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Medicare Analysis

The Medicare Reform Debate: What Is the Next Step?

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Abstract: Medicare costs are rising faster than projected revenues. Action to close the emerging deficit is inescapable. We propose converting Medicare from a "service reimbursement" system to a "premium support" system. These changes would resemble many that are now reshaping private employer-based insurance. Our reform would encompass not just the "public" Medicare program but also the "real" Medicare, which includes the supplemental plans to which most Medicare beneficiaries have access. Approved plans would have to offer stipulated services. We review numerous technical issues in moving to a new system that cannot be solved quickly and that preclude quick budget savings.

Medicare is at the core of two current policy debates. One centers on the steps needed to balance the federal budget over the next seven to ten years. The other focuses on how existing entitlement programs might best be modified to cope with the retirement of the baby-boom generation, which will begin at the end of the first decade of the twenty-first century. Cuts in Medicare undertaken to balance the budget now will probably contribute only modestly to meeting the second, more serious challenge; realistically, measures designed to deal with the consequences of the baby-boom generation's retirement will contribute little to short-run deficit reduction. This paper describes a reform proposal designed to address the second of these issues: the long-range future of Medicare.

Five central facts will shape the debate on the future of Medicare. First, Medicare enjoys overwhelming support among the American electorate, a popularity that is well deserved because the program has achieved all of its designers' major objectives. Second, the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts. Third, legislative reform of the entire health care system is now off the political agenda and likely will remain so for years to come. Fourth, there exists a strong and broad consensus against raising taxes. Fifth, dramatic changes are taking place in the way health care is financed and delivered for the non-Medicare population.

The implications of these facts are straightforward. First, before changes are made in Medicare, policymakers will have to assure the general population and beneficiaries alike that the reforms will not compromise the attributes of the program that the public values so much. Second, Congress will have to act soon to restore Medicare's financial viability. Third, the measures that Congress adopts will not be part of any major legislative effort to reform the overall health care system. Fourth, most, if not all, of the budgetary savings on Medicare will come from reducing federal payments to providers and raising costs to beneficiaries, not from raising Medicare payroll taxes. Fifth, congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.

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Popularity And Success: A Brief History Of Medicare

Two views on how to provide assistance. Before the enactment of Medicare, few retired elderly or nonworking disabled persons had reliable health insurance coverage. The private insurance that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. The elderly and disabled feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it. To address these problems, President Lyndon Johnson proposed the Medicare program in February 1964.

The debate around this initiative displayed two conflicting principles about how government should act when private-sector services are inadequate. One view is that government should assist only those persons who are too poor to buy the service. The principle behind this approach is that, with few exceptions, markets should be permitted to allocate all goods and services. A compassionate society should provide aid to the destitute. But this assistance should disturb the operation of markets as little as possible, it is argued, because markets have intrinsic virtues, such as efficiency and consistency with the principles of personal autonomy and freedom.[1]

The other view holds that the best way, on balance, to provide some types of assistance is through a universal entitlement—aid available without regard to personal income or means but based on some more or less objective indicator of need. Advocates of this approach invoke arguments based on social solidarity or efficiency; they simply assert that, despite the value of markets in other contexts, certain goods and services should be provided to everyone at some basic level.

When Congress approved Medicare, it embraced the second philosophy by establishing a universal entitlement to stipulated benefits for everyone age sixty-five and older who has worked in a job subject to payroll taxation or who is a spouse of an entitled worker.[2] At the time, some Republicans and southern Democrats opposed this view and agreed to support Medicare

only if other Democrats would embrace a companion program of health care benefits available only to those with incomes and assets below quite modest levels. The Republican program, Medicaid, replaced various state programs of health care assistance for the poor with an open-ended federal matching grant that imposed various federal mandates and restrictions. The compromise legislation, which incorporated both programs, passed in the House of Representatives by a vote of 307 to 116 on 27 July 1965 and in the Senate by a vote of 70 to 24 the next day. President Johnson signed the Social Security Amendments of 1965, as this momentous legislation was so ingloriously called, on 30 July 1965.

Political alignments have changed over time. A new cadre of conservative representatives and senators now sees Medicaid not as the preferred method of financing health care for the indigent but as federal meddling in a domain in which states should not be hindered and as an element of a welfare system that works to the long-term disadvantage of those whom it is intended to help. They would like to see Medicaid transformed into a block grant under which each state would be given a fixed sum that it could use with few federal restrictions to provide health care services to the indigent. Some also would convert Medicare from a universal entitlement into means-tested assistance. Several proposals along these lines would impose higher costs on participants with high incomes; others would provide a voucher to assist participants who wanted to leave the program to buy private coverage in the marketplace.[3]

Growth in popularity and costs. Together with supplemental (Medigap) policies, Medicare has provided elderly and disabled persons with access on a nondiscriminatory basis, and with an unrestricted choice of providers, to the same health services that workers and their families enjoy. Moreover, beneficiaries are heavily subsidized.[4] Thus, the program's extreme popularity is understandable. The public's support for Medicare is reflected in the positions taken by politicians, few of whom seem prepared to acknowledge that Medicare benefits may need to be cut. However, it is clear that something fundamental will have to be done to modify the program because of the unsustainable growth of its projected costs.

The explosive growth of Medicare costs is neither new nor mysterious. Almost from its inception, Medicare has proved to be more costly than anticipated. The projection that the Health, Education, and Welfare actuaries made in 1965 that in 1990 the Hospital Insurance part of Medicare (Part A) would cost $9.061 billion, less than one-seventh of its actual level, has often been used to underscore this point.[5] Over the 1970s Medicare expenditures grew at an annual rate of 17.5 percent and in the 1980s at 12.1 percent; costs are projected to grow at a rate of 10.3 percent in the 1990s. While growth per enrollee has been rapid, Medicare grew less rapidly than national or private health care spending over 1984–1993.[6]

Some of the program's overall growth is attributable to increases in the number of beneficiaries, which has expanded by about 2.5 percent per year since 1968. Not all of the increase in beneficiaries reflects increased numbers of aged persons—the original focus of the program; legislation passed during the 1970s added disabled persons and persons suffering from end-stage renal disease (ESRD) to the program.

Benefit expansion also has contributed some to the growth in costs. For example, to the list of covered services Congress has added hospice care; mammography; Pap smears; hepatitis, influenza, and pneumococcal pneumonia vaccines; and kidney dialysis and transplants. Administrative actions also have expanded services; the redefinition of allowable home health and skilled nursing facility services has contributed significantly to cost increases in recent years.

Although benefits have increased somewhat over the program's thirty years, the Medicare benefit package remains comparatively parsimonious. In contrast to typical employer-sponsored insurance, Medicare provides no benefits for outpatient drugs and provides poor catastrophic coverage. In addition, Medicare deductibles and copayments for inpatient hospital services—currently $716 for the first day of hospitalization and $179 per day for hospitalization of more than sixty but fewer than ninety-one days per year—are far higher than those of typical private insurance plans.[7] Like most private health plans, Medicare does not cover long-term nursing home services and does not provide dental or vision coverage. It does, however, pay for home health services and short-term skilled nursing facility services. Medicare's benefit package is less generous than about 85 percent of private health plans. The program covers only about 45 percent of the total annual health care bill of the elderly, who, on average, spend considerably more out of pocket on health care than the nonelderly spend.[8] Medicare benefit cuts would only increase these disparities.

The major contributor to the explosive growth of both Medicare and other health care costs has been the increased capabilities of medicine. The proliferation of medical technology has produced many new diagnostic tools, procedures, treatments, and drugs. Few people advocate policies that might dampen this source of cost growth, nor would it be reasonable to deny Medicare participants the fruits of medical advances available to those with employer-sponsored or private health insurance.

Some Considerations Relevant For Reform

Successful and sensible Medicare reform must build on an appreciation of the way in which the current program operates, of its central charac-

teristics, and of the larger health care environment of which it is a part. Reformers must be aware of the limited contribution Medicare now makes to covering the health care expenditures of the aged and disabled, the program's bifurcated structure, the limited role of managed care, the potential under the existing payment structure for pernicious competition on risk selection, the uncertainty of cost projections, and the interaction between Medicare and Medicaid.

Public Medicare and "real Medicare." The federally financed Medicare benefit package is not the health insurance plan that most Medicare participants actually live with. Approximately 65 percent of elderly and disabled Medicare participants also are covered by employer-sponsored retiree plans or private Medigap plans, or both.[9] These plans supplement Medicare, usually by covering deductibles, copayments, some prescription drugs, and hospitalization beyond ninety days.[10] In addition, approximately 16 percent of Medicare participants also have some sort of Medicaid coverage. About 12 percent are categorically eligible (Supplemental Security Income recipients) or meet state Medicaid eligibility standards.[11] For these "dual eligibles," Medicaid pays Medicare Part B premiums, deductibles, and copayments and covers services—primarily prescription drugs and long-term care—that are covered by Medicaid but not Medicare. For those with incomes below the poverty line who are not dually eligible (qualified Medicare beneficiaries, or QMBs), Medicaid pays Part B premiums, deductibles, and coinsurance. The key point is that persons who are covered one way or another by Medicaid, like those with Medigap and retiree policies, face low or no deductibles and little or no cost sharing.

The public Medicare system, therefore, does not define the health care system in which most Medicare-eligible persons participate. Instead, most live with a hybrid system that comes in two forms, both of which have the public Medicare program as their base. For most, the hybrid is a blend of Medicare, which is available to most elderly and disabled persons for very modest premiums (now $46.10 per month), and employer-sponsored retiree coverage or private Medigap insurance. This version has a benefit package that is much more generous than that of Medicare alone. However, if a former employer is not paying at least part of the cost of the supplemental coverage, the cost of this version of the hybrid is considerably more than the cost of Medicare alone. Monthly Medigap premiums average about $70.[12] The second form of the hybrid, a blend of Medicare and Medicaid, offers even more generous benefits and costs the beneficiary less than Medicare alone or the other form of the hybrid.

Most discussion of Medicare reform focuses on the public program alone, not the hybrid system. But because the large majority of beneficiaries live with the coverage and incentives of the hybrid system, sensible policy

change can be formulated only by considering how best to transform the entire system. Not doing so risks adopting ineffectual reforms or reforms that have unintended consequences, which can be illustrated by examining a commonly advocated policy for reducing Medicare costs: increasing the Part B deductible and raising coinsurance.

