

Draft

ADDRESSING MEDICARE'S CHALLENGES

MARCH, 1999

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I. Overview

- Importance of Medicare
- Challenges Facing Medicare
- Options for Addressing Medicare's Financial Crisis

II. Medicare Commission

III. President's Plan for Medicare Reform

I. OVERVIEW

IMPORTANCE OF MEDICARE

- **Medicare pays for health care for 39 million elderly and disabled Americans:** About 34 million elderly and 5 million people with disabilities receive Medicare.
- **Helps those who would otherwise be uninsured:** Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.
- **Improves life expectancy, access to care and reduce poverty:** Since 1965:
 - Life expectancy of the elderly has increased by 20 percent (79 to 82 years)
 - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)
 - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

FINANCIAL CHALLENGES FACING MEDICARE

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 million to 47 million in 2010, to 80 million by 2035.
- **Fewer workers:** At the same time, the ratio of workers (who support Medicare) to beneficiaries is expected to decline by over 40 percent by 2030. (3.6 workers per beneficiary in 2010, declining to 2.3 in 2030)
- **Cost growth will rise:** Medicare has recently reigned in cost growth. However, it is expected to rise again as the effects of recent policy changes wear off (from 3 percent per beneficiary for 98-02 to 6 percent for 2003-10).
- **Trust Fund crisis:** Medicare's Trust Fund (for institutional services) will become insolvent in 2008 according to the 1998 Trustees' Report. Even though the 1999 Report will likely show a better prognosis, Medicare will still run out of funds many before Social Security does. With no changes, Medicare's spending will outstrip its financing and produce a \$1 trillion shortfall by 2020.

ADDITIONAL CHALLENGES FACING MEDICARE

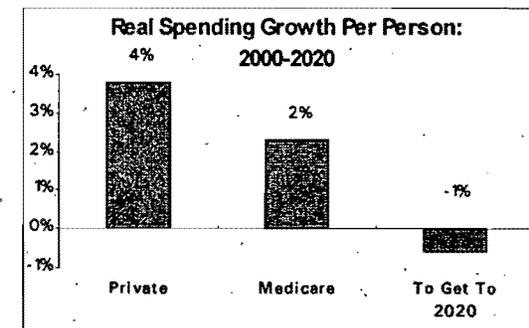
- **Inadequate benefits:** Medicare's benefits are not very generous. In particular:
 - No prescription drug coverage: Even though drugs are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.
 - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a \$768 deductible for hospital care, and \$192 per day after two months.
 - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.
 - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries buy expensive and inefficient Medigap coverage.
- **Fewer private tools for reducing costs:** Current laws prohibit Medicare from adopting some of the most effective private sector tools to save Medicare money.

OPTIONS FOR ADDRESSING MEDICARE'S FINANCING CRISIS

- **Options to address Medicare's long-term solvency:** A wide range of ideas have been considered to help solve Medicare's fiscal imbalance. These can be categorized as:
 - Reducing provider payments and increasing efficiency
 - Restricting or reducing benefits
 - Increasing beneficiary contributions to Medicare, and/or
 - Adding new revenue to Medicare

1. REDUCING PROVIDER PAYMENTS AND INCREASING EFFICIENCY

- **Strong, fiscal discipline is always a goal for Medicare:** Since 1992, overpayments to health care providers have been reduced and payment systems have been modernized. In addition, there has been great successes in reducing fraud, waste and abuse. As a result, Medicare is now growing at a rate that is below the private sector health spending.
- **However, impossibly low Medicare growth rates would be needed to extend Medicare's life through provider payment reductions and efficiency alone:** Spending growth per beneficiary would have to be constrained to 2.8 percent per year -- in every year -- to get to 2020. This rate is:
 - Over 60 percent below projected private health insurance spending per person (7.3 percent) and about 1 percentage point below inflation
- **Unsustainable provider cuts:** To ensure solvency through 2020, Part A provider payments would have to be cut by 18 percent --almost \$150 billion over 5 years.



2. RESTRICTING OR REDUCING BENEFITS

- **Restricting the benefits that Medicare covers is a second option:** However:
 - Medicare's benefits are already less generous than 4 out of 5 employers' health insurance plans.
 - All experts agree -- Medicare's benefits should be expanded to include prescription drugs and improved cost sharing, not reduced.
- **Only removing major, critical services could keep Medicare solvent in the long-run:** Because Medicare already has a limited benefits package, limiting it even more would probably not solve its long-term problems. Even removing the following services would not be sufficient to get to 2020:
 - All skilled nursing facility plus hospice spending
 - All Part A home health spending
 - Graduate medical education and disproportionate share hospital spending.

