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THE PRESIDENT HAS SEEN

6-1-99

Sperling  
Jennings  
Podesta

THE WHITE HOUSE

WASHINGTON

May 29, 1999

15%

→ How much over 10yr  
→ How much to 2020  
→ if we can, give to  
Tech cuts

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

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SUBJECT: Briefing Memorandum for Medicare Meeting

On Tuesday, you will have a Medicare meeting in which we will review key elements and several packages of reforms, seeking your guidance as we develop a plan. Our goals for this plan include: (1) significant dedication of the surplus for Medicare, which will extend the life of the Medicare Trust Fund as well as reduce debt; (2) serious modernization of Medicare, including making it more competitive; (3) substantial prescription drug benefit; and (4) sufficient savings to make our prescription drug benefit fiscally responsible. These goals conform to your principles for reform articulated at the AARP in February.

Below, we describe the major elements of reform, key parameters of a prescription drug benefit, and illustrative packages. Ultimately, your primary decisions about the Medicare plan will hinge on how the prescription drug benefit is designed and financed. Packages showing options for drug benefits and financing options are shown at the end of the memo.

KEY ELEMENTS

**Modernizing Traditional Medicare.** One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also unanimously agree that these policies are worth including in the plan. They save an estimated \$14 billion over 10 years.

**Competitive Managed Care Payments.** A more controversial issue is whether to allow competition to determine Medicare premiums and government payment rates. Premium support, the centerpiece of the Breaux-Thomas proposal, would set all Medicare premiums competitively, including that of the traditional program. Because it would result in a lower government contribution for traditional Medicare, the actuary projects that the traditional program premiums would rise by 10 to 20 percent, effectively driving people into managed care. Your advisors are recommending an option that is fundamentally different because it would protect the traditional Medicare premium, assuring that competition is based on choice, not financial coercion.

Although this option does not produce as much savings as does the Breaux-Thomas premium support model (\$10 versus \$50 billion over 10 years), it would be considered structural reform since it gives incentives to encourage beneficiaries to choose low-cost plans. There is a risk, however, that base Democrats will view it as a "voucher" or something akin to Breaux-Thomas and conservative Democrats and many Republicans may think that it does not go far enough. Regardless, all of your advisors are in favor of including this proposal.

Parlan  
cannot put  
in sheet?

**Income-Related Premium.** An income-related premium is a progressive form of increasing beneficiary contributions. You have supported this policy in the past (1992, 1993, and 1997) so long as it is designed well. All of your advisors recommend that it begin at \$80,000 for singles, \$100,000 for couples, which produces about \$25 billion over 10 years and affects about 2 million beneficiaries. Some are willing to go lower to avoid the use of surplus funding to help finance the drug package.

*Minister*

**Cost Sharing.** Changes can both make Medicare's cost sharing more rational and help fund the prescription drug benefit. The following is the list of options under review:

- Eliminate preventive cost sharing: Cost sharing can inhibit beneficiaries from using their new Medicare preventive benefits. Eliminate all cost sharing would cost \$3 billion over 10 years and is unanimously recommended by your advisors.
- Add lab 20% copay: Only lab and home health services do not have any copays, and most experts agree that a lab copay could decrease excess use (the typical 20% copay would be about \$5-10). It would save about \$9 billion over 10 years and is supported by your advisors.
- Change nursing home copay to 20% coinsurance: The nursing home benefit's current cost sharing structure is not rational. Beneficiaries pay nothing for the first 20 days, but then pay nearly \$100 per day (about 33%) for days 21-100. This proposal would apply a 20% copay (about \$60 per day) for all covered days. This helps sicker beneficiaries, but applies a new copay to short-term nursing home residents. While we aimed to make this cost neutral, it actually saves \$4 billion over 10 years. It is possible to lower the copayment to make it budget neutral.
- Index the Part B deductible to inflation: The \$100 Part B deductible has not been updated since the 1980s, and is lower than most private fee-for-service insurance plans. This proposal would simply index the current deductible to general inflation (by 2010, it would be \$135) and save about \$2 billion over 10 years. Most advisors recommend this, particularly if it eliminates the need for a home health copay. Some are willing to increase the deductible (to \$150) if it would avoid the need for surplus spending.
- Add \$5 home health copay. Most experts agree that a carefully designed home health copay can reduce excess use without harming beneficiaries. At the same time, home health users are among the most vulnerable (older, sicker); increasing this benefit's cost sharing has the appearance of being inconsistent with your long-term care initiative; and the new prospective payment system will reduce use without copays. Although a number of your advisors agree that this is good policy, they believe that it is not necessary in the context of the other beneficiary cost sharing proposals outlined above (saves \$7 billion over 10 years).

**Provider Payment Reductions.** Provider savings are difficult to find given (a) our FY 2000 budget used the limited options for the next few years; (b) the BBA of 1997 package relied heavily on providers savings; and (c) all major provider groups have launched a campaign not just against additional savings but in support of increased spending to offset the Balanced Budget Act in the near term. Even conservative Democrats like Senators Conrad, Moynihan, and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, and other providers. Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. If we conclude that administrative actions are inadequate, targeted legislative fixes could help avoid a negative response to your proposal. However, because of the limited availability of on budget surplus dollars in 2000, finding early-year savings to offset these costs would be extremely difficult. Your advisors believe that a credible Medicare reform plan, taking into account provider constraints, could achieve about \$40 billion over 10 years (more or less depending on the degree of fixes).

**PRESCRIPTION DRUG BENEFIT.** The part of your Medicare plan that will receive the most attention is its prescription drug benefit. The base Democrats will judge your plan in large part by how generous this benefit is. Many of them have signed onto the Kennedy-Rockefeller plan, which provides for 20 percent coinsurance up to a cap, and then provides 100 percent coverage after the beneficiary has spent \$4,200 on drugs. This bill costs over \$300 billion over 10 years. On the other hand, conservative Democrats are interested in the least costly benefit that can be validated, even minimally, as meaningful. The following table shows our major options.

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

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

All of your advisors support a policy in which we cover 50 percent of the costs of prescription drugs up to at least \$5,000. We believe that this will have a simple, clear message: if you choose to pay a modest premium, we will pay half of your prescription drug costs up to \$5,000. Another reason that your advisors support this is that every year, every beneficiary will see a benefit every time that they buy a prescription drug because there is no deductible. The two issues of difference among your advisors are how much the premium (and overall benefit) should be subsidized and whether or not there should be catastrophic coverage.

On the subsidy issue, the Medicare actuary has concluded that 50 percent is the minimum subsidy amount that is necessary to attract enough healthy beneficiaries to avoid adverse selection. Some of your advisors think that a 50 percent premium is the most that we should do because anything higher will create too large of an entitlement that will be too hard to restrain in the future. Other advisors feel, however, that unless the premium subsidy is closer to 67 percent (and under \$20 to start), the premium will be too high and the overall attractiveness of the plan could be hampered.

A second, major issue is whether the benefit is capped or covers catastrophic costs. Most policy experts believe that "true insurance" should not have caps and are concerned about capped options that leave the sickest beneficiaries unprotected. The Kennedy-Rockefeller bill, for this reason, includes catastrophic coverage. However, capped drug benefits have the advantage of constraining costs because the government's maximum spending growth is limited while the catastrophic coverage has the potential for more unconstrained growth in the out years.

**FINANCING GAP.** If all of the advisors' recommendations on key elements were adopted, there would be Medicare savings of about \$100 billion over 10 years. This is about \$30-90 billion below the cost of the drug benefits being considered. Options to fund this shortfall include one or more of the following:

- Making the drug benefit less generous. The level of the subsidy could be reduced from 67 to 50 percent, raising the premium by roughly \$10 per month. One could also reduce the benefits, but most of your advisors believe that further diminishment of the base drug coverage package would be unappealing to beneficiaries and their advocates.
- Increasing provider and/or beneficiary savings: Most of your advisors are loathe to consider additional provider and/or beneficiary savings for fear that it would undermine the political support for the package. However, some would argue that it might be advisable, at least as an initial positioning strategy, to increase these savings (primarily by maximizing the BBA extenders and minimizing the BBA fixes) to avoid using the surplus.
- Including an additional tobacco tax: Because the tobacco tax in our budget is unlikely to be used by the Congress, an additional tobacco tax may not be viewed as a credible financing source. It is also unpopular with the House Democratic leadership. However, the Senate Finance Committee may be more supportive of the tobacco tax than the surplus as a source of funding. A \$0.50 tax (on top of your budget's \$0.55 tax) would generate about \$45 billion in revenue from 2000-09.