In most private insurance plans, deductibles and coinsurance serve to discourage the use of low-benefit care. Deductibles also spare insurers the administrative cost and spare the insured person the added premiums to cover the cost of processing many small claims. Because the Medicare Part B deductible is relatively low, its effect in these respects is limited. At $100 a year, it is well below the typical deductible for private insurance and only one-eighth what it was in 1967 relative to annual average per capita charges. The coinsurance for most Part B services, 20 percent, is similar to that of private plans. However, some services, such as clinical laboratory, home health, and skilled nursing facility services for the first twenty days, require no coinsurance. Some critics of the current system have suggested that increasing the Part B deductible, extending coinsurance to all services, and raising it to 25 percent would curtail the use of low-benefit services and reduce administrative costs. Federal spending thereby would be held down and concentrated on more costly episodes of illness.

Under current arrangements, however, Medicare deductibles and coinsurance do not serve their intended purposes, and increasing them would not have the intended effects. Except for the 18 percent who lack supplemental coverage, Medicare beneficiaries do not face coinsurance because retiree supplements, Medigap, or Medicaid typically pays it.[13] Many supplementary policies also pick up the Part B deductible. Increases in coinsurance or deductibles, therefore, would not materially reduce use of low-benefit care or deter nuisance claims. Instead, retiree policies and Medigap vendors would liberalize their coverage of coinsurance and deductibles and would boost premiums. A few people might drop Medigap coverage or buy less-generous coverage, and they might demand somewhat fewer medical services. But most Medicare beneficiaries would either keep their supplemental coverage and pay the higher premium or let Medicaid pay the higher coinsurance and deductible.

While doing little to reduce low-benefit services and nuisance claims, increases in coinsurance and deductibles would transfer costs from the Medicare trust fund to Medicare eligibles (for those with Medigap insurance), their former employers, or other accounts in the federal budget and the states. While such transfers may or may not be desirable, there may well be better ways to accomplish them.

One implication of the foregoing discussion is that retiree, Medigap, and Medicaid coverage actually increase the budget cost of Medicare, by short-

circuiting the economizing effects of deductibles and cost sharing on demand and administrative costs. Supplemental insurance increases Medicare costs by raising the use of Medicare-covered services, but these added costs do not show up in the premiums for these policies.

To reform the hybrid, public/private Medicare system that people actually use and pay for, it will be necessary to consider the systemic effects of changes in the public program. Reform of Medicare should not be confined to the public program but should encompass rules affecting the sale and pricing of supplemental policies.

The A and B of Medicare reform. Part A of Medicare pays for inpatient hospital care, home health care, hospice care, and limited skilled nursing services; Part B pays for physician services, outpatient hospital and clinic care, laboratory and other diagnostic tests, and other services. Persons age sixty-five and older who are eligible for Social Security or Railroad Retirement benefits, those who have received disability benefits for two or more years, and those with ESRD are automatically entitled to Part A benefits.[14] Whether or not they are eligible for Part A, all persons age sixty-five and older may join Part B by paying a monthly premium; so too may disabled and ESRD participants in Part A.

Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete. Services once provided only in hospitals on an inpatient basis are now provided routinely on an outpatient basis, in physicians' offices, or even at home. The line between care provided during a hospital stay and that provided after discharge is increasingly blurred. Yet reimbursement for inpatient hospital care under the diagnosis-related group (DRG) system and that for outpatient hospital and physician services under the resource-based relative value scale (RBRVS) system and other fee schedules remain distinct and serve to reinforce a structure for the delivery of care that is becoming anachronistic. This payment system is not easily integrated with managed care arrangements and capitated payment systems.

No good case can be made, in our judgment, for perpetuating Parts A and B of Medicare. To the extent that the public sector has a legitimate role to play in the financing of health care for the elderly and disabled, that interest is common across the range of covered medical services. The distinction that Part B is "voluntary" is close to meaningless, because 97 percent of the participants in Part A elect to participate in Part B.[15]

The distinct methods of financing Parts A and B—the former with a payroll tax and the latter through premiums and regular appropriations—have created different political and economic dynamics for the two parts. Part A enjoys the advantage of an earmarked tax and is subject to the

discipline that stems from the fact that outlays cannot, in practice, exceed revenues from that tax plus accumulated reserves and the interest earnings of those reserves. Congress originally declared that it intended to charge eligible households half of the cost of Part B. However, Congress lacked the political will to deliver on that promise, thereby freeing Part B from the budgetary discipline that has driven the debate about Part A. Any major reform of Medicare should unify Parts A and B. The consolidation should not, however, be used as an opportunity to relax the limited fiscal constraints under which the program now operates and tap into general revenues to support Part A.

Fee-for-service and risk contracts. Medicare is rapidly becoming the last remnant of relatively unmanaged fee-for-service care in the United States. As of 1995 a majority of nonelderly Americans with private health insurance were covered under one form or another of managed care.[16] This extremely elastic term includes health maintenance organizations (HMOs) in their various forms and preferred provider organizations (PPOs). Health care delivery, financing, and risk-sharing arrangements are blooming in huge numbers and riotous diversity.

Except in Medicare. Medicare participants can enroll in one of three delivery and financing arrangements. More than 90 percent "choose" the traditional fee-for-service arrangement.[17] Managed care plans that are reimbursed on the basis of reasonable costs serve another 2 percent, and managed care plans that are paid on a capitated basis (risk contracts) serve 7 percent. Under these risk contracts, plans provide the Medicare benefit package for 95 percent of the average cost of fee-for-service Medicare benefits in their county (adjusted average per capita cost, or AAPCC).[18] The number of Medicare beneficiaries covered by such plans is increasing, but their penetration is projected to lag far behind the penetration of this form of payment for the nonaged population.

The use of Medicare risk contracts varies widely across the United States, reflecting the huge geographical variation in the availability of managed care plans, the limited information that is provided to participants about their options, and the lack of familiarity among the elderly population with managed care delivery systems. Overall, about three-quarters of the Medicare population live in an area in which a managed care option is available.[19] Nevertheless, there is no significant Medicare enrollment by risk contractors in twenty-eight states.[20] These plans have no incentive to market aggressively in counties in which the AAPCC is low. The AAPCC's year-to-year volatility also represents a deterrent. The highest penetration of risk contracts is found in California and Arizona, where close to 30 percent of all Medicare participants get their care from such plans.[21] All of this implies that reforms that propose to move Medicare

beneficiaries into managed care plans will take time. Institutional capabilities will have to be developed, and participants will have to learn more about and become more comfortable with managed care delivery systems.

The "cherry-picking" potential in Medicare. Insurance carriers or managed care plans can increase their profits either by providing services more efficiently or by seeking to insure persons with lower-than-average health care costs. In the case of employer-sponsored plans, the potential of the latter approach is limited because the sponsor is generally seeking coverage for an entire employee group and its dependents. The opportunity to "cherry pick" is greater under Medicare because beneficiaries enroll as individuals, and the stakes are higher because variability of the costs of care among Medicare enrollees—the disabled and the elderly—is far greater than that among the general population.

Medicare risk contractors must accept any Medicare participant who wants to join their plan. Nevertheless, disproportionate numbers of participants who have lower-than-average costs have signed up for these plans under the current Medicare program. Estimates suggest that Medicare's current payments to risk contractors, which are set at 95 percent of the AAPCC, are roughly 6 percent more than the costs that these lower-than-average-risk participants would incur in the standard Medicare program.[22] In other words, risk contracting raises costs to the government, although the risk contractors may produce health care more efficiently than other providers do and therefore may save money for the nation.

The extent to which vendors consciously try to attract only better-than-average risks to their plans is not known. To date, these vendors have been able to maintain acceptable profit margins and even offer additional benefits because they generally can provide services more inexpensively than the fee-for-service sector can, competition among risk contractors is low, and Medicare payment is generous. But if profit margins narrow, competitive pressures to engage in marketing and other administrative practices that attract low-cost enrollees and repel high-cost enrollees could intensify.

The profit-boosting potential of such efforts could be substantial, given the skewed nature of health care costs. Roughly 5 percent of Medicare participants account for more than half of the program's total cost; one-quarter of the program's participants account for more than 90 percent of the costs.[23] Under the existing payment system, a provider can boost profits significantly by small reductions in high-risk enrollments. A plan might attract a disproportionate number of healthy or younger elderly enrollees by offering exercise classes or other services that such participants find attractive or by locating its facilities in certain geographic areas. Similarly, subtle differences in the availability of services might make a plan unattractive to people with certain chronic health problems or might encourage participants who become heavy users to leave a plan. The current policy of permitting Medicare participants to switch from managed care plans into the traditional Medicare delivery system with a month's notice facilitates such practices.

All of this suggests that if Medicare is going to move from a fee-for-service reimbursement system toward one that emphasizes capitation, payments made to the plans will have to be better calibrated to the health risks of persons covered by those plans. Care will have to be given to ensure that plans do not engage in subtle practices to ward off high-risk participants.

Cost variations. The Medicare benefit package is uniform nationwide, but its cost is not. In 1992 reimbursements nationally averaged $4,341 per person served but varied from a low of $3,048 in Nebraska to a high of $5,114 in Louisiana.[24] The variations across substate areas are even greater: Cost per enrollee in Miami, Florida, is 2.4 times that in Waco, Texas.[25] Such differences reflect interstate variations in DRG prices and RBRVS fees, salary levels, and medical practice patterns and the propensity to use services. Such variations survive without serious scrutiny in a system that simply pays for services rendered or that pays fixed fees to providers based on local costs. But such variations would be hard to justify or sustain if Medicare shifts from paying for services to paying for insurance. Pressure would arise to justify variations in payments per person. While variations associated with differences in input prices could be rationalized, it is doubtful that a persuasive case could be made for per person reimbursements that are 68 percent higher in Louisiana than in Nebraska.

Uncertainty about costs. Actuarial projections that Part A of Medicare will be insolvent in a few years add a sense of urgency to the need to "do something" to fix Medicare. The impossibility of balancing the budget in seven (or even ten) years without large reductions in Medicare raises this sense of urgency to almost frantic levels.