3. INCREASING BENEFICIARY PAYMENTS

- **Making beneficiaries pay more:** A third option for addressing Medicare's long-term financing crisis is to have beneficiaries pay for more of the cost of care.
 - Beneficiaries already pay for almost half of their health care costs: Because of its less generous benefits and higher cost sharing, Medicare only pays 52 percent of the total health care costs of its beneficiaries.
 - Although there are an increasing number of beneficiaries with higher income, nearly two-thirds of elderly households have income below \$20,000.

4. ADDING NEW FINANCING TO MEDICARE

- **Adding new financing to Medicare:** The fourth and final option is adding revenues to the program. In the past, this option has rarely been used by Congress and the Administration to bolster the program's financial status.
- **Different -- and larger-- financing crisis:** However, as virtually every independent analyst has concluded (e.g., Reischauer, Aaron, Tyson, Altman), the retirement of the baby boom generation makes this crisis different. The demographics make it impossible to address the financing challenge solely through provider payment cuts and efficiency gains.
- **Two choices: Raise taxes or dedicate part of the surplus to Medicare:** The amount of financing needed to pay for Medicare's shortfall -- even after significant restructuring -- can only come from the surplus or a new tax increase.

II. MEDICARE COMMISSION SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is its “premium support” proposal. This would allow private plans to compete for Medicare beneficiaries on price and extra benefits. The plan also includes a number of other policies such as modernizing traditional Medicare, adding an unlimited 10 percent home health copay, and raising Medicare’s eligibility age.
- **Savings from the Proposal:** According to Commission staff, the proposal would increase Federal spending by \$8 billion over the next 5 years, and decrease it by \$66 billion over 10.
- **Final Vote on the Breaux-Thomas Proposal:** The proposal received 10 rather than the required 11 votes to report it out as a Commission recommendation.

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL (Dollars in Billions, Commission estimates)

	<u>00-04</u>	<u>00-09</u>
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
BUDGET SAVINGS*	+6	-66

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare:** The year-long deliberations of the Medicare Commission has helped highlight the problems facing the Medicare program.
- **The Breaux-Thomas proposal has advanced the debate.** The plan has recommended a number of ideas worth serious consideration, including:
 - Making Medicare's traditional plan more competitive: It recommends that the program use the same effective, competitive management tools that are used in the private sector.
 - Simplifying Medicare's complicated, confusing and multiple deductible structure: It recommends creating a single, simple deductible. It also eliminates cost sharing for preventive services.
 - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF THE BREAUX-THOMAS MEDICARE PROPOSAL

- **Does not address Medicare's long-term solvency:** Because it includes no financing options, the Breaux-Thomas proposal does not address long-term solvency. The lack of financing makes the problem much larger to solve in the future and shifts more of the burden to our nation's children.
- **Raises the age eligibility for Medicare:** The most rapidly growing group of the uninsured are between the ages of 55-65. Raising the eligibility age of Medicare without a policy that assures that there will not be even more uninsured elderly is simply the wrong thing to do.
- **Includes flawed "premium support" proposal:** The Breaux-Thomas proposal would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to the independent Medicare actuary. Although the proposal attempts to address this problem for beneficiaries with no private plan options, those with limited or unattractive private options would be forced to pay more to stay in the system.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare:**
Neither the President nor his 4 appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conform to the principles that he outlined in January:
 - Making Medicare more efficient and competitive;
 - Maintaining and improving Medicare's guaranteed benefits; and
 - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare:** Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:
 - Competitive pricing for services like medical supplies;
 - Selectively contracting with lower-cost, high-quality providers; and
 - Paying one price for a specific conditions (e.g., diabetes or heart attacks) rather than on a service-by-service basis.
- **Examining other policies to reduce overpayment and increase competition:** The Administration will also examine specific options to reduce fraud and overpayment, extend effective payment policies, and make managed care payments more competitive.

MAINTAINING AND IMPROVING MEDICARE'S GUARANTEED BENEFITS

- **Ensuring that Medicare's guarantee is strong:** Medicare protects some of our most vulnerable citizens -- the elderly and people with disabilities -- from excessive health care costs. Proposal to strengthen Medicare must not do so at the expense of this guarantee.
- **Providing a long-overdue prescription drug benefit:**
 - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.
 - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable, regardless of where they live or whether they are in a managed care plan.
- **Simplifying and improving Medicare's cost sharing**

DEDICATING PART OF THE SURPLUS TO MEDICARE

- **Providing new financing by dedicating part of the surplus to Medicare:** The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years. This amount would equal \$686 billion over the period.
 - Investing now prevents larger problem later. Even though the Medicare shortfall is projected to accumulate to over \$1 trillion by 2020, the President's \$686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing with interest later.
 - One-time, fixed contribution: The plan does not create an unlimited tap on general revenue for Medicare. Instead, it invests a fixed proportion of the surplus -- in large part created by the baby boom generation -- in Medicare to pay for services for the temporary but overwhelming influx of retirees in the future.
 - Better option than raising taxes: Medicare's 2.9 percent payroll tax would have to be raised by 20 percent to get Medicare through 2020. It would be borne by all workers -- including younger and low-income workers.

