

March 6, 1999

NOTE TO: Rick Foster

SUBJECT: Illustrative Calculations of Beneficiary Premiums and Government Contributions under Senator Breaux's "Alternative" Premium Support Formula

The attached table presents the subject illustrations for three geographic cost areas ("low," "average," and "high" cost) and three levels of plan costs within each area (similarly, "low," "average," and "high"). Illustrations are also shown for the national Medicare fee-for-service (FFS) plan. The examples illustrate how the "alternative" premium support formula included in Senator Breaux's Medicare legislative package would operate under a variety of situations.

The table lists the determination of beneficiary premiums and corresponding government contributions for each of the illustrative plans, based on our understanding of the proposal.¹ The following statements summarize the calculations:

Weighted Average Premium (WAP) - Assumption used for this illustration; represents the average cost for all participating plans, weighted by the number of enrollees in each plan.

85% of WAP - For informational purposes, 85 percent of WAP is the first "bendpoint" in the "alternative" premium support formula used in this illustration.

Full geographic cost factor - Reflects local health care costs relative to the national average. (In practice, this factor has traditionally been based on Medicare fee-for-service costs.)

Partial geographic adjustment - Factor is a 75/25 blend of the local and national rates. Approximates the blend under current law which is a 50/50 blend of local rates and an input-price-adjusted national rate. Pending a more specific provision, we have assumed this geographic adjustment based on preliminary indications from the Medicare Commission staff.

Plan cost - Plan costs vary within geographic areas due to such factors as degree of efficiency within the plan, the plan's ability to negotiate discount rates from provider networks, and the plan's benefit package.

Partial geographic adjustor - Plans are assumed to submit bids that will allow them to recover their full costs. In practice, they would accomplish this result by adjusting their actual costs by the same geographic adjustment as would be used in the calculation of their plan payment.

Plan bid - Plan cost divided by the partial geographic adjustor.

¹ Our understanding of Senator Breaux's proposal is based on staff documents and explanations. If our understanding is incorrect for any reason, the examples shown in this memorandum would be subject to change.

Beneficiary premium - Under the "alternative" formula, the beneficiary pays nothing for plans with bids below 85 percent of WAP. For plans with bids between 85 percent and 100 percent of WAP, the beneficiary's marginal contribution is 82 percent (i.e., for every additional dollar, the beneficiary pays \$0.82 and the government pays \$0.18). For plans above 100 percent of WAP, the beneficiary pays an additional premium equal to 100 percent of the difference between the plan bid and the WAP.

Using a high-cost plan in a low-cost area as an example, the beneficiary premium would be calculated as follows:

$$\begin{aligned} \text{Beneficiary premium} &= 0.0 \cdot 85 \cdot \text{WAP} + .82 \cdot (\text{WAP} - 85 \cdot \text{WAP}) + 1.0 \cdot (\text{Plan bid} - \text{WAP}) \\ &= 0.0 \cdot 85 \cdot \$5,100 + .82 \cdot (\$6,000 - \$5,100) + 1.0 \cdot (\$8,471 - \$6,000) \\ &= \$0 + \$738 + \$2,471 \\ &= \$3,209 \end{aligned}$$

Government contribution - Calculated as the plan bid times the partial geographic adjustor minus the beneficiary premium. Continuing the example from above:

$$\begin{aligned} \text{Government contribution} &= (\$8,471 \cdot 85) - \$3,209 \\ &= \$3,991 \end{aligned}$$

Payment to plan - Calculated as the sum of the beneficiary premium and the government contribution. Note that the plan payments equal plan costs.

These examples illustrate the nature of the premium support formula but are not intended to portray every possibility or to suggest what proportion of actual premium/contribution determinations might fall into one or another of the illustrative categories. As indicated in the examples, beneficiary premiums could be zero, for plans with sufficiently low costs, or could represent a substantial portion of total costs in higher-cost plans. (In practice, the proposal by Senator Breaux would limit the actuarial value of a plan's benefit package; this limitation is not necessarily reflected in the attached examples, which do not distinguish between higher costs attributable to broader benefit coverage from those arising from inefficient delivery of care.)

Note that as the government contribution is only partially geographically adjusted, beneficiaries pay less in low-cost areas and more in high-cost areas than they would pay with a fully geographically adjusted plan bid. For example, beneficiaries in "average-cost" plans in the illustrative low-, average-, and high-cost areas would pay premiums representing 9.4 percent, 12.3 percent, and 14.2 percent, respectively, of total plan costs. With full geographic adjustment of the government contribution, beneficiaries in the illustrative average plans would all pay a \$738 premium, equivalent to 15.4 percent, 12.3 percent, and 9.5 percent of plan costs, respectively. Conversely, in the absence of any geographic adjustment, the premium in the illustrative low-cost areas would be zero and the corresponding high-cost-area premium would be 33 percent of plan costs.

We have separately estimated that the average per-beneficiary cost for the national fee-for-service plan would be somewhat greater than the weighted average premium for all plans under Senator Breaux's proposal. As indicated in the examples, if this cost differential were \$100 then the beneficiary premium under the FFS plan would be \$100 greater than the premium associated with the weighted average cost level or, in the illustration, \$838. This example illustrates the intentionally steep increase in beneficiary premiums for plans with above-average costs: in this instance, a 1.7-percent increase in plan cost, relative to the average, results in a 13.6-percent increase in the beneficiary premium. The intent is to provide a strong incentive for beneficiaries to select lower-cost plans.

The partial geographic adjustment, together with the "alternative" formula, causes a possible anomaly in government contribution rates. This effect can be seen in the comparison of the government contributions for average- and high-cost plans in a low-cost area. Because proportionately more of the cost is paid by the beneficiary as described above, the government contribution for the high-cost plan is lower than the government contribution for the average-cost plan. This may or may not be an intended consequence.