Two aspects of the actuarial projections are relevant to the process of reform. The first is that the actuarial projections are extremely volatile. The period until projected insolvency has changed by many years from one trustees' report to another (Exhibit 1). Some of these changes are attributable to legislation, but many are not, such as the change from 1992 to 1993. The estimated cost of Part A benefits, measured as a percentage of taxable payroll, also has oscillated widely. To illustrate, the trustees' reports of 1982, 1987, 1994, and 1995 placed the cost of Part A, as a share of taxable payroll, at 6.7 percent, 3.65 percent, 4.52 percent, and 4.17 percent, respectively. The change from 1994 to 1995 is particularly noteworthy, because no relevant legislation was enacted between the two projections. We know of no methodological breakthroughs to suggest that similar variations will not occur in the future. Thus, the magnitude of reductions in Medicare

Exhibit 1
Number Of Years From Medicare Hospital Insurance (Part A) Trustees' Projection Until Insolvency

Year of trustees' report	Years until insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20[a]
1976	About 15[a]
1977	About 10[a]
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966–1995.
[a] Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

costs or of increases in payroll taxes necessary to close projected deficits is not known with any certainty.

The second aspect of the projections that is relevant to reform is that the gap between current revenues and current benefits is so large that even the large fluctuations in projected costs shown in Exhibit 1 give no hope that the current system can be sustained. In 1995 actuaries projected that the Part A trust fund would be insolvent in 2002. The large cuts in Medicare Part A implied by the budget resolution for fiscal year 1996 would only delay insolvency by a few years. The twenty-five-year actuarial projections

indicate that Part A outlays would have to be cut 30 percent or revenues increased 43 percent to balance the program. Since any legislative changes would be small at first, the changes in the terminal years of the projection period would have to be considerably larger.

The growth of spending under Part B is considerably higher than under Part A, in large measure because many services that were once provided in hospitals can now be provided on an outpatient basis or in physicians' offices. As a share of gross domestic product (GDP), Part A is projected to increase from 1.62 percent in 1995 to 2.83 percent in 2020, a 75 percent increase. Part B is projected to increase from 0.93 percent of GDP to 3.18 percent over the same period, a 242 percent increase.

Medicaid and Medicare. State Medicaid programs, as has already been pointed out, have been called upon to supplement Medicare for low-income participants. Dually eligible participants have whatever benefits their state's Medicaid program provides and assistance to pay their Medicare Part B premiums, coinsurance, and deductibles. Medicaid programs also have been required to cover the Part B premiums, coinsurance, and deductibles of QMBs. State Medicaid programs pay the full actuarial cost of Part A for elderly and disabled persons who have incomes below the poverty line but do not have sufficient work histories to be eligible for Part A. As of January 1995 Medicaid also pays Part B premiums for those with incomes between 100 percent and 120 percent of the poverty threshold.

Congress has adopted these requirements over the past decade because Medicare's coverage, by itself, is not overly generous. Low-income participants in poor health who lack this supplemental protection could find most of their limited income absorbed by out-of-pocket spending for health care. But these requirements also have imposed a significant burden on states, which, on average, pay 43 percent of the costs of Medicaid.

As Medicare evolves or is changed, the logic of dividing the responsibility for health care for the low-income aged and disabled between these two programs will weaken. As more participants have the opportunity to join plans that offer benefit packages that include prescription drug coverage and catastrophic protection and that have low cost-sharing requirements, the need for the QMB protection will diminish. Furthermore, if premium subsidies must be provided, equity suggests that they should be uniform nationwide. Estimates suggest that fewer than half of persons eligible for QMB subsidies have received them. The take-up rate is thought to vary considerably because of differences in states' outreach efforts. The possibility that Medicaid payments per recipient might be capped or transformed into a block grant reinforces the logic of having Medicare assume full responsibility for covering the acute health care costs of low-income aged and disabled persons.

A Program For Medicare Reform

Goals and principles. Any fundamental social policy reform should be guided by clear principles and goals. The following four should direct the changes that Medicare will require. (1) Reforms should deal not just with "public" Medicare but with the full package of benefits most Medicare beneficiaries use. (2) Under a reformed Medicare program, the quality of health care provided to the elderly and disabled should not be materially different from that available to the general population. Nor should the delivery system for this population be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care). (3) Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide high-quality care at the lowest possible cost. This does not necessarily mean, as some advocates of managed care seem to suggest, that the least costly providers are the best, nor does it define the limits of care that public financing should support. (4) Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population.

Designing an entirely new program is usually easier than reforming an existing one. Program designers need to concern themselves with objectives and feasibility. Program reformers must attend not only to these concerns but also to current entitlements and people's sense of ownership in these entitlements. For Medicare, the political acceptability of proposed changes hinges not just on whether they are, in some sense, objectively fair, but also on how they affect the access of two very vulnerable groups, the elderly and the disabled, to choices and services they regard as rights. Furthermore, creating new administrative and institutional frameworks is typically easier than transforming existing ones. Established institutions and bureaucracies that feel threatened typically resist reform. The reforms described here, which we believe would have to be phased in over a considerable period of time, attempt to reflect these constraints.

A new Medicare system. We propose converting Medicare from a "service reimbursement" system into a "premium support" system. Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a PPO, or operate through an HMO. Plans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately would receive a predetermined amount to be applied to the purchase of a health plan providing defined services. Because health care costs differ by health care market area, support given to enrollees would have to vary across health market areas, but not within them. As indicated below, risk adjustments among insurers based on the characteristics of their clients also would be necessary.

Plans would be required to offer defined services. Insurers would be permitted to sell coverage for additional services not covered under the basic plan, but only if marketing and delivery of these services were divorced from those of the basic plan. To the extent that such supplemental coverage induced use of basic services (for example, cost-sharing supplements), a premium surcharge would be imposed and rebated to Medicare.

The marketing of insurance to Medicare beneficiaries would follow the principles developed for the operation of managed competition.[25] The first step would be to define health care market areas, whose boundaries would be based on the supply of medical care. They typically would be metropolitan areas or large portions of states where population density is low, and they could cover portions of more than one state.

Entities interested in bearing the risk of providing health care for the Medicare population would be invited to submit bids for providing the defined benefit package in a particular market area for the "average" Medicare enrollee. The federal Medicare payment in each market area would be the same regardless of which plan the enrollee chose. If the enrollee chose a plan that cost more than the federal Medicare payment for the area, the participant would pay the balance. This supplementary payment can be thought of as a replacement for the cost of retiree and Medigap insurance.

Local marketing organizations would be established to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private, not-for-profit agencies, would receive information from insurers, ensure that it was presented to Medicare enrollees in a comprehensible and even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail or querulous, to minimize sales abuses. Enrollees would select an insurance plan for the coming year and would be permitted to switch plans during an annual open enrollment period.

Because some participants have much higher than average expected health costs, plans would receive risk-adjusted payments from Medicare based on age, sex, disability status, and other health indicators. Good methods of making such risk-adjusted payments do not now exist.[27] It is uncertain whether today's imperfect methods would suffice to offset attempts by insurers to select favorable risks or if improved methods could be

developed.[28] For this reason, our approach should be introduced gradually and evaluated periodically. For the first few years a blend of cost-based and capitated reimbursement may be necessary. We advocate this approach not because we necessarily believe that managed care and managed competition will produce huge savings. Such savings are highly uncertain and depend on unpredictable developments. Rather, a framework that forces people to face the consequences of their choices in the delivery of medical care should encourage them to choose the plans whose style of care matches their preferences, and we believe that enrollees should bear the financial consequences of their choices. Trends in health care spending are dominated by advances in medical technology, some of which are overused. Further advances in technology are inevitable and welcome, although they will be expensive.[29] Which should be used and how extensively should be determined by the persons who use them. Furthermore, we believe that a market in which plans offering similar benefits compete along dimensions that consumers can understand will promote efficient service delivery.

This framework lends itself to budget control in ways that the current Medicare system does not. Medicare now establishes a variety of price limits—DRG prices for hospital admissions and RBRVS fees for physician services—but since it cannot (and should not) control the quantity of services, it cannot control the total cost of care or federal spending. Under this system, neither health care providers nor patients have any incentive to limit physician services or hospital admissions. The result is the possibility of overuse of medical services.[30] The small area variations in the use of various medical procedures and the cost advantages of some managed health care providers support this possibility.

Problems Of Design And Transition

Converting Medicare from a fee-based reimbursement system into a premium support system will be neither quick nor easy. A number of issues and problems must be addressed before such an alternative can be instituted nationally.

(1) What should be the benefit package in the new plan? It would be a grave mistake, in our view, to use the current Medicare benefit package for the new plan. Instead, the benefit package should combine the current Medicare package with some modest coverage of prescription drugs and catastrophic protection. Plans should be required to offer this new benefit package in one of two standard forms: a low-cost-sharing variant and a high-cost-sharing variant. The expanded benefit package offered in the low-cost-sharing version would provide coverage similar to what many Medicare participants enjoy and pay for in the current hybrid system. They will not willingly accept less and, in our view, should not be expected to. They pay premiums for this package and should continue to do so.

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

(2) How should the federal payment be set? This issue has several dimensions. First, should the federal payment be set at the cost of the least expensive plan capable of covering a substantial portion of the participants in a region, or above that minimum? We believe that, initially at least, payments should be based on a defined benefit package, adjusted for variations in actual costs and use among regions, not on the basis of actual bids or the lowest bid within a region. The low bid in a region might reflect a highly efficient plan. But it also could reflect an unusually spartan delivery system or a low-quality plan; such outliers should not affect the federal support available in a region. If the federal payment were set at the lowest bid, several problems could develop. First, more participants might seek to join the plan whose costs were covered completely by the federal payment than the plan could absorb while maintaining quality. Second, low-income participants might be denied choice and could be concentrated in the one or two plans that required no supplemental premiums.

The initial federal payment should be set at 95 percent of the cost of the current Medicare package in the market area, adjusted to remove indirect medical education, direct medical education, and disproportionate-share payments.[31] If providers charge the Medicare payment plus the premium for a Medigap plan, enrollees now covered by Medigap plans would face a premium that is 5 percent higher than the cost of their current hybrid coverage. But if competing plans are able to provide this level of service at lower cost, enrollees would face a smaller cost increase or might even achieve savings if the reduction in price were sufficient.