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- Using the surplus: Using a portion of the surplus dedicated to Medicare solvency for prescription drugs could be justified given the tremendous drop in the Medicare baseline (\$240 billion over 10 years from 1998 to 1999). While there are credible arguments for using the surplus, it clearly has to be considered in the broader Social Security / surplus context. Some fear that without more progress on Social Security solvency, tapping any portion of the surplus for prescription drugs before the solvency of Social Security and Medicare has been addressed could strengthen the Republicans' argument for using the surplus to finance a large tax cut.

*No-Use  
Wants - tax cut  
to MC reform  
Bill*

**ILLUSTRATIVE PACKAGES.** On the following page, you will find illustrative options that show combinations of drug benefits and additional offsets. Every option includes our recommended "base policy" which reflects the preliminary recommendations of your advisors. It assumes that each drug benefit design has a zero deductible and a 50 percent copayment. The elements of the drug benefit options that affect its cost are: (1) the degree to which it is subsidized (and therefore what the premium would be) and (2) the level to which the benefit is capped or alternatively, whether it provides for any catastrophic protection. It is likely that we will use some version of these options to help focus our discussion with you during the Tuesday Medicare reform meeting.

<b>OPTION 1: No Additional Financing</b>	<b>OPTION 2: Additional Tobacco Tax</b>	<b>OPTION 3: Surplus</b>
<b>Base:</b>	<b>Base:</b>	<b>Base:</b>
Competition -10	Competition -10	Competition -10
Modernize Medicare -14	Modernize Medicare -14	Modernize Medicare -14
Income-Related Premium (\$80/100) -25	Income-Related Premium (\$80/100) -25	Income-Related Premium (\$80/100) -25
Cost Sharing	Cost Sharing	Cost Sharing
Preventive buy-down +3	Preventive buy-down +3	Preventive buy-down +3
Lab 20% coinsurance -9	Lab 20% coinsurance -9	Lab 20% coinsurance -9
Nursing home 20% -5	Nursing home 20% -5	Nursing home 20% -5
Indexing Deductible -1	Indexing Deductible -1	Indexing Deductible -1
Provider Savings -40	Provider Savings -40	Provider Savings -40
<b>Subtotal: -100</b>	<b>Subtotal: -100</b>	<b>Subtotal: -100</b>
<b>Additions:</b>	<b>Additions:</b>	<b>Additions:</b>
Income-Related Premium (\$60/90) -7	Tobacco Tax -45	Surplus -90
More Provider Cuts -7	Income-Related Premium (\$60/90) -7	
Raise Deductible to \$150 and index -10		
<b>Subtotal: -24</b>	<b>Subtotal: -52</b>	
<b>Drug Benefit:</b>	<b>Drug Benefit:</b>	<b>Drug Benefit:</b>
\$5,000 Limit +123 50% Premium: \$24/\$48*	\$5,000 Limit +164 67% Premium: \$16/\$32*	\$5,000 Limit +154 67% Premium: \$16/\$32*
	\$10,000 Limit +142 50% Premium: \$31/\$55*	\$10,000 Limit +189 67% Premium: \$21/\$36*
	No Dollar Limit +135 50% Premium: \$24/\$58*	No Dollar Limit +180 67% Premium: \$16/\$39*
State MOE -5	State MOE -5	State MOE -5
<b>TOTAL** -6</b>	<b>TOTAL** +7-22</b>	<b>TOTAL** -6-30</b>

\*Monthly premiums in 2002 and 2009. Part B premium is \$57 / \$95 in 2002 / 2009.

\*\* This amount is a necessary "cushion" pending final cost estimates. Drug estimates assume about \$5 billion in savings from state maintenance of effort.

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

# REVISED

OPTION 1: No Additional Financing	OPTION 2: Additional Tobacco Tax	OPTION 3: Surplus
<b>Base:</b>	<b>Base:</b>	<b>Base:</b>
Competition -10	Competition -10	Competition -10
Modernize Medicare -14	Modernize Medicare -14	Modernize Medicare -14
Income-Related	Income-Related	Income-Related
Premium (\$80/100) -25	Premium (\$80/100) -25	Premium (\$80/100) -25
Cost Sharing	Cost Sharing	Cost Sharing
Preventive buy-down +3	Preventive buy-down +3	Preventive buy-down +3
Lab 20% coinsurance -9	Lab 20% coinsurance -9	Lab 20% coinsurance -9
Nursing home 20% -5	Nursing home 20% -5	Nursing home 20% -5
Indexing Deductible -1	Indexing Deductible -1	Indexing Deductible -1
Provider Savings -40	Provider Savings -40	Provider Savings -40
<b>Subtotal: -100</b>	<b>Subtotal: -100</b> <i>was "10"</i>	<b>Subtotal: -100</b>
<b>Additions:</b>	<b>Additions:</b>	<b>Additions:</b>
Income-Related	Tobacco Tax -45	Surplus -90
Premium (\$60/90) -7	Income-Related	
More Provider Cuts -7	Premium (\$60/90) -7	
Raise Deductible to \$150 and index -10		
<b>Subtotal: -24</b>	<b>Subtotal: -52</b>	
<b>Drug Benefit:</b>	<b>Drug Benefit:</b>	<b>Drug Benefit:</b> <i>was "154"</i>
\$5,000 Limit +123 50% Premium: \$24/\$48*	\$5,000 Limit +164 67% Premium: \$16/\$32*	\$5,000 Limit +164 67% Premium: \$16/\$32*
	\$10,000 Limit +142 50% Premium: \$31/\$55*	\$10,000 Limit +189 67% Premium: \$21/\$36*
	No Dollar Limit +135 50% Premium: \$24/\$58*	No Dollar Limit +180 67% Premium: \$16/\$39*
State MOE -5	State MOE -5	State MOE -5
<b>TOTAL** -6</b>	<b>TOTAL** +7-22</b>	<b>TOTAL** -6-31</b>

\*Monthly premiums in 2002 and 2009. Part B premium is \$57 / \$95 in 2002 / 2009.  
 \*\* This amount is a necessary "cushion" pending final cost estimates.  
 Drug estimates assume about \$5 billion in savings from state maintenance of effort.  
 NOTE: The policy with the \$10,000 cap is more expensive than the catastrophic option only because it offers more generous coverage in the early years (00 to 06); the catastrophic option is more expensive in the out-years.

# **MEDICARE PRINCIPALS' MEETING**

## **DRAFT: MAY 24, 1999**

### **I. Budget Neutral / Paid-For Options**

- Medicare Buy-In
- Medicare "Medigap" Option (note: actuaries still assessing budget implications\_
- Medicare Board
- Coordinated Care for Dual Eligibles

### **II. Base Package and Additions**

# I. BUDGET-NEUTRAL OPTIONS

## MEDICARE “MEDIGAP” OPTION: BACKGROUND

- **Limited benefit causes beneficiaries to purchase supplemental insurance:** Medicare’s benefits are less generous than 4 of 5 private employers’ since it lacks prescription drug coverage, has a high hospital deductible, and has no catastrophic cost protection. For this reason, about 85 percent of Medicare beneficiaries have additional sources of health insurance coverage. Some beneficiaries – one fourth of Medicare managed care enrollees and one-seventh of those in retiree health plans – also buy Medigap, resulting in duplication of coverage.
- **Expensive and declining:** The typical Medigap premium for a 65-year old is from \$80 to \$100 per month (without drug coverage). It can be much higher in certain areas or for older or sicker people. The proportion of beneficiaries covered by Medigap declined by one-fourth in the last decade. Although more affordable, retiree health coverage has also been declining, and premiums paid for by beneficiaries has been increasing.
- **Supplemental insurance is inefficient:** Individual supplemental insurance can have mark-ups of 30 percent, compared to 10 percent for employer insurance and 2 percent for Medicare. Moreover, most beneficiaries choose Medigap plans with first-dollar coverage, resulting in higher Medicare use and costs than beneficiaries in retiree plans which usually have some type of cost sharing, at least for out-of-network providers.

## MEDICARE MEDIGAP OPTION

- **New Medicare Option:** Optional Medicare policy that:
  - Eliminates hospital deductible and copays, since hospitalization is rarely optional
  - Reduces most cost sharing from 20 percent to nominal levels (e.g., \$10 per physician visit, \$15 per nursing home day); and
  - Caps out-of-pocket cost sharing liability at \$2,500 per year.

**Premium:** \$50 to \$60 per month according to preliminary estimates

**Enrollment:** When they become eligible for Medicare; when they transition out of other forms of supplemental coverage (private Medigap, retiree coverage).