Please let me know if you have any questions about these illustrations.

Sally Burner
Sally Burner

Illustrative calculations of beneficiary premiums and government contributions under Senator Breaux's "alternative" premium support formula, by geographic area and plan cost

Weighted Average Premium (WAP) \$8,000
85% of WAP \$5,100

	Low Cost Areas			Average Cost Areas			High Cost Areas			National FFS plan
	0.80	0.80	0.80	1.0	1.0	1.0	1.30	1.30	1.30	
Full geographic cost factor	0.80	0.80	0.80	1.0	1.0	1.0	1.30	1.30	1.30	
Partial geographic adjustment	0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23	
	Plan Costs			Plan Costs			Plan Costs			
	Low	Average	High	Low	Average	High	Low	Average	High	
Plan cost	\$ 3,600	\$ 4,800	\$ 7,200	\$ 4,500	\$ 6,000	\$ 7,500	\$ 5,850	\$ 7,800	\$ 9,750	\$ 8,100
+ Partial geographic adjustor	0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23	1.0
= Plan bid	\$ 4,235	\$ 5,647	\$ 8,471	\$ 4,500	\$ 6,000	\$ 7,500	\$ 4,776	\$ 6,367	\$ 7,959	\$ 6,100
Bid amount below 85% of WAP	0%	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
+ Bid amount 85% to 100% of WAP	82%	0	449	0	738	738	0	739	739	738
+ Bid amount above 100% of WAP	100%	0	0	2,471	0	1,500	0	367	1,859	100
= Beneficiary premium	\$ 0	\$ 449	\$ 3,209	\$ 0	\$ 738	\$ 2,238	\$ 0	\$ 1,105	\$ 2,697	\$ 838
Plan bid	\$ 4,235	\$ 6,647	\$ 8,471	\$ 4,500	\$ 6,000	\$ 7,500	\$ 4,776	\$ 6,367	\$ 7,959	\$ 6,100
+ Partial geographic adjustor	0.85	0.85	0.85	1.0	1.0	1.0	1.23	1.23	1.23	1.0
- Beneficiary premium	0	-449	-3,209	0	-738	-2,238	0	-1,105	-2,697	-838
= Government contribution	\$ 3,600	\$ 4,351	\$ 3,991	\$ 4,500	\$ 5,262	\$ 5,262	\$ 5,850	\$ 6,895	\$ 7,053	\$ 5,262
Beneficiary premium	\$ 0	\$ 449	\$ 3,209	\$ 0	\$ 738	\$ 2,238	\$ 0	\$ 1,105	\$ 2,697	\$ 838
+ Government contribution	3,600	4,351	3,991	4,500	5,262	5,262	5,850	6,895	7,053	5,262
= Payment to plan	\$ 3,600	\$ 4,800	\$ 7,200	\$ 4,500	\$ 6,000	\$ 7,500	\$ 5,850	\$ 7,800	\$ 9,750	\$ 6,100

Note: Plan payment = plan cost

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MEMORANDUM

TO: Medicare Commission
FROM: Senator John BreauX
DATE: February 18, 1999
SUBJECT: **CBO analysis of premium support**

Attached please find an analysis prepared by the Congressional Budget Office of using a premium support model to reform Medicare. I am pleased CBO has confirmed that introducing competition into Medicare could help reduce costs in both the short and long run. CBO also notes that improved efficiencies from a premium support system could maintain the quality of health care while reducing its costs.

I look forward to discussing this and other analyses of premium support at our meeting next Wednesday.



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

Dan L. Crippen
Director

February 18, 1999

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

Dear Senator:

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

Summary

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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Estimating Issues

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

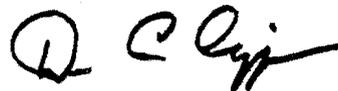
We also know that the Medicare trustees' long-term projections of spending include assumptions about future, unspecified changes in behavior and policy. The trustees essentially assume that Medicare's increasing claim on the economy and the federal budget—following Herb Stein's dictum—"cannot go on forever"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

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

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

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

Sincerely,



Dan L. Crippen
Director

c: The Honorable William M. Thomas

Enclosure

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

**Congressional Budget Office
February 1999**

OVERVIEW

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

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

BACKGROUND

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

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

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

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

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

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

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

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

THE PROPOSAL

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

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

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

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

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

(Option II is discussed later in this attachment.)

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

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

KEY ISSUES REQUIRING CLARIFICATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE ROLE OF THE BOARD

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

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

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

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

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

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

THE ALTERNATIVE OPTION

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

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

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

MEASUREMENT AND BASELINE ISSUES

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

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

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

JOHN BREAUX
LOUISIANA

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Dear Commission Member:

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

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

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

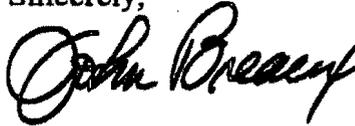
A number of events have conspired to slow down our progress toward our March 1 deadline. While I remain committed to meeting that deadline, a Commission agreement is our top priority and I realize this may take additional time. Therefore, I intend to proceed as follows:

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

3. A meeting on February 24 to fully discuss the analysis of my original proposal, and the refinements and improvements I am making to that proposal. I will endeavor to have as much analysis of this modified proposal as time will allow;
4. One or more meetings immediately thereafter to conclude the Commission work and provide our report to the Congress, the President and the American people.