During a phase-in period of perhaps five to ten years, the federal payment should grow more slowly than projected baseline costs. If growth of plan expenses slows, costs to enrollees might not increase. In any event, this mechanism would produce some relief for the federal budget. An expert commission should recommend the exact size of this reduction; this recommendation could be reevaluated every two or three years.

In the long run, the federal Medicare payment should grow at the same

rate as per capita spending on health care for the nonelderly. This formula is mechanical and may require periodic adjustment, because the per capita cost of care depends on the average age of the population, the age-specific gradient in health care costs, and the age bias of new medical technology.[32] If Congress found it necessary to reduce federal support for Medicare, it could slow payment increases, thus shifting costs to Medicare enrollees.

The second issue in setting federal payments concerns regional variation in Medicare spending per enrollee. Current cost differences reflect variations in wage rates and other input prices, availability of services, demand, and—more generally—practice patterns. If current variation is larger than is acceptable, over what period should this variation be reduced? Our view is that payment levels initially would have to reflect historical spending patterns, but that differences should be gradually narrowed until payments varied only for differences in wage rates and other input prices. Such payment differences are necessary if Medicare is to avoid penalizing the elderly or disabled for residing in a high-cost area. The objective would be to have the federal payment cover the same services throughout the country. The adjustment should be complete within a decade.

Third, plans in some regions may submit bids below the federal payment. What if enrollees select such plans? Initially, when participants are unfamiliar with the service style, quality, and other dimensions of plans offered to them, it probably would be best to require that these dividends be devoted to such supplemental services as eyeglasses or routine dental care, or to other services.[33] This policy would reduce the possibility that cash rebates would tempt infirm, low-income participants into a low-cost plan that provided unexpectedly inferior care. Over time, as the competitive marketplace developed and as participants became familiar with their options and the consequences of choosing one plan over another, differences between the federal payment and plan cost could be rebated to participants as nontaxable income or split between government and participants.

(3) Will Medicare enrollees segregate themselves, or will plan administrators market plans in ways that result in economic segregation among plans? One of the strengths of the current Medicare program is that all participants—rich and poor alike—come under the same basic plan, and providers are relatively indifferent to the incomes of their Medicare patients. In a world of competing plans, economic segregation could occur in various ways. Plans with high deductibles and high cost sharing probably would attract not only the relatively healthy but also the relatively wealthy, who can self-insure against all but the most costly illnesses. The same is likely to be true of relatively costly plans that offer enrollees an expanded choice of providers or higher-quality amenities. Because health status and income are positively correlated, such segregation will aggravate the risk adjustment problem.[34]

To have some choice of plans, low-income participants would have to be provided with some sort of premium supplement to replace the current Medicaid assistance. These supplements, which would be nonrefundable even in the long run, could be keyed to the distribution of bids in a region. For example, they might be sufficient to allow a person with an income below the poverty threshold to participate at no cost in any plan that charged a premium below the median in the region.

(4) How should a new system be phased in? This question is clearly the most important and the most difficult. Before the plan described here can operate, it is necessary to create an environment of competition among health plans, to construct the apparatus necessary to regulate the marketing of insurance and the risk adjustment procedures for allocating payments based on enrollment, and to overcome the practical difficulties of transferring costs to many current Medicare enrollees. Even in the most prepared regions, it will take years to establish the necessary institutional structure.

The plan also hinges on the availability of enough plans in each market area to create meaningful choice and competition. These plans need not include traditional HMOs, at least at the outset, but the plans must be independent and must compete with one another. HMOs would increase the range of choice available to Medicare enrollees but are not essential. To the extent that aggressively managed care is necessary to reduce the growth of health care spending, the full benefits of the reform approach we have described would be realized only when such plans existed in most places.

The most difficult transitional issues involve beneficiaries themselves. How should they be phased into the new system? This problem would be hard, but manageable, if enrollees could be enticed into the new system by more generous payments. However, the current budget climate renders that option infeasible. The simplest method would be to run the current Medicare system alongside the new system. The new system would be mandatory for everyone who turns sixty-five and becomes eligible for Medicare after a certain date. It would be optional for everyone enrolled in Medicare before that date. Presumably, many who were not required to join the new system would do so anyway because they would prefer one of the alternative plans.

This approach may not be practical everywhere because the number of new Medicare enrollees in some sparsely populated regions may be too small to support even one plan. In such areas it may be necessary to delay the transition and then shift a group—such as all persons under age seventy—into the new system at one time.

(5) What role would Medicare price controls play? Medicare now reimburses most providers according to administered prices. Most of these payments are well below reimbursements from other payers. In addition,

providers cannot bill Medicare participants for charges beyond certain specified and limited amounts.

In the new system, a plan that offered the choice of providers now available under Medicare without these price discounts would have to either charge much higher premiums or leave participants exposed to significant balance billing. This shift would represent a noticeable reduction in the opportunities available to many Medicare beneficiaries, who would find such a shift exceedingly burdensome. For this reason, we believe that the various Medicare fee schedules must be maintained for a transitional period. All plans could use these schedules for paying providers other than those in their own networks. Existing balance billing and assignment restrictions would continue. Because competitive forces would reduce the need for such limits in the new system, fee schedules could be relaxed.

(6) How much regulation will the new system require? Initially, at least, the new system will require a good deal of regulation, and much of it will have to emanate from Washington. The nation should not gamble with health care for the aged and disabled, many of whom are unlikely to be able to do well in an unregulated market. Moreover, if there is a failure, the federal government will be required to step in.

Plans will have to be certified with respect to their medical capabilities and the quality of care they provide, their administrative competence, and their financial soundness. It is reasonable to expect that the same minimum standards should be met by each plan throughout the country. While these standards may be set nationally, state agencies or specialized nonprofit organizations could enforce them.

We have already noted that state, local, or not-for-profit organizations would be responsible for organizing and ensuring the orderly functioning of the health plan market in each area. These organizations would specify, collect, and disseminate information provided by health plans to Medicare enrollees. To help enrollees make informed choices among plans, they would ensure that the information is presented clearly, simply, and uniformly. These organizations also would monitor plans to prevent them from engaging in measures designed to attract good risks.

(7) What of Medicare's other functions? Over the past thirty years Medicare has evolved into more than a system to help pay the medical bills of the aged and disabled. Through its payment system, it has come to play an important role in supporting graduate medical education. The payment system also has sustained institutions in remote locations and helped hospitals serving disproportionate numbers of uninsured persons to bear the costs of uncompensated care. The payments made under our proposed plan would not continue to support these objectives. To the extent that they remain important, they should be funded through separate grants.

Conclusion

The Medicare program, which has served the nation—particularly the elderly and disabled—extremely well during its first thirty years, faces profound changes before it reaches its golden anniversary. Budgetary and demographic developments mean that the program as it is now structured is unsustainable. As this paper goes to press, congressional action on Medicare and Medicaid is not yet complete. The outcome of the wrangling between the president and Congress that will follow is unclear. Nevertheless, if the effort to craft a compromise reconciliation bill does not fail completely, it seems likely that large cuts will be made in Medicare. How much fundamental structural change will emerge is still an open question. Most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will be made even more complex and inequitable. Medicare eligibles will be given more of an impetus to shift into one form or another of managed care. However, the legislation that is likely to emerge probably will not provide strong incentives for participants to reduce their use of low-benefit services or to seek care through efficient delivery systems.

The ultimate response to the budget and demographic pressures could take more extreme forms. The nation could establish a separate national health care system for the aged and the disabled, with its own network of providers and its own limits on use. At the other end of the spectrum, Medicare could be transformed into a pure voucher system, in which the elderly and disabled receive a voucher and are told to fend for themselves in an unregulated or lightly regulated marketplace. We believe that both of these approaches are politically unacceptable and programmatically flawed.

The approach we have presented represents a middle ground. It builds on the strengths of the current program while converting it into a system similar to the employer-sponsored insurance now available to most Americans. A major argument in its favor is that it would strengthen participants' incentives to seek services from cost-effective delivery systems and providers' incentives to operate efficiently. This plan would enable Congress to directly control the per capita budget cost of Medicare. This feature is critical in view of the certainty that the gap between Medicare costs and revenues will be narrowed as part of efforts to balance the budget. But it is important to acknowledge that our plan also facilitates significant savings by shifting costs to Medicare enrollees, a channel that will have to be used if large reductions in Medicare spending growth are to be achieved.

We close with an unfashionable warning. The history of reforms in U.S. social policy is replete with exaggerated claims of the benefits the reform will produce. To muster enthusiasm, supporters of reform paint rosy pictures

of the marvelous benefits that will ensue if only their recommendations are adopted. Reality, as it is wont to do, eventually emerges, disappointment sets in, and the perception of the competence of policymakers takes another dive. We see the makings of just such a cycle with the current enthusiasm about the benefits of managed care and of improved incentives for cost-consciousness by purchasers of health care services. They promise enormous savings if only their reforms are adopted. Careful cost accounting suggests that their claims are grossly exaggerated.[35] But even if the rosiest plausible projections of savings from managed care are realized, benefits approximating those now provided by Medicare cannot be sustained unless revenues flowing into the system are increased. In plain English, that spells "TAXES." To sustain Medicare, payroll or other taxes earmarked for Medicare must be raised, or general revenue subsidies will have to be increased. We believe that having to live within the revenues of an earmarked tax provides some discipline. We urge that this course rather than increased general revenue subsidies be used when, after heroically trying to cut costs, Congress recognizes that the American people want to keep Medicare benefits and that to do so, somebody is going to have to pay for them.