**Private Medigap:** Allowed to offer same plan in addition to existing options (which may have to be modified to reflect cost sharing changes and other reforms).

- **Pros:**
  - Affordable, rationale alternative to expensive, inefficient Medigap
  - Mitigates against cost sharing increases proposed in plan
  - Viewed as structural reform – one of major points for premium support advocates and economists. Moves towards private sector benefits package
- **Cons:**
  - Opposed by insurers and conservatives as a government take-over
  - Complicated policy that may not be worth the political pain

# MEDICARE BOARD

- **Commission Proposal: Medicare Board.** Stemming from IRS-like concerns about HCFA, the Commission proposed to create a new Board outside of Medicare to administer Medicare. One of the major reasons for the Board to remove any conflict of interest that HCFA has in running both the traditional plan and private plans, and to assure objectivity in oversight. Appointed by the President and confirmed by the Senate, the members would represent health care providers, beneficiaries, and working taxpayers.
- **Functions of the Board:**
  - Certify plans and negotiates over covered benefits and premiums
  - Operate annual open enrollment process, including information distribution
  - Enforce quality and program integrity requirements (including traditional Medicare)
- **HCFA Role:** Overall program management would be transferred to the Board. HCFA would remain responsible for the traditional program only. It would be treated as any other private health plan, and would have to develop a reserve fund and rely only on capitation payments to provide services.

# ALTERNATIVE TO THE MEDICARE BOARD

- **Modernized Medicare Administration:**
  - New public/private boards to (1) improve coverage policy; (2) advise on management; and (3) review and strengthen beneficiary education efforts.
  - Contracting reform to improve ability to use private sector for certain activities
  - Other policies like improving hiring policies and revamping the regional offices
- **Pros:**
  - Improves rather than replaces management; targets areas for private involvement
  - Does not create duplicate, unaccountable bureaucracy that could increase costs
- **Cons:**
  - May not go far enough Republicans and conservative Democrats
  - Already in the budget; could be perceived as dressing up existing action

# COORDINATED CARE FOR DUAL ELIGIBLES

- **Medicare-Medicaid dual eligibles:** About 4 million beneficiaries are fully eligible for both programs (another 2 million receive Medicaid coverage of premiums and, in some cases, cost sharing). Despite representing only 16 percent of beneficiaries, they account for about 30 percent of Medicare and 35 percent of Medicaid costs.
- **Duplicative and uncoordinated care:** Since dual eligibles typically are sicker, older, and lower income, the problems with having different sources of coverage are more serious.
  - **Complicates clinical and management coordination:** Typically, Medicare and Medicaid rely on different providers to authorize health care service use. Medicare providers have no systematic way to know that a beneficiary is enrolled in Medicaid.
  - **Different financial incentives and Medicare “maximization”:** Medicare and Medicaid differ in reimbursement and coverage policies, especially related to managed care. Also, some state explicitly design programs to cost shift to Medicare.
  - **Separate pools of money not being managed in ways that are best for beneficiaries and best for the program.**

# OPTIONS FOR COORDINATING CARE FOR DUAL ELIGIBLES

- **Identification and assessment of dual eligibles:** Medicaid would notify Medicare when it enrolls a dual eligible. Newly-enrolled dual eligibles would be sent information on their coverage and could receive a Medicare clinical assessment. This assessment, designed by geriatricians, would aid in the early detection of high risk beneficiaries who could benefit from care coordination. Can we do more?
- **Demonstration of care coordination models:** Medicare would fund a demonstration of three models to pay for care coordination: (a) a managed care option, where Medicare and Medicaid pay capitation amounts to a single plan for coordination of care; (b) a “gatekeeper” model, where a primary care provider authorizes Medicare and Medicaid services; and (c) a coordinator model, where a provider suggests but does not authorize services. The Federal government would coordinate with the states, but providers would be the grantees.
- **Pros:**
  - Tests models to improve care and allocate resources more efficiently
  - Responds to Congressional proposals to give states Medicare managed care payments – can argue that coordination does not require capitation
- **Cons:**
  - Depending on scope of our proposals, it could look modest relative to Congressional proposals that give states more Medicare money
  - States would object to data requirements, focus on Medicare rather than Medicaid

## II. BASE PACKAGE

(NOTE: All estimates preliminary / subject to change. 2000-2009 estimates in billions)

<b>DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE *</b>	<b>-\$350</b>
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### OPTIONS:

<b>Prescription Drug Benefit</b>	<b>+\$160</b>
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Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start  
\$19 Premium in 2002 (67%), Covers 50% of Costs up to \$5,000

<b>Modernizing Traditional Medicare</b>	<b>-\$14</b>
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<b>Additional Provider Savings (modified BBA extenders)</b>	<b>-\$45</b>
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<b>Income-Related Premium (\$80/100,000)</b>	<b>-\$25</b>
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### **Cost Sharing**

Eliminating Prevention Cost Sharing	<b>+\$3</b>
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Add Lab Coinsurance (20%)	<b>-\$4</b>
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Rationalize Nursing Home Copay	<b>-\$0</b>
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### **Budget Neutral / Paid for Policies**

Medicare Buy-In, Medigap Option, Dual Eligible Coordination, etc.

<b>TOTAL:</b>	<b>+\$70</b>
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\* Does not offset costs

## ADDITIONS (Incremental costs of polices in billions)

SAVINGS OPTIONS (Billions)	10-Yr	SPENDING OPTIONS	10-Yr
State and Employer Maintenance of Effort on Prescription Drugs	-\$10-20	Balanced Budget Act Fixes	+\$10-25
Income-Related Premium for Prescription Drug Benefit	-\$5	Drug Benefit in 2001 (rather than 2002)	[getting]
Managed Care Competition	-\$10	Drug Benefit in 2002, Catastrophic Coverage in 2006	[getting]
Full Extender Provider Savings	-\$12	Drug Benefit in 2001, Catastrophic Coverage in 2006	[getting]
More Aggressive Income-Related Premium (\$50/75,000)	-\$15	Drug Benefit in 2002, Catastrophic Coverage in 2002	[getting]
\$5 Home Health Copay (60 visits)	-\$7		
Indexing Part B Deductible	-\$5		
25% of Medicare's Surplus	-\$85		
33% of Medicare's Surplus	-\$115		
\$0.45 Tobacco Tax (above budget)	-\$41		
Other Revenues			

# OPTION 1: FULLY FINANCED BY SAVINGS

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	-\$350
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## OPTIONS:

Prescription Drug Benefit	+\$115-20??
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Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start  
*\$29 Premium in 2002 (50%), Covers 50% of Costs up to \$5,000*  
*State and employer maintenance of effort*

### Cost Sharing

Eliminating Prevention Cost Sharing	+\$3
Add Lab Coinsurance (20%)	-\$4
Rationalize Nursing Home Copay	-\$0
Add Capped Home Health Copay	-\$7

Modernizing Traditional Medicare	-\$14
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Managed Care Competition	-\$10
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Additional Provider Savings (modified BBA extenders)	-\$45
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Income-Related Premium (\$80/100,000)	-\$25
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Budget Neutral / Paid for Policies (see base package)	
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TOTAL:	+\$x
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## OPTION 2: ADDITIONAL NON-SURPLUS FINANCING

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	-\$350
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### OPTIONS:

Prescription Drug Benefit	+\$160
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Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start \$19 Premium in 2002 (67%), Covers 50% of Costs up to \$5,000, **20% after State and employer maintenance of effort; income-related premium**

### Cost Sharing

Eliminating Prevention Cost Sharing	+\$3
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Add Lab Coinsurance (20%)	-\$4
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Rationalize Nursing Home Copay	-\$0
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Add Capped Home Health Copay	-\$7
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Modernizing Traditional Medicare	-\$14
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Managed Care Competition	-\$10
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Additional Provider Savings (full BBA extenders)	-\$57
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Income-Related Premium (\$80/100,000)	-\$25
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Tobacco Tax: \$0.45 on top of budget	-\$41
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TOTAL:

+\$0 BILLION

## OPTION 3: SURPLUS FINANCING

<b>DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE</b>	<b>-\$260</b>
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**OPTIONS:**

<b>Prescription Drug Benefit</b>	<b>+\$180</b>
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Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, **2001 start**  
 \$19 Premium in 2002 (67%), Covers 50% of Costs up to \$5,000, **20% after**  
*State and employer maintenance of effort; income-related premium*

