 period. The net impact over the same period for active and retired postal employees would be negligible.

Revenue Impact. As a result of higher drug prices, H.R. 4680 would also lead to a loss of federal income and payroll tax revenues by raising the costs of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the bill would reduce revenues by less than $50 million over the 2001-2005 period and by $0.2 billion from 2001 through 2010. Social Security payroll taxes, which are off-budget, account for $0.1 billion of that 10-year total.

Low-Income Subsidies

A central feature of the bill is the provision of assistance to low-income beneficiaries who participate in Medicare Part D. CBO expects the low-income subsidies, including payments from the SMI trust fund to state Medicaid programs for administrative costs, would increase Medicare spending by $23 billion over the 2001-2005 period and by $92 billion over the 2001-2010 period, amounts that slightly exceed the federal reinsurance payments. Because Medicaid currently pays for a share of prescription drug costs for about 13 percent of Medicare beneficiaries who are dually-eligible for both programs, about a quarter of the bill's Medicare Part D spending (the federal reinsurance payment and the low-income subsidies) would be offset by a decline in the federal share of Medicaid spending. The bill also would increase Medicaid spending for prescription drugs for some new enrollees and the U.S. territories, withhold some funds from states, increase other Medicaid benefits for new enrollees, and provide additional Medicaid payments for administration. CBO estimates those provisions would lead to a decrease in net federal Medicaid spending of $11 billion over the 2001-2005 period and a decrease of $31 billion over the 2001-2010 period.

Medicare spending on low-income subsidies. Under the bill, Medicare would subsidize spending for premiums and cost sharing under Part D for certain low-income Medicare beneficiaries (except those residing in the U.S. territories). Subsidies would be 100 percent

federally financed. Beneficiaries with incomes below 135 percent of the poverty level and with limited assets would receive a premium subsidy equal to the premium for standard coverage (or its actuarial equivalent). They would also receive a subsidy for cost sharing up to 95 percent of the maximum amount permitted under the initial coverage limit (in 2003, that would be 95 percent of $1,300, or $1,235). Individuals with incomes between 135 and 150 percent of the poverty level would receive smaller premium subsidies determined using a sliding scale, but would not be eligible for subsidies for cost sharing.

Participation in the subsidy program would grow over time as beneficiaries become aware of and apply for those subsidies, though some low-income Medicare beneficiaries who would participate in Part D and who would be eligible for subsidy assistance would choose not to participate in the subsidy program. CBO expects that about 8 million Medicare beneficiaries, or one quarter of the enrollees in Part D, would receive subsidy assistance by 2007. Most of those subsidy recipients currently receive full or partial medical assistance under Medicaid. We estimate that Medicare payments for low-income subsidies would total $23 billion over the 2001-2005 period and $90 billion over the 2001-2010 period.

The bill would require that state Medicaid programs perform eligibility determinations for the subsidies (see below for more detail) and would offer states a higher federal match rate than the average rate of 50 percent to perform those services. Although the Medicaid program would initially incur the costs of administration, Medicare's Supplementary Medical Insurance (SMI) Trust Fund would ultimately transfer funds to Medicaid to cover some of Medicaid's new administrative costs. CBO estimates that Medicare spending for those administrative costs would total $0.2 billion over the 2001-2005 period and $1.4 billion over the 2001-2010 period.

Changes in Medicaid drug spending. In 2007, about 5.5 million low-income Medicare beneficiaries are expected to be eligible for full benefits under Medicaid, which covers prescription drugs for most beneficiaries. Under the bill, the Medicare Part D benefit would become the primary payor for prescription drugs for those beneficiaries. Cost-sharing assistance provided by Medicare to full dual-eligibles under 135 percent of poverty also would replace Medicaid assistance. Thus, savings would accrue to the Medicaid program, and would be shared with the states at the regular federal match rate (57 percent, on average). Medicaid would continue to pay for prescription drug spending not covered by the new Part D benefit and for some cost-sharing subsidies, including spending in the gap between the initial coverage limit and the annual out-of-pocket limit.

CBO anticipates that state Medicaid programs would pay premiums and cost-sharing amounts for full dual-eligibles who are not eligible for subsidy assistance to enroll them in the new drug benefit program. The bill would not allow full dual-eligibles over 135 percent of poverty access to Part D subsidy assistance (except for some dual-eligibles under 150

percent of poverty who might be eligible for premium subsidies). Those beneficiaries would be worse off under the new drug benefit than under current law if Medicaid did not pay for prescription drug spending beyond the scope of the Part D benefit. Although the bill is silent on the question of whether states would be permitted to enroll and subsidize dual-eligibles above the subsidy thresholds, CBO assumes that they would be allowed to do so and would be reimbursed at the regular federal match rate for Medicaid.

Medicaid's savings would be partially offset by new drug spending. Because CBO expects that the new drug program would increase participation of full dual-eligibles in the Medicaid program, Medicaid would be required to pay for their prescription drug spending not covered by the Part D benefit or Medicare subsidies. Finally, federal Medicaid spending in the U.S. territories would increase by additional amounts provided in the bill for prescription drug assistance to low-income Medicare beneficiaries. CBO estimates that net federal Medicaid spending for prescription drugs would decline by $10 billion over the 2001-2005 period and by $39 billion over the 2001-2010 period.

Reduction in federal payments to states. The bill would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2006. The amount of the reduction would be based on the amount of low-income subsidies that Part D of Medicare would pay for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 80 percent in 2003 to 20 percent in 2006.

CBO anticipates that the reduction would be difficult to administer because it is likely that states would demand that the federal government document its spending on subsidy payments before withholding funds. CBO's estimate therefore assumes a six-month lag between the time that low-income subsidies are paid and the time that any reductions in federal Medicaid payments are made. CBO also anticipates that potential conflicts between states and the federal government over the amount of the withholding could result in HCFA making less than the full amount of the reduction specified in the bill. Overall, CBO estimates that those reductions would lower federal Medicaid outlays by $3 billion over the 2001-2005 period and by $4 billion over the 2001-2010 period.

Impact on other Medicaid benefits. In addition to its regular benefits, Medicaid pays for some or all of the premiums and out-of-pocket expenses incurred by certain Medicare beneficiaries with low incomes and limited resources. Medicaid covers Medicare premiums and cost sharing for beneficiaries with incomes below the poverty level, and the Part B premium for beneficiaries with incomes between 100 and 120 percent of the poverty level. However, many of the Medicare beneficiaries who are eligible for this Medicaid assistance are not enrolled in Medicaid; some may not be aware of their eligibility, while others may prefer to avoid the hassle of Medicaid's enrollment process and pay Medicare cost sharing

program and may choose not to participate.