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NOTES

1. Some who generally agree with this approach to aid argue that in some circumstances the provision of benefits produces unintended side effects that outweigh direct benefits to recipients, through either work disincentive effects or demoralization. This view, which is as old as the English debates over the Poor Laws, has achieved fresh currency in U.S. politics in debates over welfare reform. Thus far, however, it has not been part of the debate on Medicare reform.
2. The disabled and persons with ESRD were not covered by the original legislation.
3. Bipartisan Commission on Entitlement and Tax Reform, *Final Report* (Washington: Bipartisan Commission, January 1995); Concord Coalition, *The Zero Deficit Plan* (Washington: Concord Coalition, 1993); Congressional Budget Office, *Reducing the Federal Deficit: Spending and Revenue Options* (Washington: CBO, February 1995); and D. Bandow and M. Tanner, *The Wrong and Right Ways to Reform Medicare*, Cato Institute Policy Analysis no. 230 (Washington: Cato Institute, 8 June 1995).
4. The annual subsidy provided through Medicare to a male worker who retired from an average wage job in 1992 was $3,874.
5. Robert Meyers has pointed out the several ways in which this comparison is inappropriate and how the original estimate has been misrepresented. See R.J. Meyers, "How Bad Were the Original Actuarial Estimates for Medicare's Hospital Insurance Program?" *The Actuary* (February 1994): 6–7.
6. Health Care Financing Administration, *Medicare: A Profile* (Washington: U.S. Government Printing Office, February 1995), 51; and Congressional Budget Office, *Trends in Health Spending: An Update* (Washington: CBO, June 1993), 44–45. The growth of per capita Medicare spending was below that of private health care spending in every year from 1984 through 1991, except in 1989. M. Moon and S. Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, July 1995).
7. Coinsurance of $358 per day is required for the lifetime allowance of sixty additional days of inpatient care. The Part B deductible is $100 per year, and coinsurance is 20 percent. Coinsurance for days 20–100 of skilled nursing facility care is $89.50 per day.
8. American Association of Retired Persons, Public Policy Institute, and The Urban Institute, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington: AARP, April 1994).
9. Congressional Budget Office, unpublished estimates.
10. According to CBO estimates, approximately 39 percent of Medicare participants have Medigap policies, and 26 percent have retiree plans. For a breakdown of supplemental coverage among aged Medicare participants in 1992, see U.S. Congress, House Committee on Ways and Means, *1994 Green Book*, Committee Print WMPC 103-27 (15 July 1994), 886. The Health Care Financing Administration provides the following estimates of coverage for aged participants in 1993: 11.4 percent of elderly Medicare participants have no other coverage, 36.8 percent have Medigap policies, 33 percent have retiree policies, 11.9 percent are covered by Medicaid, and 2 percent have coverage from another source. Medigap policies are offered in ten standard forms, the most popular of which cover deductibles and coinsurance. See P.D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* (Spring 1995): 31–48.
11. CBO, unpublished estimates.
12. Karen Davis, testimony before the U.S. Senate Committee on the Budget, 3 May 1995.
13. This estimate is from CBO tabulations for the elderly and disabled. The *1994 Green Book* provides an estimate of 22 percent for the elderly in 1992, and HCFA provides an estimate of 11 percent for the elderly in 1995.
14. Persons over age sixty-four who are not eligible for Social Security can obtain Part A coverage by paying the full actuarial cost of the coverage. State Medicaid programs are required to pay this cost for persons with low incomes.
15. Most of those who are covered by Part A but choose not to join Part B are workers over age sixty-four who are covered by an employer policy and can join Part B later without penalty.
16. CBO, "The Potential Impact of Certain Forms of Managed Care on Health Expenditures" (CBO Staff Memorandum, August 1992).
17. Most are probably not aware that they have other options besides the traditional fee-for-service plan.
18. The AAPCC is calculated for county areas and is adjusted for the participant's age, sex, institutional status, reason for entitlement (age or disability), and Medicaid eligibility. Plans often provide additional services because they must not have higher margins on their Medicare business than on their non-Medicare business. The excess must be spent on additional services or returned to the government. Plans have an incentive to locate and market in county areas where the AAPCC is high. Plans can switch annually from being paid on the basis of the AAPCC or on the basis of costs.
19. HCFA, *Medicare: A Profile*, 109, Chart MC-1.
20. The Henry J. Kaiser Family Foundation, "Medicare and Managed Care" (May 1995).
21. In Riverside and San Bernardino, California, and Portland, Oregon, the figure is close to one-half.
22. R.S. Brown et al., "Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs" (Princeton, N.J.: Mathematica Policy Research,

Bob Reischauer's MODEL

WHAT IS PREMIUM SUPPORT?

- A HYBRID SYSTEM WITH

  DEFINED BENEFITS

  FIXED PAYMENTS TO PLANS

THE DEFINED BENEFIT

- BENEFITS SHOULD BE SUFFICIENTLY COMPREHENSIVE SO THAT THE VAST MAJORITY OF PARTICIPANTS DO NOT FEEL A NEED FOR SUPPLEMENTARY INSURANCE.

PAYMENTS TO PLANS (1)

- MUST BE RISK ADJUSTED
- SHOULD REFLECT DIFFERENCES IN INPUT PRICES

PAYMENTS TO PLANS (2)

- COULD BE SET ADMINISTRATIVELY
- COULD BE SET COMPETITIVELY
- COULD BE SET BY A BLEND OF COMPETITIVE AND ADMINISTRATIVE MECHANISMS

PAYMENTS TO PLANS (3)

- HOW SHOULD THE PAYMENTS TO PLANS BE DIVIDED BETWEEN THE GOVERNMENT'S CONTRIBUTION AND THE PARTICIPANT'S CONTRIBUTION?

QUESTIONS

- WHAT ROLE SHOULD TRADITIONAL MEDICARE PLAY?

- WHAT HAPPENS IN AREAS IN WHICH NO PLAN WISHES TO OFFER SERVICES?

- WHAT HAPPENS IN AREAS IN WHICH ONLY ONE OR TWO PLANS COMPETE?

- WHAT ARE THE POLITICAL CONSEQUENCES OF HAVING DIFFERENT PREMIUMS AND DIFFERENT PLAN TYPES AVAILABLE IN DIFFERENT JURISDICTIONS?

MEDICARE:

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

August, 1999

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Plan for Modernizing and Strengthening Medicare

- Making Medicare More Competitive and Efficient
- Modernizing Medicare's Benefits, Including Adding a Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21st Century

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans**: About 34 million elderly and 5 million people with disabilities receive Medicare.

- **Helps those who would otherwise be uninsured**: Before Medicare, almost half (44 percent) of the elderly were uninsured and millions more had substandard coverage. Given the recent rapid rise of the uninsured ages 55 to 65 who are even healthier than seniors, this problem would have been worse today.

- **Improves life expectancy, access to care and reduces poverty**: Since 1965:

  - Life expectancy of people who reach age 65 has increased by 20 percent (79 to 82 years)

  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)

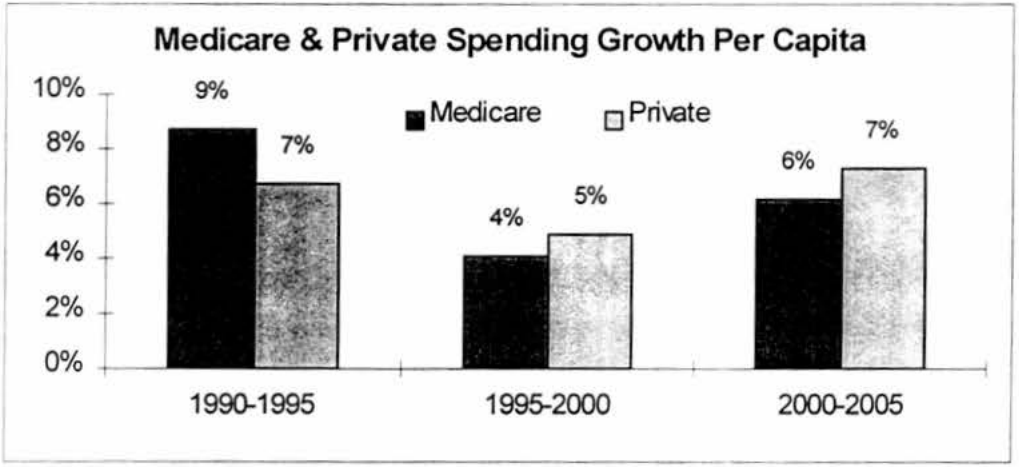
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. In 1993, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999.

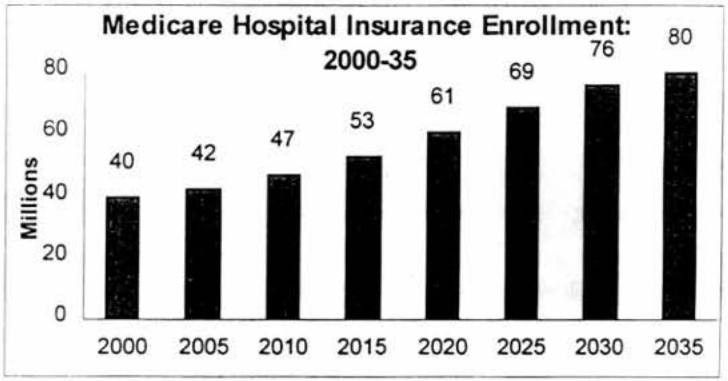
- In response, the President and Congress passed Medicare reforms in 1993 and 1997 and instituted an unprecedented crack-down on fraud and abuse. These actions, in combination with a strong economy, constrained cost growth and extended the life of the trust fund until 2015.

- The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries**: Enrollment in Medicare will climb when the baby boom generation retires -- from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.



- **Fewer workers**: The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (from 3.6 workers per beneficiary in 2010 to 2.3 in 2030).

- **Cost growth will rise**: Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

- **About 75 percent of beneficiaries lack decent, dependable, private-sector drug coverage.**

  - Medigap, individually purchased supplemental policies, has grown very expensive and less common, covering only about 8 percent of beneficiaries. Its premiums have been rising rapidly, increase dramatically with age, and generally cost 2 to 3 times as much as President's premiums.

  - Medicare managed care plans provide 17 percent of beneficiaries, frequently cover drugs, but 11 million beneficiaries do not have access to any managed care plans. The value of Medicare managed care drug benefits is declining – nearly 3/5^{ths} of plans will cap drug spending below $1,000 in 2000. The proportion of plans with caps of $500 or less will increase by 50 percent.

  - Medicaid and other public programs cover another 17 percent of beneficiaries, but eligibility is restrictive and participation is very low (less than 50 percent).

  - Over one-third of beneficiaries have no coverage at all. Prescription drugs have become central to modern medicine, yet at least 13 million Medicare beneficiaries have no coverage. Over half (54 percent) of beneficiaries without drug coverage have income above 150 percent of poverty (about $12,750 for a single, $17,000 for a couple).