**Cost Sharing**

Eliminating Prevention Cost Sharing	+\$3
Add Lab Coinsurance (20%)	-\$4
Rationalize Nursing Home Copay	-\$0

<b>Modernizing Traditional Medicare</b>	<b>-\$14</b>
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<b>Managed Care Competition</b>	<b>-\$10</b>
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Additional Provider Savings (modified BBA extenders)	-\$45
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<b>Balanced Budget Act Fixes</b>	<b>+\$10</b>
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Income-Related Premium (\$80/100,000)	-\$25
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<b>25 Percent of Medicare's Dedicated Surplus</b>	<b>-\$90</b>
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<b>TOTAL:</b>	<b>-\$5</b>
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# **MEDICARE PRINCIPALS' MEETING**

## **MAY 25, 1999**

### **I. FOLLOW-UP FROM MAY 24 MEETING:**

- **Home Health Information**
- **Base Options and Additions**

### **II. PACKAGES AND DRUG OPTIONS**

- **Tobacco Tax and Additional Provider / Beneficiary Contributions**
- **Surplus**
- **Options for Reducing Out-Year Drug Costs**

### **III. MEDICARE BOARD**

# BASE PACKAGE

(NOTE: All estimates preliminary / subject to change. 2000-2009 estimates in billions)

<b>DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE *</b>	<b>-\$350</b>
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## OPTIONS:

<b>Prescription Drug Benefit</b>	<b>+\$165</b>
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Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start  
\$16 Premium in 2002 (67%), Covers 50% of Costs up to \$5,000

<b>Modernizing Traditional Medicare</b>	<b>-\$14</b>
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<b>Additional Provider Savings (modified BBA extenders)</b>	<b>-\$45</b>
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<b>Income-Related Premium (\$80/100,000)</b>	<b>-\$25</b>
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### Cost Sharing

Eliminating Prevention Cost Sharing	+\$2
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Add Lab Coinsurance (20%)	-\$6
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Rationalize Nursing Home Copay	-\$0
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### Budget Neutral / Paid for Policies

Medicare Buy-In, Medigap Option, Dual Eligible Coordination, etc.

<b>TOTAL:</b>	<b>+\$77</b>
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*\*Does not offset costs*

## ADDITIONS (Incremental costs of polices in billions)

SAVINGS OPTIONS (Billions)	10-Yr	SPENDING OPTIONS	10-Yr
State and Employer Maintenance of Effort on Prescription Drugs*	-\$10-20	Balanced Budget Act Fixes	+\$10-25
Income-Related Premium for Prescription Drug Benefit*	-\$5	Drug Benefit in 2001 (rather than 2002)	+\$10
Managed Care Competition	-\$10	Drug Benefit in 2002, Catastrophic Coverage in 2006	+\$30
Full Extender Provider Savings	-\$12	Drug Benefit in 2001, Catastrophic Coverage in 2006	+\$40
More Aggressive Income-Related Premium (\$50/75,000)	-\$15	Drug Benefit in 2002, Catastrophic Coverage in 2002	+\$50
\$5 Home Health Copay (60 visits)*	-\$7		
Indexing Part B Deductible *	-\$5		
25% of Medicare's Surplus	-\$90		
33% of Medicare's Surplus	-\$115		
\$0.45 Tobacco Tax (above budget)	-\$41		
Other Revenues			

\*DRAFT / NOT FROM ACTUARIES.

## OPTION 1: TOBACCO TAX AND ADDITIONAL REDUCTIONS

(Trustees' 1999 Baseline, Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
<b>PRESCRIPTION DRUG BENEFIT</b>												
\$0 ded., 50% to \$5000 (no catastrophic)	0.0	0.0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	38.5	164.1
State MOE (Rough)	0.0	0.0	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-1.7	-5.0
Employer MOE (Rough)	0.0	0.0	-0.4	-0.5	-0.6	-0.8	-0.9	-0.9	-1.0	-1.1	-1.5	-6.2
<b>NET DRUG COST</b>	<b>0.0</b>	<b>0.0</b>	<b>6.5</b>	<b>13.2</b>	<b>15.5</b>	<b>18.6</b>	<b>21.5</b>	<b>23.8</b>	<b>25.8</b>	<b>27.9</b>	<b>35.2</b>	<b>152.9</b>
<i>Premiums (67% subsidy)</i>	0.0	\$0	\$16	\$17	\$21	\$24	\$27	\$29	\$30	\$32		
<b>COMPETITION</b>												
Managed Care	0.0	0.0	0.0	0.0	0.0	-0.7	-1.5	-2.0	-2.5	-2.8	0.0	-9.5
Modernizing Traditional Program	0.0	-0.6	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.6	-3.9	-14.0
<b>TRADITIONAL PROGRAM SAVINGS</b>												
Modified BBA Extenders	0.0	0.0	0.0	-1.3	-2.7	-4.3	-6.0	-8.1	-10.4	-12.8	-4.0	-45.5
<b>INCOME-RELATED PREMIUM</b>												
\$80/100,000	0.0	-0.4	-2.9	-2.6	-2.5	-2.7	-2.9	-3.2	-3.5	-3.8	-8.4	-24.5
<b>COST SHARING</b>												
Adding 20% Lab Copay	0.0	0.0	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-1.7	-5.6
Eliminating Preventive Copays	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.6	1.9
Rationalizing Nursing Home Copays	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>**Home Health or Index Deductible</b>	0.0	0.0	-0.6	-0.7	-0.8	-0.9	-0.9	-1.0	-1.0	-1.1	-2.1	-7.0
<b>MEDICARE SAVINGS</b>	<b>0.0</b>	<b>-2.2</b>	<b>-6.4</b>	<b>-7.9</b>	<b>-9.7</b>	<b>-12.8</b>	<b>-15.7</b>	<b>-19.3</b>	<b>-22.8</b>	<b>-26.5</b>	<b>-26.3</b>	<b>-123.4</b>
<b>TOBACCO TAX (+\$0.45)</b>	<b>-4.8</b>	<b>-3.9</b>	<b>-3.7</b>	<b>-3.7</b>	<b>-4.1</b>	<b>-4.2</b>	<b>-4.3</b>	<b>-4.3</b>	<b>-4.2</b>	<b>-4.1</b>	<b>-20.3</b>	<b>-41.4</b>
<b>SAVINGS</b>	<b>-4.8</b>	<b>-6.2</b>	<b>-10.1</b>	<b>-11.6</b>	<b>-13.8</b>	<b>-17.0</b>	<b>-20.0</b>	<b>-23.6</b>	<b>-27.0</b>	<b>-30.6</b>	<b>-46.5</b>	<b>-164.7</b>
<b>TOTAL</b>	<b>-4.8</b>	<b>-6.2</b>	<b>-3.7</b>	<b>1.6</b>	<b>1.7</b>	<b>1.6</b>	<b>1.6</b>	<b>0.2</b>	<b>-1.2</b>	<b>-2.7</b>	<b>-11.3</b>	<b>-11.8</b>
<b>SURPLUS FOR TRUST FUND SOLVENCY</b>	<b>18.3</b>	<b>20.3</b>	<b>28.1</b>	<b>26.9</b>	<b>30.4</b>	<b>33.4</b>	<b>40.8</b>	<b>45.9</b>	<b>50.3</b>	<b>55.6</b>	<b>124.0</b>	<b>349.9</b>

NOTES: Cost sharing estimates, MOE estimates rough estimates/ not done by actuaries. BBA extenders reduced pro-rata; cost sharing postponed to 2002 to correspond to drug benefit start.

