

MEDICARE PRINCIPALS' MEETING

MAY 28, 1999

I. PROVIDER SAVINGS:

- **Spending: BBA Administrative / Legislative Fixes: 2000-2002**
- **Savings: Extending Certain BBA Policies: 2003-2009**
- **Strategy**

II. COMPETITION

III. DISCUSSION OF PRESENTATION FOR 6/1/99 MEETING

**I. MEDICARE PROVIDER PAYMENTS:
BALANCED BUDGET ACT: NEAR-TERM SPENDING
(2000-2002)**

	ADMINISTRATIVE OPTIONS (COSTS FOR FY 2000-09, \$ IN BILLIONS)	LEGISLATIVE OPTIONS (COSTS FOR FY 2000-09, \$ IN BILLIONS)
HOSPITALS	Delay transfer policy 2 yrs (or delay forever) ^{1,2}	+1.6 (+8.9)
	Daschle Rural Options	<i>Modest</i>
	Outpatient (transition, delay) ^{1,2}	<i>Modest</i>
NURSING HOMES	Delay implementation of therapy caps	<i>Modest</i>
HOME HEALTH	Extend time period for overpayment to 3 yrs	<i>Modest</i>
	Change surety bond	<i>Modest</i>
MANAGED CARE	None recommended	

1. Helps Academic Health Centers. Also DSH carve-out

2. Helps Rural Hospitals

BALANCED BUDGET ACT: LONG-TERM SAVINGS 2003-2009

POLICY	BBA 2002 POLICY (SAVINGS FOR FY 2000-09, \$ BILLIONS)		ALTERNATIVE (COSTS FOR FY 2000-09, \$ IN BILLIONS)		
					Change
Hospital					
PPS Update	Update – 1.1	-35.4	Update – 1.0 Rural Update – 0.5	-29.9	+3.9
PPS Exempt Update	Proportional Update	-4.7	Same	-4.7	--
PPS Capital	2.1% Reduction	-1.8	1.0% Reduction	-0.9	+0.9
PPS Exempt Capital	15% Reduction	-0.7	Same	-0.7	--
DSH Reduction	Up to 5% cut	-1.4*	No extender	--	+1.4*
Outpatient Update	Update – 1.0	-8.0	Same Rural Update – 0.5	-7.5	+0.5
Nursing Home	Update – 1.0	-2.1	No extender	--	+2.1
Home Health	Update x	na	No extender	--	--
Hospice	Update – 1.0	-1.2	Same	-1.2	--
Lab	Freeze	-3.5	Update – 1	-1.1	+2.5
Ambulatory Surg Cnt	Update – 2	-0.3	Update – 1	-0.2	+0.1
Ambulance	Update – 1	-0.4	Same	-0.4	--
DME, PEN, Prosthetics & Orthotics:	Freeze for DME, PEN P & O: Update - 1	-2.4	Update – 1 for DME, PEN, P & O	-1.1	+1.3
Interactions		+3.6		+3.6	0
TOTAL	TOTAL	-56.9	TOTAL	-44.1	+13.4

NOTE: Option to extend permanently rather than 2009. Estimates preliminary /not all from actuaries

OPTIONS FOR SETTING GOVERNMENT AND BENEFICIARY CONTRIBUTIONS FOR PRIVATE PLANS

- **Option 1: Based on Average Premium of All Plans:** As under current law, the beneficiary premium for traditional Medicare would be set at 12 percent of traditional program costs. The government contribution for private plans would be based on the enrollment-weighted average of all plan bids (including traditional Medicare), with payments capped at 96 percent of traditional Medicare costs.
- **Option 2: Based on Traditional Program Costs:** As under current law, the beneficiary premium for traditional Medicare would be set at 12 percent of traditional program costs. The government contribution for private plans would also be based on traditional Medicare costs, with a “discount” (i.e., lower government payment) for private plans consistent with current law.

II. COMPETITION

- **Goal:** Improve competition and efficiency without achieving savings through traditional plan premium increases
- **Assumption in all options:**
 - No premium increases for traditional Medicare
 - Guarantees defined set of benefits, including prescription drug benefit
 - Replaces competition on extra benefits with price competition (as under all competitive options, including Breaux-Thomas)
 - Implemented in 2004 with full risk & geographic adjustment
- **Issues with all options:**
 - Could be perceived as a double standard – traditional program is the basis of payments, but traditional program premium is protected.
 - Little savings: \$10 billion from 2004-09 (Begins in 2004)

Option 1: Payments Based on Average of All Plans

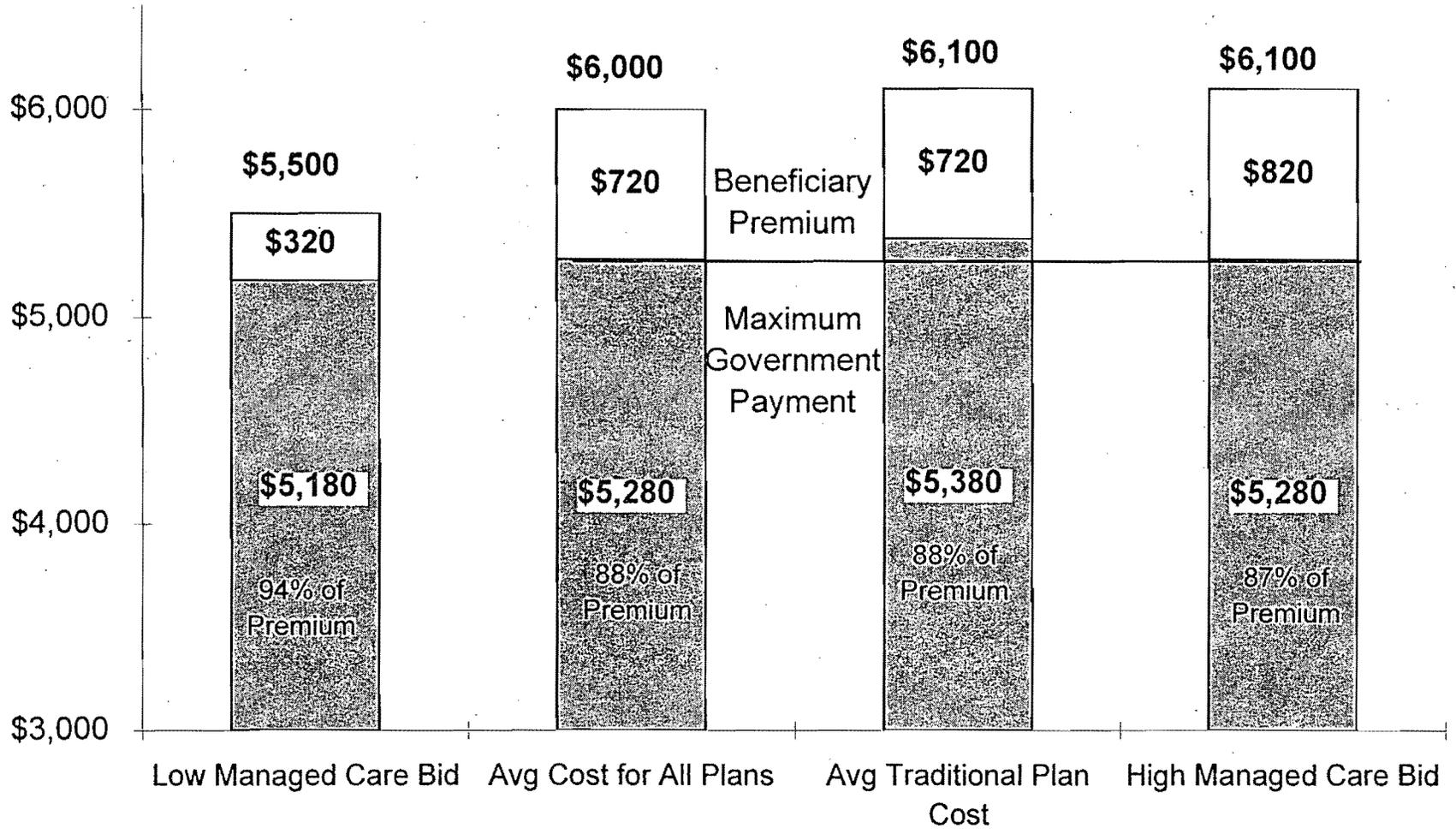
- **Pros**

- For conservative Democrats, resembles Breaux-Thomas proposal without the major problem – increasing traditional Medicare premium.
- Saves from both reduced payments to private plans and increased enrollment, which lowers the average and thus the private plan payment schedule.

- **Cons**

- Because it is closer to the original Breaux-Thomas model, it is more vulnerable to being modified into an unacceptable premium support plan.
- Differs from Option 2 if private plan enrollment is high and bids are low, in which case government payments to private plans would be lower. Although this might produce greater savings, it would also distort price competition by making the traditional program a better deal relative to a private plan with the same costs, reducing private plan enrollment.