- **Private retiree health plans, which cover less than 25 percent of beneficiaries, are declining.** The number of firms offering retiree health insurance coverage dropped by 25 percent between 1993 and 1998. This trend will almost inevitably continue without new incentives to retain it.

OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

- **Insufficient flexibility in traditional Medicare to adopt best private sector practices to reduce costs and increase quality.** Medicare is governed by statutory constraints that limit its ability to adopt innovative payment and management strategies.

- **Medicare pays managed care plans a flat rate, set by a complex statutory formula, that has nothing to do with plan prices.**

  - Overpaid. A June 1999 report from the General Accounting Office found that the Balanced Budget Act has not eliminated managed care plan overpayments. For example, managed care plans in Los Angeles can provide the traditional Medicare benefits package for 79 percent of what they are currently paid.

  - No price competition – only competition on providing extra benefits. Managed care plans offer extra benefits with the overpayment – they cannot compete on price.

    - Hard for beneficiaries to comparison shop on benefits

    - Easy to attract healthy or avoid sick beneficiaries by custom-designing benefits

    - Unfairly subsidizes benefits in high-cost / high-payment areas: over 75 percent of rural beneficiaries do not even have the option of joining managed care.

II. PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21st Century

- **Reduces Medicare spending by $72 billion /10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years, fully financed by the offsets in the proposal.

- **Extends the life of the Medicare trust fund for a quarter of a century.** This will significantly reduce the need for excessive reductions in Medicare spending when its costs explode as the baby boom generation retires.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	*-5*	*-64.5*
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	*+27*	*+110*
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	*-22*	*-45.5*
Surplus Allocation	*-50*	*-374*

* Includes $5.7 billion in interactions/premium offset
** Does not count toward package

I. MAKING MEDICARE MORE EFFICIENT
Private Sector Purchasing & Quality Improvement Tools for Traditional Medicare

- **Allowing Traditional Medicare to Adopt Best Private Practices.** This proposal would build on the President's commitment to give traditional Medicare the ability to adopt payment and quality improvement tools that are frequently used in the private sector.

  - Promoting the use of high-quality, cost-effective providers. Give beneficiaries a financial incentive (e.g., lower cost sharing) to choose selected providers (like a PPO); pay facilities that meet quality and cost standards a single price (Centers of Excellence).

  - Encouraging primary care case management and disease management. Structure payments to promote coordination of services for certain diseases or beneficiaries who have high health costs to reduce hospitalizations.

  - Coordinating care for dual eligibles. The 17 percent of beneficiaries who are Medicare-Medicaid dual eligibles account for 28 percent of spending. Provide information to help coordinate benefits; test models in traditional Medicare to coordinate services.

  - Using competitive pricing, selective contracting, negotiated discounts. These market-oriented practices will make Medicare a stronger negotiator and more efficient manager.

Competitive Defined Benefit Proposal

- **Competitive defined benefit proposal.** This proposal would pay managed care plans based on competitive prices, not on fixed rates. If a plan's price is higher than 96 percent of traditional program costs, the beneficiary would pay a higher premium. If it is less, the beneficiary would pay a premium that is lower than the Part B premium.

- **Saves through competition, not rate reductions.** Unlike the current system, Medicare would save money when beneficiaries choose lower cost plans. For each dollar saved, beneficiaries would receive 75 cents, the government 25 cents.

- **Price competition promotes informed beneficiary choice.** By having plans compete over a defined benefit, beneficiaries can make "apples-to-apples" comparisons over price and quality. This eliminates the problem of plans designing benefits to attract healthy enrollees.

- **Plan payments more rational.** Rather than receiving a rate based on a complicated formula, managed care plans would get paid what they bid, although the higher the price, the higher the beneficiary premium. The government payment includes the costs of prescription drugs, risk adjustment and full geographic adjustment in high-cost areas.

Example: Competitive Defined Benefit Proposal

Option	Plan Price (monthly)	Split of Plan Payments *Beneficiary*	*Government*
Low-Price Plan	$433.33	$0.00 0%	$433.33 100%
Medium-Price Plan	$490.00	$42.50 9%	$447.50 91%
Price Equals 96% Of Traditional Costs	**$500.00**	**$50.00 10%**	**$450.00 90%**
High-Price Plan	$520.00	$70.00 13%	$450.00 87%

Smoothing Out Balanced Budget Act Policies: Short- and Long-Term

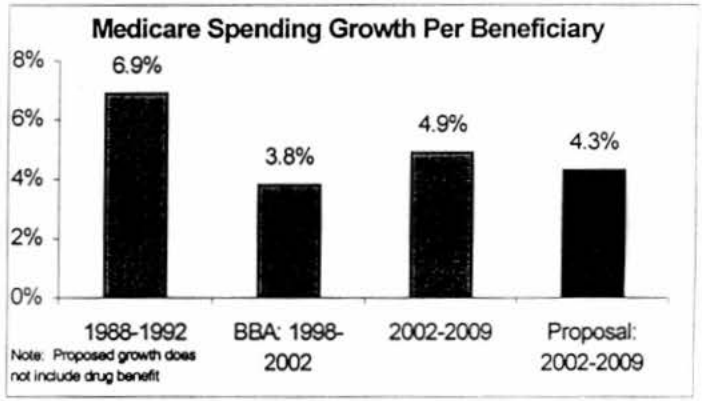
- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this, this plan includes:

  - Administrative actions. The plan includes immediate administrative actions to moderate the impact of the BBA on hospitals, academic health centers, and home health agencies.

  - Better targeting disproportionate share hospital payments. These payments would be removed from managed care payments and paid directly to qualifying hospitals.

  - $7.5 billion quality assurance fund. This fund would be used to modify BBA provisions that have been determined by the Administration, Congress, and health experts to be severely undermining providers' ability to delivery high-quality, affordable health care.

- **Constraining out-year program growth, but more moderately than BBA 1997.** To moderate program growth after most of the provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates. They are more modest than those included in the BBA 1997 and would result in a growth rate that is 15% higher than it would have been had BBA rates continued.



Improving Medicare Management

- **Modernizing Medicare management.** The President's plan includes a major modernization reform of the management of Medicare. It would:

  - **Increase accountability through public/private advisory boards.** These include:

    - Management Advisory Council. Panel of public and private sector management experts to identify and recommend best management practices for Medicare.

    - Medicare Coverage Advisory Committee. Experts in medicine and science, consumer and industry representatives would provide advise on coverage policy.

    - Citizens' Advisory Panel on Medicare Education. Experts in consumer education and health policy and health care providers would monitor and evaluate Medicare's consumer education initiatives.

- **Increasing personnel flexibility.** Medicare has taken strides in hiring experts from the private sector to manage its programs. It has contracted with an outside evaluator to determine how best it can prepare its staff for the challenges of the next century.

MODERNIZING MEDICARE BENEFITS
Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002.

  - Meaningful coverage. Medicare would cover half of drug costs from the first prescription up to $5,000 in spending per year ($2,500 in Medicare payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers.

  - Affordable premiums. Beneficiaries would pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded (no premiums below 150% of poverty; no cost sharing below 135% of poverty).

  - Private management. Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers or similar entities to manage the benefit. No price controls would be used.

  - Medicare support for retiree coverage. Medicare would pay a reduced premium subsidy for beneficiaries who receive coverage through their employers' health plan.

→ Sarah Bianchi

MEDICARE PRINCIPALS' MEETING

MAY 13, 1999

I. Update on Drug Estimates

II. Graduate Medical Education

I. UPDATED DRUG ESTIMATES

OPTIONS:	2001 Premium	2000-04	2000-09
LIMIT: $10,000 IN SPENDING			
$0 Deductible, 50% copay ($5,000 cap): Fully Implemented: 7/1/01			
° 50% Premium Subsidy	$33/mo	$45 b	$154 b
° 67% Premium Subsidy	$23/mo	$69 b	$206 b
° 75% Premium Subsidy	$17/mo	$70 b	$232 b
$0 Deductible, 50% copay ($5,000 cap): Fully Implemented: 2008			
° 50% Premium Subsidy	$29/mo	$42 b	$147 b
° 67% Premium Subsidy	$20/mo	$57 b	$197 b
° 75% Premium Subsidy	$15/mo*	$64 b	$222 b
LIMIT: $5,000 IN SPENDING			
$0 Deductible, 50% copay ($2,500 cap): Fully Implemented: 2005			
° 50% Premium Subsidy	$29/mo	$37 b	$133 b
° 67% Premium Subsidy	$19/mo	$50 b	$177 b
° 75% Premium Subsidy	$15/mo	$56 b	$199 b
$0 Deductible, 33% copay ($2,500 cap): Fully Implemented: 2005			
° 50% Premium Subsidy	$37/mo	$46 b	$170 b
° 67% Premium Subsidy	$25/mo	$61 b	$226 b
° 75% Premium Subsidy	$19/mo	$69 b	$254 b
$0 Deductible, 50% copay up to $5000; 20% copay after $5000: Fully Implemented: 2005**			
° 50% Premium Subsidy	$29/mo	$37 b	$150 b
° 67% Premium Subsidy	$19/mo	$50 b	$200 b
° 75% Premium Subsidy	$15/mo	$56 b	$225 b

Assume start of July 1, 2001. Fiscal years, cash basis, dollars in billions. ** Not from actuaries / extrapolated from Kennedy estimates
Note: If started on January 1, 2002, costs are reduced by $10 to $20 billion, depending on option.