CBO believes that the attractiveness of assistance for a prescription drug benefit would boost the number of low-income Medicare beneficiaries enrolled in Medicaid by about 1.5 million by 2006 (a 20 percent increase). The bill would require state Medicaid programs to determine the eligibility of Medicare beneficiaries for the low-income subsidies under Part D of Medicare. Some beneficiaries, while applying for those subsidies in a local Medicaid office, would learn that they are eligible for additional assistance under Medicaid and would enroll. CBO estimates that provision would increase federal Medicaid spending by $2 billion over the 2001-2005 period and by $10 billion over the 2001-2010 period.

Administrative Costs for Medicaid. The bill would affect Medicaid spending for administrative costs in a number of ways. As noted above, state Medicaid programs would be required to determine the eligibility of Medicare beneficiaries for low-income subsidies under Part D. The federal Medicaid matching rate for costs related to those determinations would rise from 60 percent in 2003 to 100 percent after 2006. (The current match rate for most administrative costs is 50 percent.) CBO assumes that states would reclassify some of their regular administrative expenses as Part D administrative costs to take advantage of the higher match rate. As noted above, Medicare (SMI) would transfer funds to Medicaid to cover the portion of Medicaid's administrative costs reimbursed above the regular federal match rate.

The bill would also necessitate increased spending on administration as more low-income Medicare beneficiaries enroll in Medicaid, but would yield savings as states would have reduced responsibility for handling prescription drug claims for full-dual eligibles. CBO estimates that net federal Medicaid outlays for administration would increase by $0.7 billion over the 2001-2005 period and $1.6 billion over the 2001-2010 period.

Disease Management Project

H.R. 4680 would direct the Administrator of the MBA to conduct a three-year demonstration project to evaluate the impact of disease management services on the costs and health outcomes of Medicare Part B beneficiaries with certain illnesses. Eligible beneficiaries would have to have advanced-stage congestive heart failure, diabetes, or coronary heart disease and would be required to secure the approval of their physicians in order to participate.

Participants would be entitled to additional prescription drug benefits paid through the enrolling disease management organization (DMO). More specifically, the organization would pay for a beneficiary's premium, deductible, and cost-sharing under Part D plus any

amounts not covered by the plan because of the initial coverage limit. The organization would pay for all prescription drug costs for participants who are not enrolled under Part D. CBO expects that offering such highly desirable drug benefits would create strong demand for disease management services among chronically ill beneficiaries.

Given the nature of the contractual agreements outlined in the bill, however, whether disease management organizations would enter into contracts under those conditions is uncertain. Much of that uncertainty involves the interpretation of how the fee would be negotiated between DMOs and the Administrator. The bill would require that the fee paid to DMOs be negotiated in a manner that would guarantee a "net reduction in expenditures under the Medicare program" for participating beneficiaries. However, accurately estimating the benchmark spending against which the savings or costs would be measured would be extremely difficult, particularly because the bill would delay the implementation of improved risk adjustment factors. As a result, CBO believes that there is no assurance that the demonstration project could be implemented so as to reduce Medicare expenditures and that, on the contrary, it would increase costs to the Medicare program overall.

Moreover, the extent to which DMOs would be willing to be participate in the project is unclear. CBO assumes that it is unlikely that DMOs would assume full risk for any additional costs associated with the expanded drug benefit unless those costs are reflected in the negotiated fee. Under the bill, DMOs are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, or D. If DMOs must guarantee a "net reduction in expenditures under the Medicare program," with those expenditures defined to include additional premium and cost-sharing assistance paid under the project, CBO assumes that all DMOs would decline to participate. However, if those drug benefit payments are included in the negotiated fee, CBO assumes DMOs would enter into those agreements.

Without any legislative restrictions on the number of qualifying beneficiaries allowed to join the demonstration project, CBO would assume that up to 300,000 of them would enroll, if DMOs decided to participate and offer those benefits. Assuming an equal probability that regulations implementing the project would include or exclude payments for drug benefits from the negotiated fee, CBO estimates that such enrollment in the demonstration project would increase federal spending by about $1.1 billion over the 2001-2005 period. However, because the Manager's Amendment to the bill would limit participation to 30,000 enrollees, CBO estimates that the demonstration project would increase net federal spending by $0.3 billion over 2001-2005 period and by $0.4 billion over the 2001-2010 period.

Medicare Coverage and Appeals Process

H.R. 4680 would modify the current appeals process for the Medicare fee-for-service program to make it similar to the appeals process under the Medicare+Choice program. The bill would allow Medicare beneficiaries the right to an initial determination of coverage before services are provided. The bill would provide for external contractors to independently handle reconsiderations for denied services, impose time limits for the appeals processes, provide rules for the review of local and national coverage decisions, authorize continuing education for reviewers and adjudicators, limit beneficiaries' liability, and eliminate the Secretary's ability to overturn or modify the decisions of the Provider Reimbursement Review Board with regard to appeals by Part A providers. CBO estimates those provisions would increase direct spending by about $50 million in 2001, $0.7 billion between 2001 and 2005, and $3 billion from 2001 through 2010. Assuming appropriation of the necessary amounts, CBO assumes that the appeals and coverage provisions would increase discretionary spending by $44 million in 2001 and by $1.1 billion over the 2001-2010 period.

Medicare+Choice Reforms

Under current law, payment rates for Medicare+Choice plans are defined according to plan members' county of residence, and are then adjusted for each beneficiary's demographic and risk characteristics. The geographic payment rates are the highest of three different rates: a minimum floor rate; a blend of the county-specific rates existing before the Balanced Budget Act of 1997 and the national average rate, adjusted for local costs; or the previous year's rate increased by 2 percent. The floor and county-specific rates are updated each calendar year by the expected rate of increase in per-capita Medicare costs, minus specified percentage reductions from that rate of increase over the 1998-2002 period. The updated county rates are used to calculate a new national average and hence the new blended rates. The share of the national average rate in the blend will increase until reaching 50 percent local and 50 percent national rates some time after 2002. Finally, a "budget neutrality adjustment" is applied to the blended rates to ensure that the expected Medicare+Choice payments are the same as if all payments were completely based on local rates. That adjustment may either increase or lower the counties' rates depending upon interactions with other factors in the payment system.

The bill would eliminate the reductions from the national per capita growth rate for 2001 and 2002. In 2002, the bill would increase the floor payment rate from an estimated $432 to $450 and would allow plans to choose to be paid a 50:50 blend of local and national rates beginning in 2002. Between 2002 and 2005, the bill would establish a minimum update of 2.5 percent instead of 2 percent for counties served by one or fewer plans. The bill would

eliminate the budget neutrality adjustment beginning in 2003, and in 2004, would allow plans to negotiate a rate of payment with HCFA regardless of the county-specific rate, as long as the negotiated rate does not exceed the national average per-capita cost and does not increase more than the expected rate of increase for private insurance, minus the cost of prescription drugs. Finally, the bill would phase in implementation of improved methods of adjusting payments to reflect differences in health status, with full implementation delayed until 2013. CBO estimates that those provisions would increase Medicare outlays by $4 billion over the 2001-2005 period and by $13 billion over the 2001-2010 period.