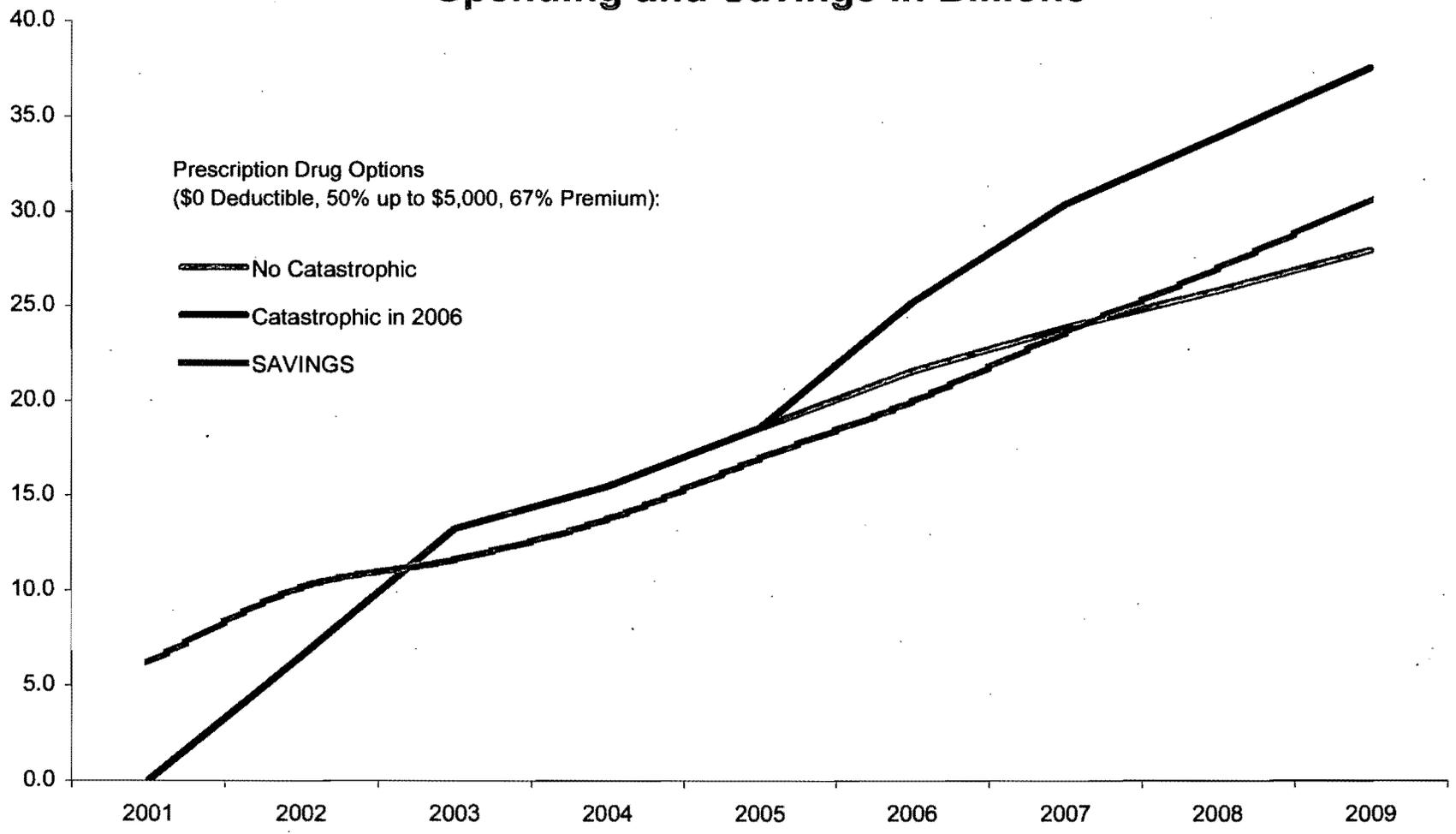
## OPTION 2: SURPLUS

(Trustees' 1999 Baseline, Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
<b>PRESCRIPTION DRUG BENEFIT</b>												
\$0 ded., 50% to \$5000, 20% beyond	0.0	0.0	7.4	14.3	16.7	19.9	26.6	32.0	35.6	39.3	38.5	191.9
State MOE (Rough)	0.0	0.0	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-1.7	-5.0
Employer MOE (Rough)	0.0	0.0	-0.4	-0.5	-0.6	-0.8	-0.9	-0.9	-1.0	-1.1	-1.5	-6.2
<b>NET DRUG COST</b>	<b>0.0</b>	<b>0.0</b>	<b>6.5</b>	<b>13.2</b>	<b>15.5</b>	<b>18.6</b>	<b>25.2</b>	<b>30.4</b>	<b>33.9</b>	<b>37.5</b>	<b>35.2</b>	<b>180.7</b>
<i>Premiums (67% subsidy)</i>	0.0	\$0	\$16	\$17	\$21	\$24	\$35	\$24	\$40	\$44		
<b>COMPETITION</b>												
Managed Care	0.0	0.0	0.0	0.0	0.0	-0.7	-1.5	-2.0	-2.5	-2.8	0.0	-9.5
Modernizing Traditional Program	0.0	-0.6	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.6	-3.9	-14.0
<b>TRADITIONAL PROGRAM SAVINGS</b>												
Modified BBA Extenders	0.0	0.0	0.0	-1.3	-2.7	-4.3	-6.0	-8.1	-10.4	-12.8	-4.0	-45.5
<b>**BBA Fixes: Admin and legislative</b>	0.5	1.0	1.5	1.5	1.5	1.5	1.0	0.5	0.5	0.5	6.0	10.0
<b>INCOME-RELATED PREMIUM</b>												
\$80/100,000	0.0	-0.4	-2.9	-2.6	-2.5	-2.7	-2.9	-3.2	-3.5	-3.8	-8.4	-24.5
<b>COST SHARING</b>												
Adding 20% Lab Copay	0.0	0.0	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-1.7	-5.6
Eliminating Preventive Copays	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.6	1.9
Rationalizing Nursing Home Copays	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>MEDICARE SAVINGS</b>	<b>0.5</b>	<b>-1.2</b>	<b>-4.3</b>	<b>-5.7</b>	<b>-7.4</b>	<b>-10.3</b>	<b>-13.8</b>	<b>-17.8</b>	<b>-21.3</b>	<b>-24.9</b>	<b>-18.2</b>	<b>-106.3</b>
<b>SURPLUS (Savings Minus Drug Costs)</b>	<b>0.0</b>	<b>0.0</b>	<b>-2.2</b>	<b>-7.5</b>	<b>-8.1</b>	<b>-8.2</b>	<b>-11.4</b>	<b>-12.6</b>	<b>-12.5</b>	<b>-12.6</b>	<b>-17.8</b>	<b>-75.1</b>
<b>TOTAL SAVINGS</b>	<b>0.5</b>	<b>-1.2</b>	<b>-6.5</b>	<b>-13.2</b>	<b>-15.5</b>	<b>-18.6</b>	<b>-25.2</b>	<b>-30.4</b>	<b>-33.9</b>	<b>-37.5</b>	<b>-35.9</b>	<b>-181.5</b>
<b>TOTAL</b>	<b>0.5</b>	<b>-1.2</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>-0.7</b>	<b>-0.7</b>
<b>SURPLUS FOR TRUST FUND SOLVENCY</b>												
Drug Surplus as % of Original	18.3	20.3	28.1	26.9	30.4	33.4	40.8	45.9	50.3	55.6	124.0	349.9
			8%	28%	27%	25%	28%	27%	25%	23%		

NOTES: Cost sharing estimates, MOE estimates rough estimates/ not done by actuaries. BBA extenders reduced pro-rata; fixes are a plug; cost sharing postponed to 2002 to correspond to drug benefit start.