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

Sincerely,



JOHN BREAUX
United States Senator

To: Medicare Commission

2/17/1999

From: Jeff Lemieux

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

Highlights:

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

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

Data Update:

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

Preliminary Staff Estimate: Senator Breaux's Medicare Proposal

2/16/99

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

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

Introduction: Major Estimating Issues

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

Transition Costs or Savings in Premium Support

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

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

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

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

Long-Run Savings from Price Competition in Premium Support

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

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

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

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

long run.

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

Description of the Proposal

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

Premiums: Two Alternative Schedules

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

FEHB-Style Formula presented by Senator Breaux

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

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

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

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

Alternative Formula

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

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

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

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

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

The Medicare Board

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

premiums are collected under current law.

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

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

Risk adjusters for plans would include

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

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

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

Raising the Normal Age of Eligibility to that of Social Security

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

Modernizing the Government-Run Fee-For-Service Plan

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

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

Medigap Reform

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

Carving Out Direct Medical Education

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

³

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

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

Financing

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

Minor and Conforming Changes

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

Basis of the Estimate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transition Issues: Two Premium Formulas

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

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

Modernizing the Fee-For-Service Plan and Reforming Medigap

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

⁸ Congressional Budget Office, "Projections of National Health Expenditures: 1997-2008," *The Economic and Budget Outlook* (January 1998).

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

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

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

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

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

⁹

For example,

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

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

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

Impact on Health Plans and Beneficiaries

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

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

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

¹⁰ Government payments would be adjusted as specified above.

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

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

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

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

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

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

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

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

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

¹²

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

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

Impact on Other Programs

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

Further specifications for Darla/Breaux premium support proposal

Questions posed to Darla Romfo on January 30, 1999:

1. Would the Medigap "price-reflects-true-cost" proposal be implemented through a premium tax? For example, if induced Medicare cost = $.50(\Delta OOP) = \$500$, then apply roughly $\$500/\1200 or 40% premium tax on Medigap premiums? (Or, equivalently, tax Medigap insurer a like amount?) Note that if Medigap coverage of combined A/B Medicare deductible is prohibited, then amount of induced Medicare cost would be different.

Darla asked us to check this one with Jeanne Lambrew. *SHOULDNT PO.*

2. For FFS beneficiaries, drug coverage is optional. Does that imply that each year beneficiaries can choose such coverage or not?

Per original "voluntary" proposal, beneficiaries would have a one-time opportunity only. *yes*

3. Government vs. beneficiary cost allocation questions:

- a. Full geographic variation in payments is specified. This differs from present law—intended? *PO Present Law*
- b. What happens for plans with costs $< 85\%$ of WAP? Is $(.85 * WAP - \text{Plan Cost})$ rebated to beneficiaries? Would plans be required to add extra benefits * instead?

Per Darla and Sarah Lyons, they did not intend the kind of formula described in the specifications. Intent was an 85/15 split at 100% WAP and 90/10 below some bendpoint (e.g., 90% WAP). They will, however, double-check this intent. *

4. Income-related premium questions:

- a. Are the "ending points" (\$105,000 and \$130,000) also indexed to CPI? *INDEX; use correct Phase-out*
YES
- b. The specified 2.5%/\$10,000 slope for future years is inconsistent with the starting formula (which is about 4.55%/\$10,000).

Ignore the 2.5%/\$10,000. Use indexed starting and ending points to go from 15% to 40% premium shares.

Caveats mentioned to Darla:

1. The age 62-67 buy-in proposal would have only a minimal impact on the issue of more uninsured individuals if the age of eligibility is increased, unless a significant government subsidy of coverage is specified. [Not mentioned to Darla: proposal in its original self-financing form might not work at all, due to higher level of amortization premium with 5 years of coverage.]

50

75

2. Use of a combined deductible for all services, with coinsurance rates that vary by service, causes a potentially serious anomaly with the allocation of costs between Medicare and beneficiaries:

Deductible = \$350	\$5,000 hospital bill	If hospital bill arrives first, then bene payment is:
Hospital coinsurance = 0%	\$2,000 physician bill	$\$350 + .20(\$2,000) = \$750$
Physician coinsurance = 20%		If physician bill arrives first, then bene payment is:
		$\$350 + .20*[(\$2,000 - \$350)] = \680

Part A + B
Merged

Who pays what

DRAFT PRELIMINARY: FOR INTERNAL USE ONLY
Medicare Monthly Premiums
(CBO January 1997 Baseline, Calendar Years)

	1998	1999	2000	2001	2002
Current Law *	\$45.80	\$47.10	\$48.50	\$50.00	\$51.50
President's Budget Options					
25% Premium*	\$45.80	\$49.50	\$52.50	\$55.90	\$61.20
25% Premium Including Home Health Transfer in 1998 *	\$53.10	\$57.10	\$60.40	\$64.30	\$70.10
25% Premium that Fully Includes Home Health Transfer in 2004	\$46.80	\$51.70	\$55.90	\$60.70	\$67.60
25% Premium that Fully Includes Home Health Transfer in 2007	\$46.50	\$51.00	\$54.90	\$59.30	\$65.70
Balanced Budget Act					
31.5% Premium Relative to Current Baseline	\$57.70	\$62.40	\$66.20	\$70.40	\$77.10
Vetoed Policy: 31.5% Premium Relative to March 1995 Baseline*	\$59.30	\$64.10	\$73.10	\$80.10	\$88.90

* CBO scored

Annual Difference in 2002 between Premium	Phased In By	Phased In By
	2004	2007
President's Base 25% Premium	+ \$77	+ \$54
25% Premium with Home Health: No Phase In:	-\$30	-\$53
Republican 31.5% Premium Relative to President's Base:	-\$114	-\$137
Vetoed Premium:	-\$256	-\$278

