

PREMIUMS FOR DRUG BENEFIT CLINTON-GORE		
YEAR	PREMIUM	
	CBO	OMB
2002	\$23.40	\$25
2003	\$24.40	\$26
2004	\$31.50	\$33
2005	\$32.90	\$34
2006	\$39.50	\$41
2007	\$41.30	\$42
2008	\$47.90	\$49

*Medicare pays 50 percent of the cost of the basic premium and 100 percent of the cost of the catastrophic protections. In aggregate, the Medicare drug benefit premium split is approximately 56 percent Federal and 44 percent beneficiary.

PREMIUMS FOR DRUG BENEFIT BREAUX-FRIST [CBO ESTIMATES]	
YEAR	PREMIUM
2002	NO BENEFIT
2003	\$38.20 **50 percent higher than Clinton-Gore proposal
2004	\$41.40
2005	\$45.00
2006	\$45.70
2007	\$52.80
2008	\$58.70

PREMIUMS FOR BUSH-LIKE BENEFIT	
2002	NO BENEFIT
2003	NO BENEFIT
2004	NO BENEFIT
2005	Unknown. ** Benefit may begin, but premium would likely 50 percent higher than Administration plan and 20 percent less valuable.

Robin -
We've included the CBO numbers so you can make an apples to apples comparison - but the Administration uses the more conservative OMB estimates -

CJ
- John Listerman health bill out 2008

- Certain about 175%
- Printer guidelines - 621 \$/hr
- Universal Medical
- Reimbursement
- Norms have language
- LTE

- (A)
- Jack - Kestich - KAO GME
 - CARRIE WISER
 - UPL on Friday
 - Printer guidelines
 - Get strategy letter of OAA

-Frist - Lott
⇒ Edwards

Practise at 6:00 PM
Taylor
score

Taylor

Where:
10:00 Note ~~score~~ ^{baseball}

set
10:15 - practice session / Test

Matthayson ← 1:30 - Power / Note score

Tuesday at
6:00
Baseball

Taylor

Sunday 2:30 - practice session

6:00 work
score

Ryan Williams
The Body
will ailly
Mikem Lantz
Learns ones
Name when
with

MANAGED CARE PAYMENTS
(in billions)

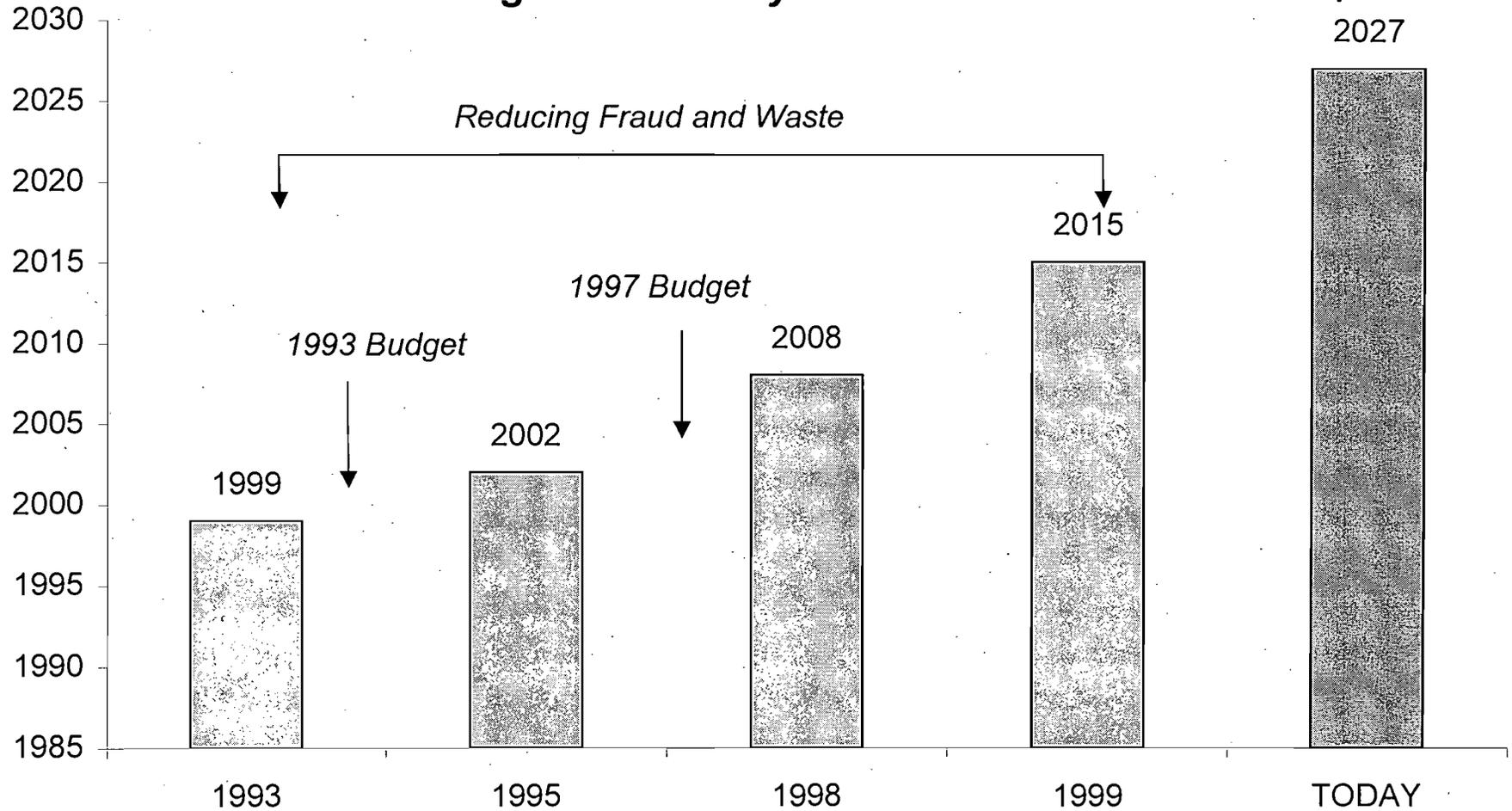
Policy	5 year number	10 year number
Direct – Prescription Drugs	\$29.2	\$86.9
Indirect Effect of FFS Givebacks (Specified Portion)	\$1.3	\$3.1
Indirect Effect of FFS Givebacks (Unspecified Portion)	\$1.9	\$4.3
Total	\$32.4	\$94.3

Preliminary estimates of proposals to restructure the Medicare benefit package											
Benefit Package Options											
Medical		RX			Medigap ¹	Per capita spending					
Deductible	Coins	Deductible	Coins	Max OOP	Allowed	Total Exp	Mcare Reimb	Medicare OOP	Rx OOP ²	Medigap Prem ³	Total OOP
Current Law	Current Law	Current Law	Current Law	Current Law	Y						
\$250	15%	100	20%	\$ 2,000	N	\$7,073	\$6,272	\$801	\$201	\$0	\$801
\$250	20%	200	20%	\$ 3,750	N	\$6,924	\$5,801	\$1,123	\$252	\$0	\$1,123
\$250	20%	200	30%	\$ 3,750	N	\$6,886	\$5,723	\$1,163	\$298	\$0	\$1,163
\$250	20%	200	50%	\$ 3,750	N	\$6,815	\$5,595	\$1,220	\$365	\$0	\$1,220
\$500	20%	200	20%	\$ 3,750	N	\$6,864	\$5,664	\$1,200	\$251	\$0	\$1,200
¹ As we consider it is highly improbable that the purchase of Medigap policies could be prohibited, these estimates are for illustrative purposes only.											
² RX out-of-pocket is included in Medicare out-of-pocket under proposed law scenarios. It is shown separately for informational purposes only.											
³ Medigap premiums include both self-purchased and employer sponsored premiums.											
SOURCE: 1995 MCBS Cost & Use aged to 1999 using per capita growth rates from 1998 Trustees' Report intermediate assumptions.											
										Office of the Actuary	
										Health Care Financing Administration	
										6/3/98	

Modernizing and Strengthening MEDICARE

Extending the Solvency of Medicare to 2027

*President's
Reform
Proposal
2027*



Medicare Reform & Prescription Drug ~~Program~~ Rules

File

For all options: 50% premium, \$250 deductible, original low-income protections, coinsurance amounts based on OOP expenditures, indexed to drug CPI. One PBM per area. If possible, please also apply the Administration's employer subsidy proposal to the option with the greatest program costs.

Option 1

50% coinsurance from \$251-\$2000
25% coinsurance from \$2001-\$3500
Stop-loss above \$3500

Option 2

50% coinsurance from \$251-\$2000
25% coinsurance from \$2001-\$4000
Stop-loss above \$4000

Option 3

Years 2003-2005
50% coinsurance from \$251-\$1500
25% coinsurance from \$1501-\$3500
Stop-loss above \$3500

Years 2006-2010
Stop-loss above \$3000

Option 4

Years 2003-2005
75% coinsurance from \$251-\$1000
50% coinsurance from \$1001-\$3000
25% coinsurance from \$3001-\$4000
Stop-loss above \$4000

Years 2006-2010
50% coinsurance from deductible level-\$1500
25% coinsurance from \$1501-\$3000
Stop-loss above \$3000

Option 5

Years 2003-2005
50% coinsurance from \$251-\$3000
stop-loss \$3000

Years 2006-2010
50% coinsurance from deductible to \$1000
25% coinsurance \$1001 to stop loss-level

FAX COVER

COMMITTEE ON GOVERNMENT REFORM

DEMOCRATIC STAFF OFFICE

HON. HENRY A. WAXMAN

**RANKING MINORITY MEMBER
B350A RAYBURN HOUSE BUILDING
PHONE (202) 225-5051
FAX (202) 225-4784, 8185**

DATE: Nov. 8, 1999

TO: Chris Jennings, White House, 456-5557

FROM: Phil Barnett

SUBJECT: National Prescription Drug Pricing Report

**NO. OF PAGES: 19
(INCLUDING COVER SHEET)**

COMMENT:

**IF THERE IS A PROBLEM WITH THIS
TRANSMITTAL, PLEASE CALL OFFICE A.S.A.P.**

DRAFT -- DRAFT -- DRAFT -- DRAFT -- DRAFT -- DRAFT -- DRAFT
EMBARGOED UNTIL NOV. 9, 1999



**Prescription Drug Pricing in the United States:
Drug Companies Profit at the Expense of Older Americans**

**Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives**

November 9, 1999

Table of Contents

Executive Summary		i
A. Methodology		i
B. Findings		i
I. The Vulnerability Of Older Americans to High Drug Prices		1
II. Are Drug Companies Exploiting the Vulnerability of Older Americans?		3
III. Methodology		4
A. Selection of Drugs		4
B. Determination of Drug Prices for Seniors		4
C. Determination of Drug Prices for Favored Customers		5
D. Determination of Drug Prices for Pharmacies		6
E. Determination of Drug Dosages		6
F. Price Differentials for Other Consumer Goods		6
IV. Drug Companies Charge Older Americans Discriminatory Prices		7
A. Discrimination in Drug Pricing		7
B. Comparison with Other Consumer Goods		8
C. Drug Company Versus Pharmacy Responsibility		9
V. Drug Manufacturer Profitability		10
VI. Appendices		12

EXECUTIVE SUMMARY

Many senior citizens in the United States cannot afford the high prices of prescription drugs. One of the principal causes of these high prices is price discrimination by drug manufacturers. This report by the minority staff of the Committee on Government Reform quantifies the extent of prescription drug price discrimination in the United States and its impacts on seniors.

The report finds that older Americans and others who pay for their own drugs are charged far more for their prescription drugs than are the drug companies' most favored customers, such as health maintenance organizations and the federal government. The report finds that a senior citizen in the United States paying for his or her own prescription drugs must pay, on average, more than twice as much for the drugs as the drug companies' favored customers. And the report finds that this is an unusually large price differential -- more than six times greater than the average price differential for other consumer goods.

In effect, the pricing strategies of drug manufacturer victimize those who are least able to afford it. As a result of price discrimination, large corporate and governmental customers with market power are able to buy their drugs at low prices while senior citizens, who often have the greatest need and the least ability to pay, are forced to pay the highest prices for prescription drugs.

A. Methodology

This study investigates the pricing of the five brand name prescription drugs with the highest sales to the elderly. It estimates the differential between the prices charged to the drug companies' most favored customers, such as HMOs and the federal government, and the prices charged to seniors who lack prescription drug coverage. The results are based on surveys of retail prescription drug prices in over 1000 chain and independently owned drug stores in nearly 100 congressional districts in 38 states and the District of Columbia. These prices are compared to the prices paid by the drug companies' most favored customers. For comparison purposes, the study also estimates the differential between prices for favored customers and retail prices for other consumer goods.

B. Findings

Older Americans pay inflated prices for commonly used drugs. For the five drugs investigated in this study, the average price differential was 134% (Table 1). This means that senior citizens and other individuals who pay for their own drugs pay more than twice as much for these drugs than do the drug companies' most favored customers. In dollar terms, senior citizens must pay on average \$58.46 to \$97.88 more per prescription for these five drugs than favored customers.

Table 1: Average Prices for the Five Best-Selling Drugs for Older Americans Are More Than Double the Prices That Drug Companies Charge Their Most Favored Customers.

Prescription Drug	Manufacturer	Use	Prices For Favored Customers	Average Prices For Seniors	Average Differential For Senior Citizens	
					Percent	Dollar
Zocor	Merck	Cholesterol	\$27.00	\$107.66	299%	\$80.66
Norvasc	Pfizer, Inc.	High Blood Pressure	\$59.71	\$118.96	99%	\$59.25
Prilosec	Astra/Merck	Ulcers	\$59.10	\$117.56	99%	\$58.46
Procardia XL	Pfizer, Inc.	Heart Problems	\$68.35	\$133.22	95%	\$64.87
Zoloft	Pfizer, Inc.	Depression	\$125.73	\$223.61	78%	\$97.88
Average Price Differential					134%	

For other popular drugs, the price differential is even higher. This study also analyzed a number of other popular drugs used by older Americans, and in some cases found even higher price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens was 1,566%. A typical prescription for this drug would cost the manufacturer's favored customers only \$1.75, but would cost the average senior citizen over \$29.00. For Micronase, a diabetes treatment manufactured by Upjohn, a prescription would cost favored customers \$10.05, while seniors in the United States are charged an average of \$50.52, a price differential of 403%.

Price differentials are far higher for drugs than they are for other goods. The report compared drug prices at the retail level to the prices that the pharmaceutical industry gives its most favored customers, such as HMOs and the federal government. Because these customers typically buy in bulk, some difference between retail prices and "favored customer" prices would be expected. The study found, however, that the differential was much higher for prescription drugs than it was for other consumer goods. The average price differential for the five prescription drugs was 134%, while the price differential for other goods was only 22%.

Pharmaceutical manufacturers, not drug stores, are primarily responsible for the discriminatory prices that older Americans pay for prescription drugs. In order to determine whether drug manufacturers or retail pharmacies cause the high prescription drug prices paid by seniors in the United States, the report compared average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that the pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. Average retail prices in the United States are actually below the published national Average Wholesale Price, which represents the manufacturers' suggested price to pharmacies. The differential between retail prices and a second indicator of pharmacy costs, the Wholesale Acquisition Cost, which represents the average price wholesalers actually pay for drugs, is only 22%. This indicates that it is drug manufacturer pricing policies that account for the inflated prices charged to older Americans and other customers.

I. THE VULNERABILITY OF OLDER AMERICANS TO HIGH DRUG PRICES.

Numerous surveys and studies have concluded that older Americans pay high costs for prescription drugs and are having a difficult time paying for the drugs they need. The cost of prescription drugs is particularly important for older Americans because they have more medical problems, and take more prescription drugs, than the average American. This situation is exacerbated by the fact that the Medicare program, the main source of health care coverage for the elderly, fails to cover the cost of most prescription drugs.

According to the National Institute on Aging, "as a group, older people tend to have more long-term illnesses -- such as arthritis, diabetes, high blood pressure, and heart disease -- than do younger people."¹ Other chronic diseases which disproportionately affect older Americans include depression and neurodegenerative diseases such as Alzheimer's disease, Lou Gehrig's disease, and Parkinson's disease. Older Americans spend almost three times as much of their income (21%) on health care than those under the age of 65 (8%).²

The latest survey data indicate that 86% of Medicare beneficiaries are taking prescription drugs.³ Almost 14 million senior citizens, 38% of all Medicare beneficiaries, use more than \$1,000 of prescription drugs annually.⁴ The average older American uses 18.5 prescriptions annually.⁵ It is estimated that the elderly in the United States, who make up 12% of the population, use one-third of all prescription drugs.⁶

Although senior citizens have the greatest need for prescription drugs, they often have the most inadequate insurance coverage for the cost of these drugs. With the exception of drugs administered during inpatient hospital stays, Medicare generally does not cover prescription

¹ National Institute on Aging (NIA), *NIA Age Page* (1997) (online at www.nih.gov/nia/health/pub/medicine.htm).