Coverage of Drugs and Biologicals under Part B

The bill would expand the Part B outpatient drug benefit to include coverage of certain drug products that are not usually self-administered by the patient but are administered incident to a physician's service. CBO estimates that this provision would increase federal spending by $0.7 billion over the 2001-2005 period and by $1.3 billion over the 2001-2010 period.

SPENDING SUBJECT TO APPROPRIATION

The bill would establish the Medicare Benefits Administration to oversee the prescription drug benefit and to assume certain responsibilities of the Health Care Financing Administration. Subject to appropriation of the necessary amounts, CBO estimates those activities would increase federal spending by $0.2 billion in 2001 and by $5.4 billion over the 2001-2005 period. With the administrative costs of the coverage and appeals provision and the effect on federal purchasers of higher prices for prescription drugs (both described above), CBO estimates that enacting H.R. 4680 would increase discretionary spending by a total of $6.6 billion over the 10-year period, assuming appropriation of the necessary amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	390	1,550	9,180	12,800	15,960	18,360	21,080	23,780	26,450	29,440
Changes in receipts	0	0	0	-2	-5	-10	-10	-15	-20	-25	-35

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs). This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs could result in a shift of premium payments away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues to states. CBO cannot estimate the magnitude of those losses because we have no basis for predicting the size of such shifts or the degree to which such plans would have been taxable in the absence of the preemption.

The bill includes a number of preemptions that would be intergovernmental mandates as defined by UMRA, but those preemptions would impose no costs on state, local, or tribal governments. Among the preemptions are protections from civil or criminal liability for certain federal contractors, waivers of state licensing requirements, and preemption of laws establishing minimum coverage requirements.

Other Impacts

CBO estimates that the bill would reduce state Medicaid spending by about $3 billion over the 2001-2005 period and by $19 billion over the 2001-2010 period. A number of factors would contribute to that reduction. State Medicaid programs would benefit as coverage responsibility for dual-eligibles shifts from Medicaid to PDPs for prescription drug coverage and to Medicare for cost-sharing subsidies. However, some savings would be offset by prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. As a result CBO estimates that net state spending for prescription drug coverage would decline by $8 billion over the 2001-2005 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state revenues by $3 billion over the same period. Additionally, increased Medicaid enrollment and other changes are expected to increase state spending by

$1.6 billion over the 2001-2005 period.

As a condition of approval for their Medicaid plans, states would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare and would be required to transmit that information to the MBA. However, states have the ability to alter their programmatic and financial responsibilities for Medicaid to accommodate this additional determination requirement; consequently, this requirement would not be an intergovernmental mandate as defined in UMRA. Additional costs would total approximately $0.3 billion over the 2001-2005 period. Costs would decrease over time because the matching rate from the federal government would increase annually until 2007 when it would reach 100 percent.

State and local governments that provide health insurance to their employees or retired employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in the costs of their health plans. Because CBO cannot predict how states would restructure the prescription drug component of their health plans, we cannot estimate the amount of such savings.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On June 21, 2000, CBO produced a preliminary analysis of H.R. 4680, as modified in discussions with staff. That analysis concluded the bill would increase direct spending by $38.6 billion over the 2001-2005 period and by $155 billion over the 2001-2010 period. The current estimate is $1.4 billion higher over the first five years and $4 billion higher over the 10-year period. Two revisions in the committee-approved bill—the addition of the disease management project, and an increase in the updates to rates paid to Medicare+Choice plans in 2001 and 2002—increased the estimate by $1.5 billion for the 2001-2005 period and by $3.4 billion for the 2001-2010 period. The remaining differences are due to numerous refinements of estimating assumptions and to differences between specifications discussed with staff and the legislative language in the reported bill and subsequently modified by the

Manager's Amendment dated June 28, 2000.

This estimate includes one significant change in the display of the estimated cost of administering the low-income subsidy. The previous estimate combined the transfer from SMI to Medicaid for administering the low-income subsidy and the administrative spending that is funded through Medicaid. The current estimate displays those components separately.

The estimated impact on revenues is unchanged. The estimate of spending subject to appropriation was incomplete in the previous analysis.

ESTIMATE PREPARED BY:

Federal Costs: Charles Betley, Tom Bradley, Julia Christensen, Jeanne De Sa, Eric Rollins, and Christopher Topoleski (226-9010); and Sandra Christensen, Karuna Patel, and Judith Wagner (226-2666).

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ESTIMATE APPROVED BY:

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CONGRESSIONAL BUDGET OFFICE
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WASHINGTON, DC 20515

Dan L. Crippen
Director

ADMIN Cmte:

June 28, 2000

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Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

Sincerely,

Dan L. Crippen

Enclosure

cc: Honorable Charles B. Rangel
Ranking Democrat

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 28, 2000

H.R. 4680
Medicare Rx 2000 Act

As ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000

SUMMARY

The Medicare Rx 2000 Act would:

- Establish a prescription drug benefit for Medicare enrollees and a subsidy program for certain low-income participants;
- Establish a new Medicare Benefits Administration (MBA) to oversee the prescription drug benefit and the Medicare+Choice program, and to administer the low-income subsidy program;
- Establish a disease management demonstration project;
- Modify Medicare's coverage and appeals process;
- Adjust payment rates for Medicare+Choice plans; and
- Expand coverage of certain injectable and infusable drugs under Medicare Part B.

The Manager's Amendment would permit the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, cap participation in the disease management project at 30,000, and extend the deadline for Medicare+Choice plans to announce whether they will participate in the program in 2001. The amendment also contains several technical corrections.

H.R. 4680 would affect both direct spending and revenues; therefore, pay-as-you go procedures would apply. CBO estimates that enacting the bill would increase direct spending by $0.4 billion in 2001, by $40 billion over the 2001-2005 period, and by $159 billion over the 2001-2010 period. The prescription drug benefit and the changes in

coverage and payment rates for medical benefits for Medicare enrollees account for nearly all of those increases in direct spending. We estimate that on-budget revenues and off-budget revenues would each decline by less than $50 million a year from 2003 through 2010. The bill also would lead to an increase in the market price of prescription drugs, which would result in:

- Slight increases in direct spending for Medicaid and health benefits for retired federal employees,
- Slight increases in discretionary spending for health programs of several federal agencies, and
- A small decrease in federal tax revenues.

Each of those effects would be less than $50 million in most years.