Option 1: Payments Based on All Plans' Average *Traditional Medicare Premium Protected / Private Plans Not*



Note: \$720 is approximately current law

Option 2: Payments Based on Traditional Program Only

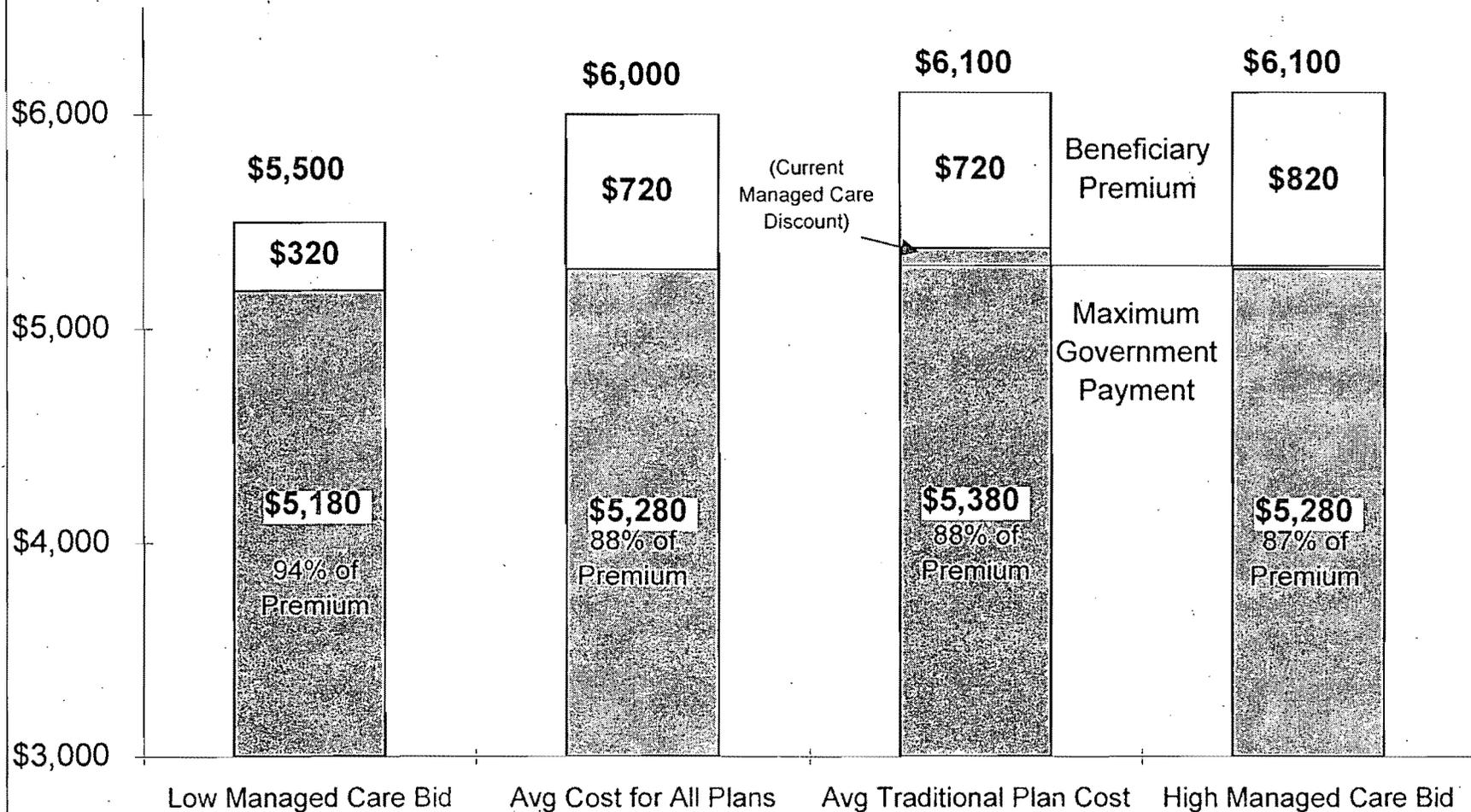
- **Pros**

- Price competition among all plans, including traditional Medicare, limiting the criticism that the traditional program is getting a special deal.
- Requires no special rules to protect the traditional premium, making it less vulnerable to movement towards the Breaux-Thomas proposal. At the same time, it leaves Option 1 available if compromise towards Breaux-Thomas is necessary.

- **Cons**

- Could be viewed as too incremental relative to Breaux-Thomas.
- Private plan payment schedule is more linked to the traditional program costs than Option 1. This provides more incentives for beneficiaries to switch to a private plan if traditional program costs rise (leading to government and beneficiary savings from greater price competition) but also means higher payments to private plans in this case.

Option 2: Payments Based on Traditional Medicare *Traditional Medicare Premium Automatically Protected*



Note: \$720 is approximately current law.

Under current law, managed care plans are paid a discounted amount based on the local traditional fee-for-service plan costs

III. PRESENTATION FOR JUNE 1, 1999 MEETING

- **KEY ELEMENTS**

- **Modernizing Traditional Medicare**
- **Making Managed Care Payments Competitive**
- **Income-Related Premium**
- **Cost Sharing**
 - Eliminate preventive service cost sharing
 - Add 20% lab copay
 - Change skilled nursing facility to 20%
 - Index Part B deductible to inflation
 - Home health copay
- **Provider Savings / BBA Fixes:**

- **DRUG BENEFIT**

- **Base Option: \$0 deductible, 50% copay to \$5,000; 67% premium subsidy, begins in 2002**

PACKAGE OPTIONS

1. No Additional Revenue:

- Drug benefit: No catastrophic; 50% premium subsidy
- Additional Savings: Lower income-related premium, increased deductible additional provider extenders

2. Tobacco Tax Financing:

- Drug benefit:
Option 1: No catastrophic; 67% premium subsidy
Option 2: Catastrophic (50/50 or 80/20); 50% premium subsidy
- Tobacco Tax: \$41 billion / 10 (+\$0.45 tax on top of budget)
- Additional Savings: May need additional savings as well

3. Surplus Financing:

- Drug benefit:
Option 1: No catastrophic; 67% premium subsidy, \$10,000 cap
Option 2: Catastrophic (50/50 or 80/20); 67% premium subsidy

REVISED DRAFT: April 5, 1999

BACKGROUND MEMORANDUM ON COMPETITION IN MEDICARE

FROM: Chris J. and Jeanne L.

This memo briefly summarizes the issues and options associated with competition in Medicare. It does not include cost estimates; instead, it provides background information to facilitate an informed discussion of policy options that will be presented at the next principal's meeting.

I. COMPETITION IN THE CURRENT MEDICARE PROGRAM AND PREMIUM SUPPORT

Medicare Today. Medicare spending in 1998 and the first part of 1999 has been very low, and the outlook for Medicare's solvency has improved significantly. In 1993, the Medicare Hospital Insurance Trust Fund was projected to be insolvent in 1999; today, it is projected to become exhausted in 2015. The positive news regarding the trust fund can be attributed in large part to three major factors: the enactment of Medicare reforms and over \$100 billion in savings in the 1997 Balanced Budget Act (BBA); the strong economy that has increased revenues and decreased inflation, and success in combating Medicare fraud. The BBA added prospective payment systems to several services and reduced Medicare overpayment.

Despite these successes, Medicare faces the retiring baby boom without many of the tools and competitive incentives that could make the program more capable of meeting this demographic challenge. Under current law, the traditional Medicare program cannot use negotiation, competitive bidding, and other market-oriented approaches to reduce costs. And, although CBO has traditionally not estimated significant savings from these types of policies, our actuaries have estimated that Medicare costs could be reduced by \$15 to 20 billion over 10 years if we did.

Medicare managed care payments are also not set competitively. Managed care plans are paid according to a rate schedule (Medicare pays all plans about 96 percent of traditional program costs in the county -- regardless of the plan's premium). Because of the historic overpayments to managed care and the lack of risk adjustment, it is not clear that Medicare saves money from managed care enrollment today. Because of the flat payment rate, the government gets no additional savings if beneficiaries in the traditional program join a lower-cost plan or if they switch from a higher-cost private plan to a lower-cost private plan. However, beneficiaries have an incentive to choose lower cost plans, since they can get 100 percent of the savings back in the form of supplemental benefits (e.g., prescription drug benefit, lower cost sharing). Although the extra benefits offered by managed care are attractive to beneficiaries, the Medicare program does not share in the savings. Competition under the current system, therefore, is based on benefits rather than price. These extra benefits can be designed to be more attractive to healthier populations, which results in further segmentation of healthy from sick beneficiaries.