² AARP Public Policy Institute and the Lewin Group, *Out of Pocket Health Spending By Medicare Beneficiaries Age 65 and Older: 1997 Projections* (Feb. 1997).

³ Health Affairs, *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, 237 (Jan./Feb. 1999).

⁴ National Economic Council, Domestic Policy Council, *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage* (July 22, 1999).

⁵ *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3, at 237.

⁶ Senate Special Committee On Aging, *Developments in Aging: 1993*, 103d Cong., 2d Sess. 35 (1994) (S. Rpt. 403).

drugs. According to a recent analysis by the National Economic Council, approximately 75% of Medicare beneficiaries lack dependable, private-sector prescription drug coverage.⁷

Thirty-five percent of Medicare recipients, over 13 million senior citizens, do not have any insurance coverage for prescription drugs.⁸ In rural areas, the problem is even worse, with 48% of Medicare recipients lacking any prescription drug coverage.⁹ In total, Medicare beneficiaries pay more than half of their drug costs out of their own pockets.¹⁰

Even when seniors have prescription drug coverage, the coverage is often inadequate. The number of firms offering retirees prescription drug coverage is declining, from 40% in 1994 to 30% in 1998.¹¹ Medigap policies are often prohibitively expensive, while offering inadequate coverage.¹² Medicare managed care plans are also sharply reducing benefits and coverage.¹³

The high costs of prescription drugs and the lack of insurance coverage cause enormous hardships for older Americans. One survey found that 13% of older Americans -- more than one

⁷ *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, *supra* note 4.

⁸ *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3.

⁹ *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, *supra* note 4 (supplemental materials).

¹⁰ Health Care Financing Administration, *The Characteristics and Perceptions of the Medicare Population*, 107 (1996).

¹¹ *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, *supra* note 4.

¹² For example, one typical Medigap policy requires beneficiaries to meet a \$250 deductible, and then covers only 50% of the cost of prescription drugs, up to a maximum benefit of \$1,250. *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3.

¹³ While some Medicare managed care plans may offer optional prescription drug coverage, these plans are dramatically reducing coverage, with nearly 60% reporting that they will cap prescription drug benefits below \$1,000, and 28% reporting that they will cap benefits below \$500 in the year 2000. These managed care plans are also withdrawing coverage for over 400,000 seniors this year, and are expected to drop coverage for an additional 50,000 next year. Overall, only 6% of Medicare recipients obtain prescription drug coverage through managed care plans. *Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*, *supra* note 4; *Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries*, *supra* note 3.

out of every eight -- were forced to choose between buying food and buying medicine.¹⁴ By another estimate, five million older Americans are forced to make this difficult choice.¹⁵

II. ARE DRUG COMPANIES EXPLOITING THE VULNERABILITY OF OLDER AMERICANS?

Independent analysts who have investigated the drug industry have concluded that drug manufacturers engage in "price discrimination." In 1998, for example, the Congressional Budget Office (CBO) conducted a detailed examination of drug pricing. CBO found that drug manufacturers employ pricing practices that force consumers without prescription drug coverage to pay the highest prices for drugs. According to CBO:

Different buyers pay different prices for brand-name prescription drugs. . . . In today's market for outpatient prescription drugs, purchasers that have no insurance coverage for drugs . . . pay the highest prices for brand name drugs.¹⁶

In March 1999, the Federal Trade Commission (FTC) released a comprehensive analysis of prescription drug pricing that reached a similar conclusion. As in the CBO study, the FTC study found that drug manufacturers engage in price discrimination. According to the FTC: "A notable example of differential pricing is the so-called 'two tiered pricing structure' under which pharmaceutical companies set lower prices to large buyers like hospitals, HMOs, and PBMs, and charge higher prices to other buyers that include the uninsured and independent and chain retail pharmacies."¹⁷

Although these and other analyses conclude that drug manufacturers engage in price discrimination, few analyses have sought to quantify the extent of price discrimination and its impact on senior citizens. This report investigates these issues. It analyzes whether the drug companies are exploiting the vulnerability of older Americans through discriminatory pricing practices and whether these pricing practices cause the high drug prices being paid by older Americans. The results presented in this report are a compilation of the results of prescription drug pricing studies prepared by the minority staff for nearly 100 members of Congress.

¹⁴ Families USA Foundation, *Worthless Promises: Drug Companies Keep Boosting Prices*, 6 (Mar. 1995).

¹⁵ Senate Special Committee on Aging, *A Status Report -- Accessibility and Affordability of Prescription Drugs For Older Americans*, 102d Cong., 2d Sess. 2 (1992) (S. Rpt. 100).

¹⁶ Congressional Budget Office, *How Increased Competition from Generic Drugs Has Affected Prices and Returns in the Pharmaceutical Industry*, xi (July 1998).

¹⁷ Federal Trade Commission, *The Pharmaceutical Industry: A Discussion of Competitive and Antitrust Issues in an Environment of Change*, 75 (Mar. 1999).

III. METHODOLOGY

A. Selection of Drugs

The principal drugs investigated in this report are the five patented, nongeneric drugs with the highest annual sales to older Americans in 1997. The list was obtained from the Pennsylvania Pharmaceutical Assistance Contract for the Elderly (PACE). The PACE program is the largest outpatient prescription drug program for older Americans in the United States for which claims data is available, and is used in this study, as well as by several other analysts, as a proxy database for prescription drug usage by all older Americans. In 1997, over 250,000 persons were enrolled in the program, which provided over \$100 million of assistance in filling over 2.8 million prescriptions.¹⁸

B. Determination of Drug Prices for Seniors

In response to requests from members of Congress, the minority staff has analyzed prescription drug pricing in nearly 100 congressional districts in 38 states since July 1998.¹⁹ In conducting these investigations, the minority staff and the staff of the members of Congress have

¹⁸ Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly January 1 - December 31, 1997* (Apr. 1998).

¹⁹ The members of the U.S. House of Representatives who have released reports analyzing prescription drug pricing in their districts are Reps. Neil Abercrombie (HI); Thomas H. Allen (ME); Tammy Baldwin (WI); Thomas M. Barrett (WI); Ken Bentsen (TX); Shelley Berkley (NV); Marion Berry (AR); David E. Bonior (MI); Leonard L. Boswell (IA); Sherrod Brown (OH); Lois Capps (CA); Robert E. Cramer, Jr. (AL); Joseph Crowley (NY); Elijah E. Cummings (MD); Danny K. Davis (IL); Peter A. DeFazio (OR); Diana DeGette (CO); William D. Delahunt (MA); Rosa L. DeLauro (CT); Lloyd Doggett (TX); Michael F. Doyle (PA); Chet Edwards (TX); Harold E. Ford, Jr. (TN); Martin Frost (TX); Charles A. Gonzalez (TX); Gene Green (TX); Baron P. Hill (IN); Maurice D. Hinchey (NY); Ruben Hinojosa (TX); Steny H. Hoyer (MD); Eddie Bernice Johnson (TX); Dennis H. Kucinich (OH); Nick Lampson (TX); John B. Larson (CT); Barbara Lee (CA); Ken Lucas (KY); Bill Luther (MN); James H. Maloney (CT); Frank Mascara (PA); Carolyn McCarthy (NY); James P. McGovern (MA); Martin T. Mehan (MA); George Miller (CA); John P. Murtha (PA); Eleanor Holmes Norton (DC); David R. Obey (WI); Nancy Pelosi (CA); David D. Phelps (IL); Earl Pomeroy (ND); Ciro D. Rodriguez (TX); Bobby L. Rush (IL); Bernard Sanders (VT); Max Sandlin (TX); Janice D. Schakowsky (IL); Ronnie Shows (MS); Louise McIntosh Slaughter (NY); Debbie Stabenow (MI); Fortney Pete Stark (CA); Ted Strickland (OH); Bart Stupak (MI); Mike Thompson (CA); John F. Tierney (MA); Karen Thurman (FL); Jim Turner (TX); Mark Udall (CO); Tom Udall (NM); Bruce F. Vento (MN); Peter J. Visclosky (IN); Henry A. Waxman (CA); Robert E. Wise, Jr. (WV); Lynn Woolsey (CA); David Wu (OR); and Albert R. Wynn (MD). Senators Max Baucus (MT) and Tim Johnson (SD) have also released reports.

surveyed over 1000 chain and independently owned pharmacies. In this report, average drug prices for seniors are calculated by averaging the prices obtained from these pharmacies.

C. Determination of Drug Prices for Favored Customers

Drug pricing is complicated and drug companies closely guard their pricing strategies. For example, drug companies require HMOs to sign confidentiality agreements before offering them pricing discounts. The best publicly available indicator of the prices drug companies charge their most favored customers is the prices the companies charge the federal government.

The federal government pays for prescription drugs through several different programs. One important program is the Federal Supply Schedule (FSS), which is a price catalogue containing goods available for purchase by federal agencies. Drug prices on the FSS are negotiated by the Department of Veterans Affairs (VA) and approximate the prices that the drug companies charge their most favored nonfederal customers. According to the U.S. General Accounting Office, "[u]nder GSA procurement regulations, VA contract officers are required to seek an FSS price that represents the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer under comparable terms and conditions."²⁰ To obtain additional price discounts available to the private sector, the VA has established at least two additional negotiated-price programs: (1) a VA formulary that operates similarly to the formularies established by well-managed HMOs,²¹ and (2) a Blanket Price Agreement (BPA) program, under which the VA commits to purchasing minimum quantities of particular prescription drugs. Yet another program through which the federal government obtains prescription drugs is section 340(b) of the Public Health Service Act, which entitles four agencies (the VA, the Indian Health Service, the Department of Defense, and the Public Health Service) to purchase drugs at a maximum price of 24% below the manufacturer's average nonfederal price.

²⁰ U.S. General Accounting Office, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain* 6 (June 1997) (emphasis added). In an April 21, 1999, letter to Rep. Henry A. Waxman, GAO confirmed that "federal supply schedule prices represent the best publicly available information on the prices that pharmaceutical companies charge their most favored customers." Letter from William J. Scanlon, Director, GAO Health Financing and Public Health Section.

²¹ For a detailed description of the Department of Veterans Affairs Formulary program, see the National Formulary Content Page, online at www.dppm.med.va.gov/newsite/national.htm.

This analysis uses the lowest negotiated price paid by the federal government as a proxy for the prices paid by drug companies most favored customers.²² All prices were updated in September 1999 to reflect current pricing.

D. Determination of Drug Prices for Pharmacies

The report also examines two other pricing indicators: (1) the Average Wholesale Price (AWP) and (2) the Wholesale Acquisition Cost (WAC). These two prices provide an indicator of the extent of markups that are attributable to the pharmacy (in contrast to those that are due to the drug manufacturer). The AWP represents the price that manufacturers suggest that wholesalers charge retail pharmacies; the WAC represents the actual average price that wholesalers pay to acquire drugs. The typical wholesaler markup on drugs for sale to pharmacies is an additional 2% - 4%.²³ Both AWP and WAC were obtained from the Medispan database and were updated in June 1999 to reflect current pricing.

E. Determination of Drug Dosages

When comparing prices, the study used the same criteria (dosage, form, and package size) used by the GAO in its 1992 report, *Prescription Drugs: Companies Typically Charge More in the United States Than In Canada*. For drugs that were not included in the GAO report, the study used the dosage, form, and package size common in the years 1994 through 1997, as indicated in the *Drug Topics Red Book*. The dosages, forms, and package sizes used in the study are shown in Appendix B.

F. Price Differentials for Other Consumer Goods

In order to determine whether the differential between the most favored customer prices and retail prices for drugs commonly used by older Americans is unusually large, the study compared the prescription drug price differentials to price differentials on other consumer products. To make this comparison, a list of consumer goods other than drugs available through the FSS was assembled. FSS prices were then compared with the retail prices at which the items could be bought at a large national chain.²⁴

²² For Norvasc, Prilosec, Procardia XL, Zoloft, Micronase, and Synthroid, the Federal Supply Schedule price was used as the indicator of best price. For Zocor the VA's formulary price was used as the indicator of best price.

²³ Patricia M. Danzon, *Price Comparisons for Pharmaceuticals: A Review of U.S. and Cross-National Studies* (April 1999).

²⁴ The items used were paper towels, envelopes, rubber bands, toilet paper, pencils, Rolodexes, tape dispensers, waste baskets, correction fluid, post-it notes, paper clips, and scissors.

IV. DRUG COMPANIES CHARGE OLDER AMERICANS DISCRIMINATORY PRICES

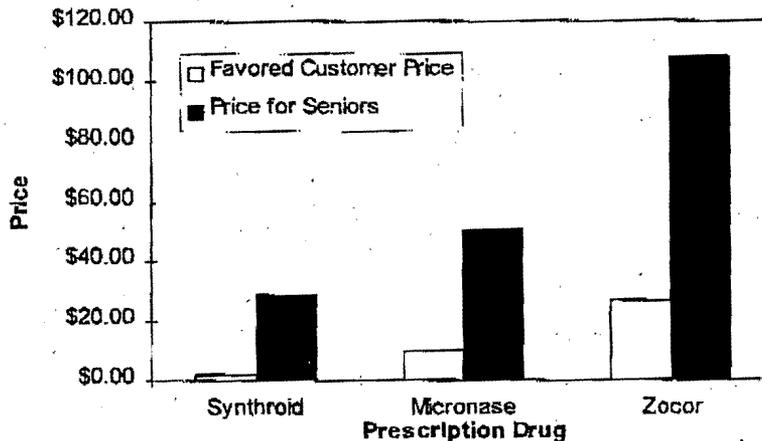
A. Discrimination in Drug Pricing

In the case of the five drugs with the highest sales to seniors, the average price differential between the price that would be paid by a senior citizen in the United States and the price that would be paid by the drug companies' most favored customers was 134% (Table 1). This means that the average price that older Americans and other individual consumers pay for these drugs is more than double the price paid by the drug companies' favored customers, such as HMOs and the federal government.

For individual drugs, the price differential was even higher. Among the five best selling drugs, the highest price differential was 299% for Zocor, a cholesterol treatment manufactured by Merck. The average senior without drug coverage must pay \$107.66 for 60 tablets of Zocor, compared to a favored customer price of just \$27.00.

For other popular drugs, the study found even greater price differentials. The drug with the highest price differential was Synthroid, a commonly used hormone treatment manufactured by Knoll Pharmaceuticals. For this drug, the average price differential for senior citizens was more than 1,550%. One hundred tablets of this drug would cost the most favored customers only \$1.75, but would cost the average senior citizen \$29.15. For Micronase, a diabetes treatment manufactured by Upjohn, the average price differential was 403% (Figure 1).

Figure 1: Older Americans Pay Inflated Prices for Prescription Drugs.



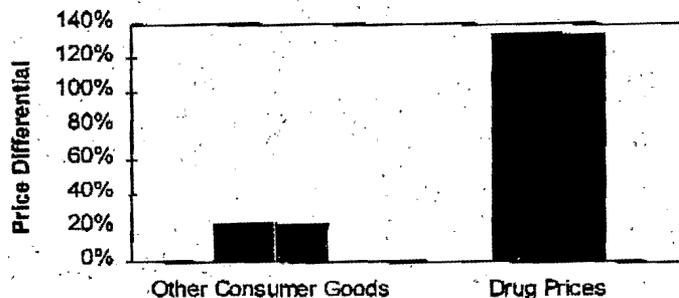
Every drug looked at in this study had a large price differential. Among the five highest selling drugs, four (Zocor, Norvasc, Prilosec, and Procardia XL) had price differentials that exceeded 90%. The lowest price difference was still high -- 78%, for Zoloft.

In dollar terms, Zoloft, an antidepressant, had the highest price differential. Senior citizens in the United States must pay nearly \$100 more for 100 tablets of Zoloft than a favored customer. The difference between seniors' prices and prices for favored customers was more than \$80.00 for 60 tablets of Zocor and over \$50.00 per prescription for each of the remaining three best selling drugs (Procardia XL, Norvasc, and Prilosec).