SELECTED ANNUAL DRUG COSTS, LIMITS, AND PREMIUMS

(Dollars in billions; cash basis; fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
50% COPAY UP TO $10,000 OF COSTS												
Fully Implemented in 2008		$2,000	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed		
50% Subsidy		0.4	13.0	13.8	15.6	17.2	19.0	20.8	22.9	25.1	**42.7**	**147.8**
Monthly Premium		*$29*	*$31*	*$33*	*$38*	*$40*	*$45*	*$47*	*$51*	*$55*		
67% Subsidy		0.5	17.3	18.4	20.8	22.9	25.4	27.8	30.5	33.5	**57.0**	**197.1**
Monthly Premium		*$20*	*$21*	*$22*	*$25*	*$27*	*$30*	*$31*	*$34*	*$36*		
75% Subsidy		0.6	19.5	20.7	23.3	25.8	28.5	31.2	34.3	37.7	**64.1**	**221.6**
Monthly Premium		*$15*	*$16*	*$16*	*$19*	*$20*	*$22*	*$24*	*$26*	*$27*		
50% COPAY UP TO $5,000 OF COSTS												
Fully Implemented in 2005		$2,000	$2,000	$3,000	$4,000	$5,000	indexed					
50% Subsidy		0.4	11.2	11.9	13.9	16.0	17.6	19.0	20.5	22.2	**37.3**	**132.6**
Monthly Premium		*$29*	*$24*	*$29*	*$34*	*$38*	*$40*	*$43*	*$45*	*$48*		
67% Subsidy		0.5	14.9	15.8	18.5	21.3	23.4	25.3	27.4	29.6	**49.7**	**176.8**
Monthly Premium		*$19*	*$16*	*$20*	*$23*	*$25*	*$27*	*$28*	*$30*	*$32*		
75% Subsidy		0.5	16.7	17.8	20.9	24.0	26.3	28.5	30.8	33.3	**55.9**	**198.8**
Monthly Premium		*$15*	*$12*	*$15*	*$17*	*$19*	*$20*	*$21*	*$23*	*$24*		
50% COPAY UP TO $5,000, 20% COPAY ABOVE *												
Fully Implemented in 2005		$2,000	$2,000	$3,000	$4,000	$5,000	indexed					
50% Subsidy		0.4	11.2	11.9	13.9	18.9	20.7	22.5	24.3	26.4	**37.3**	**150.1**
		$29	*$24*	*$29*	*$34*	*$42*	*$45*	*$47*	*$50*	*$53*		
67% Subsidy		0.5	14.9	15.9	18.6	25.1	27.6	30.0	32.5	35.2	**49.8**	**200.2**
		$19	*$16*	*$20*	*$23*	*$28*	*$30*	*$32*	*$33*	*$35*		
75% Subsidy		0.5	16.7	17.8	20.9	28.3	31.1	33.7	36.5	39.6	**56.0**	**225.1**
		$15	*$12*	*$15*	*$17*	*$21*	*$22*	*$24*	*$25*	*$27*		
Medicare Part B Premium		***$52***	***$57***	***$62***	***$66***	***$70***	***$75***	***$80***	***$85***	***$90***		

All options have no deductible

* Not estimated by the actuaries. Assumes that catastrophic protection begins in 2005 (calculated by adding marginal cost of Kennedy proposal to base proposal).

GRADUATE MEDICAL EDUCATION

- **Medicare Spending.** In 1999, Medicare will spend an estimated:

  - $2.5 billion in direct medical education (DME) and
  - $5.3 billion in indirect medical education (IME).

  This is about half of all funding for graduate medical education

- **Issues**:

  - Medical education is a societal benefit, and should be funded more broadly and equitably than by a payroll tax

  - Amount and distribution of funding determined by formula automatically

- **Options**

  - Do nothing

  - Create trust fund financed by premium assessment

  - Create trust fund financed by surplus

CREATE A NEW MEDICAL EDUCATION TRUST FUND

- **Pros:**
  - Viewed as structural reform by experts
  - Could reduce the need to give back funding to academic health centers, thus freeing up savings for funding the drug benefit
- **Cons:**
  - May not be enough for teaching hospitals – especially if they do not support the non-Medicare sources of financing
  - Difficult issue – has been proposed repeatedly but never acted on

OPTION 1: TRUST FUND FINANCED BY PREMIUM ASSESSMENT

Option:

- Move Medicare direct medical expenditure payments out of Part A to new trust fund

- Complement Medicare funding with private health insurance premium assessment:
  - 1.5% premium assessment (Moynihan): $5 billion / year
  - 1.0% premium assessment (Cardin): $3.2 billion / year

- **Pros:**

  - Would be viewed as most reform-oriented, validated by experts

  - Supported in Health Security Act; favored by academic health centers

  - More progressive and appropriate source of financing

- **Cons:**

  - Some Democrats and most Republicans will oppose as new tax on health insurance that will raise costs and possibly increase the uninsured

  - May not be worth political and administrative challenges, especially if small

2. TRUST FUND FINANCED BY SURPLUS

Option:

- Move Medicare direct medical expenditure payments out of Part A to new trust fund
- Dedicate some fraction of surplus to trust fund

- **Pros**:
  - Since all people benefit from medical education, general revenue may be an appropriate financing source
  - Relieves pressure on Medicare without new tax
- **Cons:**
  - Spends the surplus without significantly helping to fund the drug benefit
  - Likely to be criticized by Republicans and possibly some Democrats as a gimmick

MEDICARE OPTIONS
April 28, 1999

I. STATUS OF POLICIES

II. SOURCES & USES

III. BBA POLICIES / MODIFICATIONS

IV. INCOME-RELATED PREMIUM

I. DECISIONS / UPCOMING MEETINGS

• **BBA Strategy**	Today
• **Income-Related Premium**	Today
• **Phased-In Drug Estimates**	Circulated ASAP
• **Graduate Medical Education Carve-Out**	Next Meeting
• **Cost Sharing Rationalization**	Next Meeting
• **Competitive Models**	Possibly Late Next Week
• **Financing Issues**	Possibly Late Next Week

II. SOURCES & USES

(Dollars in billions, fiscal years)

SOURCES	Savings (10 yrs)	USES	Costs (10 yrs)
Providers			
Balanced Budget Act extension/fixes	-25-40		
Modernizing traditional Medicare	-14		
Competitive private plan payments	-5-10**		
SUBTOTAL	**-44-64**		
Beneficiaries		**Beneficiaries**	
Income-related premium	-22-40	Voluntary drug benefit	+150-200
Cost sharing savings *	*	Cost sharing investments *	*
SUBTOTAL	**-22-40**	**SUBTOTAL**	**+150-200**
TOTAL	**-66-104**	**TOTAL**	**+160-225**
Medicare anti-fraud	-4	**Medicare buy-in**	+4
Surplus	-343		
ADDITIONAL FINANCING			
Cost sharing	-10		
Other (e.g., tobacco)	x		

All estimates preliminary / not all estimates from the HCFA actuaries

* Cost sharing changes will either be budget neutral or add to the savings

** Placeholder – not yet estimated by the actuaries

III. BBA POLICIES / MODIFICATIONS

- **Major Contributor to Balancing the Budget**. Roughly 40 percent of all spending reductions in the Balanced Budget Act of 1997 came from Medicare.

- **Extended Medicare Solvency**. At the time of the BBA, the actuaries estimated that these changes would extend the life of the Medicare Trust Fund for a decade. Combined with the strong economy and successful anti-fraud efforts, the Medicare Trust Fund is now solvent through 2015, and its spending growth per person is below the private sector.

- **Structural Reforms.** In several service categories, the savings came from restructuring:

  - **Managed care:** Reformed payment system
  - **Home health:** Prospective payment system
  - **Skilled nursing facilities:** Prospective payment system
  - **Hospital outpatient departments:** Prospective payment system

- **Payment Reduction.** In most other service areas, savings came from reduced payments and/or updates on payments. Most of these policies expire after 2002. As a result, Medicare spending growth is projected to rise beginning in 2003.

MEDICARE SAVINGS IN THE BALANCED BUDGET ACT OF 1997
(CBO 1997 estimates, dollars in billions)

PROVIDER	5 yrs	10 yrs
Hospitals	-35	-72
Managed Care	-22	-96
Home Health	-16	-50
Skilled Nursing Facilities	-10	-32
Physicians/ Nurses	-5	-8
Other Part B Providers *	-8	-23
Medicare as secondary payer	-8	-20
Part B Premiums	-15	-93
Preventive Benefits	+4	+9
TOTAL	**-115**	**-385**
For reference: Breaux-Thomas	-1	-102

* Includes: Labs, therapy caps, oxygen providers, etc.

CONCERNS ABOUT BBA

- **HOSPITALS:**
  - Repeal transfer policy
  - Limit impact of outpatient prospective payment system
  - Carve out disproportionate share hospital payments from managed care
  - Eliminate indirect medical education cuts in BBA

- **NURSING FACILITIES:**
  - Eliminate or allow exceptions to the therapy caps
  - Develop an outlier policy for medically complex patients
  - Exclude non-therapy ancillary services from prospective payment
  - Restore baseline spending ($9 billion)

- **HOME HEALTH:**
  - Develop an outlier policy for medically complex patients
  - Eliminate FY 2000 15 percent reduction in limits
  - Increase home health per visit cost limits to 112 % of mean
  - Restore full market basket update (reduced last fall for fix)

- **MANAGED CARE**
  - Delay implementation of risk adjustment; implement budget neutral
  - Increase rates

TOTAL COST: $30-40 billion over 10 years.

OPTIONS FOR BBA EXTENDERS / MODIFICATIONS

Straight extenders: Include policies in Breaux-Thomas proposal

- **PROS:**
  - Cover from the Medicare Commission
  - Hands-off approach to extenders / provider payment reductions in general

- **CONS**
  - Dead on arrival
  - Could jeopardize provider support / send them to Republicans who are working on fixes

Extenders with specific modification: Include specific modifications and/or administrative fixes.

- **PROS:**
  - More realistic since Congress is unlikely to pass the unmodified extenders
  - Explicitly addresses some of the providers' most pressing concerns

- **CONS**
  - Any modifications could risk our plan being considered serious structural reform
  - Providers not helped will complain; those helped will say it is not enough

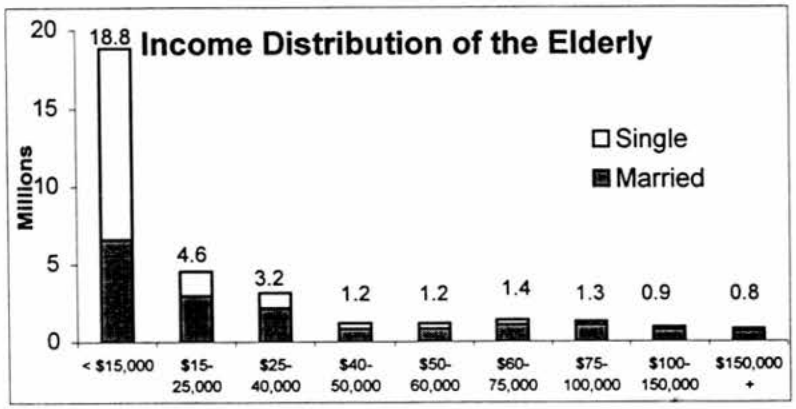
Extenders with general commitment for modification: Include funds but not specific policies.