Comparison of High-Income Premium Options, 2002
(CBO January 1997 Baseline, Calendar Years)

	HIGH INCOME PREMIUMS					
	\$90 / 115,000 (HSA)		\$60 / 90,000 (BBA)		\$50 / 90,000 (Blue Dogs)	
	Monthly Premium	Annual Increase*	Monthly Premium	Annual Increase*	Monthly Premium	Annual Increase*
Federal Savings						
IRS Administered	<i>1998-2002: \$5.9 b</i>		<i>1998-2002: \$6.6 b</i>		<i>1998-2002: \$7.7 b</i>	
DHHS Administered**	<i>1998-2002: \$4.2 b</i>		<i>1998-2002: \$4.8 b</i>		<i>1998-2002: \$5.4 b</i>	
DHHS w/ \$1,000 Cap**	<i>1998-2002: \$3.0 b</i>		<i>1998-2002: \$3.6 b</i>		<i>1998-2002: \$4.1 b</i>	
Single Beneficiaries						
With Incomes of:						
\$50,000	\$61.20	-	\$61.20	-	\$61.20	-
\$75,000	\$61.20	-	\$97.90	+ \$440	\$122.40	+ \$734
\$95,000	\$122.40	+ \$734	\$146.90	+ \$1,028	\$171.40	+ \$1,322
\$100,000	\$183.60	+ \$1,469	\$159.10	+ \$1,175	\$183.60	+ \$1,469
\$125,000	\$183.60	+ \$1,469	\$183.60	+ \$1,469	\$183.60	+ \$1,469

Note: All premium estimates from CBO. Savings from high-income premium options do not include the \$9.0 b from the 25% extender.

* Difference relative to the 25% extender

** Reduces savings by 28%; consistent with previous CBO scoring of income-related premiums administered through DHHS

*** ROUGH ESTIMATE: Assumes reduction of 25% of savings due to \$1,000 cap.

Assumes that the maximum subsidy is 75% and Part B savings consistent with the President's \$82 billion package.

Note: In the vetoed Balanced Budget Act of 1995, the 2002 premium (31.5% relative to the March 1995 CBO baseline) was: \$88.90

	Single		Couple	
	Begins	Ends	Begins	Ends
HSA	\$90,000	\$100,000	\$115,000	\$125,000
BBA	\$60,000	\$110,000	\$90,000	\$150,000
Chaffee-Breaux	\$50,000	\$100,000	\$75,000	\$150,000

Keep ourselves informed

Prevention: vaccination ok
possible → \$200 million
Epidemiology
in decline → \$200
in population

① Total \$

② Add-ons

- \$4.2 Billion in Super

Barium

Admin.

MEPA
Demo study in April.
check the study.

- Prevention
- Respite - + \$3.3 Billion - Kill
- Outpatient Hospital Department
Co-insurance fix → \$6 Billion

Congressional

- Prevention
- Medical Malpractice - Cap - ~~\$100,000~~ - \$25,000

HE (State + Local)

③ A to B transfers

A. HHC -

B. GME and DSH - separate education fund.
Keep patients out die

④ Income related premium

⑤ Medicare managed care

- AAPCC changes
- PSOs and additional choices



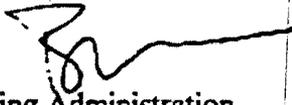
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

JUN 24 1997

The Administrator
Washington, D.C. 20201*Income Related Premium File*

To: Nancy-Ann Min DeParle
Associate Director for Health
Office of Management and Budget

From: Bruce C. Vladeck 
Administrator
Health Care Financing Administration

Subject: Income-Related Premium Proposals

An income-related premium proposal for Part B of Medicare is being considered during the Senate Budget Reconciliation discussions. Apart from whether the Administration supports such a policy, there are a few issues about how the policy should be designed. This memo discusses two critical design issues: (1) the administration of an income-related premium, and (2) the maximum beneficiary contribution.

The Senate amendment, offered by Roth-Moynihan, would be administered by the Department of Health and Human Services (HHS). The income-related premium would begin for single beneficiaries at \$50,000 and be phased-in between \$50,000 and \$100,000 and begin at \$75,000 for couples and be phased-in between \$75,000 and \$125,000. Of the savings from the proposal, \$1.5 billion will be used for block grants to states to protect low-income beneficiaries against Part B premium increases.

Administration of an Income-Related Medicare Part B Premium

An income-related Medicare Part B premium proposal should be administered by the Internal Revenue Service (IRS), rather than HHS. The income-related premium in the Administration's Health Security Act was administered by the IRS. In addition, the income-related premium was administered by the IRS in the 1988 Medicare Catastrophic Coverage Act (before that law was repealed).

Collection of the income related premium through the income tax system is much simpler than administration by HHS. IRS could administer it by adding one line to the 1040 tax form for the beneficiary's specific liability and some language to the instructions for the beneficiary to calculate their liability. It would be more convenient for beneficiaries for IRS, rather than HHS, to administer the income related premium.