B. Comparison with Other Consumer Goods

The report analyzed whether the large differentials in prescription drug pricing could be attributed to a volume effect. The drug companies' most favored customers, such as HMOs and the federal government, typically buy large volumes of drugs. Thus, it could be expected that there would be volume-related differences between the prices charged the most favored customers and retail prices. The report found, however, that the differentials in prescription drug prices were much greater than the differentials in prices for other consumer goods. The report found that, in the case of other consumer goods, the average difference between retail prices and the prices charged most favored customers, such as large corporations and institutions, was only 22%. The average price differential in the case of prescription drugs was more than six times larger than the average price differential for other consumer goods (Figure 2). This indicates that a volume effect is unlikely to explain the large differential in prescription drug pricing.

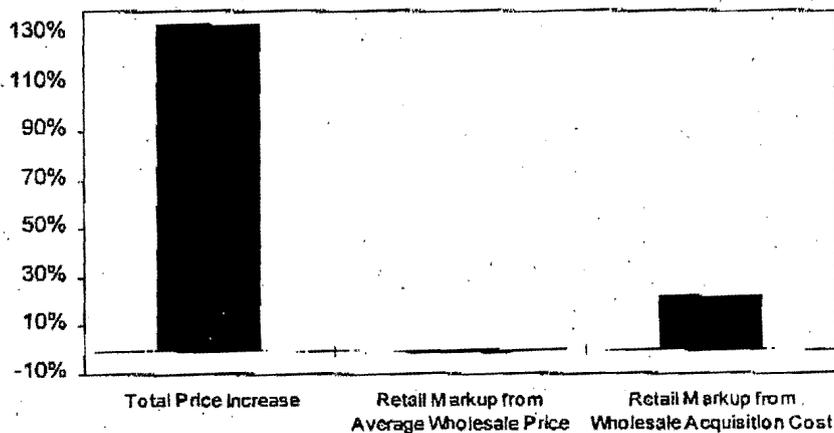
Figure 2: Price Differentials on Drugs Commonly Used by Older Americans Are Far Higher Than Differentials for Other Consumer Goods.



C. Drug Company Versus Pharmacy Responsibility

The report also sought to determine whether drug companies or retail pharmacies are responsible for the high prices being paid by older Americans. To do this, the report compared the average wholesale prices that pharmacies pay for drugs to the prices at which the drugs are sold to consumers. This comparison revealed that pharmacies appear to have relatively small markups between the prices at which they buy prescription drugs and the prices at which they sell them. The report found that the average retail price for the five best-selling prescription drugs was actually lower than the published Average Wholesale Price, and only 22% above the Wholesale Acquisition Cost (Figure 3). This finding indicates that it is drug company pricing policies, not retail markups, that account for the inflated prices charged to older Americans and other individual customers. These findings are consistent with other experts who have concluded that because of the competitive nature of the pharmacy business at the retail level, there is a relatively small profit margin for retail pharmacists.²⁵

Figure 3: Drug Companies, Not Retail Pharmacies, Are Responsible for High Prescription Drug Costs

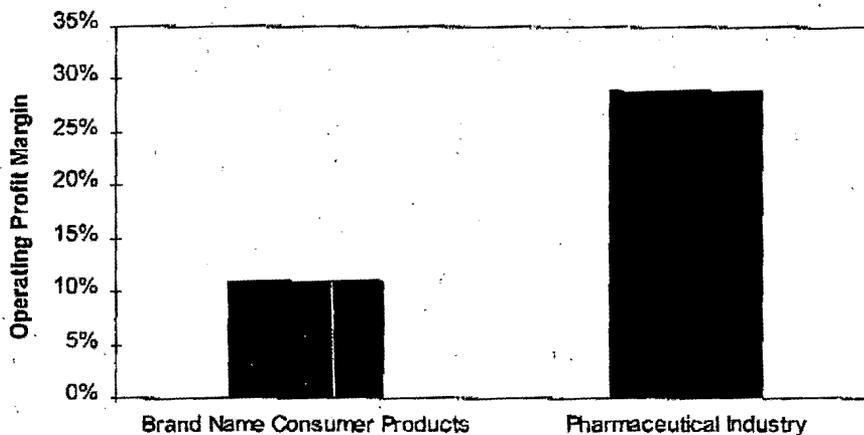


²⁵ National Association of Chain Drug Stores, *Did You Know . . .* (pamphlet) (citing financial data assembled by Keller Bruner & Company, P.C., Certified Public Accountants 1995).

V. DRUG MANUFACTURER PROFITABILITY

Drug industry pricing strategies have boosted the industry's profitability to extraordinary levels. The annual profits of the top ten drug companies are over \$25 billion.²⁶ Moreover, the drug companies make unusually high profits compared to other companies. The average manufacturer of branded consumer goods, such as Procter & Gamble or Colgate-Palmolive, has an operating profit margin of 10.5%. Drug manufacturers, however, have an operating profit margin of 28.7% -- nearly three times greater (Figure 4).²⁷

Figure 4: The Pharmaceutical Industry's Profit Margins Are Larger Than Those for Other Companies.



These high profits appear to be directly linked to the pricing strategies observed in this report. For instance, Merck, the country's largest pharmaceutical manufacturer, had a 24% increase in sales and a 12% increase in profits in the first quarter of 1999.²⁸ According to industry analysts, Merck's increased profits have been due in large part to sales of Zocor,²⁹ which is sold in the United States at a price differential of 299%. Zocor itself accounts for 13% of Merck's revenues.³⁰

²⁶ Fortune, *1999 Fortune 500 Industry List* (1999) (Online at www.pathfinder.com/fortune500/ind21.html).

²⁷ Paul J. Much, Houlihan Lokey Howard & Zukin, *Expert Analysis of Profitability* (Feb. 1998).

²⁸ AP, *Merck Sales Jump by 24 Percent* (April 23, 1999).

²⁹ USA Today, *Drugmakers Have Healthy Outlook* (July 20, 1998).

³⁰ *Merck Sales Jump by 24 Percent*, *supra* note 28.

Pharmaceutical companies have been rapidly increasing their prices for drugs used by senior citizens. These price hikes make it even more difficult for uninsured senior citizens to afford prescription drugs. In 1998, the prices for the 50 prescription drugs most frequently used by senior citizens increased by 6.6%, more than four times the inflation rate.³¹ The price of Synthroid, which is sold at a price differential of more than 1,550%, increased by more than six times the inflation rate.³²

Overall, profits for the major drug manufacturers grew by over 21% in 1998, compared to 5% to 10% for other companies on the Standard & Poors Index. The drug manufacturers' profits are expected to grow by up to an additional 25% in 1999.³³ According to one analyst, "the prospects for the pharmaceutical industry are as bright as they've ever been."³⁴

³¹ Families USA, *Hard to Swallow: Rising Drug Prices for America's Seniors* (Nov. 1999).

³² *Id.*

³³ *Drugmakers Have Healthy Outlook*, *supra* note 29.

³⁴ *Id.*

Appendix A**The Five Top Selling Patented, Nongeneric Drugs for Seniors
Ranked by 1997 Total Dollar Sales**

Rank	Drug	Manufacturer	Indication
1.	Prilosec	Astra/Merck	Ulcer
2.	Norvasc	Pfizer, Inc.	High Blood Pressure
3.	Zocor	Merck	Cholesterol reduction
4.	Zoloft	Pfizer, Inc.	Depression
5.	Procardia XL	Pfizer, Inc.	Heart Problems

Source: Pharmaceutical Assistance Contract for the Elderly ("PACE"), Pennsylvania Department of Aging, *Annual Report to the Pennsylvania General Assembly: January 1 - December 31, 1997* (Apr. 1998).

Appendix B

Information on Prescription Drugs Analyzed in This Study

Brand Name Drug	Dosage and Form	Indication	Prices (Dollars)				Price Differential (Average Retail Price vs. Favored Customer Price)
			Favored Customer Price	Wholesale Acquisition Cost	Average Wholesale Price	Average Retail Price	
Zocor	5 mg. 60 tablets	Cholesterol reducer	\$27.00	\$86.07	\$106.84	\$107.66	299%
Norvasc	5 mg. 90 tablets	High Blood Pressure	\$59.71	\$96.00	\$119.17	\$118.96	99%
Pritosec	20 mg. 30 cap.	Ulcer	\$59.10	\$100.34	\$119.57	\$117.56	99%
Procardia XL	30 mg. 100 tab.	Heart Problems	\$68.35	\$111.46	\$138.37	\$133.22	95%
Zoloft	50 mg. 100 tab.	Depression	\$125.73	\$182.98	\$227.13	\$223.61	78%
Synthroid	.05 mg. 100 tab.	Hormone Treatment	\$1.75	N/A	N/A	\$29.15	1566%
Micronase	2.5 mg. 100 tab.	Diabetes	\$10.05	N/A	N/A	\$50.52	403%

Appendix C

Price Comparisons For Non-Prescription Drug Items

Item	FSS Price	Retail Price	Differential
Binder Clip, small, 1 box	\$0.49	\$0.49	0%
Rubber Bands, 1 lb.	\$2.57	\$2.67	4%
Toilet Paper, 96 Rolls	\$44.74	\$47.98	7%
Rolodex, 500 Card	\$13.24	\$14.29	8%
Tape Dispenser	\$1.44	\$1.69	17%
Wastebasket, Plastic, 13 qt.	\$2.95	\$3.49	18%
Scissors	\$10.88	\$12.99	19%
Pencils, #2, 20-pack	\$1.03	\$1.26	22%
Paper Towels, 30 Rolls	\$22.94	\$29.98	31%
Post-It Notes	\$2.08	\$2.89	39%
Envelopes, 500, White, 20 lb. weight	\$6.45	\$9.49	47%
Correction Fluid, 18 ml., dozen.	\$6.66	\$9.99	50%
Average Price Differential			22%

STRENGTHENING MEDICARE FOR THE 21st CENTURY

President Clinton has proposed to strengthen Medicare by making it more competitive and efficient; modernizing its benefits; and improving its financing. This plan would both offer a long-overdue prescription drug benefit to Medicare beneficiaries and use a portion of the surplus to secure the life of the Medicare Trust Fund for at least the next 25 years. It would also add structural reforms that constrain cost growth by making Medicare fee-for-service and managed care compete more effectively. Lastly, the plan would smooth out and moderate Balanced Budget Act provider payment changes that are excessive. *The New York Times* editorial board described the proposal as "well-considered" and said it would "constitute the most substantial change to Medicare since its creation in 1965."

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. In recent years, the President and Congress have worked together to extend the life of the Medicare trust fund from 1999 to 2015. Building on this success, this plan:

- Gives Medicare new private purchasing and quality improvement tools to improve care and constrain costs;
- Injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money over time for both beneficiaries and the program;
- Reduces average annual Medicare spending growth, ensuring that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act expire in 2003.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefits package does not include all the services needed to treat health problems facing the elderly and people with disabilities. To address this, the President's plan:

- Establishes a new prescription drug benefit that is affordable and available to all Medicare beneficiaries. All beneficiaries would have the option to purchase this benefit that provides for privately-negotiated price discount and covers 50 percent of the costs from the first prescription for spending up to \$5,000 when fully implemented. Premiums for this coverage would begin at \$24 in 2002 and phase in to \$44 per month in 2008;
- Eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies;
- Rationalizes cost-sharing requirements to help pay for the prescription drug and preventive benefits by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- Reforms Medigap policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- Includes the President's Medicare Buy-In proposal which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. Medicare enrollment will double from almost 40 million today to 80 million by 2035, creating a need to strengthen Medicare financing. To address this, the plan dedicates part of the budget surplus to secure the life of the Medicare trust fund for the next quarter century.

- It is impossible to reduce provider payments enough to extend the life of the Medicare trust fund for any significant length of time. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person.
- Dedicating over \$300 billion to Medicare solvency has the additional effect of buying down the debt faster, helping to eliminate public debt by 2015. This would make America debt-free for the first time in the 160 years

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

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2025. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

I. MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare Trust Fund from 1999 to 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms.
- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums.
- **Constrains out-year program Medicare spending growth.** To ensure that program growth does not significantly increase after most current Medicare savings policies expire, the proposal includes out-year policies that protect against a return to excessive growth rates.

II. MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the President's Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:
 - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2009.
 - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the \$5,000 limit is reached.
 - Cost about \$26 per month beginning in 2003 (when the coverage is capped at \$2,000 in spending) and \$51 per month when fully phased-in by 2009. (This is one-half to one-third of the typical cost of private Medigap premiums.)
 - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$15,000 single/ couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.
 - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: \$160 billion over the next 10 years, beginning in 2003.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would:
 - Eliminate existing copayments and the deductible for preventive service, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, mammographies.
 - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.
 - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would rationalize the current cost sharing requirements for Medicare by:
 - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.
 - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY.

The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2025.** Dedicating \$300 billion of the surplus over 10 years to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2025, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

MEDICARE: BACKGROUND FACTS

PRESCRIPTION DRUGS

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.**
 - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years.
 - Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.
- **Millions of beneficiaries have no drug coverage.**
 - At least 13 million beneficiaries have absolutely no prescription drug coverage.
 - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately \$17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.
- **Total prescription drug spending for women on Medicare averages \$1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about \$12,750 for a single, \$17,000 for a couple), despite older women's lower average income.
- **Rural beneficiaries are at particular risk.** Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries.

FINANCIAL HEALTH OF MEDICARE

- **Improvements in Medicare Trust Fund.** When President Clinton took office, the Medicare Trust Fund was projected to be bankrupt in 1999. Today, its solvency is projected to last to about 2015 (note: with the BBA givebacks this fall, it is 2104 but this is not public). And, under his plan to strengthen and modernize Medicare, solvency would be extended to at least 2025 – the longest period of solvency in Medicare’s history.
- **Last year, for the first time in Medicare’s history, spending declined.** This resulted from a combination of a strong economy and low inflation, vigilant efforts on reducing Medicare fraud, and legislative and administration actions to effectively manage this program. Recent success in reducing fraud include:
 - Collecting about \$500 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings.
 - Excluded nearly 4,000 providers or organizations that have been convicted of certain health care offenses, lost their licenses, or engaged in other professional misconduct from participating in Medicare, Medicaid or other federally sponsored health care programs
 - Reduced improper Medicare payments by about \$10.6 billion -- a 45 percent drop in over the last two years.

FUTURE CHALLENGES

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires -- from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.
- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (from 3.6 workers per beneficiary in 2010 to 2.3 in 2030).
- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.
- **Inadequate financing:** To significantly extend Medicare solvency, Medicare spending growth per beneficiary would have to be constrained to less than inflation.

KEY MEDICARE FACTS

CURRENT PROGRAM

- Covers 39 beneficiaries, about 34 million elderly, 5 million people with disabilities
- In 1999, gross spending is \$230 billion (Federal payments \$210 billion net of premiums)
- About 15 percent of beneficiaries are in managed care
- Part B premium in 1999 is \$45.50 and in 2000

ACCOMPLISHMENT

- 99 percent of the elderly are insured today, compared to 56 percent in 1963
- Since Medicare was created, life expectancy for 65 year olds has increased by 20 percent (live 3 years longer).
- Poverty rate among the elderly: from 29 percent in 1966 to 10.5 percent in 1995.

PRESIDENT'S ACCOMPLISHMENTS

President's 1993 Budget:

- Extended life of the Trust Fund from 1999 to 2002

Balanced Budget Act of 1997

- Savings over 5 years: \$115 billion; Savings over 10 years: \$385 billion
- Life of the Trust Fund: Through 2008 (from 2002)
- Spending growth per beneficiary: 3.3% from 1998 to 2003, well below private projections of about 5% per capita
- Only slight growth as percent of Federal budget: From 12% in 1997 to 13% in 2002

Contribution to deficit reduction:

- One quarter — \$800 billion — of the entire deficit reduction between 1992 and 2002 comes from reduced Federal spending on health care. 42 percent of the \$1.8 trillion total reductions in spending (exclusive of the revenue increases) between 1992 and 2002

MODERNIZING MEDICARE: BALANCED BUDGET ACT OF 1997

NEW BENEFITS

- **New preventive benefits that should save Medicare money in the long-run:**
 - Mammography screening
 - Screening Pap smears & pelvic exams
 - Prostate cancer screening
 - Colorectal cancer screening
 - Diabetes self-management and test strips
 - Bone mass measurement

MANAGED CARE REFORMS

Improved payment methodology

- **Ends overpayment to managed care plans.** The well-documented, flawed payment rates will be corrected through slower growth rates for the next 5 years.
- **Reduces bias against rural managed care.** Managed care rates will phase in a 50 / 50 blend of local and national rates, with a "floor" for the lowest rate counties and a minimum growth rate for all.