Subject to appropriation of the necessary amounts, CBO estimates that administering the prescription drug benefit and modifying the coverage and appeals process would cost $0.2 billion in 2001 and $6.5 billion over the 2001-2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments. Other provisions in the bill would result in net savings to state and local governments of approximately $3 billion over the 2001-2005 period and $19 billion over the 2001-2010 period.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4680 is shown in Table 1. The bill would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all federal agencies for employee health benefits. It also would reduce federal revenues by a small amount. The bill would have no effect on outlays or revenues in 2000.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By Fiscal Year, in Billions of Dollars									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare Outlays										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	a	a	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid Outlays										
Change to current-law drug spending	0	0	-2.6	-3.7	-4.1	-4.6	-5.1	-5.7	-6.3	-7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	-0.6	-1.3	-1.2	-0.8	-0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	-2.7	-4.1	-3.9	-3.8	-3.7	-3.9	-4.4	-4.9
Effect of higher drug prices on outlays by federal programs										
Medicaid	0	0	a	a	a	a	a	a	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	a	a	a	a	a	a	a	a
Subtotal, on-budget	0	0	a	a	a	a	a	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	a	a	a	a	a	a	a	a
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	a	a	a	a	a	a	a	a
Social Security payroll taxes (off-budget)	0	0	a	a	a	a	a	a	a	a
Total	0	0	a	a	a	a	a	a	a	-0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	0	0	a	a	a	a	a	a	a	a
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

SOURCE: Congressional Budget Office

NOTES: SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits

a Costs or savings of less than $50 million.

BASIS OF ESTIMATE

Prescription Drug Benefits

H.R. 4680 would create a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. CBO estimates that the Part D provisions would increase direct spending by $35 billion over the 2001-2005 period and by $142 billion from 2001 through 2010. Of that 10-year total, $81 billion represents outlays for federal reinsurance payments to plans offering qualified prescription drug coverage and $92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by $31 billion in net federal Medicaid savings associated with the new drug program, because part D would replace Medicaid coverage for some individuals. (States would also accrue additional net Medicaid savings totaling $3 billion through 2005 and about $19 billion over the 2001-2010 period.)

CBO estimates that the cost associated with administering the new Part D benefit and other related activities, subject to the appropriation of the necessary amounts, would total $2 billion over the 2001-2005 period and more than $5 billion over the 2001-2010 period.

Two other provisions, which would modify Part B coverage of certain drugs and biologicals and create a disease management demonstration project, would add almost $2 billion over the 10-year period.

Coverage of the Part D Program. H.R. 4680 would provide federal reinsurance payments to entities offering qualified prescription drug coverage to Medicare beneficiaries. Eligible entities would include sponsors of prescription drug plans (PDPs), Medicare+Choice organizations, and qualified retiree prescription drug plans—all of which would have to offer qualified drug coverage and comply with other requirements under Part D. Either the specified standard coverage or a benefit design that is at least actuarially equivalent to standard coverage would meet the bill's requirements. Such qualified coverage also would have to include access to negotiated prescription drug prices for all of a beneficiary's purchases of covered drugs.

The bill defines standard coverage for 2003 as a $250 deductible; 50 percent coinsurance—or an actuarially equivalent cost-sharing rate—on the next $2,100 in total drug spending to reach an "initial coverage limit" of $1,050, and an annual limit on out-of-pocket spending of $6,000 (see Table 2). Qualified standard coverage would make the beneficiary responsible for paying 100 percent of drug costs for all drug spending above the $1,050 benefit maximum but below the $6,000 out-of-pocket limit. In other words, in 2003 a beneficiary would begin to pay 100 percent of drug costs after annual drug spending exceeded $2,350 until a total of $7,050 was spent in that year. After annual drug spending exceeded $7,050,

the beneficiary would pay no more for drugs and the plan would pay 100 percent of any additional drug spending in that year. The dollar amounts for the deductible, initial coverage limit, and out-of-pocket limit would be updated annually by the percentage increase in average per capita expenditures for covered outpatient drugs for Medicare beneficiaries.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary*	
		Spending in the Interval	Cumulative Spending
$ 0 to 250	100 percent	$ 250	$ 250
$ 250.01 to 2,350	50 percent	1,050	1,300
$ 2,350.01 to 7,050	100 percent	4,700	6,000
Above $ 7,050	0 percent	0	6,000

*Assumes beneficiary spends the full amount in the interval.

Alternative coverage designs would qualify under Part D as long as:

- The actuarial value of total coverage is at least equal to the actuarial value of standard coverage,
- The unsubsidized value of coverage (after receiving federal reinsurance payments) is at least actuarially equivalent to the unsubsidized value of standard coverage,
- The benefit design provides for payments by the plan under the initial coverage limit to be at least actuarially equivalent to the amount paid under standard coverage, and
- The limit on out-of-pocket spending is the same as the limit required for the standard package for beneficiaries whose drug spending equals at least $2,350 (in 2003).

H.R. 4680 also would allow third parties (such as Medicaid or employer-sponsored health insurance) to pay a beneficiary's cost-sharing obligation below the out-of-pocket limit and would require that the plan count those third-party contributions toward the beneficiary's out-of-pocket contributions.

The bill would require sponsors of qualifying plans to cover prescription drugs, insulin, and biologicals but would prohibit coverage for a specific list of drugs, such as hair growth products. Drugs currently covered under Medicare Parts A and B would continue to be

products. Drugs currently covered under Medicare Parts A and B would continue to be covered under current law rules.

Qualifying PDPs would assume full financial risk for costs not subject to federal reinsurance subsidies but would be permitted to obtain insurance to cover that risk. The bill would permit insurers to coordinate with other entities to manage the pharmacy benefit. CBO assumes that most insurers would administer the benefit through pharmacy benefit management (PBM) companies.

Administration and Oversight. The bill would create a new agency in the Department of Health and Human Services called the Medicare Benefits Administration (MBA) to administer the new Part D drug benefit, the low-income subsidy program, and the Medicare+Choice program. The plan oversight function currently within the Health Care Financing Administration (HCFA) would be consolidated within the new agency. Premiums set by plans would be subject to rate review and negotiation with the Administrator of the MBA.

H.R. 4680 would require that each Part B beneficiary have access to at least two qualifying plans, at least one of which is a PDP. The MBA could provide financial incentives to existing sponsors to ensure the availability of two plans. If two plans are not available in an area, the MBA would be required to offer a qualifying prescription drug plan. The MBA could establish such a plan on a regional or nationwide basis. CBO assumes that the MBA would offer coverage through its own plan only to beneficiaries who do not have a choice of two qualifying private plans.

Federal Payments for Reinsurance. Sponsors of PDPs, Medicare + Choice organizations, and qualified retiree prescription drug plans who offer qualified drug coverage would be eligible for federal reinsurance payments. Those federal payments would be based on the lesser of the drug costs per enrollee paid by the plan or the amount that would have been paid by the plan if the coverage offered was standard coverage. Such payments by the plans would be considered "allowable drug costs" for the federal reinsurance subsidy. In 2003, the reinsurance schedule for each enrollee would be:

- 30% of allowable drug costs for total drug spending between $1,251 and $1,350;
- 50% of allowable drug costs for total drug spending between $1,351 and $1,450;
- 70% of allowable drug costs for total drug spending between $1,451 and $1,550;
- 90% of allowable drug costs for total drug spending between $1,551 and $2,350,

- 90% of allowable drug costs for total drug spending exceeding $7,050.