- **PROS:**
  - Indicates willingness to deal with providers without committing to specific policies

- **CONS**
  - Lack of detail would lead to criticism that our proposal is more a political than policy document

IV. INCOME-RELATED PREMIUM

- **Currently, all beneficiaries pay the same Part B premium**. This premium represents only 25 percent of Part B costs – the government pays for 75 percent. Given the looming financial crisis in Medicare, proposals have been made to reduce the premium subsidy for the wealthiest.



- **Previous support for income-related premium.** In 1992, 1994, and 1997, the President has supported proposal or indicated support for a well-designed income-related premium that:
  - Does not fully phase out the subsidy (keeps 25 percent subsidy for the highest income)
  - Indexes the income thresholds to inflation
  - Is administered by Treasury.

- **Options:** The major question is when to begin phasing down the subsidy:
  - **$90,000 for singles, $115,000 for couples** (1 million people): $8 b over 5 / $22 b over 10
  - **$75,000 for singles, $90,000 for couples**: (2.4 million people) $10 b over 5 / $29 b over 10
  - **$50,000 for singles, $75,000 for couples** (4 million people): $15 b over 5 / $40 b over 10

MEDICARE OPTIONS DISCUSSION

JUNE 1, 1999

I. BASE PACKAGE

II. MAJOR ISSUES

III. ILLUSTRATIVE PACKAGES

I. BASE PACKAGE: $100 BILLION

(Savings in Billions, 2000-2009)

• **Modernizing Medicare and Making it More Competitive**	
° Traditional Medicare: Adding Private Sector Management Tools	-$14
° Competitive Pricing in Managed Care	-$10
• **Improving Medicare's Financing**	
° Income-Related Premium	-$25
° Dedicating 15 Percent of the Surplus to Strengthen Medicare ($350 billion / not counted towards savings)	
• **Modernizing Medicare's Benefit Structure**	
° Cost Sharing Changes	-$12
• **Provider Savings** (modified BBA extenders/subject to change)	-$40
• **Other Non/Low-Cost Policies**	
TOTAL	-$100

II. MAJOR ISSUES

- **Design and Cost of Drug Benefit:**
  - Amount of premium subsidy / government contribution
  - Amount of coverage of high (catastrophic) cost

- **Matching Drug Benefit Costs with Financing Options:**
  - Reduce Drug Benefit and Additional Traditional Medicare Savings
  - Add New Financing: Tobacco Tax or Surplus

PRESCRIPTION DRUGS: COSTS OF VARIOUS OPTIONS

(Costs in Billions, 2000-2009, Excludes Maintenance of Effort Savings)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
$5,000 LIMIT	Cap:	$2,000	$2,000	$3,000	$4,000	$5,000	indexed			
50% Premium	0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	123.0
Premiums		*$24*	*$25*	*$31*	*$36*	*$41*	*$43*	*$45*	*$48*	
67% Premium	0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	164.1
Premiums		*$16*	*$17*	*$21*	*$24*	*$27*	*$29*	*$30*	*$32*	
$10,000 LIMIT *	Cap:	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	indexed	
50% Premium	0	7.2	13.8	15.6	17.2	19.0	20.8	22.9	25.1	141.6
Premiums		*$31*	*$33*	*$38*	*$40*	*$45*	*$47*	*$51*	*$55*	
67% Premium	0	9.6	18.4	20.8	22.9	25.4	27.8	30.5	33.5	188.8
Premiums		*$21*	*$22*	*$25*	*$27*	*$30*	*$31*	*$34*	*$36*	
NO LIMIT:	Cap:	$2,000	$3,000	$3,000	$4,000	$5,000	None			
50% Premium	0	5.6	12.0	13.3	15.1	17.3	21.0	24.1	26.5	134.8
Premiums		*$24*	*$30*	*$31*	*$36*	*$41*	*$51*	*$54*	*$58*	
67% Premium	0	7.4	15.9	17.7	20.2	23.1	28.0	32.1	35.4	179.9
Premiums		*$16*	*$20*	*$21*	*$24*	*$27*	*$34*	*$36*	*$39*	

** Note: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years of its design (00 to 06); the catastrohpic option is more expensive in the out-years*

III. ILLUSTRATIVE OPTIONS

(Savings in Billions, 2000-2009)

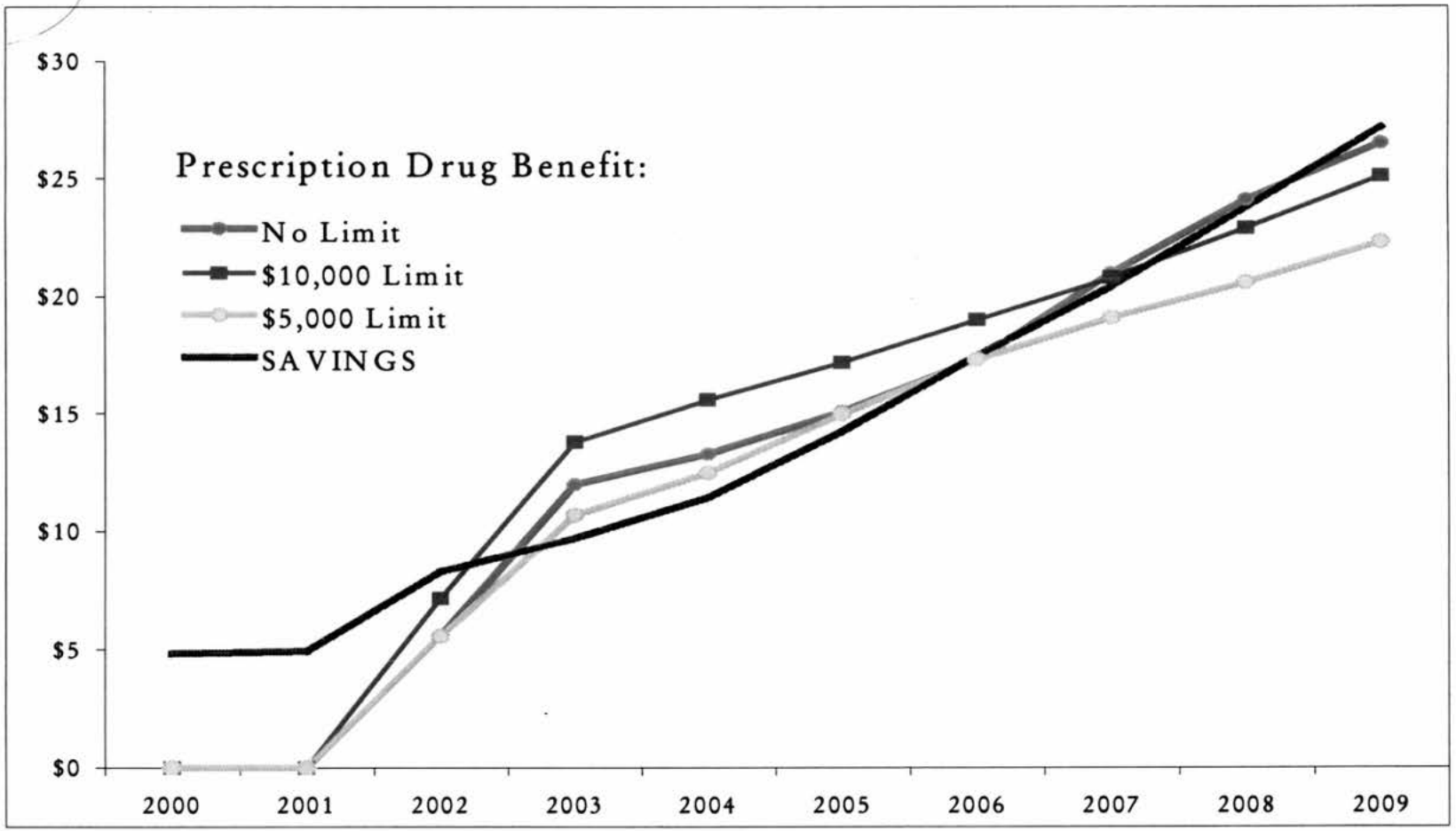
OPTION 1: No Additional Financing		OPTION 2: Additional Tobacco Tax		OPTION 3: Surplus	
Base:	-100	**Base:**	-100	**Base**:	-100
Additions:		**Additions**:		**Additions**:	
$60/90 Income-Related Premium	-7	Tobacco Tax and Additional Traditional Medicare Savings	-35-64	Amount from Surplus*	-64-89
More Provider Cuts	-7				
Raise Deductible to $150, index	-10				
Total Savings:	-124	**Total Savings:**	-135-164	**Total Savings:**	-164-189
Drug Benefit:		**Drug Benefit**:		**Drug Benefit**:	
$5,000 Limit	+123	**$5,000 Limit**	+164	**$5,000 Limit**	+164
50% Premium: $24 in 02, $48 in 09		67% Premium: $16 in 02, $32 in 09		67% Premium: $16 in 02, $32 in 09	
		$10,000 Limit	+142	**$10,000 Limit**	+189
		50% Premium: $31in 02, $55 in 09		67% Premium: $21 in 02, $36 in 09	
		No Dollar Limit	+135	**No Dollar Limit**	+180
		50% Premium: $24 in 02, $58 in 09		67% Premium: $16 in 02, $39 in 09	
State maintenance of effort	-5	State maintenance of effort	-5	State maintenance of effort	-5

NOTE: The policy with the $10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

* These amounts are 18% and 25% respectively of the $350 billion over 10 years dedicated from the surplus to Medicare.

GROWTH IN DRUG BENEFIT SPENDING & SAVINGS

(Costs/Savings in Billions, 2000-2009)



NOTE: All drug spending estimates assume a 50% premium subsidy and do not include maintenance of effort.
Savings estimates include base package plus tobacco tax (about $141 billion over 10 years).
All estimates are preliminary and subject to change.