Premium Support. Recognizing the limits of competitive incentives in Medicare, Robert Reischauer and Henry Aaron developed a concept called premium support. They described premium support as when "Medicare pays a defined sum toward the purchase of an insurance policy that provided a defined set of services" -- in other words, it maintains the guarantee of a defined set of benefits, but limits the government contribution to create an incentive for beneficiaries to seek care from efficient plans. They suggested that plans, including traditional Medicare, develop premiums for how much it costs to provide the defined benefits and the government sets its contribution based on the average (or median) premium. Beneficiaries choosing plans, including the traditional program, whose premiums are higher than average would pay more -- those choosing lower-cost plans would pay less than under current law.

Premium support comes closer to a traditional voucher program than the current Medicare program since payments for the traditional program would be limited to the government maximum contribution -- beneficiaries would bear the risk of underfinancing of the traditional program. However, there are some critical differences between premium support and a traditional voucher proposal. Premium support includes a guarantee of defined benefits; even if the government contribution is limited, health plans must provide the statutorily-set of Medicare benefits. Also, the government shares with beneficiaries the risk of unexpected health care cost inflation. This is because the maximum government contribution is set as a percent of actual Medicare spending, either for the traditional program, managed care, or both. If Medicare costs go up, so does the maximum government contribution (similar to what happens in Medicare Part B, where the government pays 75 percent of costs). Even though this provides some built-in protection against risk to the beneficiary, the extent of that protection depends on its design.

Savings in premium support are generated in several ways. First, there are direct savings because the government is paying less for lower-cost plans rather than the flat dollar amount under current law. Second, to the extent that the national average premium is reduced over time as people move to managed care, the payment schedule also is reduced and the Federal government saves. And third, increased revenues result from higher premiums for traditional Medicare. Under virtually all premium support models, the traditional plan premium would be higher than the national average, defining it as a "high-cost plan" and resulting in higher premiums. However, the Reischauer-Aaron concept of premium support would provide a richer, better benefits package which would make the inefficient and expensive Medigap market that supplements Medicare either unnecessary or significantly less expensive. The savings that beneficiaries reap would make them more able and willing to finance the choice of a higher-cost traditional program that includes additional benefits.

Breaux-Thomas Proposal. The Breaux-Thomas proposal included a premium support model that loosely resembles a Reischauer-Aaron concept since the government would pay health plans a percent of plan costs up to a limit -- a percent of the national average premium (a dollar amount based on the per capita costs of the traditional program and the premiums for private plan, adjusted for enrollment). Beneficiaries would pay more for plans above the national average --

including the traditional program -- and less for lower-cost plans (see chart 1). However, it does not explicitly improve the Medicare package and it does not provide a clear guarantee of defined benefits, both of which are central to the concept of premium support.

Of greatest concern is the use of increased premiums for the traditional program as a mechanism to implicitly, financially coerce beneficiaries into managed care options. Our actuaries estimated that the premiums for traditional Medicare would be 18 to 30 percent higher than current law (10 to 20 percent if traditional program savings are included). To fend off the concerns about this premium hike, the final version of the Breaux-Thomas plan allowed beneficiaries in areas without private plan options to pay current-law premiums for traditional Medicare. However, this fix is not given to beneficiaries for whom managed care is not a good option (the very old, beneficiaries with special health need), and those in areas with one limited or substandard plan.

II. OPTIONS FOR MANAGED CARE COMPETITION

The Breaux-Thomas premium support proposal is clearly a politically and policy-flawed design. However, there are options for reforming Medicare managed care payments that reduce Federal costs, improve efficiency, and protect the premium for the traditional program. Most analysts agree that our current system for paying managed care plans is inefficient, with little savings accruing to the government. More importantly, it is harder for beneficiaries to compare choices based on extra benefits than on premiums. Allowing plans to compete on lower premiums would raise the cost consciousness of beneficiaries about their plan choices, creating incentives for them to help reduce program costs. At the same time, it represents a major change from the current system, in which all beneficiaries pay the same, Part B premium.

This section describes assumptions and the key policy parameters in designing a competitive approach to managed care payments. All options are structured to prevent the premium for beneficiaries choosing the traditional program from rising. These options also assume that Medicare benefits are guaranteed and explicitly defined; that plan payments are fully adjusted for risk of the beneficiary and local costs; and that private plans have some flexibility in reducing beneficiary cost sharing. Since risk adjustment under current law will not be fully phased in until 2004, this would probably be the earliest implementation date.

Under these options, the current law premium is \$720 per year or 12 percent of total costs which is equivalent to 25 percent of Part B costs. The goal of protecting the traditional program premium is unanimously shared within the Administration because any approach that we adopt should produce savings through competition, not implicitly raising the Medicare premium. However, it should be noted that by protecting the traditional program's premium, it probably would not be considered premium support by those who advocate for it. Notwithstanding its potential similarities to the Breaux-Thomas concept, managed care plans will likely oppose since they are, in most options, but at a competitive disadvantage relative to the traditional program. Additionally, there will be both less private plan enrollment and less savings as a result.

Another major assumption in the options is that the government splits the savings with beneficiaries when they choose lower-cost plans. This does not occur under current law, since the government pays a flat rate for all plans and the beneficiaries gets 100 percent of the savings in the form of extra benefits. It is possible under these options to give beneficiaries 100 percent of the savings back in the form of lower premiums. However, to ensure some direct savings to the government for beneficiaries, the options assume that both the government and beneficiaries pay less for lower-cost plans. Additionally, since we have not yet had any experience with beneficiaries and price competition, there is some concern about providing such large financial incentives to go to managed care. Our actuaries suggest that the government cannot take more than 25 percent of the savings from choosing a lower-cost plan, since taking a higher cut would discourage beneficiaries from choosing private plans.

Setting the Maximum Government Contribution. As stated earlier, the difference between premium support and a voucher proposal is that the maximum government payment is set as a percent of actual Medicare spending, not some arbitrary budget-driven factor that could shift greater risk to beneficiaries. However, exactly how this maximum is designed determines the extent to which competition occurs, beneficiaries choose private plan options, and the government saves. There are three major options for the setting the government contribution, described below.

Option 1: Premium Support-Like Payment Methodology with Explicit Premium Protection for Traditional Program. The first option would set the maximum government contribution based on the national weighted average premium (see chart 2). This is the same basis for payments in the Breaux-Thomas plan with one exception. There would be a special rule that would ensure that the traditional plan premium does not rise above current levels for all beneficiaries, not just those in counties with no private plans.

Pros

- Maintains the savings that result from increased private plan enrollment, but assures that Medicare beneficiaries are not financially coerced into HMOs.
- Assures that private plan premiums are related to traditional Medicare, since traditional Medicare will dominate the national average which serves as the anchor for payments.

Cons

- Because it is the closest to the original Breaux-Thomas model, it is the most vulnerable to being modified into an unacceptable premium support plan.
- Creates odd incentives since a private plan that costs the same as the traditional plan because of the special exception.

- Could be perceived as a double standard -- payments to managed care plans are set using the traditional program costs but the traditional program is exempted from competition.

Option 2: Nationalized Competitive Pricing for Private Plans. The second option would set the maximum government contribution regionally, based on the local weighted average of private plan premiums (see chart 3). This approach not only excludes the traditional premium from being set under the new system, but excludes it from affecting the maximum government contribution. Thus, managed care payments would essentially be de-linked from traditional Medicare, whose premium would be set as under current law.

Pros

- Most straightforward way of protecting the traditional program's premium since it is totally separate from the competition
- This is the one competitive option that even the most liberal of Democrats in Congress could support.
- Would likely pay private plans less than other options because excluding the traditional program, which is usually higher, from the average premium lowers the average.

Cons

- Could create instability in premiums in private plans and has less of an incentive for beneficiaries to join private plans. As such, it has no supporters in the Administration.
- Most likely to result in lowest participation by managed care plans, thus reducing plan options, beneficiary migration to plans, and overall government savings.
- Would likely not be viewed as "real" competition in Medicare since the traditional program would be totally excluded.

Option 3: Modified Current Payment Methodology to Assure Savings for Government and Beneficiaries. The third option would set the maximum government contribution based on the traditional program's premium, similar to current law (see chart 4). Rather than basing private plan payment schedule on private plan premiums, it would link them to the traditional program. Specifically, the maximum government payment to the private plans would be set as a percent of the traditional program, guaranteeing the premium for traditional Medicare will be 12 percent. Beneficiaries who choose private plans with premiums below that amount would get a large proportion of the savings as a reduced Part B-like premium -- the government would save by paying the plan less. This is similar to our current managed care payment methodology, that

pays for private plans based on traditional program costs, but differs since it allows price, not benefits, competition.

Pros

- Provides financial incentives for beneficiaries to opt for low-cost plans without putting private plans at a competitive disadvantage relative to the traditional program (since there is no special exception for the traditional program).
- Could be described as a next step in our current policy, maintaining the link to the traditional program but rewarding beneficiaries for opting for low-cost plans.
- While it uses the traditional program premium as a benchmark, it does not require special rules to protect the traditional premium, making it less vulnerable to movement towards a voucher proposal.