The bill also would require the MBA to adjust the subsidy payments so that the total of such subsidy payments for each year is equal to 35 percent of covered outpatient drug payments made by plans based on standard coverage. CBO assumes it would take at least one year to calculate the amount of the adjustment, so those adjustments would be made with a two-year lag.

Plans would charge beneficiaries a premium to cover drug spending that is not subsidized by the federal government plus the plan's cost of administering the benefit and the plan's profit. CBO estimates that plans would charge beneficiaries an annual premium that would average $470 in 2003 and would grow to $809 in 2010.

Enrollment. All Medicare beneficiaries would have a one-time chance to purchase qualified drug coverage from the sponsor of a qualifying plan when they first become eligible for Medicare and during a six-month open enrollment period starting in 2003. During that time, insurers would not be allowed to underwrite their premiums or exclude beneficiaries from coverage based on pre-existing conditions. Rather, the plan would have to charge the same premium to all enrollees in a service area who maintain continuous prescription drug coverage. (Service area is not defined.) Continuous prescription drug coverage refers to prescription drug coverage offered under a PDP, a Medicare+Choice plan, Medicaid, a group health plan, certain Medigap policies, a state pharmaceutical assistance program, or a program of the Department of Veterans Affairs. Beneficiaries would be allowed to change plans each year.

Plans could charge a higher premium to enrollees who did not enroll at the first opportunity or who let coverage lapse for 63 days or longer, except in a few limited circumstances.

Medicare+Choice Drug Benefits. H.R. 4680 would require that all Medicare+Choice plans offering drug benefits meet the qualified prescription drug coverage standards under Part D. However, a Medicare+Choice plan could elect not to offer prescription drug coverage. Medicare+Choice plans that offer qualifying coverage under Part D would be able to charge a separate prescription drug premium and receive federal reinsurance payments.

CBO's Estimating Assumptions for Prescription Drug Benefits

Participation. CBO assumes that Medicare enrollees who have drug coverage under current law that is not federally subsidized would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes that beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit. Of those

who purchase Part B but do not have drug coverage, CBO assumes that 46 percent would purchase a qualified drug plan. In total, CBO estimates that 80 percent of beneficiaries in Part B (equal to 74 percent of all Medicare enrollees) would participate in the drug benefit provided by H.R. 4680.

10 M PEOPLE

CBO also expects states to pay the premiums charged by sponsors of qualified drug plans and the cost-sharing obligations of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid benefits, because that would shift some of the costs for drug coverage for those dual-eligibles from the states to Medicare.

Effectiveness of PBMs. Under H.R. 4680, PBMs would compete against one another for the business of managing the benefit for sponsors of qualifying prescription drug plans. The bill would allow PBMs to use a broad range of current market tools to manage the pharmacy benefits for PDPs, though it would impose certain restrictions on the PBMs' activities.

PBMs would be allowed to negotiate discounts with pharmacies that agree to participate in their networks but would need to guarantee access that is convenient to beneficiaries. PBMs would also be allowed to design restrictive formularies and negotiate rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. However, the bill specifies that the formularies would need to cover all therapeutic classes, which could dilute some of their negotiating power with manufacturers. As long as cost-sharing requirements under a plan are actuarially equivalent to the standard plan for spending under the benefit maximum, the bill would allow PBMs to establish differential copayment requirements that encourage beneficiaries to select lower-priced options, such as generic, preferred formulary, or mail-order drugs.

The appeals process specified under the bill would allow access to off-formulary drugs at a physician's request when the on-formulary drug is considered not as effective as the off-formulary version for the patient or has significant adverse effects for the enrollee. CBO assumes this process would interfere with a PBM's ability to negotiate rebates from manufacturers in certain circumstances. Considering all these factors, CBO estimates that PBMs would be able to reduce spending by an average of about 25 percent from what an uninsured retail purchaser would pay under current law.

Drug Pricing Assumptions and Effects on Other Federal Purchasers. Enrollees whose drug expenses exceed the stop-loss amount would no longer be price-conscious. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 2 percent higher if H.R. 4680 is enacted.

Higher drug prices would also affect spending by other federal programs for prescription drugs. Medicaid, the Federal Employees Health Benefits (FEHB) program, the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the U.S. Coast Guard would all be affected.

CBO estimates that higher drug prices would increase direct spending for Medicaid and for annuitants covered by the FEHB program by less than $50 million over the 2001-2005 period and by $0.3 billion over the 2001-2010 period. Subject to the appropriation of necessary amounts, discretionary spending by federal agencies for active workers covered by the FEHB program, DOD, VA, PHS, and the U.S. Coast Guard would increase by $0.1 billion over the 2001-2010 period. The net impact over the same period for active and retired postal employees would be negligible.

Revenue Impact. As a result of higher drug prices, H.R. 4680 would also lead to a loss of federal income and payroll tax revenues by raising the costs of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the bill would reduce revenues by less than $50 million over the 2001-2005 period and by $0.2 billion from 2001 through 2010. Social Security payroll taxes, which are off-budget, account for $0.1 billion of that 10-year total.

Low-Income Subsidies

A central feature of the bill is the provision of assistance to low-income beneficiaries who participate in Medicare Part D. CBO expects the low-income subsidies, including payments from the SMI trust fund to state Medicaid programs for administrative costs, would increase Medicare spending by $23 billion over the 2001-2005 period and by $92 billion over the 2001-2010 period, amounts that slightly exceed the federal reinsurance payments. Because Medicaid currently pays for a share of prescription drug costs for about 13 percent of Medicare beneficiaries who are dually-eligible for both programs, about a quarter of the bill's Medicare Part D spending (the federal reinsurance payment and the low-income subsidies) would be offset by a decline in the federal share of Medicaid spending. The bill also would increase Medicaid spending for prescription drugs for some new enrollees and the U.S. territories, withhold some funds from states, increase other Medicaid benefits for new enrollees, and provide additional Medicaid payments for administration. CBO estimates those provisions would lead to a decrease in net federal Medicaid spending of $11 billion over the 2001-2005 period and a decrease of $31 billion over the 2001-2010 period.

Medicare spending on low-income subsidies. Under the bill, Medicare would subsidize spending for premiums and cost sharing under Part D for certain low-income Medicare beneficiaries (except those residing in the U.S. territories). Subsidies would be 100 percent

federally financed. Beneficiaries with incomes below 135 percent of the poverty level and with limited assets would receive a premium subsidy equal to the premium for standard coverage (or its actuarial equivalent). They would also receive a subsidy for cost sharing up to 95 percent of the maximum amount permitted under the initial coverage limit (in 2003, that would be 95 percent of $1,300, or $1,235). Individuals with incomes between 135 and 150 percent of the poverty level would receive smaller premium subsidies determined using a sliding scale, but would not be eligible for subsidies for cost sharing.