# Medicare Option 1: Tobacco and Additional Provider/Beneficiary Savings Spending and Savings in Billions



**SELECTED ANNUAL DRUG COSTS, LIMITS, AND PREMIUMS:**  
**\$0 Deductible, 50% Coinsurance up to \$5,000 (\$2,500 Cap) (Dollars in billions; cash basis; fiscal years)**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Started in 2002 00-04	Started in 2002 00-09	Started in 2001 00-04	Started in 2001 00-09
<b>50% PREMIUM SUBSIDY</b>															
<b>2002 Start</b>	<u>Cap:</u>	<u>\$0</u>	<u>\$1,000</u>	<u>\$1,000</u>	<u>\$1,500</u>	<u>\$2,000</u>	<u>\$2,500</u>	<u>indexed</u>							
NO CATASTROPHIC Premiums	0	0.0	5.6	10.7	12.5	15.0	17.3	19.1	20.6	22.3	24.3	28.8	123.0	40.3	132.9
		<b>\$0</b>	<b>\$24</b>	<b>\$25</b>	<b>\$31</b>	<b>\$36</b>	<b>\$41</b>	<b>\$43</b>	<b>\$45</b>	<b>\$48</b>	<b>\$51</b>				
CATASTROPHIC (20%) IN 2006 Premiums	0	0.0	5.6	10.7	12.5	15.0	20.0	24.0	26.7	29.5	32.9	28.8	143.9	40.3	152.9
		<b>\$0</b>	<b>\$24</b>	<b>\$25</b>	<b>\$31</b>	<b>\$36</b>	<b>\$52</b>	<b>\$36</b>	<b>\$61</b>	<b>\$66</b>	<b>\$72</b>				
CATASTROPHIC (20%) IN 2002 Premiums	0	0.0	7.3	14.5	16.6	19.3	22.0	24.4	26.9	29.7	33.2	38.4	160.7	51.5	171.9
		<b>\$0</b>	<b>\$33</b>	<b>\$35</b>	<b>\$42</b>	<b>\$47</b>	<b>\$52</b>	<b>\$57</b>	<b>\$61</b>	<b>\$66</b>	<b>\$72</b>				
<b>67% PREMIUM SUBSIDY</b>															
<b>2002 Start</b>	<u>Cap:</u>	<u>\$0</u>	<u>\$1,000</u>	<u>\$1,000</u>	<u>\$1,500</u>	<u>\$2,000</u>	<u>\$2,500</u>	<u>indexed</u>							
NO CATASTROPHIC Premiums	0	0.0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	32.4	38.5	164.1	53.7	177.9
		<b>\$0</b>	<b>\$16</b>	<b>\$17</b>	<b>\$21</b>	<b>\$24</b>	<b>\$27</b>	<b>\$29</b>	<b>\$30</b>	<b>\$32</b>	<b>\$34</b>				
CATASTROPHIC (20%) IN 2006 Premiums	0	0.0	7.4	14.3	16.7	19.9	26.6	32.0	35.6	39.3	43.9	38.5	191.9	53.7	203.9
		<b>\$0</b>	<b>\$16</b>	<b>\$17</b>	<b>\$21</b>	<b>\$24</b>	<b>\$35</b>	<b>\$24</b>	<b>\$40</b>	<b>\$44</b>	<b>\$48</b>				
CATASTROPHIC (20%) IN 2002 Premiums	0	0.0	9.7	19.3	22.2	25.8	29.3	32.6	35.9	39.6	44.3	51.2	214.4	68.7	229.9
		<b>\$0</b>	<b>\$22</b>	<b>\$24</b>	<b>\$28</b>	<b>\$31</b>	<b>\$35</b>	<b>\$38</b>	<b>\$41</b>	<b>\$44</b>	<b>\$48</b>				
Part B Premium Projections		<b>\$52</b>	<b>\$57</b>	<b>\$62</b>	<b>\$66</b>	<b>\$70</b>	<b>\$75</b>	<b>\$80</b>	<b>\$85</b>	<b>\$90</b>	<i>na</i>				

## **OPTIONS FOR REDUCING OUT-YEAR DRUG COSTS**

- **With catastrophic coverage, index break-point to drug cost growth**
- **Phase down premium subsidy or add deductible**
- **Trigger aggressive price discounts if contractors cannot constrain costs**

# MEDICARE BOARD

- **Commission Proposal: Medicare Board.** Stemming from IRS-like concerns about HCFA, the Commission proposed to create a new Board outside of Medicare to administer Medicare. One of the major reasons for the Board to remove any conflict of interest that HCFA has in running both the traditional plan and private plans, and to assure objectivity in oversight. The members would represent health care providers, beneficiaries, and working taxpayers.
- **Functions of the Board:**
  - Certify plans and negotiates over covered benefits and premiums
  - Operate annual open enrollment process, including information distribution
  - Enforce quality and program integrity requirements (including traditional Medicare)
- **HCFA Role:** Overall program management would be transferred to the Board. HCFA would remain responsible for the traditional program only. It would be treated as any other private health plan.

# CONCERNS ABOUT AND ALTERNATIVE TO THE MEDICARE BOARD

- **CONCERNS:**
  - Removes control of Medicare from Administration and Congress, lessening accountability, program integrity and quality protections
  - Bifurcates responsibilities for administering Medicare, which results in duplicative bureaucracy and beneficiary confusion
  
- **ALTERNATIVE:**
  - **Increased Accountability:** New public/private boards to (1) improve coverage policy; (2) advise on management; and (3) review and strengthen beneficiary education efforts. Contracting reform to improve ability to use private sector for certain activities. Revamping the regional and central office relationship.
  - **Modernizing Management:** Strategic plan to improve hiring policies.

## AGENDA: DEPUTIES MEETING

### I. Review schedule

Wednesday: BBA modifications: legislative and administrative  
Review new FFS ideas  
Discuss packages

Thursday: Principals' Meeting:

- New Drug Estimates
- Draft Packages
- Non-budget items: Board, Medigap, coordinated care

Friday: Deputies' meeting: Review competition, packages

Monday: Principals' meeting:

- Revised Packages
- Competition

II. **Board:** HHS to present

III. **Medigap:** See attached

IV. **Drug MOE** (time permitting):

- **Employers:** One-time assessment when they discontinue retiree coverage. Need to figure out how much / how this would be calculated (e.g., do you take into account future retirees' costs?)

- **States:** One-time or ongoing MOE, based on estimated state savings due to the new benefit

**DRAFT****HCFA STRATEGIES FOR THE NEW MILLENNIUM****I. PANELS OF HIGH LEVEL PRIVATE/PUBLIC EXPERTS****Coverage**

HCFA is establishing a new open, understandable, and predictable Medicare coverage process. It is publishing a list and timetable of coverage issues under review and forming a public Medicare Coverage Advisory Committee of nationally recognized experts in medicine, scientific and professional disciplines, as well as consumer and industry representatives, to provide recommendations to HCFA regarding Medicare coverage of new medical treatments and services.

**Management: Private Sector Innovations**

The Secretary is creating a Management Advisory Council of private/public sector experts to advise HCFA on how to improve overall performance, accountability and operations. It will assist HCFA in identifying and adapting private sector innovations in customer service, health care value purchasing, and management and guide a new executive leadership development program to bring private sector expertise to the government.

**National Medicare Education Program**

A new Citizens Advisory Panel on Medicare education will advise HCFA on assuring that the Medicare education program is meeting the needs of beneficiaries for information that is timely, relevant, and useful in making health plan choices.

**II. RE-ENGINEERING CONTRACTOR PROCUREMENT AND OVERSIGHT**

HCFA's contractor initiative seeks new legislative authority combined with administrative changes to allow Medicare to purchase fiscal intermediary and carrier services competitively, select from a larger pool of potential contractors, and improve contractor oversight and evaluation.

**III. APPROPRIATE STAFFING**

HCFA is contracting with a private sector management expert to help assess appropriate staffing needs for a 21st century Agency. Like the revamped IRS, HCFA is seeking new personnel authorities that will help it pay competitively and hold employees accountable for results.

**IV. OTHER STRATEGIES**

HCFA is introducing more market-based strategies into Medicare by conducting demonstrations of competitive bidding for durable medical equipment and other Part B services, and with the assistance of expert industry panels, demonstrating competitive pricing for managed care plans. HCFA is emphasizing solicitation of industry and consumer input through increased use of Town Hall meetings.

## Medicare High Option

### Assume that:

New cost sharing options would begin in CY 2001 (10% SNF coinsurance for days 1-100; \$5 home health copay up to 60 visits; 20% lab coinsurance; no preventive cost sharing)

Policy begins in CY 2001

### Optional Supplemental Coverage within Medicare:

The concept would be to offer to beneficiaries the unsubsidized option to buy supplemental coverage through Medicare to cover catastrophic costs and reduce cost sharing. The option for the coverage would be limited, after a one-time open enrollment, to people entering Medicare or who have had continuous coverage through Medicare managed care or some private source (like HIPAA).

### Coverage:

#### Institutional Services:

Hospital deductible is reduced to \$0 per year; copays for hospital eliminated; coverage extended to 365 days

SNF cost sharing is reduced to \$10 per day (days 1 through 100)

Home health cost sharing is not reduced (assuming a base policy of \$5 per visit capped)

No cost sharing for hospice

#### Professional services:

Physician are reduced to \$10 per visit; includes extra billing

OPD is reduced to \$15 per visit

DME services are reduced to 5% coinsurance

Laboratory services are reduced to \$5 per visit

Therapy services are reduced to \$5 per visit

Out-of-Pocket Cap: \$2500

**Medigap:** A new Option K would be added that has the same coverage as does the new Medicare high option. Other plans would remain the same.

DRAFT

## SAVINGS

### NEW BASE:

#### Competition

- Modernization package (same as previously estimated)
- Managed care competition (full geographic adjustment for high-cost, partial for low-cost)

#### BBA

- Though 2009: Commission package with following changes
  - PPS update: -1.0 except for rural hospital: -0.5 phased up to -1.0
  - PPS capital: Reduce reduction by half (to -1 percent) ??
  - OPD update: -0.5 for rural hospitals phased up to -1.0 (same as inpatient)
  - Lab: Update at CPI - 1
  - ASC: Update at CPI -1
  - DME, PEN: Update at CPI - 1
- Same as above, but permanently
- Give-backs: ??