New choices

- **New plan options for beneficiaries.** Beneficiaries' managed care options will be expanded to include preferred provider organizations, provider-sponsored organizations, private fee-for-service plans with consumer protections, and, on a demonstration basis, medical savings accounts.
- **Consumer information to encourage beneficiaries to participate.** Beneficiaries will be educated about their plan options through a series of reforms, including standardized information, enrollment periods, and nation education and publicity campaigns.

FEE-FOR-SERVICE PAYMENT REFORMS

- **Prospective payment systems for the fastest growing services:**
 - Home Health
 - Skilled Nursing Facilities
 - Hospital Outpatient Departments
 - Rehabilitation Hospitals
- **Prudent purchasing.** The ability to efficiently manage the program will be improved by new competitive pricing demonstrations and allowing Medicare to change payments by up to 15 percent per year to bringing line with inherent reasonableness.

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	--	--	na
1974	--	--	na
1975	"Late 1990s"	--	na
1976	"Early 1990s"	--	na
1977	"Late 1980s"	--	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
1994	2001	7	- 4.14
1995	2002	7	- 3.52
1996	2001	5	- 4.52
1997	2001	4	- 4.32
1998	2008	10	-2.10
1999	2015	16	-1.46

MEDICARE LEGISLATIVE PROPOSALS: FY 2001 PRESIDENT'S BUDGET

(Dollars in billions, negative numbers reflect savings and positive numbers reflect costs)

SOURCES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	Totals	
											FYs 01-05	FYs 01-10
Competitive Defined Benefit	0.000	0.000	-0.100	-0.500	-1.200	-1.600	-1.800	-2.100	-2.200	-2.400	-1.800	-11.900
Fee-For-Service Modernization & Quality Improvement												
Preferred Provider Organizations	0.000	-0.200	-0.300	-0.500	-0.700	-0.900	-1.100	-1.100	-1.100	-1.300	-1.700	-7.200
Centers of Excellence/Bundled Payments per Case	-0.010	-0.150	-0.200	-0.210	-0.620	-0.730	-0.840	-0.860	-0.870	-0.980	-1.190	-5.470
Disease Management Services/Primary Care Case Mgmt.	0.000	0.000	0.000	0.000	0.000	0.000	-0.100	-0.100	-0.100	-0.200	0.000	-0.500
Comp. Acq. Of Items and Serv./Flexible Purchasing	0.000	0.000	0.000	0.000	-0.100	-0.200	-0.200	-0.200	-0.200	-0.200	-0.100	-1.100
Contracting Reform	0.000	0.000	0.000	-0.100	-0.100	-0.200	-0.200	-0.200	-0.200	-0.100	-0.200	-1.100
Beneficiary Cost Sharing												
Reinstate Cost-Sharing for Laboratory Services	0.000	0.000	-0.610	-0.870	-0.960	-1.030	-1.090	-1.150	-1.200	-1.250	-2.440	-8.160
Index the Part B Deductible to CPI	0.000	0.000	-0.040	-0.090	-0.130	-0.190	-0.250	-0.310	-0.380	-0.440	-0.260	-1.830
Proposals to Reduce Waste, Fraud, and Achieve Fair Payment												
Eliminate Physician Mark-Up of Outpatient Drugs	-0.130	-0.240	-0.260	-0.270	-0.290	-0.300	-0.320	-0.330	-0.350	-0.370	-1.190	-2.860
Eliminate Overpayments for Epogen	-0.070	-0.080	-0.090	-0.090	-0.090	-0.100	-0.100	-0.110	-0.110	-0.110	-0.400	-0.920
Limit Eligibility for Physician Bonus Payments in Urban Areas	-0.030	-0.040	-0.040	-0.040	-0.040	-0.050	-0.050	-0.050	-0.050	-0.060	-0.190	-0.450
Eliminate Abuse of Partial Hospital Benefit	-0.030	-0.040	-0.060	-0.060	-0.070	-0.080	-0.080	-0.090	-0.100	-0.110	-0.250	-0.690
Clarify Partial Hospitalization Benefit	-0.050	-0.070	-0.090	-0.100	-0.120	-0.140	-0.150	-0.170	-0.190	-0.200	-0.430	-1.280
Establish a National Limit for All Prosthetics and Orthotics	-0.110	-0.180	-0.200	-0.210	-0.230	-0.250	-0.270	-0.290	-0.320	-0.340	-0.930	-2.400
30% Reduction for four high-priced lab tests	-0.080	-0.130	-0.140	-0.150	-0.160	-0.170	-0.180	-0.190	-0.210	-0.220	-0.660	-1.630
Require Insurers to Provide MSP Data	-0.040	-0.170	-0.190	-0.200	-0.210	-0.230	-0.240	-0.260	-0.280	-0.300	-0.800	-2.110
Reduce Medicare Bad Debt Payments	-0.340	-0.440	-0.470	-0.500	-0.540	-0.580	-0.620	-0.660	-0.710	-0.750	-2.280	-5.580
M+C: Go-to planned risk-adjustment phase-in in 2002	0.000	-0.810	-0.200	0.000	0.000	0.000	0.000	0.000	0.000	0.000	-0.810	-0.810
Traditional Provider Payments /4												
Reduce PPS Hospital Update by 0.8 percent. pts. (0.4 for Rurals)	0.000	-0.030	-0.670	-1.400	-2.210	-2.350	-2.540	-2.700	-2.870	-3.050	-4.300	-17.820
Reduce PPS Capital Payments by 2.1 percent	0.000	-0.010	-0.180	-0.220	-0.220	-0.060	-0.030	-0.040	-0.040	-0.040	-0.630	-0.830
Reduce Other Hospital Update	0.000	-0.010	-0.140	-0.280	-0.410	-0.430	-0.470	-0.500	-0.520	-0.560	-0.840	-3.310
Reduce Other Hospital Capital payments by 15 percent	0.000	-0.010	-0.060	-0.080	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010	-0.160	-0.210
Hospital Interactions	0.000	0.000	0.020	-0.020	-0.080	-0.090	-0.080	-0.080	-0.080	-0.080	-0.070	-0.490
Reduce Lab Payment Update: CPI-1.0 percentage points	0.000	0.000	-0.020	-0.060	-0.100	-0.120	-0.130	-0.140	-0.150	-0.160	-0.180	-0.880
Reduce Ambulance Update: CPI-1.0 percentage points	0.000	0.000	0.000	0.000	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010	-0.060
Reduce DME, PEN, P&O Update: CPI-1.0 percentage points	0.000	0.000	-0.030	-0.080	-0.140	-0.170	-0.190	-0.200	-0.220	-0.240	-0.250	-1.270
Interactions												
Medicare Interactions	0.000	0.000	0.160	0.240	0.300	0.440	0.470	0.500	0.510	0.540	0.710	3.180
Part B Premium Offsets	0.180	0.310	0.440	0.580	0.660	0.750	0.790	0.880	0.920	0.990	2.170	6.500
Medicaid Interactions	-0.020	-0.020	-0.020	-0.020	-0.020	-0.020	-0.020	-0.020	-0.020	-0.020	-0.100	-0.200

55

(4)

MEDICARE LEGISLATIVE PROPOSALS: FY 2001 PRESIDENT'S BUDGET

(Dollars in billions, negative numbers reflect savings and positive numbers reflect costs)

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	Totals	
											FYs 01-05	FYs 01-10
USES:												
Prescription Drug Benefit (total net budget impact)	0.000	0.000	6.850	14.480	16.790	18.980	21.710	24.150	27.160	30.230	38.110	160.340
Beneficiary Cost Sharing												
Eliminate Cost Sharing for Preventive Benefits	0.000	0.000	0.250	0.360	0.390	0.420	0.440	0.460	0.480	0.490	1.000	3.290
Extension of QI-1 Provision	0.000	0.000	0.000	0.100	0.100	0.100	0.100	0.100	0.200	0.200	0.200	0.900
Medicare Buy-In (Total impact, Medicare & SSA)	0.000	0.250	0.350	0.410	0.450	0.450	0.440	0.430	0.430	0.430	1.450	3.630
Other Initiatives												
Cancer Clinical Trials	0.250	0.490	0.010	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.750	0.750
Permanently Extend Part A Coverage for Working Disabled	0.000	0.000	0.000	0.000	0.010	0.030	0.040	0.060	0.080	0.100	0.010	0.320
Expand Coverage for Immunosuppressive Drugs	0.010	0.010	0.010	0.010	0.010	0.020	0.060	0.060	0.070	0.080	0.040	0.310
TOTAL MEDICARE IMPACT	-0.460	-1.340	3.990	10.140	9.940	11.210	12.980	14.790	17.360	19.560	22.270	98.180
MEMORANDUM												
Surplus for HI solvency	15.400	12.600	0.000	0.000	0.000	26.000	47.000	57.000	61.000	80.000	28.000	299.000
Reserve for Catastrophic Drug Benefit	0.000	0.000	0.000	0.000	0.000	4.000	5.000	6.800	8.400	10.800	0.000	35.000

Notes:

1/ Proposals scored under the FY 2001 President's Budget baseline. Totals may not sum due to rounding.

2/ Savings reflect fee-for-service effects and managed care interactions except for Competitive Defined Benefit and M+C Risk Adjustment Phase-In in 2002

3/ Not included in the table is a proposal to shift one Medicare+Choice payment from FY 2003 to FY 2002, with a net effect of zero over five and ten years.

4/ Traditional Provider Payment proposals are effective 2003-2005. FY 2002 savings may result under some proposals due to interactions with 2002 managed care payment rates.

**Differences Between CBO and OMB in Scoring the President's
FY 2001 Budget Mandatory Health Proposals**

FAMILYCARE PROPOSAL

CBO has scored the Administration's FamilyCare proposal considerably below the level scored by OMB in the President's FY 2001 Budget. While OMB estimates the total cost of the proposal to be \$76 billion over ten years, CBO scores the proposal at approximately \$57 billion over the same period. The chart below summarizes the differences between the two estimates.

Comparison of CBO and OMB's Estimate of the FamilyCare Proposal
(\$'s in billions, FYs 2001-2010)

	CBO	OMB	Difference
SCHIP	\$64	\$12	+\$52
Medicaid	-\$7	\$64	-\$71
Total	\$57	\$76	-\$19

Although OMB and CBO both start from the same point - the \$50 billion increase in the SCHIP allotments - different assumptions are made about the effect of that increase on the overall cost of the FamilyCare program. OMB assumes that the increase in the allotments will increase Medicaid program expenditures, resulting in overall program costs of \$76 billion. These costs are largely related to the requirement to cover parents below 100% of poverty without limitation beginning in 2006, the expected increase in Medicaid enrollment of children resulting from the expansion of eligibility to include their parents and potential spending on Medicaid above the allotment amounts.

CBO assumes that the allotments will constrain the growth of the program throughout the ten year budget window and limits overall costs to \$57 billion. The majority of these costs, \$50 billion, results from the full expenditure of the increased allotments. CBO does not believe that the increased allotments provide sufficient budget authority over ten years to support the proposed size of the FamilyCare program and hence, the allotments are constraining. It appears that CBO does not recognize that the proposal enables states to spend beyond the \$50 billion "cap" beginning in 2006.

The differences between OMB and CBO's approaches to scoring this proposal can be seen more clearly in the division of costs between the Medicaid and SCHIP programs. While OMB scores the majority of the costs of FamilyCare under Medicaid, CBO scores nearly all of the costs in SCHIP and takes some savings in Medicaid. OMB attributes \$64 billion of the \$76 billion total cost of FamilyCare to Medicaid and \$12 billion to SCHIP. OMB expects most of the spending related to parental coverage to occur under the Medicaid program because (1) most of the parents initially covered under for FamilyCare will be parents of Medicaid-eligible children and (2) states will be required to cover parents up to 100% of the federal poverty level in Medicaid

beginning in FY 2006.

CBO's \$57 billion net cost of FamilyCare is derived from \$64 billion in SCHIP spending and \$7 billion in Medicaid savings. CBO shows most of the Medicaid savings in FY 2006 and FY 2007, the first two years that Medicaid coverage of parents is mandated. CBO attributes these savings to (1) states that would have expanded coverage to parents through Medicaid anyway, who would now pay for such coverage through the SCHIP allotments rather than through Medicaid and (2) buying out the base of children above Medicaid mandatory levels. CBO appears to assume that both the costs and savings related to the FamilyCare proposal are driven by the size of the allotments, rather than by the parameters of the program. CBO apparently has not considered the scoring impact of lifting the allotment cap for parents below 100% of poverty in 2006 and instead attributes much of the spending under the allotments to the buy-out of the base and states that opt to cover parents over 100% of poverty.

CBO's assumption that the size of the allotment limits the overall cost of the program carries over into their estimates related to coverage. While OMB estimates that roughly 4.1 million new people will be covered through FamilyCare, CBO estimates that between 2.7 and 2.9 million new people will be covered.

MEDICARE PROPOSALS

CBO has scored the President's Medicare proposals at \$90.3 billion (including the Medicaid impacts of the President's Medicare prescription drug benefit). This estimate is \$7.9 billion lower than OMB's estimate of the proposals. The chart below summarizes the differences between the two estimates.

Comparison of CBO and OMB's Estimate of the Medicare Proposals
(\$'s in billions, FYs 2001-2010)

	CBO	OMB	Difference
Change in Direct Medicare Outlays	\$68.6	\$62.8	+\$5.8
Medicaid Impacts of the Prescription Drug and Other Proposals	\$19.5	\$33.5	-\$14.0
Other Budget Effects*	\$2.2	\$1.8	+\$0.4
Total	\$90.3	\$98.2	-\$7.9

*Includes the Cancer Clinical Trials proposal and the SSA effects of the Medicare Buy-In proposal. Columns may not sum due to rounding.

Following are the major explanations for the major differences between CBO and OMB's estimates:

Medicare Prescription Drug Proposal. CBO estimates the net budget impact of the proposal to be \$149 billion, or \$11 billion lower than OMB's estimate of \$160 billion. CBO and OMB's

estimate of the Medicare impacts of the Medicare Prescription Drug Proposal are relatively close—CBO estimates a cost of \$131 billion, or \$4 billion more than OMB's estimate of \$127 billion. However, CBO estimates lower costs for the Medicaid impact from the Prescription Drug Proposal. CBO estimates the Medicaid costs to be \$19 billion, or about \$15 billion less than OMB's estimate of \$33 billion. This difference is likely due to the fact that CBO's estimate for induced Medicaid enrollment due to the availability of the prescription drug benefit is lower than OMB's assumption. CBO also estimates lower monthly premiums for the prescription drug benefit than OMB. CBO estimates that the premium will be \$24 in 2003 and \$48 by 2009 when the benefit is fully phased-in. In comparison, OMB estimates the premium to be \$26 in 2003 and \$51 when the benefit is fully phased-in.

Medicare Savings Proposals. CBO estimates that the Medicare savings proposals will save \$69 billion, or \$2 billion less than OMB's estimate of \$71 billion (note: these numbers do not include the costs of waiving beneficiary cost-sharing for preventive benefits as discussed below). CBO has scored higher savings for the President's Competitive Defined Benefit proposal (\$14 billion vs. \$12 billion) and the imposition of new beneficiary cost-sharing (\$11 vs. \$10 billion). However, CBO has scored significantly less savings than OMB for the President's fee-for-service modernization proposals (\$8 billion vs. \$15 billion). CBO's estimates of the proposals to constrain out-year growth and the proposals to reduce waste, fraud, and overpayment are relatively close to OMB's estimate. Different estimates for interactions and premium offsets explain the remaining differences.

Medicare Buy-In Proposal. In prior years, CBO and OMB have produced similar estimates for the President's proposal to allow certain individuals ages 55-64 to buy-in to the Medicare program. This year, however, the estimates are much different. CBO estimates that the Medicare buy-in will be almost self-financing over the 10-year window. In comparison, OMB estimates that the proposal will have Medicare benefit costs of \$2.5 billion. This difference is due to differing assumptions for enrollment triggered by the availability of the newly proposed tax credit for Buy-In premiums. CBO has dramatically increased its enrollment estimate due to the availability of this tax credit. This increased enrollment assumption leads CBO to lower its estimate for selection costs (i.e., costs due to the fact that less health individuals will more likely buy-in). In comparison, OMB did not dramatically increase its enrollment assumption due to the availability of the tax credit, and therefore it still estimates selection costs of about \$2.5 billion over 10 years.