Participation in the subsidy program would grow over time as beneficiaries become aware of and apply for those subsidies, though some low-income Medicare beneficiaries who would participate in Part D and who would be eligible for subsidy assistance would choose not to participate in the subsidy program. CBO expects that about 8 million Medicare beneficiaries, or one quarter of the enrollees in Part D, would receive subsidy assistance by 2007. Most of those subsidy recipients currently receive full or partial medical assistance under Medicaid. We estimate that Medicare payments for low-income subsidies would total $23 billion over the 2001-2005 period and $90 billion over the 2001-2010 period.

The bill would require that state Medicaid programs perform eligibility determinations for the subsidies (see below for more detail) and would offer states a higher federal match rate than the average rate of 50 percent to perform those services. Although the Medicaid program would initially incur the costs of administration, Medicare's Supplementary Medical Insurance (SMI) Trust Fund would ultimately transfer funds to Medicaid to cover some of Medicaid's new administrative costs. CBO estimates that Medicare spending for those administrative costs would total $0.2 billion over the 2001-2005 period and $1.4 billion over the 2001-2010 period.

Changes in Medicaid drug spending. In 2007, about 5.5 million low-income Medicare beneficiaries are expected to be eligible for full benefits under Medicaid, which covers prescription drugs for most beneficiaries. Under the bill, the Medicare Part D benefit would become the primary payor for prescription drugs for those beneficiaries. Cost-sharing assistance provided by Medicare to full dual-eligibles under 135 percent of poverty also would replace Medicaid assistance. Thus, savings would accrue to the Medicaid program, and would be shared with the states at the regular federal match rate (57 percent, on average). Medicaid would continue to pay for prescription drug spending not covered by the new Part D benefit and for some cost-sharing subsidies, including spending in the gap between the initial coverage limit and the annual out-of-pocket limit.

CBO anticipates that state Medicaid programs would pay premiums and cost-sharing amounts for full dual-eligibles who are not eligible for subsidy assistance to enroll them in the new drug benefit program. The bill would not allow full dual-eligibles over 135 percent of poverty access to Part D subsidy assistance (except for some dual-eligibles under 150

percent of poverty who might be eligible for premium subsidies). Those beneficiaries would be worse off under the new drug benefit than under current law if Medicaid did not pay for prescription drug spending beyond the scope of the Part D benefit. Although the bill is silent on the question of whether states would be permitted to enroll and subsidize dual-eligibles above the subsidy thresholds, CBO assumes that they would be allowed to do so and would be reimbursed at the regular federal match rate for Medicaid.

Medicaid's savings would be partially offset by new drug spending. Because CBO expects that the new drug program would increase participation of full dual-eligibles in the Medicaid program, Medicaid would be required to pay for their prescription drug spending not covered by the Part D benefit or Medicare subsidies. Finally, federal Medicaid spending in the U.S. territories would increase by additional amounts provided in the bill for prescription drug assistance to low-income Medicare beneficiaries. CBO estimates that net federal Medicaid spending for prescription drugs would decline by $10 billion over the 2001-2005 period and by $39 billion over the 2001-2010 period.

Reduction in federal payments to states. The bill would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2006. The amount of the reduction would be based on the amount of low-income subsidies that Part D of Medicare would pay for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 80 percent in 2003 to 20 percent in 2006.

CBO anticipates that the reduction would be difficult to administer because it is likely that states would demand that the federal government document its spending on subsidy payments before withholding funds. CBO's estimate therefore assumes a six-month lag between the time that low-income subsidies are paid and the time that any reductions in federal Medicaid payments are made. CBO also anticipates that potential conflicts between states and the federal government over the amount of the withholding could result in HCFA making less than the full amount of the reduction specified in the bill. Overall, CBO estimates that those reductions would lower federal Medicaid outlays by $3 billion over the 2001-2005 period and by $4 billion over the 2001-2010 period.

Impact on other Medicaid benefits. In addition to its regular benefits, Medicaid pays for some or all of the premiums and out-of-pocket expenses incurred by certain Medicare beneficiaries with low incomes and limited resources. Medicaid covers Medicare premiums and cost sharing for beneficiaries with incomes below the poverty level, and the Part B premium for beneficiaries with incomes between 100 and 120 percent of the poverty level. However, many of the Medicare beneficiaries who are eligible for this Medicaid assistance are not enrolled in Medicaid; some may not be aware of their eligibility, while others may prefer to avoid the hassle of Medicaid's enrollment process and pay Medicare cost sharing

program and may choose not to participate.

CBO believes that the attractiveness of assistance for a prescription drug benefit would boost the number of low-income Medicare beneficiaries enrolled in Medicaid by about 1.5 million by 2006 (a 20 percent increase). The bill would require state Medicaid programs to determine the eligibility of Medicare beneficiaries for the low-income subsidies under Part D of Medicare. Some beneficiaries, while applying for those subsidies in a local Medicaid office, would learn that they are eligible for additional assistance under Medicaid and would enroll. CBO estimates that provision would increase federal Medicaid spending by $2 billion over the 2001-2005 period and by $10 billion over the 2001-2010 period.

Administrative Costs for Medicaid. The bill would affect Medicaid spending for administrative costs in a number of ways. As noted above, state Medicaid programs would be required to determine the eligibility of Medicare beneficiaries for low-income subsidies under Part D. The federal Medicaid matching rate for costs related to those determinations would rise from 60 percent in 2003 to 100 percent after 2006. (The current match rate for most administrative costs is 50 percent.) CBO assumes that states would reclassify some of their regular administrative expenses as Part D administrative costs to take advantage of the higher match rate. As noted above, Medicare (SMI) would transfer funds to Medicaid to cover the portion of Medicaid's administrative costs reimbursed above the regular federal match rate.

The bill would also necessitate increased spending on administration as more low-income Medicare beneficiaries enroll in Medicaid, but would yield savings as states would have reduced responsibility for handling prescription drug claims for full-dual eligibles. CBO estimates that net federal Medicaid outlays for administration would increase by $0.7 billion over the 2001-2005 period and $1.6 billion over the 2001-2010 period.

Disease Management Project

H.R. 4680 would direct the Administrator of the MBA to conduct a three-year demonstration project to evaluate the impact of disease management services on the costs and health outcomes of Medicare Part B beneficiaries with certain illnesses. Eligible beneficiaries would have to have advanced-stage congestive heart failure, diabetes, or coronary heart disease and would be required to secure the approval of their physicians in order to participate.

Participants would be entitled to additional prescription drug benefits paid through the enrolling disease management organization (DMO). More specifically, the organization would pay for a beneficiary's premium, deductible, and cost-sharing under Part D plus any

amounts not covered by the plan because of the initial coverage limit. The organization would pay for all prescription drug costs for participants who are not enrolled under Part D. CBO expects that offering such highly desirable drug benefits would create strong demand for disease management services among chronically ill beneficiaries.