In contrast, administration by HHS would be a formidable undertaking. HHS does not now collect information on beneficiary income. In addition to serious concerns about the privacy of information regarding income, there would be a 2 or 3 year delay in information provided by the

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IRS. In fact, these problems in administration of an income-related premium by HHS have led CBO to use estimate that at least 30 percent less would be collected if administered by HHS, rather than IRS. Among the issues are:

- (1) IRS would have to provide HHS with beneficiary income information since HHS does not have such information. And IRS would need to supply beneficiary income information for a year to HHS twice, first to estimate income and then to reconcile actual and estimated income.
- (2) The income information provided by IRS would be two or three years old, depending on how quickly IRS could supply income data to HHS. For example, tax return information from 1996 may not be available early enough in 1997 to give HHS enough time to estimate 1998 income, give beneficiaries an opportunity to challenge the estimate, and get billings systems ready before 1998. As a result, 1995 IRS income data might be needed to estimate 1998 beneficiary incomes.
- (3) Use of income data two or three years old is problematic. It would be inherently confusing. In addition, past income is not a good indicator of a Medicare beneficiary's future income. For example, if a beneficiary had a capital gain in 1995, that gain would be included in the beneficiary's 1995 income used to project 1998 income. Similarly, beneficiaries' earning prior to retirement would result in overstated estimates of current income in many cases.
- (4) Since beneficiaries would have to be given an opportunity to refute the HHS estimate of their income, beneficiaries could be confused about why they had to supply income data to two government agencies, IRS and HHS. And they might be confused about why income projected by HHS was based on an earlier year than the income for which they had several months earlier filed a tax return.
- (5) HHS would have to bill and collect income-related premiums quarterly from as many as 2 million high-income beneficiaries. If high-income beneficiaries did not make payments, they would be terminated from Medicare Part B coverage. It is unlikely that HHS could give SSA information on beneficiary's income related premium status and ask SSA to withhold the right amounts from monthly benefits.
- (6) IRS would have to send HHS each high income beneficiary's income after the beneficiary filed their tax returns and HHS would have to reconcile estimated and actual income and collect underpayments from or refund overpayments to beneficiaries. If a beneficiary had died, collections and refunds would have to be made to the surviving spouse or estate. All these issues could likely lead to contention between beneficiaries and HHS.

Page 3

The somewhat analogous administration of the retirement earnings test through the Social Security Administration (SSA) has provided a disproportionate share of the administrative workload of that agency and is one of the primary sources of beneficiary confusion and dissatisfaction with SSA.

Collecting and reconciling information about beneficiary incomes would be an entirely new function for HHS, one that some beneficiaries may not find appropriate, given the sensitivity of such information. In an era of ever more constrained funding for program administration, requiring HHS to take on these administrative functions without a significant increase in administrative funding and number of employees (FTEs) would be nearly impossible.

Requiring HHS to take on these new duties, which are well beyond the scope and capabilities of the agency at present, would also subject HHS to harsh and unwarranted criticism. This would be particularly counterproductive for HHS, which has devoted considerable effort in recent years to increasing beneficiaries' trust in the agency.

The Maximum Beneficiary Contribution

The Administration's Health Security Act proposed that beneficiaries pay a maximum contribution of 75 percent at or above the top income level. We proposed a 25 percent subsidy for the highest income beneficiaries.

There is an important rationale for this policy. If the entire subsidy is removed, the younger and healthier persons among highest income beneficiaries would have strong incentives to drop out of Part B coverage. On average, Medicare spending for high-income beneficiaries is about 15 percent lower than for all beneficiaries. Since their average expenses would be considerably less than their Part B premium contributions, they could probably purchase a Part B benefit package privately, at less cost than a Medicare premium equal to 100 percent of the average cost for all aged beneficiaries. If a significant number of high-income beneficiaries dropped out, it would raise costs for those who remain.

cc: Secretary Shalala
Chris Jennings

bcc: Kevin Thurm
Gary Claxton
LaVarne Burton
Rich Tarplin

FROM THE OFFICE OF

Finance Committee Medicare Fil

Senator Daniel Patrick Moynihan

New York

FOR IMMEDIATE RELEASE
Friday, July 16, 1999

CONTACT: Mike Waterman
(202) 224-4451

SENATE FINANCE DEMOCRATS ANNOUNCE TAX CUT PROPOSAL

Senator Daniel Patrick Moynihan (D-NY), along with the other Democratic Members of the Senate Finance Committee today proposed a tax cut of about \$295 billion over 10 years. In addition, Sen. Moynihan agreed that the \$2 trillion in Social Security surpluses should be saved for Social Security, and that the \$1 trillion in projected non-Social Security surpluses should be divided equally among Medicare, discretionary spending priorities, and the proposed tax cut.

In a statement, Sen. Moynihan said, "After deliberating, my Democratic colleagues on the Finance Committee have agreed that a net tax cut of about \$295 billion over 10 years, given current surplus projections, is appropriate."

Sen. Moynihan went on to say, "I am pleased to say there is virtual unanimity among Democrats and Republicans that all of [the \$2 trillion in] Social Security surpluses should be saved for Social Security...."

"Where disagreement arises, however, is on how to allocate the remaining one trillion dollars of *non*-Social Security surpluses projected for the next ten years...."

"We believe a responsible approach is to reserve about a third of the non-Social Security surpluses for Medicare; another third for restoring funding to discretionary spending priorities; and...the final third for tax relief of \$295 billion targeted to working Americans."

Senator Moynihan's full statement and a summary of the tax proposals are attached.

###

STATEMENT OF SENATOR DANIEL PATRICK MOYNIHAN
upon release of a fiscally responsible tax plan by
Senate Finance Committee Democrats

July 16, 1999

After deliberating, my Democratic colleagues on the Finance Committee have agreed that a net tax cut of about \$295 billion over 10 years, given current surplus projections, is appropriate.

Through fiscal discipline, the Federal government has finally moved from an era of seemingly intractable budget deficits, into an era of budget surpluses, with the Congressional Budget Office projecting surpluses of nearly \$3 trillion over the next ten years. Roughly two-thirds of that amount -- about \$2 trillion -- will be generated by surpluses in the Social Security program. I am pleased to say there is virtual unanimity among Democrats and Republicans that all of those Social Security surpluses should be saved for Social Security.