Cost-Sharing for Preventive Benefits. Consistent with prior estimates, CBO estimates higher costs than OMB for the proposal to eliminate cost-sharing for certain preventive benefits. CBO estimates the proposal will cost about \$6.6 billion over 10 years (before managed care impacts), compared to OMB's estimate of \$3.3 billion.

CBO Estimate of Effect of Medicare Provisions in President's Budget for 2001 on Mandatory Spending

18/2000 +

In billions of dollars, by fiscal year

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	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001- 2005	2001- 2010
Summary													
Gross Medicare Outlays													
Drug Benefit	0	0	0	14.7	21.6	26.8	29.9	35.1	38.7	44.4	49.0	63.1	260.4
Competitive Defined Benefit	0	0	0	(1.9)	(4.2)	(7.2)	(11.0)	(12.5)	(14.2)	(16.1)	(18.1)	(13.3)	(85.2)
Expand Eligibility to New Enrollees	0	0	1.8	3.3	4.0	5.0	5.8	6.5	7.1	7.9	9.1	14.1	50.4
Traditional Benefits for Current-law Enrollees	0	(0.8)	2.1	(6.9)	(4.5)	(6.0)	(6.4)	(7.1)	(7.7)	(8.5)	(9.2)	(16.1)	(54.9)
Subtotal, Gross Medicare Outlays	0	(0.8)	4.0	9.2	16.9	18.5	18.3	22.0	23.9	27.9	30.8	47.8	170.7
Offsetting Receipts (Premiums /b)													
Drug Benefit	0	0	0	(7.8)	(10.8)	(13.4)	(14.8)	(17.5)	(19.1)	(22.0)	(24.2)	(32.0)	(129.7)
Competitive Defined Benefit	0	0	0	1.6	3.5	6.1	9.3	10.6	11.9	13.5	15.2	11.2	71.5
Expand Eligibility to New Enrollees	0	0	(2.0)	(3.2)	(4.0)	(5.0)	(5.8)	(6.4)	(7.0)	(7.9)	(9.0)	(14.2)	(50.2)
Traditional Benefits for Current-law Enrollees	0	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1	2.0	6.3
Subtotal, Premiums	0	0.2	(1.7)	(9.1)	(10.7)	(11.7)	(10.7)	(12.6)	(13.4)	(15.5)	(17.0)	(33.1)	(102.1)
Net Medicare Outlays													
Drug Benefit	0	0	0	6.9	10.8	13.4	15.1	17.6	19.6	22.4	24.8	31.1	130.6
Competitive Defined Benefit	0	0	0	(0.3)	(0.7)	(1.1)	(1.8)	(2.0)	(2.3)	(2.6)	(2.9)	(2.1)	(13.7)
Expand Eligibility to New Enrollees	0	0	(0.2)	a	a	a	0.1	0.1	0.1	0.1	a	(0.1)	0.2
Traditional Benefits for Current-law Enrollees	0	(0.6)	2.5	(6.5)	(4.0)	(5.4)	(5.7)	(6.3)	(6.9)	(7.5)	(8.2)	(14.1)	(48.6)
Total, Net Medicare Outlays	0	(0.6)	2.2	0.1	6.2	6.8	7.7	9.5	10.6	12.4	13.8	14.7	68.6
Memorandum													
Net Medicare Outlays	0	(0.6)	2.2	0.1	6.2	6.8	7.7	9.5	10.6	12.4	13.8	14.7	68.6
Federal share of Medicaid payment of premiums & Net mandatory outlays	0	a	a	0.3	1.1	2.2	2.6	2.9	3.1	3.4	3.8	3.7	19.5
	0	(0.6)	2.3	0.4	7.3	9.1	10.3	12.3	13.7	15.8	17.5	18.4	88.1
Tax Expenditures for buy-in proposals	0	0	0.1	0.5	0.7	0.8	1.0	1.1	1.2	1.4	1.5	2.1	8.4
Net effect of Medicare provisions on on-budget surplus (note change in sign between outlays and effect on surplus).	0	0.6	(2.3)	(1.0)	(7.9)	(9.9)	(11.3)	(13.5)	(14.9)	(17.2)	(19.1)	(20.5)	(96.5)

CBO Estimate of Effect of Medicare Provisions in President's Budget for 2001 on Mandatory Spending

1/18/2000 +

In billions of dollars, by fiscal year

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	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001-2005	2001-2010
Drug Benefit													
Medicare Benefits	0	0	0	14.3	21.1	26.2	29.2	34.3	37.8	43.4	47.9	61.6	254.2
Subsidy to ESI plans	0	0	0	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1	1.5	6.1
Subtotal, Gross Medicare & ESI Outlays	0	0	0	14.7	21.6	26.8	29.9	35.1	38.7	44.4	49.0	63.1	260.4
Offsetting Receipts (Premiums /b)	0	0	0	(7.8)	(10.8)	(13.4)	(14.8)	(17.5)	(19.1)	(22.0)	(24.2)	(32.0)	(129.7)
Subtotal, Net Medicare and ESI Outlays	0	0	0	6.9	10.8	13.4	15.1	17.6	19.6	22.4	24.8	31.1	130.6
Medicaid Outlays	0	0	0	0.2	1.1	2.1	2.6	2.8	3.0	3.3	3.6	3.4	18.7
Subtotal, Net Federal Outlays	0	0	0	7.1	11.9	15.5	17.6	20.4	22.6	25.7	28.5	34.5	149.3
Competitive Defined Benefit													
Medicare Benefits	0	0	0	(1.9)	(4.2)	(7.2)	(11.0)	(12.5)	(14.2)	(16.1)	(18.1)	(13.3)	(85.2)
Offsetting Receipts (Premiums /b)	0	0	0	1.6	3.5	6.1	9.3	10.6	11.9	13.5	15.2	11.2	71.5
Subtotal, Net Medicare Outlays	0	0	0	(0.3)	(0.7)	(1.1)	(1.8)	(2.0)	(2.3)	(2.6)	(2.9)	(2.1)	(13.7)
Expand Eligibility to New Enrollees													
Medicare Benefits													
Buy-in for 62-64	0	0	1.8	3.1	3.8	4.6	5.3	5.9	6.4	7.1	8.2	13.2	46.2
Buy-in for 55-61	0	0	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.7	0.8	0.8	4.1
Medicare for working disabled	0	0	0	0	0	0	0	a	a	0.1	0.1	0	0.2
Offsetting Receipts (Premiums /b)													
Buy-in for 62-64	0	0	(2.0)	(3.1)	(3.7)	(4.6)	(5.3)	(5.8)	(6.3)	(7.2)	(8.3)	(13.4)	(46.2)
Buy-in for 55-61	0	0	(0.1)	(0.2)	(0.3)	(0.3)	(0.5)	(0.5)	(0.6)	(0.7)	(0.8)	(0.8)	(3.9)
Medicare for working disabled	0	0	0	0	0	0	0	a	a	a	a	0	(0.1)
Total, Net Medicare Outlays	0	0	(0.2)	a	a	a	0.1	0.1	0.1	0.1	a	(0.1)	0.2
Memoranda													
Tax expenditures for buy-in proposals													
62-65 buy-in	0	0	0.1	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	2.0	7.7
55-61 buy-in	0	0	a	a	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Total	0	0	0.1	0.5	0.7	0.8	1.0	1.1	1.2	1.4	1.5	2.1	8.4
Social Security Costs for buy-in proposals (off b)	0	0	0.1	0.1	a	a	a	a	a	0.1	0.1	0.1	0.3

CBO Estimate of Effect of Medicare Provisions in President's Budget for 2001 on Mandatory Spending

18/2000 +

In billions of dollars, by fiscal year

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001-2005	2001-2010
Traditional Benefits for Current-law Enrollees													
FFS Updates													
PPS update: MB - 0.8 (urban) & MB-0.4 (rural), 200	0	0	0	(0.5)	(1.1)	(1.7)	(1.9)	(1.9)	(2.0)	(2.1)	(2.2)	(3.3)	(13.4)
Extend update reduction for TEFRA hospitals, throu	0	0	0	(0.1)	(0.2)	(0.3)	(0.3)	(0.4)	(0.4)	(0.4)	(0.4)	(0.6)	(2.5)
Extend 2.1% reduction in PPS capital payments, 20	0	0	0	(0.1)	(0.2)	(0.1)	(0.1)	a	a	a	0	(0.5)	(0.5)
Extend 15% reduction in TEFRA capital payments,	0	0	0	(0.1)	(0.1)	a	0	0	0	0	0	(0.1)	(0.1)
Update lab payment rates by CPI-1%, 2003-2005	0	0	0	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)	(1.0)
Update ambulance payment rates by CPI-1%, 2003	0	0	0	a	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.5)
Update DME, PEN, P&O payment rates by CPI-1%,	0	0	0	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(1.0)
FFS Modernization													
Medicare PPO	0	0	(0.1)	(0.2)	(0.3)	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	(0.6)	(0.9)	(3.5)
Centers of excellence	0	0	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.3)	(0.9)
Disease management and primary care case manag	0	0	a	a	a	a	a	a	a	a	a	a	a
Competitive acquisition	0	0	0	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.8)
Contracting reform	0	0	0	0	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.8)
Cost-Sharing Changes													
20% copayment for laboratory services	0	0	0	(0.5)	(0.7)	(0.7)	(0.8)	(0.8)	(0.9)	(1.0)	(1.0)	(1.9)	(6.4)
Index Part B deductible to CPI	0	0	0	a	(0.1)	(0.2)	(0.3)	(0.3)	(0.4)	(0.5)	(0.6)	(0.3)	(2.4)
Eliminate cost sharing for preventive services	0	0	0	0.6	0.8	0.8	0.8	0.9	0.9	0.9	1.0	2.1	6.6
Other FFS Provisions													
Reduce EPO payment rate	0	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.5)	(1.2)
MSP reporting by insurers	0	a	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.5)	(1.3)
Restrictions on partial hospitalization	0	a	a	a	a	a	a	a	a	(0.1)	(0.1)	(0.1)	(0.3)
Clarify partial hospitalization benefit	0	a	a	a	a	a	a	a	a	a	(0.1)	(0.1)	(0.3)
Eliminate physician markup of outpatient drugs	0	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(1.0)	(2.1)
Reduce payments for bad debt	0	(0.4)	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	(0.6)	(0.6)	(0.6)	(0.7)	(2.3)	(5.3)
Reduce payment rates by 30% for four lab tests	0	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.5)	(1.2)
National payment limit for P&O	0	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.2)	(0.5)	(1.3)
Eliminate certain HPSA bonus payments	0	a	a	a	a	a	a	a	a	a	a	(0.2)	(0.4)
48 month coverage of immunosuppressive drugs	0	a	a	a	a	a	a	a	a	a	a	a	0.2
Medicare+Choice													
Eliminate BBRA slowdown of phase-in of risk adjus	0	0	(0.2)	(0.2)	(0.1)	a	0	0	0	0	0	(0.5)	(0.5)
Shift timing of M+C payment from Oct 2002 to Sep	0	0	3.9	(3.9)	0	0	0	0	0	0	0	0	0
Interaction with changes in FFS spending	0	0	(0.3)	(0.6)	(0.9)	(1.5)	(1.5)	(1.8)	(2.1)	(2.5)	(2.8)	(3.2)	(14.0)
Subtotals													
Subtotal, Gross Mandatory Medicare Outlays	0	(0.8)	2.1	(6.9)	(4.5)	(6.0)	(6.4)	(7.1)	(7.7)	(8.5)	(9.2)	(16.1)	(54.9)
Offsetting Receipts (Premiums /b)	0	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0	1.1	2.0	6.3
Subtotal, Net Medicare Outlays	0	(0.6)	2.5	(6.5)	(4.0)	(5.4)	(5.7)	(6.3)	(6.9)	(7.5)	(8.2)	(14.1)	(48.6)

P

CBO Estimate of Effect of Medicare Provisions in President's Budget for 2001 on Mandatory Spending

8/18/2000

In billions of dollars, by fiscal year

P

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001- 2005	2001- 2010
Memoranda													
Premiums (dollars per month, by calendar year)													
Premiums: Current Law	45.50	49.30	53.20	58.60	64.20	69.70	74.70	79.40	84.20	89.70	95.10		
President's Budget													
Part B	45.50	48.90	52.60	57.80	63.20	68.40	73.30	77.90	82.50	87.80	93.00		
Part D (drug benefit)	#N/A	#N/A	#N/A	24.10	24.90	32.30	33.50	40.10	41.70	48.20	50.90		
Status of Hospital Insurance Trust Fund													
HI Trust Fund Income (billions of dollars)													
Receipts (mostly payroll taxes)	146.9	152.9	160.7	167.8	175.3	184.2	192.6	201.6	210.6	220.6	231.0		
Special transfers from general fund	0.0	15.4	12.6	0.0	0.0	0.0	26.0	47.0	57.0	61.0	80.0		
Interest	<u>10.8</u>	<u>12.7</u>	<u>15.1</u>	<u>17.4</u>	<u>19.4</u>	<u>21.3</u>	<u>23.8</u>	<u>27.7</u>	<u>32.7</u>	<u>38.3</u>	<u>44.5</u>		
Total Income	157.7	180.9	188.4	185.2	194.6	205.6	242.5	276.3	300.3	319.8	355.5		
HI Trust Fund Outlays													
HI Trust Fund Surplus (Income minus Outlays)	24.6	40.5	42.2	34.6	34.2	33.6	66.7	85.7	97.0	102.6	123.6		
HI Trust Fund End-of-Year Balance	163.0	203.5	243.7	276.2	310.4	344.0	407.6	493.4	590.4	693.0	816.6		
Surplus without special transfers													
Surplus without special transfers	24.6	24.7	28.4	32.8	32.2	31.4	37.9	34.0	32.2	30.0	27.4		
End-of-year balance without special transfers	163.0	187.7	216.1	248.9	281.0	312.5	350.4	384.4	416.6	446.6	474.0		

Notes:

- a. Costs or savings of less than \$50 million.
- b. Premiums are offsetting receipts (an offset to outlays). A positive value is equivalent to an increase in outlays.

BBRA = Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999

CPI = Consumer price index for urban consumers

DME = Durable medical equipment

EPO = Erythropoietin

ESI = Employer-sponsored insurance

FFS = Fee-for-service

HPSA = Health professional shortage area

MB = Market basket (input price index for hospital services)

MSP = Medicare as secondary payer

M+C = Medicare+Choice

PEN = Parenteral and enteral nutrition

PPO = Preferred provider organization

PPS = Prospective payment system

P&O = Prosthetics and orthotics

TEFRA = Tax Equity and Fiscal Responsibility Act of 1982 (facilities are paid on a reasonable cost basis)

CBO TESTIMONY

Statement of
Dan L. Crippen
Director
Congressional Budget Office

on
The President's Proposal for Medicare Reform

before the
Committee on Finance
United States Senate

July 22, 1999

NOTICE

This statement is not available for public release until it is delivered at 2:00 p.m. (EDT), Thursday, July 22, 1999.

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the President's recommended changes to the Medicare program. Those recommendations build on several of the major Medicare provisions in the President's budget proposal for fiscal year 2000. They also reflect some of the ideas generated by the Bipartisan Commission on the Future of Medicare, which completed its work in March. In addition, the President's proposal takes into account the growing concerns that some groups of health care providers have about the effects of the Balanced Budget Act of 1997 on Medicare payments.

Key features of the President's proposal include adding a prescription drug benefit to Medicare, making broad changes to the traditional fee-for-service program, converting the Medicare+Choice program into a competitive defined benefit program, and transferring revenues from the general fund to Medicare. The proposal lacks specificity in several important areas, however. That vagueness limits the Congressional Budget Office's (CBO's) ability to estimate the costs of some parts of the proposal and makes the estimates that CBO has been able to produce more uncertain.

My testimony today describes the major provisions of the President's proposal as outlined in the July 2, 1999, report from the Domestic Policy Council. It then discusses CBO's analysis of those provisions and provides cost estimates where feasible.

OVERVIEW OF THE ESTIMATE

CBO estimates that the President's proposal would increase outlays for Medicare and Medicaid by \$111.1 billion over the 2000-2009 period (see Table 1). By comparison, the Administration estimates the 10-year cost of the proposal at \$45.7 billion. In CBO's view, outlays for the prescription drug benefit would be \$168.2 billion, offset in part by \$57.1 billion in savings from fee-for-service changes and from greater price competition among managed care plans (see Table 2). More than one-quarter of the net increase in federal spending would occur in the Medicaid program, including new spending for prescription drugs that would be paid for entirely by the federal government.