Given the nature of the contractual agreements outlined in the bill, however, whether disease management organizations would enter into contracts under those conditions is uncertain. Much of that uncertainty involves the interpretation of how the fee would be negotiated between DMOs and the Administrator. The bill would require that the fee paid to DMOs be negotiated in a manner that would guarantee a "net reduction in expenditures under the Medicare program" for participating beneficiaries. However, accurately estimating the benchmark spending against which the savings or costs would be measured would be extremely difficult, particularly because the bill would delay the implementation of improved risk adjustment factors. As a result, CBO believes that there is no assurance that the demonstration project could be implemented so as to reduce Medicare expenditures and that, on the contrary, it would increase costs to the Medicare program overall.

Moreover, the extent to which DMOs would be willing to be participate in the project is unclear. CBO assumes that it is unlikely that DMOs would assume full risk for any additional costs associated with the expanded drug benefit unless those costs are reflected in the negotiated fee. Under the bill, DMOs are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, or D. If DMOs must guarantee a "net reduction in expenditures under the Medicare program," with those expenditures defined to include additional premium and cost-sharing assistance paid under the project, CBO assumes that all DMOs would decline to participate. However, if those drug benefit payments are included in the negotiated fee, CBO assumes DMOs would enter into those agreements.

Without any legislative restrictions on the number of qualifying beneficiaries allowed to join the demonstration project, CBO would assume that up to 300,000 of them would enroll, if DMOs decided to participate and offer those benefits. Assuming an equal probability that regulations implementing the project would include or exclude payments for drug benefits from the negotiated fee, CBO estimates that such enrollment in the demonstration project would increase federal spending by about $1.1 billion over the 2001-2005 period. However, because the Manager's Amendment to the bill would limit participation to 30,000 enrollees, CBO estimates that the demonstration project would increase net federal spending by $0.3 billion over 2001-2005 period and by $0.4 billion over the 2001-2010 period.

Medicare Coverage and Appeals Process

H.R. 4680 would modify the current appeals process for the Medicare fee-for-service program to make it similar to the appeals process under the Medicare+Choice program. The bill would allow Medicare beneficiaries the right to an initial determination of coverage before services are provided. The bill would provide for external contractors to independently handle reconsiderations for denied services, impose time limits for the appeals processes, provide rules for the review of local and national coverage decisions, authorize continuing education for reviewers and adjudicators, limit beneficiaries' liability, and eliminate the Secretary's ability to overturn or modify the decisions of the Provider Reimbursement Review Board with regard to appeals by Part A providers. CBO estimates those provisions would increase direct spending by about $50 million in 2001, $0.7 billion between 2001 and 2005, and $3 billion from 2001 through 2010. Assuming appropriation of the necessary amounts, CBO assumes that the appeals and coverage provisions would increase discretionary spending by $44 million in 2001 and by $1.1 billion over the 2001-2010 period.

Medicare+Choice Reforms

Under current law, payment rates for Medicare+Choice plans are defined according to plan members' county of residence, and are then adjusted for each beneficiary's demographic and risk characteristics. The geographic payment rates are the highest of three different rates: a minimum floor rate; a blend of the county-specific rates existing before the Balanced Budget Act of 1997 and the national average rate, adjusted for local costs; or the previous year's rate increased by 2 percent. The floor and county-specific rates are updated each calendar year by the expected rate of increase in per-capita Medicare costs, minus specified percentage reductions from that rate of increase over the 1998-2002 period. The updated county rates are used to calculate a new national average and hence the new blended rates. The share of the national average rate in the blend will increase until reaching 50 percent local and 50 percent national rates some time after 2002. Finally, a "budget neutrality adjustment" is applied to the blended rates to ensure that the expected Medicare+Choice payments are the same as if all payments were completely based on local rates. That adjustment may either increase or lower the counties' rates depending upon interactions with other factors in the payment system.

The bill would eliminate the reductions from the national per capita growth rate for 2001 and 2002. In 2002, the bill would increase the floor payment rate from an estimated $432 to $450 and would allow plans to choose to be paid a 50:50 blend of local and national rates beginning in 2002. Between 2002 and 2005, the bill would establish a minimum update of 2.5 percent instead of 2 percent for counties served by one or fewer plans. The bill would

eliminate the budget neutrality adjustment beginning in 2003, and in 2004, would allow plans to negotiate a rate of payment with HCFA regardless of the county-specific rate, as long as the negotiated rate does not exceed the national average per-capita cost and does not increase more than the expected rate of increase for private insurance, minus the cost of prescription drugs. Finally, the bill would phase in implementation of improved methods of adjusting payments to reflect differences in health status, with full implementation delayed until 2013. CBO estimates that those provisions would increase Medicare outlays by $4 billion over the 2001-2005 period and by $13 billion over the 2001-2010 period.

Coverage of Drugs and Biologicals under Part B

The bill would expand the Part B outpatient drug benefit to include coverage of certain drug products that are not usually self-administered by the patient but are administered incident to a physician's service. CBO estimates that this provision would increase federal spending by $0.7 billion over the 2001-2005 period and by $1.3 billion over the 2001-2010 period.

SPENDING SUBJECT TO APPROPRIATION

The bill would establish the Medicare Benefits Administration to oversee the prescription drug benefit and to assume certain responsibilities of the Health Care Financing Administration. Subject to appropriation of the necessary amounts, CBO estimates those activities would increase federal spending by $0.2 billion in 2001 and by $5.4 billion over the 2001-2005 period. With the administrative costs of the coverage and appeals provision and the effect on federal purchasers of higher prices for prescription drugs (both described above), CBO estimates that enacting H.R. 4680 would increase discretionary spending by a total of $6.6 billion over the 10-year period, assuming appropriation of the necessary amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	390	1,550	9,180	12,800	15,960	18,360	21,080	23,780	26,450	29,440
Changes in receipts	0	0	0	-2	-5	-10	-10	-15	-20	-25	-35

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs). This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs could result in a shift of premium payments away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues to states. CBO cannot estimate the magnitude of those losses because we have no basis for predicting the size of such shifts or the degree to which such plans would have been taxable in the absence of the preemption.

The bill includes a number of preemptions that would be intergovernmental mandates as defined by UMRA, but those preemptions would impose no costs on state, local, or tribal governments. Among the preemptions are protections from civil or criminal liability for certain federal contractors, waivers of state licensing requirements, and preemption of laws establishing minimum coverage requirements.