Cons

- Maintaining the traditional program at the center of private plan payments could lead to criticism about how efficient this option is -- if traditional program costs skyrocket, private plans are automatically paid more.
- Could be viewed as too incremental and would be most disliked by the managed care industry that has argued for including the traditional program in the competition and against linking payments to the traditional program.

THE WHITE HOUSE

WASHINGTON

March 30, 1999

BACKGROUND MEMORANDUM ON PRESCRIPTION DRUGS

FROM: Chris J. and Jeanne L.

This memo provides background for tomorrow's discussion on a Medicare prescription drug benefit. It describes the need for coverage, expenditure patterns, and the various moving parts of a new benefit. We have also attached an article by Laura D'Andrea Tyson on the topic.

BACKGROUND

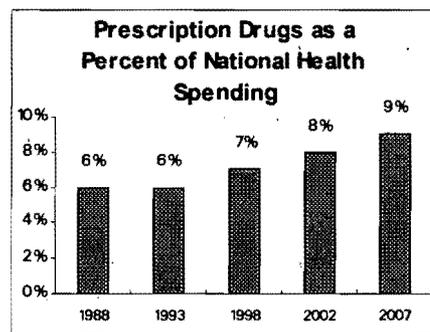
PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

Increasing reliance on drugs. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulants with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g., drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

Rising share of national health spending. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.

New drugs and growth in the pharmaceutical industry.

Although the need for drugs is growing, the rapid spending increase is also driven by the number of new drugs, which are introduced at high prices, particularly if there is no therapeutical alternative. Between 1994 and 1998, the FDA approved nearly 150 new drugs (a 140% increase from the 1960s), and one of the leading pharmaceutical associations estimates that over 350 biotechnology medicines are now in development. Also, in the last several years, the industry has made unprecedented investments in advertising, increasing demand for drugs. Sales by research-based pharmaceutical companies were \$125 billion in 1998, a 12 percent increase over 1997. Profits are expected to continue to grow.



MEDICARE BENEFICIARIES: GREATEST NEED FOR PRESCRIPTION DRUGS

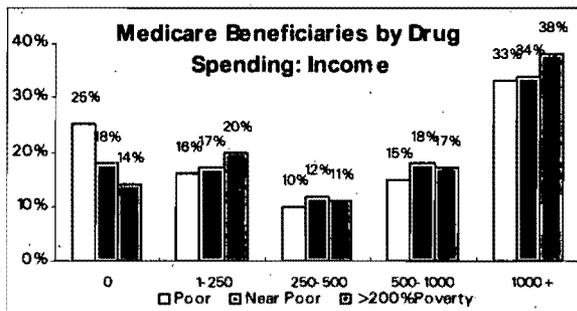
Elderly and people with disabilities rely more on prescription drugs. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.

Despite their higher use of drugs, many Medicare beneficiaries pay higher prices for them. Beneficiaries without drug coverage pay significantly more than large HMOs, employers and the Veterans' Administration pay for the same drugs. Moreover, American senior citizens pay higher prices for drugs than citizens in other nations. For example, the average retail price for the top ten drugs for seniors are 72 percent higher in the U.S. versus Canada (use is higher in Canada as well).

COMPARISON OF PRICES FOR DRUGS

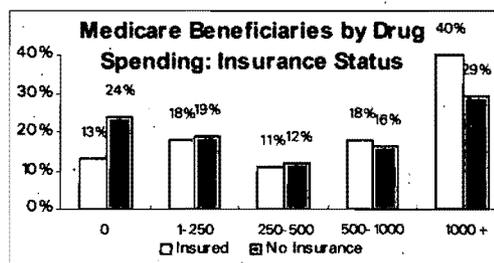
<u>Drug</u>	<u>Use</u>	<u>Price for Preferred Customers</u>	<u>Regular Price</u>
Prilosec	Ulcers	\$56.38	\$111.94
Zocor	Cholesterol	\$42.95	\$104.80
Procardia	Heart	\$67.35	\$126.86
Zoloft	Depression	\$123.88	\$213.72

Source: Minority staff report to Committee on Gov't reform



Distribution of beneficiaries' spending on drugs. According the HCFA actuaries' projections for 2000, over 50 percent of beneficiaries will have prescription drug spending of \$500 or more -- about 13 million have spending that is greater than \$1,000. This expenditure distribution varies somewhat by income. About one in four poor beneficiaries have no drug spending, compared to 14 percent of middle to high income beneficiaries.

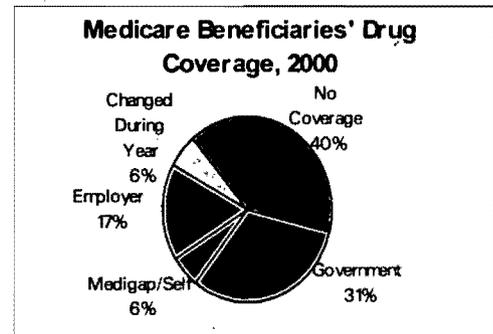
Drug spending also varies by whether beneficiaries have insurance coverage. In general, those with some type of insurance coverage (private or public) have higher spending and utilization than those with no insurance coverage for prescription drugs. Although beneficiaries with drug coverage are somewhat less healthy and thus may need more drugs, there appears to evidence that the lack of coverage discourages use of prescription drugs.



The distribution of drug spending also varies by what type of insurance coverage beneficiaries have. Nearly half (47 percent) of beneficiaries with employer-sponsored retiree coverage have more than \$1,000 in annual expenditures, versus 33 percent of those in Medicare managed care.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES

Private supplemental drug coverage: Only 23 percent of Medicare beneficiaries are expected to have private insurance for drug coverage (retiree coverage or Medigap) -- down from 38 percent in 1995. Whereas most people under age 65 have employer-based coverage, only about 17 percent have employer-sponsored retiree coverage. Another 6 percent of beneficiaries have Medigap or other private insurance that pays for prescription drugs. Both sources of coverage have been declining rapidly as the cost of coverage rises.



Retiree health insurance: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). The actuaries project that, by 2000, only 17 percent of beneficiaries will have this type of coverage in the absence of a new Medicare benefit.

Medigap: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in 3 of its 10 standard plans. The standardized Medigap benefit includes a \$250 deductible, 50 percent coinsurance, and a cap on benefits spending of \$1,250 or \$3,000. Medigap premiums are expensive, ranging from \$402 to \$7,196 per year, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage is well over \$1,000 more than a Medigap plan without drug coverage (\$2,073 v \$913 in 1998). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

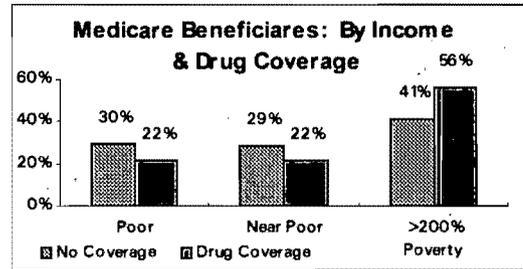
Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996. At the same time, Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. The actuaries project that only 6 percent of beneficiaries will have Medigap drug coverage in 2000.

Public coverage: About 30 percent of beneficiaries have some type of government coverage.

Medicare managed care: About two-thirds of plans offer some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 58 percent had coverage that is greater than \$1,000 and 42 percent had coverage limited to \$1,000 or less. Increasing costs and reducing Medicare overpayments could reduce coverage in the future.

Medicaid: Only Medicare beneficiaries who are eligible for Medicaid through the Supplemental Security Income program or a medically needy (spend down) option are eligible for prescription drug coverage. These dual eligibles typically have income at or below 60 percent of poverty.

Beneficiaries without coverage for drugs. About 16 million beneficiaries (40%) are projected to have no drug coverage in 2000. Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about \$17,000 for a single, \$23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



CONSEQUENCES OF THE LACK OF DRUG COVERAGE

Less use of needed prescription drugs. The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. Although it is difficult to distinguish appropriate from over-utilization, virtually all researchers acknowledge that the lack of insurance coverage for drugs results in underutilization of drugs, even essential drugs.

Greater institutionalization. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodilators) when their Medicaid drug coverage was limited. The increased cost of institutionalization exceeded the savings from reduced use of drugs by 20 fold. Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. A different study of stroke patients found that those treated promptly with drugs to thin clots had significantly lower health care costs.

Larger financial burden. Even after controlling for health status and income, elderly people with private insurance for drugs have half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent higher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine.

Shorter lives. Given the importance of prescription drugs to modern medicine, the actuaries suggest that under-use of them by Medicare beneficiaries can reduce life expectancy. Ironically, this means that adding a prescription drug benefit could raise -- not lower -- costs of hospitalization and other services, since beneficiaries would live longer.