TABLE 1.
TEN-YEAR ESTIMATES OF THE PRESIDENT'S MEDICARE PROPOSAL (In billions of dollars)

	Administration	CBO
Benefit Payments^a		
Prescription drug benefit	118.8	168.2
Changes to fee-for-service Medicare	-64.2	-48.2
Competitive defined benefit ^b	<u>-8.9</u>	<u>-8.9</u>
Subtotal	45.7	111.1
Transfers from the General Fund	<u>327.7</u>	<u>327.7</u>
Total	373.4	438.8

SOURCES: Congressional Budget Office (based on the July 1999 baseline) and Office of Management and Budget.

a. Includes effect on Medicaid.

b. Administration's estimate.

TABLE 2.
ESTIMATED COST OF THE PRESIDENT'S MEDICARE PROPOSAL (By fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total, 2000- 2004	Total, 2000- 2009
Prescription Drug Benefit												
Medicare outlays	0	0	14.1	20.9	26.4	29.9	34.6	38.3	44.3	48.8	61.3	257.3
Medicaid outlays	0	0	0.8	1.6	3.0	4.6	5.1	5.4	5.8	6.2	5.3	32.4
Part D premium receipts	<u>0</u>	<u>0</u>	<u>-7.1</u>	<u>-9.9</u>	<u>-12.5</u>	<u>-14.1</u>	<u>-16.3</u>	<u>-17.9</u>	<u>-20.8</u>	<u>-22.8</u>	<u>-29.5</u>	<u>-121.5</u>
Subtotal	0	0	7.8	12.6	16.8	20.5	23.3	25.8	29.3	32.2	37.2	168.2
Changes to Fee-for-Service Medicare												
Adjustments to providers' payments	0.4	1.7	0.9	-1.1	-2.3	-3.3	-4.3	-5.5	-6.8	-8.1	-0.3	-28.3
Adjustments to beneficiaries' cost sharing	0	0	-0.1	-0.3	-0.4	-0.6	-0.7	-0.9	-1.0	-1.2	-0.9	-5.3
New options for paying providers	0	-0.2	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.2	-3.5
HMO and Medicaid interactions	a	0.4	0.1	-0.5	-0.9	-1.6	-1.9	-2.7	-3.6	-4.5	-0.8	-15.1
Part B premium interaction	<u>-0.1</u>	<u>-0.2</u>	<u>-0.1</u>	<u>0.1</u>	<u>0.3</u>	<u>0.5</u>	<u>0.6</u>	<u>0.8</u>	<u>1.0</u>	<u>1.2</u>	<u>-0.1</u>	<u>4.0</u>
Subtotal	0.4	1.7	0.5	-2.1	-3.8	-5.4	-6.7	-8.8	-10.8	-13.1	-3.3	-48.2
Competitive Defined												

Competitive Defined Benefit ^b	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>-0.4</u>	<u>-1.0</u>	<u>-1.5</u>	<u>-1.8</u>	<u>-2.0</u>	<u>-2.2</u>	<u>-0.4</u>	<u>-8.9</u>
Total	0.4	1.7	8.3	10.5	12.6	14.1	15.1	15.2	16.4	16.8	33.5	111.1
Medicare	0.4	1.6	7.5	8.9	9.7	9.5	10.1	9.8	10.7	10.7	28.1	78.9
Medicaid	a	a	0.8	1.6	3.0	4.6	5.0	5.4	5.7	6.1	5.4	32.2

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: Numbers may not add up to totals because of rounding.

a. Less than \$50 million.

b. Administration's estimate.

PRESCRIPTION DRUG BENEFIT

The President's proposal would create a voluntary outpatient prescription drug benefit under a new Part D of Medicare. The benefit would begin in 2002 and would be fully phased in by 2008. The benefit would pay half of the cost of prescription drugs (up to a specified cap) and would be financed by premium payments from enrollees and general revenues. Taking cost sharing and premiums into account, the average enrollee would pay about 75 percent of the cost of covered drugs up to the cap.

Description of the Proposal

In 2002, all Medicare enrollees would have a one-time opportunity to purchase the new benefit. In later years, enrollees would be permitted to choose the Part D option only when they first became eligible for Medicare, with two exceptions: beneficiaries whose primary coverage was employer sponsored would have a one-time opportunity to enroll after retirement (or after the retirement or death of the working spouse), and beneficiaries with employer-sponsored retiree health plans would have a one-time option to enroll if their former employer dropped prescription drug coverage for all retirees.

The new drug benefit would be administered by a pharmaceutical benefit management company (PBM) in each geographic area, selected through competitive bidding. All Part D enrollees would gain from the below-retail prices that PBMs can typically negotiate. The benefit would include no deductible and would generally pay 50 percent of an enrollee's prescription drug costs, up to an annual cap per enrollee. That cap would be set at \$1,000 in 2002 and would gradually rise to \$2,500 in 2008. Thus, in 2008, a beneficiary who purchased \$5,000 in prescription drugs would receive the maximum reimbursement of \$2,500. That beneficiary would also pay \$634.80 in Part D premiums that year. After 2008, the cap would be indexed to annual changes in the consumer price index (CPI). Assuming that the cost of prescription drugs continued to rise more rapidly than the CPI, the real value of the benefit cap would shrink, thereby eroding the benefit.

Low-income participants would receive subsidies through the Medicaid program. Medicaid would pay both the premiums and the cost-sharing expenses, at the usual federal/state matching rate, for participants who were also fully eligible for Medicaid (so-called dual-eligibles) or who had income below the poverty line. The federal government would pay all of the premiums and cost-sharing expenses for other Part D enrollees with income less than 135 percent of the poverty line and part of the premiums for Part D enrollees with income between 135 percent and 150 percent of the poverty line (see Table 3).

TABLE 3.
GOVERNMENT SUBSIDIES FOR DRUG COSTS UNDER THE PRESIDENT'S PROPOSAL (In percent)

Benefit Status	Percentage of Costs Covered by Government Payments	
	Part D Costs ^a	Costs Above the Part D Cap
Eligible for Full Medicaid Benefits	100	100
Eligible for Partial Medicaid Benefits or Not Eligible		
Income less than 100 percent of poverty level	100	0
Income between 100 percent and 135 percent of poverty level	100	0
Income between 135 percent and 150 percent of poverty level	25-50	0
Income more than 150 percent of poverty level	25	0

SOURCE: Congressional Budget Office.

NOTE: Includes government payments for drug costs in effect under current law as well as proposed new government payments.

a. Premiums and coinsurance.

Eligibility for those subsidies would be determined by state Medicaid agencies. Neither the federal nor the state governments would be liable for covering any drug expenses above the Part D benefit cap for low-income beneficiaries who were not fully eligible for Medicaid.

The President's proposal also includes an incentive that is intended to retain employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if their retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage (for enrollees who opted for the Part D benefit).

Medicare now pays for a limited list of drugs provided on an outpatient basis. Those drugs would continue to be covered under Part B. Consequently, their costs would not be included in the cap on Part D benefits.

CBO's Estimate

CBO estimates that the new Part D provisions would add a total of \$168 billion to federal costs through 2009. (By comparison, the Administration's estimate of Part D costs is about \$119 billion.) CBO estimates that Medicare outlays (net of premium receipts) would be \$136 billion, and federal outlays for Medicaid would be \$32 billion (see Table 4). States would also face additional Medicaid costs--totaling some \$12 billion through 2009. CBO estimates that the premium for Part D would start at \$25.20 a month in 2002 and rise to \$52.90 in 2008 when the program was fully phased in (see Table 5).

TABLE 4.
ESTIMATED COST OF THE PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT (By fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total, 2000- 2004	Total, 2000- 2009
Medicare												
Benefits	0	0	13.0	19.3	24.4	27.7	32.1	35.5	41.0	45.2	56.6	238.1
Part D premium receipts	0	0	-7.1	-9.9	-12.5	-14.1	-16.3	-17.9	-20.8	-22.8	-29.5	-121.5
Subsidy to health plans for retirees	<u>0</u>	<u>0</u>	<u>1.1</u>	<u>1.6</u>	<u>2.0</u>	<u>2.2</u>	<u>2.6</u>	<u>2.8</u>	<u>3.3</u>	<u>3.6</u>	<u>4.7</u>	<u>19.2</u>
Net outlays	0	0	7.0	11.0	13.8	15.9	18.3	20.4	23.5	26.0	31.9	135.8
Medicaid (Federal)												
Part D benefits and premiums	0	0	0.6	1.3	2.4	3.8	4.2	4.7	5.1	5.6	4.3	27.7
Part A/B benefits and premiums	<u>0</u>	<u>0</u>	<u>0.2</u>	<u>0.2</u>	<u>0.5</u>	<u>0.9</u>	<u>0.8</u>	<u>0.8</u>	<u>0.7</u>	<u>0.6</u>	<u>1.0</u>	<u>4.7</u>
Net outlays	0	0	0.8	1.6	3.0	4.6	5.1	5.4	5.8	6.2	5.3	32.4
Net Effect on Federal Spending	0	0	7.8	12.6	16.8	20.5	23.3	25.8	29.3	32.2	37.2	168.2
Memorandum:												
Medicaid (Federal)												
Net outlays at usual federal/state match rate	0	0	0.6	0.9	1.5	2.3	2.4	2.6	2.7	2.8	2.9	15.8
Net outlays at 100 percent federal match rate	0	0	0.2	0.7	1.5	2.3	2.6	2.8	3.1	3.4	2.4	16.6
Medicaid (State)												
Part D benefits and premiums	0	0	0.3	0.5	0.7	1.1	1.2	1.4	1.5	1.7	1.5	8.4
Part A/B benefits and premiums	<u>0</u>	<u>0</u>	<u>0.1</u>	<u>0.2</u>	<u>0.4</u>	<u>0.7</u>	<u>0.6</u>	<u>0.6</u>	<u>0.5</u>	<u>0.5</u>	<u>0.7</u>	<u>3.6</u>
Net outlays	0	0	0.4	0.7	1.1	1.8	1.8	2.0	2.0	2.1	2.2	11.9

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: Numbers may not add up to totals because of rounding.

TABLE 5.
ESTIMATED MEDICARE COST PER PARTICIPANT OF THE PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT (By calendar year, in dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Monthly Part D Premium	n.a.	n.a.	25.20	26.30	34.70	36.70	43.10	45.40	52.90	55.50
Cap on Benefits	n.a.	n.a.	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,565
Percentage of Participants over Cap	n.a.	n.a.	36	39	30	32	26	29	25	26
Average Benefit per Participant	n.a.	n.a.	599	619	825	857	1,049	1,089	1,277	1,345
Average Out-of-Pocket Expense per Participant ^a	1,652	1,835	1,506	1,688	1,714	1,919	1,988	2,208	2,304	2,533
Memorandum:										
Monthly Part B Premium										
Under current law	49.50	53.90	58.00	64.10	70.70	76.80	80.90	88.20	94.60	101.20
Under the proposal	49.60	54.50	58.20	63.90	70.10	75.80	79.60	86.40	92.50	98.80

SOURCE: Congressional Budget Office based on the July 1999 baseline.

NOTE: n.a. = not applicable.

a. Average out-of-pocket expense before reimbursement by medigap, employer-sponsored insurance, or Medicaid.

CBO's cost estimate assumes that most people who are enrolled in Part B of Medicare would also enroll in Part D. But some of those who have employee-sponsored drug coverage for retirees would keep that coverage rather than enroll in the new program. CBO assumes that such people account for about 20 percent of Part B enrollees. In addition, about 7 percent of those eligible for benefits under Part B do not actually enroll. CBO assumes that they would also not enroll in Part D. Under those assumptions, about 31 million people would enroll in Part D in 2002, representing approximately 80 percent of total Medicare enrollment.

In 2002, about 36 percent of participants would have drug expenses exceeding the \$1,000 cap on Part D benefits. By 2008, when the benefit cap would be \$2,500, about 25 percent of participants would have expenditures exceeding the cap. Part D benefits paid per participant would average about \$600 in 2002, rising to around \$1,280 in 2008.

CBO is estimating higher costs for the Part D benefit than the Administration. Both CBO and the Administration base their estimates of future drug spending on patterns reported in Medicare's Current Beneficiary Survey, and both adjust the amounts reported by noninstitutionalized people by approximately the same factor to account for underreporting. However, CBO's estimate also attempts to account for spending on prescription drugs by residents of nursing homes. The estimates also differ in their assumptions about the rate of growth in enrollees' spending on prescription drugs. The latest projections of national health expenditures indicate that the recent rapid rates of growth in drug spending will slow sharply over the next few years. CBO, however, assumes that the slowdown will not occur as rapidly as those projections suggest.

Other Issues

Estimating the cost of a service not now covered by Medicare is inherently more difficult than estimating the cost of a change in the way a current service is paid for. The cost of the President's proposal for covering prescription drugs is uncertain because many design aspects of the new benefit have not yet been fully specified.

Nature and Value of the Benefit. Per capita spending for prescription drugs has been growing at double-digit rates in recent years--faster than other components of health care spending. Whether that rapid growth will continue, accelerate, or moderate is uncertain. A number of innovative drugs are likely to be cleared for marketing in the near future, which would tend to increase both the use and the average price of prescription drugs. However, a number of heavily used brand-name drugs are about to lose their patent protection (allowing entry of generic substitutes), which would tend to reduce prices. Hence, projections of the rate of growth in drug use and prices are highly uncertain even in the absence of changes in insurance coverage. For this estimate, CBO assumes that recent growth trends will continue for several years and then moderate somewhat.

Another area of uncertainty is the extent to which the coverage provided under the President's proposal would increase drug utilization by enrollees. Half of Medicare enrollees already have coverage for prescription drugs (typically through a retiree health plan or Medicaid) that is at least as generous as the coverage offered under the President's plan. For the other half, the new Part D coverage would increase drug utilization by up to 25 percent, CBO estimates.

Part D is designed to ensure that most enrollees would receive some benefit. However, because of the cap on benefits, it would not protect enrollees with drug-dependent chronic conditions from very large out-of-pocket expenses. Although the benefit cap would reduce Medicare's exposure to increases in prescription drug costs, it would also limit the value of the benefit to people who are especially vulnerable to those costs. Alternatively, insurance that provided no first-dollar coverage but limited an enrollee's out-of-pocket costs would be less likely to cause increased utilization and more likely to protect enrollees from catastrophic expenses. Under such an alternative, however, fewer enrollees would expect to benefit.

Effectiveness of the PBMs. The President proposes to administer the drug benefit through private-sector PBMs, which private health plans commonly use to negotiate price discounts and control utilization. A single PBM, selected through competitive bidding, would administer the benefit in each geographic area. CBO's cost estimate assumes that those PBMs would reduce costs below the level that an uninsured retail purchaser would face by about 12.5 percent--savings that are smaller than PBMs now generate for large, tightly managed health plans. That estimate could change, however, as details of the proposal's design emerge.

PBMs produce savings for private health plans in four main ways. First, they negotiate discounts with pharmacies that agree to participate in their networks. Second, they obtain rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. (A formulary is a list of drugs preferred by the plan's sponsor, in part on the basis of their lower prices.) Third, PBMs use mail-order pharmacies, which are often better able than retail pharmacies to save money. Mail-order pharmacies are likely to have lower average operating costs, and they can substitute generic or other lower-cost drugs for the ones prescribed. Finally, PBMs establish differential copayment requirements that encourage beneficiaries to select lower-priced options such as generic, preferred formulary, or mail-order drugs. Some PBMs also use management techniques such as on-line utilization review and prior approval to evaluate care and encourage the most cost-effective treatment practices.

It is uncertain whether the PBMs chosen to administer the Part D benefit under the President's proposal would have as much freedom to use those cost-saving techniques as they have in aggressive private insurance plans. For example, the proposal specifies that PBMs would have to set dispensing fees high enough to ensure participation by most retail pharmacies, which could reduce their ability to negotiate substantial discounts from pharmacies. The proposal also specifies that beneficiaries would be guaranteed access to off-formulary drugs when medically necessary, reducing PBMs' ability to negotiate

rebates from manufacturers. Further, the proposal would limit their ability to encourage beneficiaries to choose lower-cost drugs through differential copayments. Although PBMs would not be prohibited from charging differential copayments, those copayments could not exceed 50 percent. Some private drug plans require enrollees to pay the full difference between the cost of a brand-name drug and its generic equivalent (if one exists) unless the prescribing physician specifically states that the brand-name drug is medically necessary. Such an approach would apparently not be permitted in the Part D program.