Paying down the debt by \$2 trillion is good for the economy and good for Social Security.

Where disagreement arises, however, is on how to allocate the remaining one trillion dollars of *non*-Social Security surpluses projected for the next ten years.

Our Republican colleagues, in the Budget Resolution they adopted in April, have committed to a fiscal policy which would spend nearly all of the *non*-Social Security surpluses on tax cuts. Tax cuts of that magnitude would be unwise and potentially destabilizing in an economy that has strong growth, low unemployment and zero inflation.

We believe a responsible approach is to reserve about a third of the non-Social Security surpluses for Medicare; another third for restoring funding to discretionary spending priorities; and, as I indicated at the beginning of my remarks, the final third for tax relief of \$295 billion targeted to working Americans.

We also believe it would be unwise to enact into law permanent, huge tax cuts, based simply on *projections* of surpluses. Relatively slight changes in the economy can make the actual surpluses much smaller than current projections. If we enact into law huge tax cuts, a relatively minor economic change could push the budget back into deficit.

###

SUMMARY OF SENATE FINANCE DEMOCRATIC \$295 BILLION TAX CUT ALTERNATIVE

Senator Daniel Patrick Moynihan (D-NY) and other Democratic members of the Senate Finance Committee propose a fiscally appropriate tax cut package as an alternative to Chairman Roth's mark. The \$295 billion Democratic alternative has, at its core, a broad based increase in the standard deduction.

BROAD BASED:

(\$169 BILLION)

Increases the standard deduction by \$4,350 for joint filers, \$2,150 for heads of household, and \$1,300 for single filers; and increases the phase-out levels for married EIC recipients.

- *Simplifies filing for over 12 million taxpayers -- it removes more than 3 million taxpayers from the tax rolls and allows an estimated 9 million more to claim the standard deduction.*
- *Increases the standard deduction by more than 60% for married couples, more than 34% for single parents, and more than 30% for individuals.*
- *Reduces the tax burden for more than 73% of taxpayers.*
- *Delivers marriage penalty relief for taxpayers who take the standard deduction.*
- *Provides additional marriage penalty relief to EIC recipients.*
- *Benefits hourly wage families.*

MARRIAGE PENALTY:

(\$26 BILLION)

Allows an itemized deduction equal to the lesser of \$4,350 or 20% of the lower earning spouse's earned income for taxpayers with incomes less than \$95,000.

- *Provides middle-income taxpayers with marriage penalty relief.*
- *Ensures that millions of couples receive marriage penalty relief.*

HEALTH CARE:

(\$27 BILLION)

Allows 100% deductibility of health insurance costs for self-employed individuals; permits a 30% tax credit for individuals without employer-sponsored plans; and provides tax breaks for long-term care costs.

- *Makes meaningful health insurance more affordable and accessible.*
- *Reduces the burden of long-term care costs for families.*
- *Provides tax-equity for individuals and the self-employed.*

ALTERNATIVE MINIMUM TAX:

(\$11 BILLION)

Extends the provision allowing taxpayers to claim their personal tax credits without regard to the AMT; coordinates income averaging for farmers.

- *Ensures that families and middle-income taxpayers receive the full benefit of their child, Hope, adoption, dependent care, and other personal nonrefundable tax credits.*
- *Ensures that farmers receive the full benefit of income averaging.*

ESTATE TAX:

(\$10 BILLION)

Accelerates the increase of the unified credit exemption amount to \$1 million and increases the exemption for family-owned farms and businesses by \$450,000 (up to \$1.75 million).

- *Enables family-owned farms and businesses to pass an estate on to future generations.*

TECHNOLOGY AND ECONOMIC DEVELOPMENT:

(\$31 BILLION)

Increases the low income housing tax credit from \$1.25 to \$1.50 per capita; establishes a "New Markets" tax credit to encourage \$3.75 billion of private investment in low income communities; and permanently extends the research credit.

- *Stimulates the development of high quality rental housing for families of limited means.*
- *Creates "patient capital" for economically underdeveloped areas.*
- *Promotes long-term research and development initiatives.*

EDUCATION:

(\$17 BILLION)

Provides \$24 billion in public school modernization bonds; eliminates tax on savings for college; and permanently extends employer-provided tuition assistance for higher education.

- *Tax credits for school bonds will help build new schools and renovate existing ones.*
- *Helps families prepare students for college through savings in state-sponsored college savings plans, operational in 44 states.*
- *Allows companies to compete by ensuring an educated workforce.*

SAVINGS AND PENSIONS:

(\$9 BILLION)

Offers small businesses a tax credit to start pension plans; permits portability of savings from one job to another; and increases protection of assets.

- *Expands plan availability and pension security.*
- *Prevents "leakage" of assets upon job change.*
- *Provides participants with more information about their benefits.*

ENVIRONMENT:

(\$5 BILLION)

Creates a capital gains incentive for conservation; gives tax incentives for alternative fuels and alternative fuel vehicles; increases public transportation benefits; and promotes land and endangered species conservation, urban revitalization, and waste utilization.

- *Encourages landowners, investors, and philanthropists to preserve open space and protect fish, wildlife, and endangered species.*
- *Promotes a cleaner environment by using public transportation to reduce auto emissions and road congestion, and by encouraging technological innovation.*

AGRICULTURE:

(\$5 BILLION)

Establishes tax-deferred risk management accounts; increases the volume cap for agriculture bonds; and gives farmers the full advantage of the \$500,000 capital gains tax break by extending it to farmland.