DESIGN PARAMETERS FOR A PRESCRIPTION DRUG BENEFIT

There are a number of major design features that affect the costs and coverage of a Medicare prescription drug benefit. These are outlined below.

Eligibility: One of the basic questions about a new drug benefit is who is eligible. Medicare benefits have never been limited to subsets of beneficiaries or means tested. However, the costs of a new Medicare drug benefit and concerns about substituting for existing private coverage were major reasons why some Medicare Commission members opposed a drug benefit. The Breaux-Thomas proposal did not include a new Medicare benefit. Instead, it recommended a new Medicaid (not Medicare) subsidized benefit for those with income below 135 percent of poverty (about \$11,000 for a single, \$15,000 for a couple). It would also require Medicare plans and Medigap to offer an unsubsidized drug option. The lack of a significant subsidy would raise major selection issues that would destabilize this insurance, since healthy beneficiaries would consider it unaffordable and mostly sicker beneficiaries would participate, driving up costs.

Providing low-income beneficiaries with a fully subsidized benefit is important -- and would, in fact, happen automatically if a new Medicare benefit were created. This is because, under current law, Medicaid pays for Medicare premiums for all beneficiaries with income below 135 percent of poverty. Unless this provision is changed, Medicaid would also pay for the Medicare premium for prescription drugs for low-income beneficiaries (note: in our cost estimates).

However, a low-income drug benefit will leave most beneficiaries vulnerable. Nearly 3 out of 5 beneficiaries who lack drug coverage have income above 135 percent of poverty. About 30 percent of these beneficiaries have drug expenditures that exceed \$1,000. This represents a considerable expense for beneficiaries with income between \$15,000 and \$20,000. Moreover, private coverage for drugs is unstable. The actuaries project that the proportion of beneficiaries with retiree coverage will decline from 28 to 17 percent between 1995 and 2000, and with Medigap from 10 to 6 percent. Although these declines are offset by increased enrollment in Medicare managed care, managed care plans are increasingly wary of offering a drug benefit.

For these reasons, Laura Tyson and other economists argue that the only efficient option is to extend drug coverage to all beneficiaries. Not only does this ensure that beneficiaries that need this coverage get it, but it limits the need for inefficient, expensive supplemental coverage.

Optional versus mandatory: Today, the Part B premium for Medicare is voluntary but, since the government pays 75 percent of the premium, virtually all beneficiaries take this option. In contrast, in 1988, when a catastrophic drug benefit was added to Medicare, all beneficiaries were required to pay the new premium. This mandatory premium was unpopular, particularly with beneficiaries with other, less expensive, and typically more generous coverage. This contributed to the subsequent repeal of this benefit.

Although proponents of a drug benefit would prefer that it be optional, there is one compelling reason to consider a mandatory benefit: costs. As with most insurance, a new optional drug benefit would create a "moral hazard", meaning that beneficiaries with high drugs costs are more likely to purchase the option. This results in a high average cost of the insurance which translates into higher premiums. Over time, healthier beneficiaries will be less willing to pay the higher premiums, causing the risk pool to shrink and the premiums to rise even more.

There are ways to reduce risk selection in an optional drug benefit. The most important would be to subsidize the premium for the benefit. Since nearly all beneficiaries use drugs, a reduced-price premium would encourage healthy beneficiaries to participate. The actuaries assume that even those with employer-sponsored retiree coverage would participate (employers would pay for the beneficiaries' share of the premium, and wrap around the Medicare benefit if their current benefit is more generous). Another way to ensure that an optional benefit is viable is to limit when beneficiaries can enroll. If beneficiaries can wait until they are sick to enroll, even a subsidized option could be subject to risk selection. Our actuaries assume that if there is at least a 50 percent premium subsidy and a one-time option to participate (when a beneficiary enrolls in Medicare), then all beneficiaries will participate in an optional benefit. It may also be possible to create transition rules for beneficiaries who lose their retiree coverage.

Premium subsidy: As described above, premium subsidies are important to participation in an optional drug benefit. At the same time, while they reduce the cost per beneficiary, they raise Federal spending in aggregate. The level of the premium subsidy was discussed extensively in the last days of the Medicare Commission. Laura Tyson and Stuart Altman, following logic of the actuaries, argued for at least a 50 percent subsidy. At one point, it appeared that the Commission would agree to a 25 percent subsidy for all beneficiaries, but in the end rejected it -- both on cost grounds and because of a reluctance to subsidize higher income beneficiaries.

One option that could address these concerns is an income-related premium for the optional drug benefit. It would have to be designed carefully, to avoid selection, but could both lessen the cost of the benefit and reduce government assistance for those who could afford it. It would make even more sense if there were an income-related Part B premium, simplifying the administration.

Cost sharing: In addition to the premium subsidy, the cost of a Medicare drug benefit depends on its cost sharing structure. There are four major moving parts of a drug benefit: (1) deductible, (2) coinsurance or copayments, (3) limits on out-of-pocket spending or stop-loss protection, and (4) cap on benefit payments. The cost sharing for Medicare beneficiaries with drug coverage varies dramatically. Employer-sponsored coverage is probably the most generous. Mirroring coverage for their under-65 workers, it typically has no separate deductible for drugs, low copayments, stop-loss protection, and no limit on benefit payments. Medigap, in contrast, has a separate, \$250 deductible, 50 percent coinsurance, and a cap on how much the plan will pay. Medicare managed care usually has low to no deductible and copayments, controlling costs by limiting the amount that plans pay.

EXAMPLES OF DRUG BENEFIT COST SHARING				
<u>Option</u>	<u>Deductible</u>	<u>Copay</u>	<u>Stop-Loss</u>	<u>Benefits Cap</u>
FEHBP*	\$50	20%	(\$3,750)	None
Retiree **	(\$300)	\$5/15	(\$1,750)	None
Medigap	\$250	50%	None	\$1250/3000
Kaiser DC:	\$0	\$5/20	None	\$1,000

Limits in parentheses are for all services, not just drugs
 * Blue Cross/Blue Shield standard option
 ** Typical retiree plan

These different design features affect who benefits the most from each policy. The table shows the illustrative effects of two policies. It assumes that beneficiaries are not now paying premiums -- those who now pay premiums for drug coverage would see even greater savings. For the most part, the table shows that even with a \$250 deductible, the combination of the deductible and the premium suggest that a beneficiary must have a sizable amount of drug spending to benefit from the new coverage. At the same time, capping the benefit at \$1,000 versus \$2,000 makes a substantial difference for a person with high expenditures. Benefits that help the sickest beneficiaries tend to be the most costly, since most of drug expenditures are associated with high users.

ILLUSTRATION OF DRUG BENEFIT OPTIONS				
NO DEDUCTIBLE, 50% COPAY, \$1,000 BENEFITS CAP				
CURRENT	NEW BENEFIT			
SPENDING	Premium	Copays	Total	Change*
\$0	\$300	\$0	\$300	+\$300
\$250	\$300	\$125	\$425	+\$175
\$500	\$300	\$250	\$550	+\$50
\$1,000	\$300	\$500	\$800	-\$200
\$2,000	\$300	\$1000	\$1,300	-\$700
\$3,000	\$300	\$2000	\$2,300	-\$700
\$500 DEDUCTIBLE, 20% COPAY, \$0 BENEFITS CAP				
CURRENT	NEW BENEFIT			
SPENDING	Premium	Copays	Total	Change*
\$0	\$300	\$0	\$300	+\$300
\$250	\$300	\$250	\$550	+\$300
\$500	\$300	\$500	\$800	+\$300
\$1,000	\$300	\$600	\$900	-\$100
\$2,000	\$300	\$800	\$1,100	-\$900
\$3,000	\$300	\$1000	\$1,300	-\$2700

* "+" indicates new spending; "-" indicates savings

Management of the benefit: The last major parameter of a drug benefit is its management. There are a number of ways that a new Medicare benefit could be administered and its costs constrained. The two major options are a HCFA-administered versus privately managed benefit. The Federal government has experience with both models through its health programs. Both Medicaid and the Veterans' Administration purchase prescription drugs for a large number of people. Medicaid has mandated a rebate for drugs. For drugs not covered by patents that prevent generic manufacturing, this discount is 11 percent of the average manufacturer price (AMP); for drugs covered by patents ("innovator drugs"), the discount is the greater of 15.1 percent of the AMP or the difference between a the AMP and a "best price" (defined in regulations). The Veterans' Administration uses a national formulary to negotiate lower prices for its members. Both use of a rebate program and formulary have served as effective price controls for drugs.

In contrast, most Federal employees get their prescription drugs through private managed care. Pharmacy benefit managers (PBMs) typically use computer networks and electronic card systems to link patients to the plan's formulary or list of drugs that are generic or reduced cost. PBMs also usually get discounts from drug companies for putting their drugs in their formularies and negotiate with pharmacies over the retail prices charged for prescriptions. Some studies suggest that the management tools used by PBMs can save up to 25 percent. However, questions that arise with this approach to a Medicare benefit are more complicated (e.g., how much liability does the PBM and/or beneficiary bear; how would the PBM be selected).