#### Income-Related Premium

- \$80,000 / 100,000 (need HCFA estimates)

#### Cost Sharing

- Eliminate preventive
- Lab 20%
- Nursing home?
- Index Part B deductible?

## **ADDITIONS**

### Income-Related Premium

- \$60,000 / 90,000 (need HCFA estimates)

### BBA

- Though 2009: Commission package with following changes
  - PPS update: -1.0 except for rural hospital: -0.5 phased up to -1.0
  - Lab: Update at CPI - 1
  - ASC: Update at CPI -1
  - DME, PEN: Update at CPI - 1

## **DRUG BENEFIT OPTIONS**

### No Catastrophic

1a. Start 1/1/01, 1 b: Start of 1/1/02

- 2001: 50% coinsurance up to \$1,000 benefit cap
- 2002: 50% coinsurance up to \$1,000 benefit cap
- 2003: 50% coinsurance up to \$2,000 benefit cap
- 2004: 50% coinsurance up to \$3,000 benefit cap
- 2005: 50% coinsurance up to \$4,000 benefit cap
- 2006: 50% coinsurance up to \$5,000 benefit cap
- 2007+: 50% coinsurance up to 2006 cap indexed by general inflation

### Catastrophic

2a. Start 1/1/01, 1 b: Start of 1/1/02

- 2001: 50% coinsurance up to \$1,000 benefit cap
- 2002: 50% coinsurance up to \$1,000 benefit cap
- 2003: 50% coinsurance up to \$1,500 benefit cap
- 2004: 50% coinsurance up to \$1,500 benefit cap
- 2005: 50% coinsurance up to \$2,000 benefit cap
- 2006: 50% coinsurance up to \$2,500 benefit cap
- 2007+: 50% coinsurance up to 2006 cap indexed by drug inflation, with 20% coinsurance for additional expenditures

3a. Start 1/1/01, 3 b: Start of 1/1/02

Same as above but replace 20% coinsurance after the cap with 50% (50% for all expenditures beginning in 2006)

CIRCUIT

**OPTION 1: TOBACCO TAX AND ADDITIONAL REDUCTIONS**  
 (Trustees' 1999 Baseline, Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
<b>PRESCRIPTION DRUG BENEFIT</b>												
\$0 ded., 50% to \$5000 (no catastrophic)	0.0	0.0	7.4	14.3	16.7	19.9	23.0	25.4	27.5	29.7	38.5	164.1
State MOE (Rough)	0.0	0.0	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-1.7	-5.0
Employer MOE (Rough)	0.0	0.0	-0.4	-0.5	-0.6	-0.8	-0.9	-0.9	-1.0	-1.1	-1.5	-6.2
<b>NET DRUG COST</b>	<b>0.0</b>	<b>0.0</b>	<b>6.5</b>	<b>13.2</b>	<b>15.5</b>	<b>18.6</b>	<b>21.5</b>	<b>23.8</b>	<b>25.8</b>	<b>27.9</b>	<b>35.2</b>	<b>152.9</b>
<i>Premiums (67% subsidy)</i>	0.0	\$0	\$16	\$17	\$21	\$24	\$27	\$29	\$30	\$32		
<b>COMPETITION</b>												
Managed Care	0.0	0.0	0.0	0.0	0.0	-0.7	-1.5	-2.0	-2.5	-2.8	0.0	-9.5
Modernizing Traditional Program	0.0	-0.6	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.6	-3.9	-14.0
<b>TRADITIONAL PROGRAM SAVINGS</b>												
Modified BBA Extenders	0.0	0.0	0.0	-1.3	-2.7	-4.3	-6.0	-8.1	-10.4	-12.8	-4.0	-45.5
<b>INCOME-RELATED PREMIUM</b>												
\$80/100,000	0.0	-0.4	-2.9	-2.6	-2.5	-2.7	-2.9	-3.2	-3.5	-3.8	-8.4	-24.5
<b>COST SHARING</b>												
Adding 20% Lab Copay	0.0	0.0	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-1.7	-5.6
Eliminating Preventive Copays	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.6	1.9
Rationalizing Nursing Home Copays	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>**Home Health or Index Deductible</b>	0.0	0.0	-0.6	-0.7	-0.8	-0.9	-0.9	-1.0	-1.0	-1.1	-2.1	-7.0
<b>MEDICARE SAVINGS</b>	<b>0.0</b>	<b>-1.0</b>	<b>-4.7</b>	<b>-6.1</b>	<b>-7.7</b>	<b>-10.6</b>	<b>-13.4</b>	<b>-16.8</b>	<b>-20.2</b>	<b>-23.7</b>	<b>-19.5</b>	<b>-104.2</b>
<b>TOBACCO TAX (+\$0.45)</b>	<b>-4.8</b>	<b>-3.9</b>	<b>-3.7</b>	<b>-3.7</b>	<b>-4.1</b>	<b>-4.2</b>	<b>-4.3</b>	<b>-4.3</b>	<b>-4.2</b>	<b>-4.1</b>	<b>-20.3</b>	<b>-41.4</b>
<b>SAVINGS</b>	<b>-4.8</b>	<b>-4.9</b>	<b>-8.4</b>	<b>-9.8</b>	<b>-11.8</b>	<b>-14.8</b>	<b>-17.7</b>	<b>-21.1</b>	<b>-24.4</b>	<b>-27.8</b>	<b>-39.7</b>	<b>-145.6</b>
<b>TOTAL</b>	<b>-4.8</b>	<b>-4.9</b>	<b>-1.9</b>	<b>3.5</b>	<b>3.7</b>	<b>3.7</b>	<b>3.9</b>	<b>2.7</b>	<b>1.4</b>	<b>0.1</b>	<b>-4.5</b>	<b>7.3</b>
<b>SURPLUS FOR TRUST FUND SOLVENCY</b>	<b>18.3</b>	<b>20.3</b>	<b>28.1</b>	<b>26.9</b>	<b>30.4</b>	<b>33.4</b>	<b>40.8</b>	<b>45.9</b>	<b>50.3</b>	<b>55.6</b>	<b>124.0</b>	<b>349.9</b>

NOTES: Cost sharing estimates, MOE estimates rough estimates/ not done by actuaries. BBA extenders reduced pro-rata; cost sharing postponed to 2002 to correspond to drug benefit start.

5/25 version

**OPTION 1: TOBACCO TAX AND ADDITIONAL REDUCTIONS**  
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Eliminating Preventive Copays	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.6	1.9
Rationalizing Nursing Home Copays	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
**Home Health or Index Deductible	0.0	0.0	-0.6	-0.7	-0.8	-0.9	-0.9	-1.0	-1.0	-1.1	-2.1	-7.0
<b>MEDICARE SAVINGS</b>	<b>0.0</b>	<b>-2.2</b>	<b>-6.4</b>	<b>-7.9</b>	<b>-9.7</b>	<b>-12.8</b>	<b>-15.7</b>	<b>-19.3</b>	<b>-22.8</b>	<b>-26.5</b>	<b>-26.3</b>	<b>-123.4</b>
<b>TOBACCO TAX (+\$0.45)</b>	<b>-4.8</b>	<b>-3.9</b>	<b>-3.7</b>	<b>-3.7</b>	<b>-4.1</b>	<b>-4.2</b>	<b>-4.3</b>	<b>-4.3</b>	<b>-4.2</b>	<b>-4.1</b>	<b>-20.3</b>	<b>-41.4</b>
<b>SAVINGS</b>	<b>-4.8</b>	<b>-6.2</b>	<b>-10.1</b>	<b>-11.6</b>	<b>-13.8</b>	<b>-17.0</b>	<b>-20.0</b>	<b>-23.6</b>	<b>-27.0</b>	<b>-30.6</b>	<b>-46.5</b>	<b>-164.7</b>
<b>TOTAL</b>	<b>-4.8</b>	<b>-6.2</b>	<b>-3.7</b>	<b>1.6</b>	<b>1.7</b>	<b>1.6</b>	<b>1.6</b>	<b>0.2</b>	<b>-1.2</b>	<b>-2.7</b>	<b>-11.3</b>	<b>-11.8</b>
<b>SURPLUS FOR TRUST FUND SOLVENCY</b>	<b>18.3</b>	<b>20.3</b>	<b>28.1</b>	<b>26.9</b>	<b>30.4</b>	<b>33.4</b>	<b>40.8</b>	<b>45.9</b>	<b>50.3</b>	<b>55.6</b>	<b>124.0</b>	<b>349.9</b>

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## **BBA Beneficiary Information Activities Update -- April 13, 1998**

The BBA requires several specific activities be carried out to inform Medicare beneficiaries of their new Medicare + Choice options. These activities, in priority order, are:

1. Publishing and mailing a comparative booklet to every Medicare beneficiary,
2. Establishing a toll-free telephone number and Internet website to respond to Medicare + Choice questions, and
3. Operating health information fairs.