- *Provides equitable and ratable income treatment for farmers.*
- *Attracts new farmers by reducing the cost of credit and stimulating investment in agriculture.*

SMALL BUSINESS AND OTHER:

(\$11 BILLION)

Accelerates the increase in small business expensing to \$25,000; allows 100% deductibility for self-employed health insurance; and gives small business pension incentives.

- *Encourages entrepreneurship by increasing capital investment.*
- *Enhances small business job opportunities through improved benefits.*

File Medicare → related
premium

CONCERNS ABOUT THE MEDICARE HIGH-INCOME PREMIUM

PROPOSAL

- Increases the Medicare Part B premium for higher-income beneficiaries:

Single beneficiaries: Begins at \$50,000 with full payment at \$100,000

Couple: Begins at \$75,000 with full payment at \$125,000

If the Medicare premium is about \$67 per month in 2002, this means, for people at the upper end, an increase of \$200 per month or \$2,400 per year for a single, and \$4,800 per year for a couple.

CONCERNS

- Creates complex new bureaucracy.** In practice, a high-income premium requires a complex new process:
 - IRS sends tax information to HHS before the beginning of the year. HHS uses the latest available tax information to determine who gets a high-income premium for the subsequent year
 - HHS sends notices to beneficiaries to check income. Beneficiaries verify income.
 - HHS sends income information to Social Security Administration, which deducts higher premiums from Social Security checks, or HHS sets up its own collections and billing process
 - IRS sends tax information to HHS at the end of the year to check actual income against projected income
 - HHS would increase or decrease the next year's premiums based on the previous year's error -- plus interest. If the beneficiary had died, the surviving spouse or estate would have to pay the premium owed.

This complexity has led the Congressional Budget Office to significantly discount savings from this new premium. In fact, they suggest that it will take years before the bureaucracy can respond effectively — less than half of the revenue will be collected in the first five years, and at best 85 percent of the revenue will be collected.

- Could encourage seniors to leave Medicare.** If higher income elderly face the full cost of the Medicare premium, they might drop out of Medicare Part B. This could leave Medicare with the sicker, more expensive beneficiaries. The HCFA actuaries assume that twice as many beneficiaries will drop out of Medicare if they must pay the full cost of the premium rather than 75% of the premium.

ADMINISTRATION OF INCOME RELATED PREMIUM PROPOSALS

Proposals for income-related Part B premiums could be administered as part of the individual's annual filing of their tax return or the premiums could be collected directly by HHS or SSA. This paper concludes that it is extremely inefficient for SSA or HHS to administer an income-related premium policy.

The IRS Collection Method

Collection of the income related premium through the tax return system would be straight forward. It would involve addition of one line to the 1040 tax form for the individual's specific liability. Since the income related premium is not a uniform amount for all individuals, some language in the instructions with a simple worksheet for the individual to calculate their income related premium liability would also be needed. It may be possible to revive the worksheet that was used for the income-related premium provision that was part of the Medicare Catastrophic Coverage statute (but later repealed). If the individual pay estimated taxes, the income related premium liability could be included as part of the individual's periodic filing.

The HHS or SSA Collection Method

Collection of the income related premium through HHS or SSA would be complicated involving an HHS estimation of income for all persons subject to the provision, billing and collection of the premiums, and then a reconciliation based on comparison of actual and estimated income for the year. High income individuals who file estimated taxes for a year could have to submit estimated income to two government agencies (Treasury and HHS), make quarterly payments to the same two agencies and then reconcile their income and liability for the same two agencies, even though the HHS estimated income for an individual would be based on tax return information provided to HHS from Treasury.

Section 8512 of the Balanced Budget Act (HR 2491) contained an income related premium provision administered by HHS. The language covered the initial determination of individuals subject to the income-related premium and reconciliation of actual and projected income, but HR 2491 did not specify the mechanism by which income-related premiums would actually be collected. Following is a description of the steps that would be needed for HHS or SSA to administer the income related premium building on the language of HR 2491 and amplified with additional provisions needed.

Determination of Individuals Affected and Amount of Liability (Based on HR 2491)

- o By September 1 of each year, HHS would send to each individual a notice: (a) indicating that HHS projects that the individual would be subject to the income related premium, and (b) indicating the HHS projected income for the individual.
- o HHS's estimated modified adjusted gross income (MAGI) for an individual for the year would be based on information furnished to HHS from the Treasury regarding the

individual's actual MAGI for the most recent tax year available or other information provided by Treasury.

- + HHS would have to furnish Treasury with the names of all Medicare beneficiaries and all persons who would become eligible for Medicare during the following year. Treasury would have to examine tax returns to determine which individuals might meet or exceed the income thresholds. The only agency that might have information on dates of birth of individuals and thus could develop a list of individuals projected to become 65 within the next year might be SSA.
- + In order for HHS to send individuals notices by September 1 of each year, Treasury would have to furnish income information to HHS no later than August 1 of each year. If it took Treasury 6 weeks after April 15 of a year to get all tax returns posted on their computers (i.e., by May 31), Treasury would have June and July to run their files and provide the income information to HHS. If this tight time frame worked, it would imply a two year gap between the actual income (e.g., 1996 income filed by April 15, 1997) and the estimated income (for 1998). If this time frame was too tight, it would mean a three year lag because actual information for the prior year would have to be used, i.e., using actual income for 1995 to project 1998 income.
- + The chances of errors increase by using a 3-year lag instead of a 2-year lag. For example, individuals whose income changed could receive notice of liability based on projected income from an earlier year while their income changed recently. Individuals might be confused about why their income projected by HHS was based on a year earlier than the income for which they had several months earlier filed a tax return. Another type of error could arise from failure to identify individuals whose income was just below the threshold in the prior year but now their income had increased to exceed the income related premium threshold.
- o HR 2491 allowed an individual 30 days (from the date the notice is provided to the individual) to provide HHS with information on the individual's projected MAGI for the year. If the individual provided HHS with such information, HR 2491 required HHS to use the individual's income projection rather than HHS's income projection. The bill contained no requirement for an individual who filed estimated taxes for the year to use the same estimated income calculations in determining their anticipated MAGI which could be submitted to HHS.
- o Under HR 2491, if an individual did not provide HHS with MAGI information for the year, the HHS projected MAGI for the individual would stand.
- o HR 2491 authorized Treasury to furnish officers and employees of HCFA with tax return information on individuals, including taxpayer identity information, filing status, adjusted gross income, tax exempt interest, and certain items excluded from the taxpayer's gross income. HR 2491 specified that the return information provided by Treasury could be used only for the purposes and to the extent necessary to establish the appropriate income related

premium.