During the Medicare Commission, strong arguments were made against a HCFA-administered benefit -- in particular, the adverse market effects if HCFA engaged in rate setting and regulation. Yet, others argued that it would be irresponsible to not use the leverage to get the best discounts. This is a complicated issue that staff will continue to examine.

BY LAURA D'ANDREA TYSON

WHY MEDICARE MUST DO MORE AT THE DRUGSTORE



BIG GAP:
Prescription drugs are more important than ever for the elderly, but the private insurance system isn't working well

Dramatic breakthroughs in prescription drugs have fundamentally altered the treatment of virtually every major illness over the last few decades. Thirty years ago, patients who survived a heart attack might be sent home with advice to take it easy; today they are sent home with prescriptions for medications that improve the quality and length of life. Four out of five senior citizens are prescribed at least one drug treatment every day, and one in five take five prescribed drugs daily. These trends will only strengthen as new gene research produces advances in pharmaceuticals.

But such progress carries a hefty price tag. According to the National Bipartisan Commission on the future of Medicare, of which I am a member, some 12% of the population is elderly but these people account for more than one-third of all spending on prescription drugs. Per capita spending on drugs by the elderly is more than three times that of other adults and nearly 10 times that of children. On average an elderly American spends more than \$600 a year on drugs, with 1 in 10 spending more than \$2,000 a year. At a time of little inflation, drug spending by the elderly is projected to grow at more than 8% per year.

When the Medicare program was enacted more than 30 years ago, drug coverage was not included. Drugs were not as important in medical treatment as they are now, and drug coverage was not the norm in private health insurance plans, as it is today. Consequently, as both the effectiveness and the cost of drug therapies have increased, elderly Americans, the majority of whom have annual incomes of \$25,000 or less, have been forced to find sources other than Medicare to cover their prescription drug bills. The resulting coverage is riddled with inequities, inefficiencies, and unnecessary administrative costs.

A FAILURE. About 20% of the elderly, those living below the poverty line, can obtain drug coverage by enrolling in Medicaid. About one-third receive some drug coverage through supplemental insurance policies provided through their former employers and subsidized by federal tax breaks for employer-sponsored health insurance plans.

But the private insurance market is not working well for the elderly. From 1993 to 1997, the percentage of large companies offering retiree health benefits dropped from about 40% to about 30%. About 10% of the el-

derly buy individual private insurance policies that provide a capped drug benefit. But premiums often exceed \$1,000 per year for a policy with limited nondrug benefits and an annual cap of \$1,250 on drug spending. Some elderly people obtain drug coverage by enrolling in Medicare HMO plans, but they are not available in many locations, and their drug benefits are spartan (many have a benefit cap of \$200 per quarter). Today, about 35% of the elderly—and nearly half of the elderly who are living in rural areas—have no drug insurance whatsoever.

Why hasn't the private insurance market developed affordable policies to solve the drug coverage problem for the elderly? The major reason is what economists call the "adverse selection" problem in insurance. Most drug spending reflects chronic conditions. As a result, private plans that offer generous drug benefits tend to attract high-risk, high-cost enrollees. Healthy individuals with a low risk of chronic illness prefer more inexpensive plans that limit drug benefits. As a result, insurance plans that include adequate drug benefits quickly become extremely expensive.

CUTTING A DEAL. Supplemental private insurance coverage through employers avoids this selection problem because all the employees covered by a business, high risk and low risk, elderly and non-elderly, participate together, allowing the very sharing of risk that insurance is meant to provide.

Employers can also bargain for lower prices with drug producers. Without such bargaining power, the average elderly American who doesn't have drug insurance pays twice as much for drugs as larger insurers or HMOs. And without drug insurance, a growing number of Americans are forced to choose more expensive, less effective forms of inpatient care that are covered by Medicare over less expensive, more effective forms of outpatient care that are not.

Medicare was designed in 1965 with the goal of providing each elderly American, regardless of income, with health insurance as good as that available to the non-elderly. This goal is increasingly elusive as drug therapies become more central to the prevention and treatment of illness. It is time to stop debating whether or not Medicare should include drug coverage and start assuring that drug benefits are provided competitively, efficiently, and fairly to all Medicare beneficiaries.

ROBERT HOLMGREN

Laura D'Andrea Tyson is dean of the Haas School of Business at the University of California at Berkeley and was President Clinton's chief economic adviser.

NEC MEDICARE PRINCIPALS' MEETING

Room 248, March 18, 1999

AGENDA

I. BREAUX-THOMAS PLAN

- Summary and issues

II. PROCESS AND TIMING

- Baseline issues (Medicare Trustees 1999; CBO)
- Timing relative to Breaux-Thomas plan introduction and mark-up
- Congressional Democrats interaction / input
- Legislative language

III. UPDATE ON ONGOING WORK / FUTURE DISCUSSIONS

- Drug coverage: Additional options, distributional information, background
- Cost sharing package
- Premium support issues
- New Medicare Board issues
- Merging Medicare's Trust Funds issues

30

March

BREAUX-THOMAS MEDICARE REFORM PLAN

March 18, 1999

CONTRIBUTIONS TO MEDICARE DEBATE

- **Appears to Maintain Guarantee of Defined Benefits:** Appears to ensure that beneficiaries receive the current Medicare benefits in both traditional Medicare and in private plans.

R • **Modernizes Traditional Medicare:** Allows the Health Care Financing Administration to use the effective, competitive management tools that are used in the private sector.

- **Puts Balanced Budget Act Extenders on the Table:** Extends policies to assure efficient payments to health care providers.

h • **Rationalizes Medicare Cost Sharing:** Although we are still reviewing the details, the plan acknowledges that some of Medicare's cost sharing provisions should be restructured.

Simple in the details

MAJOR CONCERNS

- **Does Not Address Medicare's Financing:** Although the Medicare Trust Funds are merged, there is no additional funding recommended for Medicare. It recommends waiting to act until Medicare's solvency is at risk.

- As the baby boom generation retires, enrollment in Medicare will double -- no amount of reducing Medicare spending can compensate for this. Waiting to find new revenues will make the problem harder to solve and shift more of the burden to our children. This is why the President proposed to dedicate part of the surplus to Medicare immediately, to save some of today's prosperity for tomorrow's needs.

- **Raises the Age Eligibility for Medicare:** Gradually, Medicare eligibility age will be increased from 65 to 67. People losing Medicare eligibility could buy into Medicare.

- Without a policy to provide assistance to low-income people no longer eligible for Medicare, there could be large increases in the numbers of the uninsured.

- **Includes Flawed "Premium Support" Plan:** Limits the amount that the government pays per beneficiary -- so that beneficiaries choosing low-cost plans pay less, and those choosing high-cost plans pay more. Private plans also can offer extra benefits and vary cost sharing.

- The President is committed to adding competition and private sector approaches to Medicare, but not at the risk of harming the existing program or its beneficiaries. The Breaux-Thomas premium support model has the potential to increase the costs of the traditional Medicare program, even for beneficiaries with limited alternatives.

- **Adds limited drug benefit:** Provides Medicaid funding to cover prescription drugs for beneficiaries with income below 135 percent of poverty (\$11,000 for a single, \$15,000 for a couple). Also requires all Medicare and Medigap plans to offer a drug benefit.

*Many in
with
direction*

*NO
2000*

- Without insurance reforms or government assistance to ensure that the premiums are affordable, the expanded access will help few beneficiaries. Moreover, most health economists agree that the current system's patchwork drug coverage is highly inefficient and expensive. Only by making a drug benefit affordable for all beneficiaries can the

OTHER ISSUES

Removes Direct Medical Education from Medicare: Shifts funding for direct medical education from Medicare to an unspecified part of the budget. Provides no details of how this would be funded. The amount transferred (\$40 billion over 10 years) is counted towards the Commission staff estimates of \$100 billion in savings from the proposal -- savings to the Federal budget would actually be \$60 billion over 10 years.

Adds an unlimited home health copay: Charges beneficiaries 10 percent coinsurance for home health visits, without any limit on the cost sharing. For the over 1 million beneficiaries who have more than 60 visits in a year, this cost sharing could represent a large financial burden.

Creates New, Powerful Medicare Board: A new Board, exempt from executive branch rules, would be given a broad range of powers including enforcing financial and quality standards, approving benefits packages and rates, deciding on service areas, and computing payments to plans. It appears that it has some authority over Medicare fee-for-service as well as private plans.