In general, we believe we are making the best possible progress on these complex activities, given that it is the first time we are doing most of them and the very short time frames that we have to accomplish them. Following are issues associated with the first two requirements.

### **Medicare Handbook**

There is no explicit requirement in the BBA to have the Medicare Handbook for beneficiaries in 1998. However, the 1998 Appropriations language delineated this as the top priority for the User Fees. The Handbook beneficiaries receive this year will include information on the 1999 Medicare + Choice Plans. We are working to design the Handbook in a way that is most useful to the beneficiary. Time is the major concern with the Handbook. We are very concerned about getting all the necessary information on the new plans so we can get the Handbook mailed out by October 1, 1998. This time frame for getting the Handbook out by that date is as follows:

5/1/98	Information from M+C Plans on premiums and benefit packages received
6/1/98	Handbook must be completed and ready for clearance
→ 7/1/98	500 versions of the Handbook must be sent to the printer <sup>1</sup>
10/1/98	Handbook is mailed out to 39 million Medicare beneficiaries <sup>2</sup>

The MSA demonstration is another time sensitive issue related to the Medicare Handbook. The MSA demonstration must be operational by January 1999. Enrollment for the demonstration can occur only in November 1998. Thus, beneficiaries will need information about this demonstration prior to that time. Since we will not have information from insurers about MSA plans in time to include in the Medicare Handbook this year, we will have to provide that information in a separate mailing to all beneficiaries. The scope of that mailing will be determined by the areas that will be covered by the demonstration.

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<sup>1</sup> Handbook must be ready by this date to allow for a minimum of three months print time.

<sup>2</sup> Households with four or less beneficiaries will receive one Handbook, with the option to receive more upon request.

### **Toll-Free Telephone Number**

The BBA requires a toll-free number to respond to inquiries regarding Medicare + Choice options be available in all areas where Medicare + Choice plans are offered. Since these plans will be available beginning January 1999 (current Medicare risk HMO plans become Medicare + Choice plans on January 1, 1999), the toll-free number must be up and ready in 1998. Given the tight time frames and enormous complexity of this endeavor, we believe a phased approach to establishing a national toll-free line is most advisable and consistent with best practices, however, we do not have that option. Thus, our plan is to have a national toll-free number operating by October 1, 1998.

Again, the critical issue with this effort is time. AT&T must have a minimum of six months to establish the network necessary for this line. We have concerns about AT&T's ability to even meet that time frame. By Tuesday, April 14, HCFA will sign a contract with call centers to get the toll-free number operating by October 1. The call center contractors will work with AT&T to get the network established. Given the numerous risks involved in this activity, we are taking several steps to mitigate those risks.

### **Internet**

We are encouraged by our progress on this activity. On March 16, we launched the new consumer information website *www.medicare.gov*. This Internet site is designed specifically with the beneficiary in mind. It provides information on who to contact in each state with a question, information about managed care and Medicare + Choice, how to recognize and report fraud and abuse, and a wellness page highlighting Medicare's preventive benefits.

Through our new website, beneficiaries (and those acting on their behalf) can access Medicare Compare. Medicare Compare will be the source for information on all Medicare + Choice plans on the Internet. Medicare Compare is currently a managed care plans comparison database that allows users to comparison shop for health plans in their geographical area. The beneficiary simply enters in his or her zip code, county, or State of residence and the Medicare Compare provides a list of health plan options available in that local area. This system currently provides information on benefits and cost-sharing, but will later be expanded to include information on quality performance and consumer satisfaction.

We have had positive reports about the new website, and by May 31, Medicare Compare will be available in a newly enhanced format.

### **User Fees**

HCFA staff will meet with OMB staff on Tuesday, April 14, to agree upon the spending plan and apportionment for the user fee money.

o Home Health Agencies

- o Interim Payment Limits -- (1) Routine Cost Limits reduced to 105% of the median and the savings from the previous freeze recaptured (Regulation on 12/31/97) and (2) Cost Limits Based on Average Per Beneficiary Cost (Regulation Published on 3/31/98) law,

Regulations published; however, there is widespread claiming that the cost limits will cause a large number of agencies to close. Litigation is occurring in several places; however, has not yet stopped implementation.

Our sense is that the authorizing committees continue to stand behind the provisions even though Senate Aging held a sympathetic hearing a few weeks ago.

- o Permanent PPS System -- This system is scheduled to take effect on 10/1/99. As you know, this has always been an ambitious effective date and the usual slippages in research (delays in getting interim findings) and implementation (time required to get the OASIS data set up and going) continue to make us nervous about this. We had planned to communicate this feeling to Hill staff in a routine legislative briefing.
- o Part A/B Shift: this has required line item billing and sequential processing of claims. Where medical review removes claims from the sequence, this delays payment of subsequent claims and there have been complaints about the effect of this on cash flow. We are considering them.
- o Inherent Reasonableness. We published an interim final regulation authorizing this on 1/7/98 and issued instructions in March. We anticipate that reductions will be made by carriers (i.e., reductions of less than 15% per year; not published in the Federal Register). There is some pressure to develop more formal parameters and standards for making determinations and, if possible, for doing the work in regulations at the national level. This would greatly slow down our efforts and we do not at this point favor it.
- o SNF PPS

- o The final regulation is fully drafted and is expected to clear and be published by May 1 as required.
- o About 20% of SNFs would be affected because their cost reporting periods begin on 7/1/98.
- o Instructions for implementing the "consolidated billing" feature are already issued and are well received -- **operational concerns have led us to defer full implementation of consolidated billing during Part B-only stays until January 1, 1998.** This is a popular move and would not affect scoring.

Outpatient PPS - 1999

by Madigan

bills introduced  
EPA  
→ the chronology

- o Industry sources tell us that there is still some sentiment for price increases for "subacute care" and perhaps future revisions to reflect pharmacy and other specific expenses -- but these are representations that we believe can be resisted.
- o Rehabilitation Hospital PPS
  - o This is not due until October 1, 2000.
  - o We are preparing by refining the Minimum Data Set (MDS) in use for NFs and also by doing staff time studies to refine Resource Utilization Groups (RUGs). Funding for this research is in hand.
  - o Some members of the rehabilitation establishment continues to favor an episode program featuring Functional Independence Measures (FIMs); however, there is also support for our approach.
- o Hospice Provisions -- all have been implemented by instructions; however, some systems changes have not been completed, necessitating retroactive adjustments and bill processing in some cases. We have received few complaints, though.

HCFA BBA Status Meeting with the White House

April 13, 1998

Medicaid Issues

- 1. DOM / Pennsylvania
- 2. NPR
- 3. New Hampshire

1. Accomplishments

HCFA has issued policy guidance on almost all of the BBA Medicaid provisions through 46 letters to States.

2. Current Status

- o We have entered the phase of developing changes to the State Medicaid Manual and to regulations
- o Two letters on FQHC's/RHC's have been cleared by OMB and are expected to be rolled out on Tuesday, April 14.
- o The DSH/IMD regulation has cleared the Department and has been sent to OMB. A meeting is needed with OMB to discuss the exception to the direct payment requirement.
- o The Administration needs to reach agreement on the methodology for budget neutrality calculations in the Section 1115 waiver process, given the BBA. We will be briefing the Secretary on this matter before bringing it to OMB.
- o We will be issuing three major regulations on managed care -- A global reg, a quality reg, and an external quality review regulation. We are aiming to issue the first two of these regulations this Summer. Because we need to go through a contracting process as part of the development of the external quality review regulation, we are expecting that reg to be promulgated near the end of the year.
- o Regarding the Qualifying Individuals benefit, we have issued the policy guidance via two State Medicaid Directors letters. We have begun the process of monitoring implementation through our regional offices. All of HCFA's consumer guides are being revised to include information on the Qualifying Individuals benefit. The Social Security Administration included a check stuffer about the QI-1 benefit in one of its mailings. We are working on getting data to provide more leads to States on individuals who may be eligible for the Qualifying Individuals benefit.

don't have response

Steps conforming ext. quality review in the plan

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2:30  
3:30