Indeed, how much incentive PBMs would have to generate savings under the program is uncertain. The President's proposal envisions competitive bidding to select the PBM for each geographic area, but it is unclear what financial risks, if any, the winning PBM would bear beyond the costs of processing claims. The proposal indicates that contractual incentives (such as performance bonuses) might be used to encourage PBMs to focus more aggressively on generating savings, but those mechanisms have not yet been specified. Nor is it clear how savings would be measured. Actual savings could disappear, even while nominal discount and rebate rates were unchanged, if the prices against which discounts and rebates were calculated rose as a consequence of the new benefit.

Program Participation. CBO's estimate assumes that everyone who participates in the Part B program would also participate in Part D, with one exception: most people who have drug coverage through retiree health plans would remain with those plans. Those assumptions are quite speculative, however, and participation rates might well be lower or higher.

As noted above, employers would receive federal payments equal to 67 percent of the Part D premium subsidy for eligible retirees if they retained (or instituted) prescription drug coverage at least as good as the new Part D benefit. That subsidy payment, together with the tax deductibility of their health plan costs, would help induce employers to keep full drug coverage in their retiree health plans rather than eliminate it or wrap their plans' benefits around the new Part D package. (Employers with a wraparound plan would require Medicare to be the primary payer for prescription drugs, with the employer's plan serving as a supplement.) For their part, most retirees in employer-sponsored plans would probably prefer to continue with those plans rather than Medicare Part D, for two reasons. First, they would generally pay a lower premium for equivalent drug coverage in a retiree health plan than in Part D because employers typically pay more than 50 percent of the benefit costs. Second, retiree health plans usually provide much more generous drug coverage than Part D would, and getting all drug benefits through the retiree plan would avoid the problems associated with coordinating benefits. Nevertheless, CBO assumes that about one-quarter of Medicare enrollees who now have drug coverage through a retiree health plan would enroll in Part D because some employers would eliminate their drug coverage altogether.

The benefits provided under Part D would be very limited because of the 50 percent coinsurance rate and the benefit cap. Moreover, through their premium payments, enrollees would pay half of whatever benefits were paid out. Consequently, the federal subsidy under Part D would amount to less than one-quarter of enrollees' drug costs, on average. Despite those limitations, Part D would offer a more generous drug benefit package than standard medigap plans do, and at a lower premium. As a result, the three medigap plans that now offer drug coverage would no longer be competitive and might ultimately be replaced by a plan that supplemented the coverage offered under Part D.

Because of the one-time option to enroll and the 50 percent subsidy of premium costs, CBO expects that all Part B enrollees with medigap coverage or with no supplementary coverage would choose to enroll in Part D. People receiving Medicaid benefits under the proposal would also enroll in Part D because states would be required to cover their drug costs if they applied.

Effects on Medicaid Costs. As Table 4 showed, the President's proposal would increase Medicaid's costs for drugs and other benefits--substantially in the case of federal costs and less sharply in the case of state costs. Although Medicaid would no longer have to pay all drug costs for Medicare beneficiaries who now receive full Medicaid benefits, those savings would be more than offset by additional Medicaid spending on behalf of other Medicare beneficiaries.

Part D would pay for a portion of the drug costs that Medicaid now pays for Medicare enrollees at all

income levels who are also fully eligible for Medicaid. That expansion of Medicare's role would lower both federal and state Medicaid costs by shifting them to Medicare. But the savings would be partly offset by the Part D premiums that Medicaid would have to pay for those dual-eligibles.

Low-income Medicare beneficiaries who are ineligible for full Medicaid benefits would also become eligible for assistance to pay for their Part D premiums and cost sharing. As noted above, the federal and state governments would share those costs for people with income below the poverty level. But the federal government alone would pay the premiums and cost sharing for beneficiaries with income between 100 percent and 135 percent of the poverty level, without any financial participation by the states. It would also pay a portion of the Part D premium costs for beneficiaries with income between 135 percent and 150 percent of the poverty level. To receive those benefits, however, eligible Medicare beneficiaries would have to enroll in the Medicaid program, and not all of them would choose to do so.

Medicaid spending would rise by more than the cost of the new prescription drug benefit. Many low-income Medicare beneficiaries who are ineligible for full Medicaid benefits are eligible to have their Medicare premiums paid by Medicaid--and in some cases, their cost sharing as well. A sizable number of them do not enroll in Medicaid, however. In 1998, an estimated 1.3 million Medicare beneficiaries with income below the poverty level were eligible for partial or full Medicaid assistance but did not participate in the program.⁽¹⁾ A further 1.3 million beneficiaries with income between 100 percent and 120 percent of the poverty level who were eligible to have their Part B premiums paid by Medicaid did not participate. The availability of a free drug benefit, made possible by enrollment in Medicaid, would attract more Medicare beneficiaries into the Medicaid program, boosting spending for other Medicaid benefits as well as for prescription drugs. Participation in Medicaid by beneficiaries who are eligible for full Medicaid benefits might also increase somewhat, although their participation is already greater than that of other groups.

For this estimate, CBO assumes that the price of drugs under the proposed Medicare benefit for Medicaid beneficiaries would be similar to the price that Medicaid obtains under current law (including Medicaid rebates). If Medicare received deeper discounts and rebates, Medicaid costs would be lower. Conversely, if Medicare paid more for drugs, Medicaid costs would be higher.

FEE-FOR-SERVICE CHANGES

The President is proposing a host of policy changes for the traditional fee-for-service sector of Medicare. Those changes include modifying the pricing rules that govern payments to providers, changing beneficiaries' cost-sharing requirements, and permitting the Secretary of Health and Human Services (HHS) to supplement certain administered pricing systems with new options for paying providers. Together, those fee-for-service policies would reduce federal spending by an estimated \$48 billion through 2009. (The Administration's estimate of fee-for-service savings is \$64 billion.)

Adjustments to Providers' Payments

The proposal would increase payments to certain providers beginning in 2000, redirect some payments to hospitals that serve a large number of low-income patients, and reduce the growth in payment rates for many services after 2002. The net effect of those provisions would be to lower payments to fee-for-service providers by an estimated \$28 billion through 2009.

To relieve some of the financial pressures that the Balanced Budget Act of 1997 imposed on providers, the President proposes changing how certain provisions of that act are put into effect. Those changes can be made administratively and do not require legislative action. They include allowing more rural hospitals to be reclassified as urban hospitals to receive higher payment rates; delaying collection of past overpayments from home health agencies; increasing payments to certain hospitals for outpatient services; and delaying the expansion of the "transfer policy," which would have reduced some hospital payments. CBO does not "score" those changes in administrative policy because they do not involve a change in law, even though they would increase baseline spending. CBO will take the policy changes

that the Administration implements into account in its next baseline projection of Medicare spending under current law.

The President is also proposing to establish a "quality assurance fund" to pay for future legislative changes that would increase payments to certain providers beginning in 2002. But his proposal does not specify policies to accomplish that increase in spending. Thus, CBO's estimate of the net impact of policies to adjust provider payments includes the Administration's figure of \$7.4 billion, although that amount could change depending on specific legislative proposals.

Another proposed change is designed to help hospitals with large caseloads of indigent patients. The portion of payment rates for Medicare's managed care plans that reflects disproportionate share hospital (DSH) payments would be eliminated. (DSH payments are additional payments that Medicare makes when beneficiaries receive inpatient care from hospitals that serve a large number of low-income patients.) Instead, Medicare would make DSH payments directly to those hospitals when they provide inpatient care to patients enrolled in managed care plans. CBO estimates that redirecting DSH payments in that way would have a negligible effect on Medicare spending.

The President's proposal would also significantly reduce payments to certain providers in the longer term by continuing payment reductions imposed by the Balanced Budget Act beyond 2002. For many services, the act holds the increases in payment rates below the rate of inflation through 2002, with full adjustment for inflation resuming in 2003. The proposal would hold those increases below inflation through 2009 for hospital inpatient care, ambulance services, prosthetics and orthotics, hospice care, ambulatory surgical center care, durable medical equipment, clinical laboratory services, and parenteral and enteral nutrition. In addition, the proposal would extend a 2.1 percent reduction in payment rates to hospitals for capital-related costs through 2009.

Adjustments to Beneficiaries' Cost Sharing

Other provisions of the President's proposal would require fee-for-service enrollees to pay more for Medicare services by indexing the Part B deductible to inflation and instituting coinsurance for clinical laboratory services. At the same time, the proposal would eliminate coinsurance for certain preventive services. The net effect of those changes would be to reduce Medicare outlays by an estimated \$5 billion through 2009.

The deductible for Part B has been \$100 since 1991. Under the proposal, it would increase by the percentage change in the consumer price index beginning in 2002.

Medicare currently pays 100 percent of the approved fee for clinical laboratory services. Except for preventive services, the proposal would impose the standard Part B deductible and 20 percent coinsurance requirement on clinical laboratory services beginning in 2002.

By contrast, the President's proposal would waive both the deductible and the 20 percent coinsurance requirement for certain preventive services. That change would substantially increase the use of those services and would also increase demand for other services--particularly those furnished by physicians. However, much of the increase in spending for physicians' services would be offset by other policies that would reduce updates to the physician fee schedule.

New Payment Options

Under current law, Medicare has limited authority to contract selectively, establish payment rates through competition or negotiation, or use many of the other techniques that private plans employ to manage spending and quality of care. The President's proposal would give the Secretary of HHS authority to adopt some of those techniques, including contracting with preferred provider organizations (PPOs), negotiating discounted rates for specific services, and developing systems to manage the care (in a fee-for-service setting) of certain diseases or beneficiaries.

The potential savings from those changes are substantial. The Administration estimates that granting the Secretary additional flexibility to manage pricing and utilization would save \$25 billion over the next decade. However, major impediments stand in the way of realizing those savings. Thus, CBO estimates that the provisions would reduce payments to fee-for-service providers by less than \$4 billion.

Providers often contract at a discount with private plans in the expectation of treating more patients. In turn, plans often require patients to pay substantially higher prices when they use providers who have not granted price concessions. As currently structured, Medicare's fee-for-service program does not have the tools that private plans use to extract such price concessions. About 85 percent of Medicare enrollees are indifferent to changes in cost-sharing requirements because they are insulated from those requirements by supplemental coverage--through employer-sponsored insurance, medigap insurance, a Medicare managed care plan, or Medicaid. Moreover, the 15 percent of enrollees without supplemental coverage might have little incentive to switch to providers granting discounts. Under current law, Medicare's coinsurance mechanism for Part B services would limit their savings to no more than 20 percent of the discount. Consequently, it is not clear that the proposal for Medicare to contract with existing PPOs is feasible. Given the limited potential for increasing their market share, PPOs would probably not be willing to offer substantial discounts to Medicare.

Other contracting options proposed by the President might yield more savings to the extent that they promoted the efficient delivery of health services by high-quality providers. Those options include the Centers of Excellence proposal (which bundles payments for facilities and physicians for certain inpatient services, including treatment of heart conditions and joint surgeries); the global payment proposal (which bundles payments for facilities, professionals, and suppliers for all care provided at a specific site); and the proposal to coordinate care for certain high-cost conditions. Those proposals account for about two-thirds of CBO's estimate of savings from granting the Secretary additional flexibility.

The President also proposes that the Secretary be given authority to contract selectively for some Part B services other than those furnished by physicians. That proposal would expand on a demonstration project in Polk County, Florida, in which Medicare is selecting suppliers through a competitive bidding process for five types of products: oxygen equipment and supplies, hospital beds and accessories, enteral nutrition products and supplies, urological supplies, and surgical dressings. The demonstration, which is still in the development stage, has produced bids between 13 percent and 31 percent lower than Medicare's existing fee schedule for those supplies. However, negotiations with bidders--including some who were unsuccessful in the first round--are continuing, and CBO anticipates that some of those potential savings will erode over time.

Moreover, the Secretary faces substantial challenges in expanding competitive bidding to other areas and other services. In recent years, providers and elected representatives have voiced significant opposition in communities in which the Secretary has tried to reduce spending through competitive bidding and selective contracting. CBO assumes that such opposition will continue to be a substantial impediment to expanding the competitive bidding model and realizing the potential savings from selective contracting.

COMPETITIVE DEFINED BENEFIT PROGRAM

The President proposes to give Medicare's managed care plans various incentives to compete on the basis of price as well as quality. This "competitive defined benefit" proposal is extremely complex, and many of its details are unclear. CBO has not yet estimated the costs of the proposal and, for the present, is using the Administration's estimate as a placeholder. That estimate indicates that Medicare would save \$8.9 billion through 2009.

Description of the Proposal

Beginning in 2003, the premium that Medicare beneficiaries paid would depend on the plan they chose. Beneficiaries who stayed in the traditional fee-for-service sector would pay the regular Part B premium.

But those who chose cheaper plans would generally pay a lower premium, and those who opted for more costly plans would pay the extra costs of that choice. Managed care plans would submit a premium offer for the standard Medicare benefit package, enabling beneficiaries to make price comparisons among plans.

The actual amount that beneficiaries paid would depend on the difference between the premium of the plan they chose and a reference price, which would be 96 percent of the average costs in the fee-for-service sector. If they enrolled in a plan with a premium below the reference price, their Part B premium would be reduced by 75 percent of the difference (with the remaining 25 percent accruing to the government). What they would pay if they chose a plan with a premium above the reference price is less clear. But the proposal indicates that the federal payment would be capped at the amount the government would pay a plan whose premium was equal to the reference price. Consequently, beneficiaries would apparently pay the full difference between the cost of the plan and the reference price, which is more than the difference between the cost of the plan and the average fee-for-service cost. That requirement would mean that enrollees in plans with a premium just below the average fee-for-service cost--say, at 98 percent of that cost--would have to pay more than the Part B premium. More generally, beneficiaries choosing plans with premiums above the reference price could face hefty additional premium payments.

Suppose, for example, that average costs in the fee-for-service sector were \$7,000 and the annual Part B premium for beneficiaries enrolled in that sector was \$840, or \$70 a month. The reference price would be 96 percent of \$7,000, or \$6,720. Beneficiaries choosing a less expensive plan with a premium, say, of \$6,300 would have their Part B premium reduced by 75 percent of the difference (\$420), or \$315. So their annual premium would be \$525, or \$43.75 a month. The government would capture 25 percent of \$420, or \$105, and would pay a total of \$5,775, which is the difference between the plan's premium and the beneficiary's payment.

In this example, if beneficiaries enrolled in plans with premiums at or below 80 percent of average fee-for-service costs, or \$5,600, their contributions would be reduced to zero and the government would pay the full premium. By contrast, if they chose a plan with a premium at 110 percent of fee-for-service costs, or \$7,700, their Part B premium would be \$1,820 (about \$152 a month)--more than double the fee-for-service premium. The government's contribution would be capped at \$5,880, the difference between the reference price and the fee-for-service premium. That premium structure would give beneficiaries strong incentives to choose lower-cost plans if any were available in their market.

Managed care plans would receive their full premiums for the defined benefit package regardless of whether those premiums were above or below the reference price. But given the price structure that beneficiaries would face, plans would have a strong incentive to keep their premium offers below the reference price; otherwise, they would have difficulty competing against the traditional fee-for-service program. In markets with multiple plans, they would also have an incentive to compete against other managed care plans on the basis of price.

The government would adjust the payments to health plans to reflect differences in risk and geographic differences in cost. Plans enrolling beneficiaries with greater-than-average health risks and plans in high-cost areas would receive higher federal payments than other plans. Payments by beneficiaries would not be adjusted for those factors, however. Rather, beneficiaries would face premiums calculated as if all plans had average risk selection and were in average-cost areas.

Risk adjustment has been considered a perennial problem for the Medicare program, and full implementation of Medicare's new risk-adjustment system is not expected until after 2003. Geographic adjustments have also been problematic. Under this proposal, the government would increase payments to managed care plans in high-cost areas to reflect "full local costs." Payments in low-cost areas would not be reduced, however, below the levels mandated by the Balanced Budget Act.

Although the basic benefit would nominally be standardized, plans would be given the flexibility to reduce or eliminate Medicare's cost sharing as long as the value of cost-sharing reductions did not exceed 10 percent of the value of the benefit package. Plans could offer additional benefits for a separate

premium. Both of those options would give them other means to compete against the fee-for-service sector and other managed care plans.