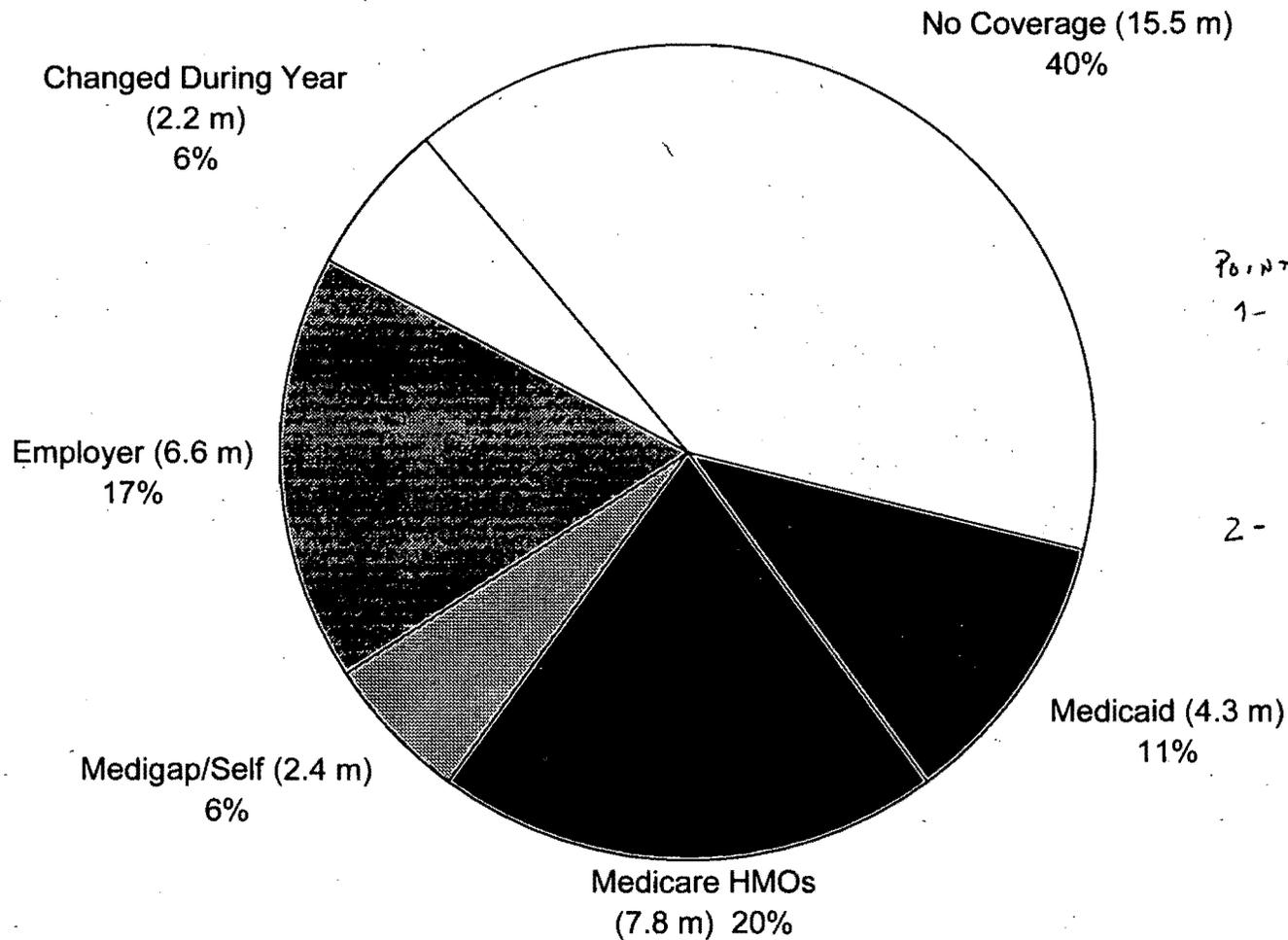
- **Merges Medicare's Parts A and B:** Recommends merging these two trust funds, and capping the general revenue contribution at 40 percent of Medicare spending. This general revenue contribution will be less than current law over time, creating a bigger financing problem than the one that we already have.

MEDICARE PRESCRIPTION DRUG BENEFIT

MAJOR PARAMETERS AFFECTING COSTS

AGENDA: March 29, 1999

Medicare Beneficiaries By Drug Coverage: 2000



POINTS:

1- UNSTABLE

- 20% Retiree
93-97

MEDIGAP:
Premium ↑
10-20 95-96

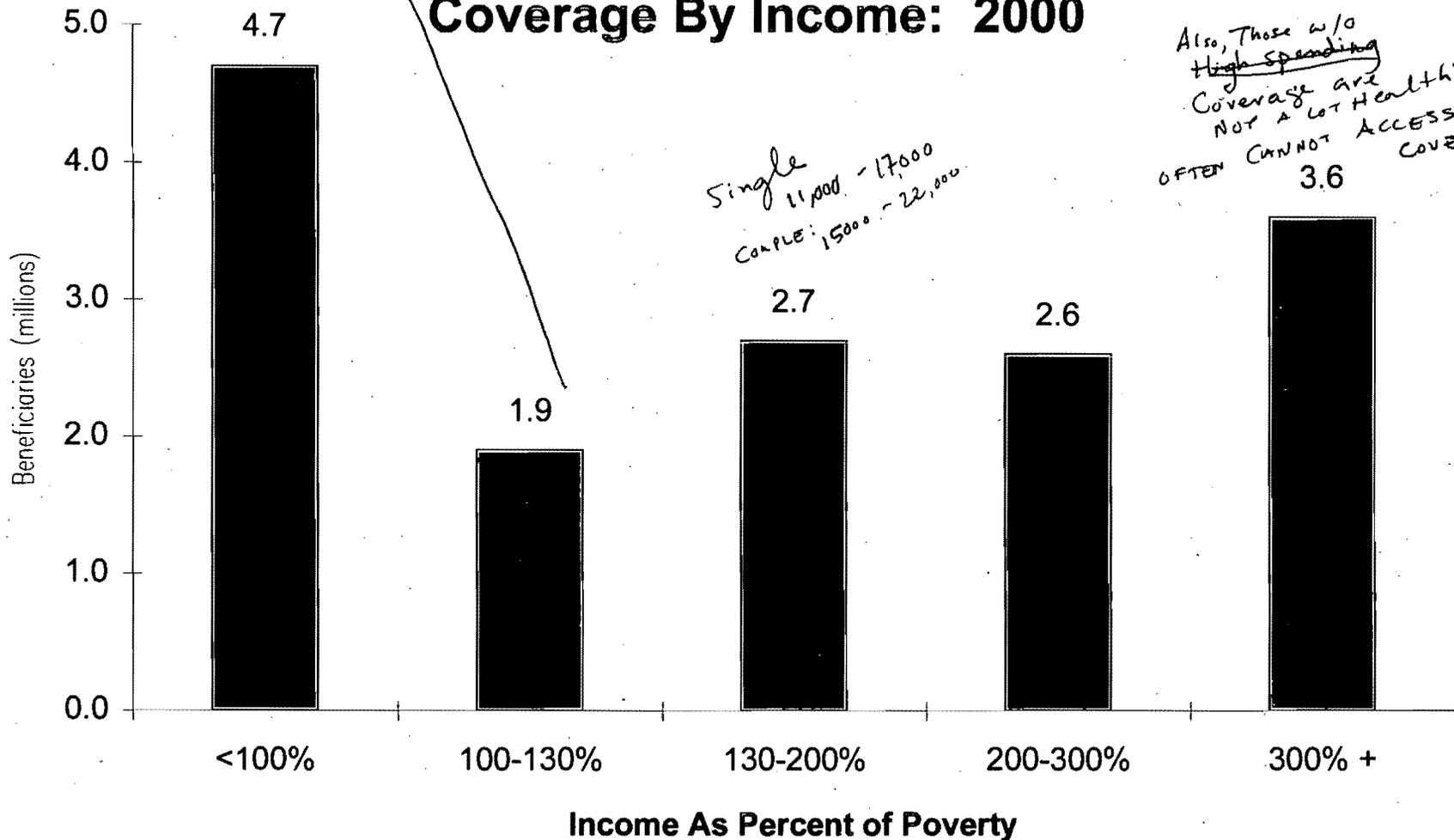
2- BENEFITS

VARY

MEDICARE -
60% Limited
Benefits

MEDIGAP
\$500 ded
50% coin
1250 Cap

Medicare Beneficiaries Without Any Drug Coverage By Income: 2000

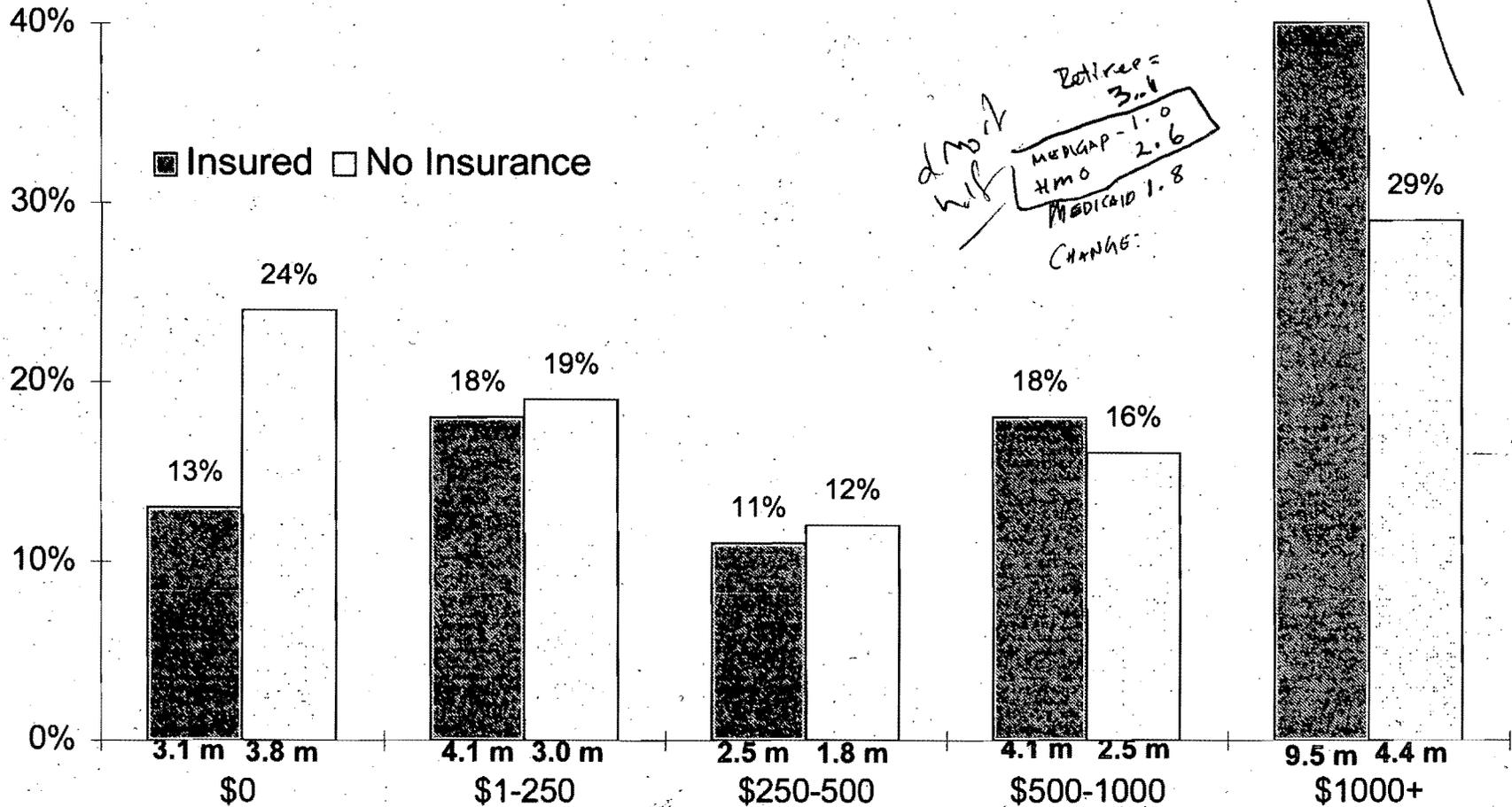


Poverty for a Single: About \$8,500; Couple: \$11,000

Note: Breaux-Thomas coverage to 135% of poverty: \$11,000 for a Single, \$15,000 for a Couple

Medicare Beneficiaries' Drug Spending: By Drug Coverage

13.9 million



dmr
wlf
 Retiree = 3.1
 MEDGAP - 1.0
 HMO 2.6
 MEDICAID 1.8
 CHANGE:

Drug Spending in 2000

PARAMETERS AFFECTING COST

ASSUMPTIONS

● Eligibility

- All Beneficiaries (versus low-income beneficiaries only)

● Premiums

- Voluntary, Limited Enrollment Options
- 50% Subsidy

● Covers All Drugs

● Management

- Pharmacy Benefits Managers (PBMs): 13 percent discount
- Allow beneficiaries to purchase at discounted rates

COST SHARING AND BENEFIT LIMITS

- **Deductible**
- **Coinsurance**
- **Benefit Payment Limits or Caps**

WSP - 1305 (Asia)

COST OF OPTIONS: DIFFERENT CAPS & COST SHARING

(Fiscal Years, Dollars in Billions)

*no more related premium
no medical offset*

<u>OPTIONS:</u>	<u>2000-04</u>	<u>2000-09</u>
HIGH		
○ <u>Uncapped</u> : \$250 deductible, 25% copay (\$41/mo)	75	243
○ <u>Capped</u> : \$0 deductible, 10% copay, \$2,000 cap (\$47/mo)	73	219
MEDIUM		
○ <u>Uncapped</u> : \$500 deductible, 25% copay (\$34/mo)	63	208
○ <u>Capped</u> : \$100 deductible, 10% copay, \$2,000 cap (\$43/mo)	67	202
LOW		
○ <u>Uncapped</u> : \$500 deductible, 50% copay (\$24/mo)	51	175
○ <u>Capped</u> : \$250 deductible, 20% copay, \$2,000 cap (\$35/mo)	55	167

Assumes: Implemented in 2001 (no cost in 2000); 50% premium subsidy; all beneficiaries participate; PBM management

ILLUSTRATION OF MEDIGAP COST SHARING

OPTION	SPENDING					
	\$0	\$250	\$500	\$1,000	\$2,500	\$5,000
Distribution 100% (38.8 million)	18% (6.8 m have \$0 spending)	18% (7.1 m spend \$1-250)	11% (4.4 m spend \$250-500)	17% (6.6 m spend \$500-1000)	24% (9.2 m spend \$1000-2500)	12% (4.7 m spend > \$2500)
MEDIGAP PLAN H						
\$500 Deductible	\$0	\$250	\$500	\$500	\$500	\$500
50% Copay	\$0	\$0	\$0	\$250	\$1,000	\$2,250
\$1,250 Cap	\$0	\$0	\$0	\$0	\$0	\$1,000
Total	\$0	\$250	\$500	\$750	\$1,500	\$3,750
Cost (+)/Savings (-) Impact: With Premium:*	+\$0 +\$1,000	+\$0 +\$1,000	+\$0 +\$1,000	-\$250 +\$750	-\$1,000 +\$0	-\$1,250 -\$250

* According to one study, the Medigap premium for Plan H for an average 65-year old was \$2,073 in 1998, compared to \$913 in Plan D, which is virtually the same except for drug coverage. This premium reflects both adverse selection and high administrative costs typically associated with Medigap.

Note: The savings to the beneficiary will be \$1,250 for all beneficiaries with spending greater than \$2,750 (\$1,750 in cost sharing and \$1,000 in premiums)

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 Volante
 M. G. S.
 P. M. K.
 J. S.
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ILLUSTRATION OF HOW COST SHARING AFFECTS BENEFICIARIES

OPTION	SPENDING					
	\$0	\$250	\$500	\$1,000	\$2,500	\$5,000
Distribution 100% (38.8 million)	18% (6.8 m have \$0 spending)	18% (7.1 m spend \$1-250)	11% (4.4 m spend \$250-500)	17% (6.6 m spend \$500-1000)	24% (9.2 m spend \$1000-2500)	12% (4.7 m spend > \$2500)
UNCAPPED (\$63 b / 5)						
\$500 Deductible	\$0	\$250	\$500	\$500	\$500	\$500
25% Copay	\$0	\$0	\$0	\$125	\$500	\$1,125
\$0 Cap	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$250	\$500	\$625	\$1,000	\$1,625
Cost (+)/Savings (-) Impact: With New Premium:*	+\$0 +\$420	+\$0 +\$420	+\$0 +\$420	-\$375 +\$45	-\$1,500 -\$1,080	-\$3,375 -\$2,955
CAPPED (\$67 b / 5)						
\$100 Deductible	\$0	\$100	\$100	\$100	\$100	\$100
10% Copay	\$0	\$15	\$40	\$90	\$240	\$490
\$2,000 Cap	\$0	\$0	\$0	\$0	\$160	\$2,410
Total	\$0	\$115	\$140	\$190	\$500	\$3,000
Cost (+)/Savings (-) Impact: With New Premium:*	+\$0 +\$420	-\$135 +285	-\$360 +\$60	-\$810 -\$390	-\$2,000 -\$1,580	-\$2,000 -\$1,580

* About \$35 / month or \$420 per year. For comparison, beneficiaries with Medigap typically pay \$1,000 additional premium for drug coverage.
 Notes: "+" indicates increased beneficiary payments; "-" indicates reduced payments. Premium estimates rough approximations; assumes that all beneficiaries do not now pay premiums; does not include discounts.