Other Impacts

CBO estimates that the bill would reduce state Medicaid spending by about $3 billion over the 2001-2005 period and by $19 billion over the 2001-2010 period. A number of factors would contribute to that reduction. State Medicaid programs would benefit as coverage responsibility for dual-eligibles shifts from Medicaid to PDPs for prescription drug coverage and to Medicare for cost-sharing subsidies. However, some savings would be offset by prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. As a result CBO estimates that net state spending for prescription drug coverage would decline by $8 billion over the 2001-2005 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state revenues by $3 billion over the same period. Additionally, increased Medicaid enrollment and other changes are expected to increase state spending by

$1.6 billion over the 2001-2005 period.

As a condition of approval for their Medicaid plans, states would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare and would be required to transmit that information to the MBA. However, states have the ability to alter their programmatic and financial responsibilities for Medicaid to accommodate this additional determination requirement; consequently, this requirement would not be an intergovernmental mandate as defined in UMRA. Additional costs would total approximately $0.3 billion over the 2001-2005 period. Costs would decrease over time because the matching rate from the federal government would increase annually until 2007 when it would reach 100 percent.

State and local governments that provide health insurance to their employees or retired employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in the costs of their health plans. Because CBO cannot predict how states would restructure the prescription drug component of their health plans, we cannot estimate the amount of such savings.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On June 21, 2000, CBO produced a preliminary analysis of H.R. 4680, as modified in discussions with staff. That analysis concluded the bill would increase direct spending by $38.6 billion over the 2001-2005 period and by $155 billion over the 2001-2010 period. The current estimate is $1.4 billion higher over the first five years and $4 billion higher over the 10-year period. Two revisions in the committee-approved bill—the addition of the disease management project, and an increase in the updates to rates paid to Medicare+Choice plans in 2001 and 2002—increased the estimate by $1.5 billion for the 2001-2005 period and by $3.4 billion for the 2001-2010 period. The remaining differences are due to numerous refinements of estimating assumptions and to differences between specifications discussed with staff and the legislative language in the reported bill and subsequently modified by the

Manager's Amendment dated June 28, 2000.

This estimate includes one significant change in the display of the estimated cost of administering the low-income subsidy. The previous estimate combined the transfer from SMI to Medicaid for administering the low-income subsidy and the administrative spending that is funded through Medicaid. The current estimate displays those components separately.

The estimated impact on revenues is unchanged. The estimate of spending subject to appropriation was incomplete in the previous analysis.

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June 28, 2000
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 4680 - Medicare Rx 2000 Act
(Thomas (R) CA and seven cosponsors)

The Administration strongly opposes House passage of H.R. 4680 because its private insurance benefit does not meet the President's test of being a meaningful Medicare prescription drug benefit that is affordable and accessible for all beneficiaries. H.R. 4680 builds on an unstable and unreliable Medigap market, an approach which the insurance industry itself has concluded is unworkable. If H.R. 4680 were presented to the President, he would veto it.

The President has made passing a voluntary Medicare prescription drug benefit one of his highest priorities. His principles for a drug benefit are that it be voluntary; be accessible to all beneficiaries; be meaningful; give eligible seniors and people with disabilities bargaining power to reduce drug prices; assure access to medically necessary drugs; and be affordable to beneficiaries and the Medicare program.

The President's plan would ensure that Medicare pays half of all participants' prescription drug costs up to $5,000 when fully phased in and that no eligible senior or person with a disability pays more than $4,000 out-of-pocket. In addition, seniors would benefit from price discounts negotiated by private pharmacy benefit managers. Beneficiaries would have a choice of getting coverage through traditional Medicare, managed care, or retiree plans. Those who voluntarily opted for the new benefit would pay a monthly premium of $25 in the first year, and low-income seniors would pay no or lower premiums and cost sharing. This coverage would start in 2002 and is part of the President's overall plan to strengthen and modernize Medicare.

The Democratic substitute, which the President strongly supports, also provides an affordable, meaningful Medicare drug benefit. It, too, covers half of costs up to $5,000 when fully phased in, includes a stop-loss of $4,000, and ensures that seniors have a choice of coverage through Medicare fee-for-service, managed care or retiree coverage. The President is dismayed that the Republican leadership refused to allow a vote on a true Medicare benefit that provides the resources necessary to ensure that premiums are affordable.

H.R. 4680 does not meet the President's principles for a meaningful prescription drug benefit. Specifically:

-- **Private insurance model does not ensure access to a dependable benefit.** H.R. 4680 relies on private insurers to offer Medicare beneficiaries a prescription drug benefit. The private insurance industry itself has repeatedly stated that they would not participate in this flawed plan. Even if they do participate, insurers could not be relied on to provide

continuous coverage in all areas -- the same problem that we have in Medicare managed care today. Under the President's plan and the Democratic substitute, all beneficiaries – including those in rural or otherwise underserved areas -- would be guaranteed a defined, accessible, reliable Medicare benefit for the same premium.

-- **Private insurance model would not be affordable to all beneficiaries.** Under H.R. 4680, Medicare would not provide a single dollar of direct premium assistance for middle-class beneficiaries (any senior with income above $12,600). Instead, the plan relies on subsidies to insurers, not seniors. Insurers would set premiums. Thus, seniors would pay different premiums from plan to plan and place to place. A rural senior would be at particular risk of facing excessive premiums since insurers would likely face little competition and less incentive to offer affordable coverage. The premium cited by the Republican leadership for H.R. 4680 has not been confirmed by the Congressional Budget Office or any other independent entity, unlike the President's plan. Even accepting the Republicans' claim that the premium would average $37 per month, this premium would be over 40 percent higher than the President's plan premium of $25 per month.

-- **Seniors would pay more for less valuable and meaningful coverage.** Under H.R. 4680, seniors and people with disabilities would pay a higher premium for less generous coverage. According to an analysis by the Department of Health and Human Services, the President's benefit would be 25 percent more valuable in 2003 and 50 percent more valuable when fully phased in than that of H.R. 4680. Moreover, private insurers may vary their benefits by setting their own deductibles, copays, and benefit limits within an actuarial value. This allows insurers to discourage enrollment by the oldest seniors and most disabled beneficiaries by offering no deductible and low copays, but also a low benefit cap that leaves a large gap in coverage before the stop-loss kicks in. In addition, private plans could limit access to community pharmacists and needed medications. Under the President's plan, seniors and people with disabilities would have a real choice: choice of using their community pharmacist and access to prescriptions that their doctor -- not their insurance company -- determines are necessary.

The Administration also objects to creating a new bureaucracy to administer the new drug benefit and Medicare+Choice. This is inconsistent with the President's principles of efficient administration of the drug benefit. The Administration believes that the prescription drug benefit should be integrated into the Medicare program like all other Medicare benefits. In addition, provisions in H.R. 4680 related to the Medicare Advisory Board and its reporting requirements raise constitutional concerns.

Pay-As-You-Go Scoring

H.R. 4680 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's estimate of the pay-as-you-go cost of this legislation is under development. The Congressional Budget Office estimates that H.R. 4680 will increase direct spending by a total of $39.7 billion over five years.

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