Other Issues

Promoting greater price competition in the Medicare program could broaden the options available to beneficiaries and slow the rate of growth of Medicare spending. Those outcomes are by no means guaranteed, however. Much would depend on the details of the proposal, many of which are unclear, and on the responses of beneficiaries and health plans to new incentives, which are uncertain. Moreover, the potential for effective price competition among health plans varies from market to market across the country. Experience with the Medicare risk program to date suggests that competition is more likely to occur in large, high-cost urban markets, although the nature of the geographic payment adjustment could modify that conclusion.

Under current law, there is effectively no price competition among Medicare+Choice plans. Medicare uses an administered pricing system to set its payments to plans, and plans are not permitted to offer cash rebates or other financial incentives to encourage enrollment. Instead, they have incentives to increase optional benefits rather than to reduce costs. Consequently, even though beneficiaries gain if they enroll in managed care plans that are more efficient than the fee-for-service sector, Medicare does not. Moreover, beneficiaries who might prefer less generous benefits for a lower price do not have that option. The President's proposal would remove that bias and allow both beneficiaries and the Medicare program to benefit from less costly choices.

The proposal goes only part way, however, toward establishing a competitive model for Medicare. The traditional fee-for-service sector--in which the large majority of Medicare beneficiaries are still enrolled--would not be required to compete fully on price with the private plans participating in Medicare. The special status of the fee-for-service sector could result in lower savings than other competitive strategies might yield.

Unlike a competitive model in which the reference premium was based on some average premium in the market, beneficiaries would not have to make payments in addition to the Medicare premium to remain in the fee-for-service sector. Moreover, the presence of low-cost plans would not affect the savings that other plans could offer beneficiaries, because the reference premium would be unaffected. Nonetheless, because the Medicare premium would be based on fee-for-service costs, if those costs rose faster than the costs of managed care plans, those plans might be able to offer beneficiaries significant premium discounts relative to the fee-for-service sector.

How plans would structure their offerings in this new type of competitive environment is very uncertain. It would depend on how responsive beneficiaries proved to be to changes in premiums. To date, what has attracted beneficiaries to switch from fee-for-service Medicare to managed care plans has been the lower cost-sharing requirements and additional benefits (especially coverage of prescription drugs) that those plans offer. With prescription drug coverage available in the fee-for-service sector under the President's proposal, managed care plans would lose one of their major comparative advantages, potentially slowing the growth of enrollment in managed care. How far reduced premiums might offset those effects is unknown. But if medigap premiums continue to rise as rapidly as they have in recent years and employers continue to limit their retirees' health benefits, plans with lower premiums that also offered reduced cost sharing would become increasingly attractive.

The mechanics for bidding and setting prices in the President's proposal are unclear, which adds to the difficulty of predicting the effects of the proposal on plans' behavior. With regard to the hold-harmless provision, for example, the proposal states that the increases in payments to low-cost areas included in the Balanced Budget Act would be maintained, but it does not provide details. The nature of the geographic adjustments for high-cost areas is also unclear. The effects on payments to plans would vary considerably if those adjustments reflected only price differences or if they also included differences in utilization patterns.

In particular, if the geographic adjustment took both price and utilization effects into account, efficient

plans in high-cost areas might be able to use high payment rates to subsidize packages of supplemental benefits as well as offer the basic Medicare package for a low or zero premium. (Although plans would be required to charge a separate premium for supplemental benefits, there is no indication that such a premium would have to be anything more than nominal.) Under those circumstances, plans in high-cost markets would be able to compete against the fee-for-service sector and each other on both price and covered benefits. Such competition would be less possible in low-cost markets. Thus, although the proposal intends to reduce the current disparities in benefits among Medicare+Choice plans across the country, that outcome would be quite uncertain.

Another novel factor affecting plans' behavior is the new prescription drug option. The proposal would require plans to offer Part D benefits to beneficiaries who chose to participate in the program. Plans would receive a premium payment from Medicare for those beneficiaries, and they could also offer a separate prescription drug benefit for an additional premium. The premium offers that plans would make would apparently cover both Part B and Part D benefits for those choosing to enroll in Part D. Plans might compete by offering Part D coverage at a low rate or offering additional drug coverage for only a modest extra premium.

Given all of the uncertainties about how the proposal would be implemented and how plans and enrollees might respond, predicting future enrollment trends in Medicare's managed care plans is hazardous. In the short term, the growth of managed care enrollment might slow or even reverse if beneficiaries saw less need to switch from the fee-for-service sector once a prescription drug benefit was available. Even if beneficiaries proved to be highly responsive to reductions in the Part B premium and plans chose to compete on that basis, the effects of the proposal on the growth of Medicare spending are quite speculative. Would there be one-time savings--possibly stretched out over several years--as beneficiaries in fee for service shifted to managed care plans, essentially accelerating the current enrollment trend? Or would competitive forces be strong enough to foster efficiencies throughout the system, slowing the growth of costs in the future? That debate has been going on in the private sector since the mid-1990s, when many enrollees in employer-sponsored plans began to shift from fee-for-service to more tightly managed plans. It has yet to be resolved.

TRANSFERS FROM THE GENERAL FUND

The President is proposing to augment Medicare's financing by making transfers from the general fund of the U.S. Treasury to the program's trust funds. Consistent with the policy outlined in the President's budget for fiscal year 2000, CBO estimates that \$288 billion would be transferred from the general fund to the Hospital Insurance (HI) Trust Fund over the next decade. That transfer would delay by several years the projected date on which the HI trust fund will become insolvent by committing future general revenues to the program. It would do nothing to address the underlying rapid growth in spending for Medicare that will eventually outrun the revenues dedicated to the program.

An additional \$40 billion would be transferred from the general fund to the Supplementary Medical Insurance (SMI) Trust Fund to finance part of the cost of the new prescription drug benefit. (For administrative purposes, Medicare's spending for prescription drugs and beneficiaries' premiums for that benefit would be accounted for in the trust fund.) The transfer would not materially alter the financial status of the trust fund. SMI benefits are funded by premiums, which cover 25 percent of costs, and general revenue, which covers the rest. The statutory formula allows SMI to maintain a small reserve to cover unforeseen contingencies, but the trust fund does not build up substantial reserves. Thus, the additional transfer associated with the prescription drug benefit simply means that the government's costs will be paid for out of general revenues.

OTHER INITIATIVES

The President's proposal includes provisions outlined in his last two budgets to allow people under age 65 to buy into Medicare. Although the buy-in provisions have not changed significantly, other facets of

the President's proposal might alter the estimates that CBO made earlier this year of participation in the buy-in program and associated costs. The proposal also calls on the National Association of Insurance Commissioners (NAIC) and the Secretary of HHS to develop new supplemental insurance options to protect beneficiaries from catastrophic costs. Such options could fundamentally alter the market for private medigap plans, which supplement Medicare.

The buy-in would be open to two groups: people ages 62 to 64 who do not have access to employment-based health insurance, Medicaid, or other public coverage; and displaced workers age 55 or older who have lost their health coverage because of a job loss. The Administration's description of the provisions, including the estimates of the premiums that participants would pay, is essentially unchanged from the description in the President's budget. But the Medicare program itself would change significantly as a result of the other reforms that the Administration is proposing, especially the addition of a prescription drug benefit. The proposal does not address how the buy-in provisions would be modified by those changes or whether participants would be able to purchase prescription drug coverage. If prescription drugs were included in the benefit package, the buy-in premiums would probably be significantly higher than the Administration is suggesting, and problems of adverse selection in the buy-in program would be exacerbated.

The President's medigap provisions partly address a significant limitation in Medicare benefits--the absence of stop-loss coverage that would protect beneficiaries from catastrophic health expenses. Those provisions would mandate several actions, short of restructuring Medicare benefits.

First, the NAIC would be asked to develop a new medigap option that would limit out-of-pocket expenses and reduce, but not eliminate, beneficiaries' payments for deductibles and coinsurance. (The President's proposal assumes that prescription drug costs would not be covered by the new option.) Such a plan could provide important financial protection while maintaining some cost sharing, which would discourage unnecessary use of covered services. The medigap plans that are now available cover most of Medicare's cost-sharing requirements, and Medicare must bear the cost of the additional use of services induced by such coverage. If people who buy medigap insurance switched to the lower-cost, more basic coverage option, Medicare might reap significant savings.

Second, the Secretary of HHS would be authorized to review the standard medigap packages to determine whether changes should be made to their content or number. The Secretary would also report to the Congress on policy options for improving supplemental coverage for Medicare beneficiaries, including the possibility of having Medicare offer additional, optional coverage to limit out-of-pocket spending. A Medicare-sponsored supplemental plan would probably be extremely popular with beneficiaries, who might view it as more valuable than private insurance because it would be backed by the federal government. Such an insurance policy would severely limit the market for the slimmed-down medigap option that the NAIC is being asked to develop.

CONCLUSION

The President's proposal provides a framework for making significant changes to the Medicare program. It is intended to modernize Medicare's benefits, enable the federal government to become a more prudent purchaser of health services, and encourage price competition among health plans to slow the growth of Medicare spending in the longer term. CBO estimates that the President's Medicare reform plan would increase federal outlays by \$111 billion over the next decade.

The President proposes a new prescription drug benefit that would provide first-dollar coverage, with an annual limit of \$2,500 in 2008, when the benefit was fully phased in. Although most Medicare enrollees would receive some benefit, the proposal would not substantially protect those in poor health who incurred very large out-of-pocket expenses for prescription drugs.

The President proposes to pay for the federal share of the prescription drug benefit through transfers from the general fund. Those transfers are simply promises to pay future benefits with future tax dollars.

How burdensome that commitment might become depends on both the growth of future spending for prescription drugs and the growth of the economy over the coming decades.

The President proposes to extend some provisions of the Balanced Budget Act that limit payment updates beyond their 2002 expiration date. The President would also provide a small amount of additional funds to reduce the impact of the act's payment reductions through as-yet-unspecified legislation. On balance, payments to providers would be reduced from baseline levels, although those reductions would accrue only after 2002.

Reducing payment rates for fee-for-service providers would yield Medicare savings without contributing to the program's efficiency. But improving the efficiency of the fee-for-service sector is key to achieving short-term cost savings and longer-term reform. Fee for service is likely to remain the plan of choice for most Medicare enrollees over at least the next decade, even under the most favorable assumptions about the growth of enrollment in managed care plans. Successful adoption of the contracting and payment methods that private health plans use to manage their costs could establish the basis for a competitive fee-for-service sector. But recent efforts to test such methods have not found much acceptance among providers, and the President's proposal treads lightly on that issue.

The President's provisions for rationalizing cost-sharing requirements would modestly increase some of those requirements and lower others, without reducing their complexity. A more thorough reform might subject all Medicare-covered services to a single deductible and uniform coinsurance rates, at the same time placing an annual limit on the amount that enrollees paid in cost sharing for all covered services (including drugs if that benefit was added to the program).

The proposed competitive defined benefit would provide new opportunities for Medicare's managed care plans to compete on the basis of price as well as the generosity of benefits and the quality of service. Although the President's proposal would introduce elements of competition among health plans that could help slow the growth of Medicare spending in the longer term, it would fall short of a fully competitive program. By establishing the fee-for-service sector as the benchmark for defining Medicare benefits and setting premiums for health plans, it would blunt the incentives for efficiency. For that reason, CBO has reservations about the magnitude of savings that could be expected from the competitive defined benefit. CBO has not completed an estimate of that part of the proposal, but the modest savings predicted by the Administration may be reasonable.

The overall effect of the President's proposal is to increase Medicare spending, largely funded with general revenues. Although it would move toward a more competitive system, the proposal would do little to reform the traditional fee-for-service sector.

1. Ellen O'Brien, Diane Rowland, and Patricia Keenan, *Medicare and Medicaid for the Elderly and Disabled Poor* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 1999), p. 9.

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Outlays in Billions for Fiscal Years	2000	2001	2002	2003	2004	2006	2007	2008	2009	5-Year	10-Year	
Option: broC1 Voluntary Rx benefit under new Part D; 1-time only enrollment option; various premium subsidies Deductible, 20% coinsurance, stoploss No employer incentives; some expansion of Medicaid benefits Medicaid is primary payer for dual eligibles												
Deductible amount				500	547	599	653	711	770	835		
Stoploss amount				2000	2189	2396	2614	2843	3082	3341		
Medicare Benefits	0.0	0.0	0.0	35.2	53.9	60.2	65.0	72.2	80.1	88.5	89.1	455.0
Administration	0.0	0.0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.1	3.0
Part D Premiums (25%)	0.0	0.0	0.0	-9.5	-13.6	-15.2	-16.4	-18.2	-20.2	-22.3	-23.1	-115.4
Subsidy to ESI plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Medicare Outlays	0.0	0.0	0.4	26.1	40.6	45.3	48.9	54.4	60.3	66.6	67.1	342.6
Medicaid Outlays												
Part D Benefits/Premiums	0.0	0.0	0.0	1.8	3.2	4.4	5.0	5.5	6.0	6.8	5.0	32.4
Part A/B Benefits/Premiums	0.0	0.0	0.0	0.1	0.2	0.5	0.8	0.8	0.7	0.8	0.3	3.7
Net Medicaid Outlays	0.0	0.0	0.0	1.9	3.4	4.9	5.8	6.2	6.7	7.2	5.3	36.1
Net Effect on Federal Spending	0.0	0.0	0.4	28.0	44.0	50.2	54.8	60.8	67.0	73.7	72.4	378.7
Memorandum:												
Monthly Part D Premium	0.00	0.00	0.00	32.46	35.55	39.56	41.68	46.11	49.95	54.07		
Part D / Part B Participants				85%	84%	83%	83%	83%	83%	83%		
Medicare Benefits	0.0	0.0	0.0	35.2	53.9	60.2	65.0	72.2	80.1	88.5	89.1	455.0
Administration	0.0	0.0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.1	3.0
Part D Premiums (50%)	0.0	0.0	0.0	-19.0	-27.2	-30.4	-32.8	-36.4	-40.4	-44.6	-48.2	-230.7
Subsidy to ESI plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Medicare Outlays	0.0	0.0	0.4	16.8	27.0	30.2	32.6	36.2	40.1	44.3	44.0	227.3
Medicaid Outlays												
Part D Benefits/Premiums	0.0	0.0	0.0	2.5	4.6	6.4	7.3	8.0	8.8	9.7	7.0	47.2
Part A/B Benefits/Premiums	0.0	0.0	0.0	0.1	0.2	0.5	0.8	0.8	0.7	0.8	0.3	3.7
Net Medicaid Outlays	0.0	0.0	0.0	2.6	4.7	6.9	8.1	8.8	9.5	10.3	7.3	50.8
Net Effect on Federal Spending	0.0	0.0	0.4	19.2	31.8	37.1	40.6	44.9	49.8	54.5	51.3	278.1
Memorandum:												
Monthly Part D Premium	0.00	0.00	0.00	64.91	71.09	79.12	83.38	92.22	99.89	108.15		
Part D / Part B Participants				85%	84%	83%	83%	83%	83%	83%		
Medicare Benefits	0.0	0.0	0.0	34.6	53.0	59.3	64.1	71.2	79.0	87.2	87.7	448.5
Administration	0.0	0.0	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	1.1	3.0
Part D Premiums (75%)	0.0	0.0	0.0	-28.0	-40.2	-44.9	-48.5	-53.9	-59.7	-65.9	-68.2	-341.1
Subsidy to ESI plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Medicare Outlays	0.0	0.0	0.4	7.0	13.2	14.8	15.9	17.7	19.8	21.7	20.8	110.3
Medicaid Outlays												
Part D Benefits/Premiums	0.0	0.0	0.0	3.4	6.4	9.0	10.2	11.3	12.4	13.8	9.8	66.2
Part A/B Benefits/Premiums	0.0	0.0	0.0	0.1	0.2	0.5	0.8	0.8	0.7	0.8	0.3	3.7
Net Medicaid Outlays	0.0	0.0	0.0	3.5	6.5	9.5	11.0	12.0	13.1	14.2	10.0	89.9
Net Effect on Federal Spending	0.0	0.0	0.4	10.5	19.8	24.2	26.9	29.7	32.8	35.9	30.0	180.2
Memorandum:												
Monthly Part D Premium	0.00	0.00	0.00	108.08	117.68	130.19	137.20	151.83	164.17	177.68		
Part D / Part B Participants				75%	75%	75%	75%	75%	75%	75%		

SOURCE:

Congressional Budget Office (July 1999 baseline).
Estimates are preliminary and will change as proposal and estimating methods are refined.

10-Aug-99