Billing/Collection of Income-Related Premiums

- o HR 2491 did not specify how the premiums would be collected. It would appear that collection could occur through either of two approaches: (1) a combination of deductions from Social Security checks and limited HHS direct billing, or (2) entirely by HHS direct billing.
- o In case of SSA making deductions from individual's Social Security checks, HHS would have to furnish the names and income-related premium amount for each individual to SSA.
 - + SSA would deduct both the income-related premium as well as the basic Part B premium amount from the individual's Social Security check. Since the income related premium amount would be different for each individual, SSA would need to make individual-specific deductions from the monthly social security check. For couples, HHS would need to allocate the income-related premium amount to each individual.
 - + Time frames might require a 3-year lag between actual income for a prior year and projected income for the year of liability. That is, if HHS were to send an individual a notice of potential liability by September 1 with a 30-day period for the individual to challenge the liability, HHS is unlikely to have the file of individuals to whom the premium applies ready before mid to late November of a year. This would appear to provide too little lead time for SSA to make the system changes and begin Social Security check deductions for the following year. HHS would probably have to move up the process and begin by sending notices on April 1, with challenges by May 1 and provision of individual-specific liabilities to SSA by July 1 for the following year. This would require using actual income from a prior year for the income projections (i.e., a 3-year lag).
 - + HHS would have to directly bill those individuals who were not yet receiving Social Security benefits (e.g., working aged) or who were not covered by Social Security. Billing could occur on a quarterly basis which might or might coincide with quarterly estimated tax payments for effected individuals.
- o In the case of exclusive HHS direct billing, HHS would have to directly bill all individuals for the applicable income-related premium (but not the basic Part B premium which would continue to be deducted from their Social Security check by SSA).
 - + HHS would send each individual with a liability a bill on a quarterly basis for the specific income-related premium amount owed by the beneficiary. This would represent a significant administrative undertaking for HHS.
 - + Here too time frames might require a 3-year lag between actual income for a prior year and projected income for the year of liability. That is, if HHS were to send an individual

a notice of potential liability by September 1, HHS might need the income information from Treasury no later than August 1 which would give Treasury effectively no more than 2 months to run the tax files with the latest filings for individuals who might have income-related premium liability. If all the necessary work could not be done within this tight time frame, then Treasury would have to furnish income information to HHS based on a prior year.

- + Though HR 2491 did not allow for changes to the individual's projected income for the year, it may be difficult to explain to beneficiaries whose income changes why HHS could not make quarterly changes to income projections. It may be all the more difficult to resist making quarterly changes if there is a 3-year lag between income information provided by Treasury and income projected by HHS. Quarterly adjustments would add to the HHS administrative burden.
- + Though HR 2491 did not specify a penalty for failure to pay the income related premium within a specified period of time, it would seem that it would have to be treated as a failure to pay the base Part B premium which is termination from Part B coverage. It may be confusing to beneficiaries to explain why they were terminated from Part B for failure to pay the income-related premium even though their basic Part B premium was still being deducted from their Social Security check.
- + An issue might be whether to send beneficiaries multiple bills before terminating their Part B coverage for failure to pay the income-related premium liability.
- + It may not be possible to coordinate the separate HHS billings for the limited set of individuals who enroll in Part B but do not have their premiums deducted from their Social Security checks and have an income related premium liability. Thus, some individuals might have two different billings for Part B coverage.

Reconciliation of Actual and Projected MAGI (Based on HR 2491)

- o HR 2491 specified that after the end of a year, Treasury would provide to HHS the actual MAGI for each individual subject to the income related premium as well as any other individual who met the income thresholds for the prior year.
 - + HHS would again have to provide Treasury with a list of all Medicare beneficiaries. Treasury would have to run the tax files for the year and develop a list of beneficiaries who were subject to the income related premium based on actual MAGI.
- o HR 2491 stipulated that HHS would compare projected and actual MAGI for the year and either increase or decrease the following year's income related premium assessment for the individual.
 - + If an individual owed additional income-related premium amount, HR 2491 specified that the following year's monthly income related premium liability would be increased by

1/12th of the amount owed (including interest).

- + If an individual were owed a refund, HR 2491 specified that the following year's monthly income related premium liability would be decreased by 1/12th of the amount owed. The bill did not specify how refunds would be handled if the individual did not have an income related premium liability for the following year. It appears that HR 2491 made refunds without interest. HR 2491 allowed refunds to be paid in a lump sum to individual's surviving spouse or the estate of a deceased individual.
- o HR 2491 provided that interest would be charged if an individual understated their income and less than the proper amount were billed for the year. However, interest would not be charge if an understated liability were based on a HHS projection of income for the individual.

Other Issues

- o The administration of an income-related premium by HHS or SSA could represent an undertaking of sufficient magnitude that it would interfere with the capacity of either organization from administering their current programs.