MEDICARE COMMISSION PRINCIPALS' MEETING
Agenda: March 15, 1999

I. UPDATE ON THE MEDICARE COMMISSION

- Date
Committee

II. BASE MEDICARE POLICIES

III. ADDITIONAL MEDICARE POLICIES

- Drug Benefit
- Income-Related Premium
- Premium Support

IV. ILLUSTRATIVE OPTIONS

- Timing

Budget
Other Lih of Test Fed

BASE MEDICARE POLICIES

(Calendar Years, Dollars in Billions)

<u>POLICIES:</u>	2000-04	2000-09
Modernizing Medicare Fee-for-Service	-9	-22
Balanced Budget Act Extenders	-7	-57
Cost Sharing Changes	-1	+1
- Combined deductible of \$350		
- Adds hospital catastrophic coverage		
- Removing preventive services coinsurance		
- Adding 20% lab copay, limited 10% home health copay		
Medigap: Prohibiting Deductible Coverage	-5	-11
Interactions	+1	+4
TOTAL	-21	-85

1 - PPO
2 - Competitive Pricing
3 - Centers of Excellence
4 - Negotiating Authority for
5 - Contracting Reform

Currently: Hosp = \$768
Part B = \$100

Currently: First Day: \$768, \$192/Day for 61-90th
\$387/Day for each Reserve Day
screening mammography, pelvic exams, colorectal screening, diabetes self-management benefits

studies show that having 1st Dollar coverage increased utilization -
Cost Medicare +30% More

AAWP

* These savings exclude the President's budget proposals whose savings are used for other purposes

* Avg. Change = \$54 / bene
- 8.4 million bene save \$ 546 (all had hospitalization)
- 18.4 million bene have increase of \$161

BACKUP: MEDICARE POLICIES

March 10, 1999

MODERNIZING FEE-FOR-SERVICE: (-\$9 billion over 5 years; -\$22 billion over 10 years)

- **Preferred Provider Arrangements:** Permit DHHS to develop preferred provider arrangements, either nationally or by region. DHHS would be able to negotiate global payments or discounted fee-for-service payments with preferred providers, perhaps starting in regions where competition in the private market has brought payment rates down below Medicare's rates.
- **Competitive Bidding and Negotiated Pricing Authority; Selective Contracting:** ^{Agency} Authorize use of either competitive bidding or price negotiations to set payment rates. DHHS would have the authority to select both the items and services and the geographic areas to be included in a bidding or negotiation process based on the availability of providers and the potential for achieving savings. Bids would be accepted only if the providers met specified quality standards. DHHS also would have the authority to selectively contract only with providers who accept negotiated or bid prices and other contract terms.
- **Purchasing Through Global Payments.** Authorize DHHS to select providers and suppliers to receive global payments for services directed at a specific condition or needs of an individual (e.g. diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME). If suppliers or providers are selected to be paid on a global basis, Medicare would not be required to contract with other entities, even if they otherwise met program standards.. Beneficiaries would voluntarily elect to participate in such arrangements for a defined period during which they would be "locked-in" for the covered services.
- **Flexible Purchasing Authority:** Give DHHS the authority to negotiate alternative administrative arrangements with providers, suppliers and physicians who agree to provide price discounts to Medicare. These discounts could be based on current fee schedules or payment rates or could involve alternative payment methods. It could be targeted to those areas where market competition in the area makes other arrangements common. In general, before an alternative arrangement went into place, DHHS would have to certify that the arrangement would achieve program savings.
- **Contracting Reform:** Provide HCFA with more flexibility to require incentive arrangements and performance-based measures in contracts with intermediaries and carriers. For example, such contracts could introduce incentives such as bonus payments for benefits saving that result from better utilization management. It would also expand the pool of available entities with which HCFA could contract for claims processing, customer service, provider outreach, provider appeals, and other program functions.

Issues:

- Providers generally do not like competitive approaches
- Republicans oppose giving HCFA authority without premium support

BBA EXTENDERS: (-\$7 billion over 5 years; -\$57 billion over 10 years)

For 2003-2007:

- Extend PPS capital reduction of 2.1 percent
- Extend the 15 percent PPS-exempt capital reduction
- Reduce hospital market basket update by 1.1 percentage points
- Reduce PPS-exempt hospital update using BBA relationship between hospital's operating costs and hospital's target amount
- Reduce SNF update by 1 percentage point
- Reduce hospice update by 1 percentage point
- Reduce OPD update by 1 percentage point
- Reduce ambulance payment updates to CPI minus 1 percentage point
- Reduce prosthetics and orthotics updates by 1 percentage point
- Freeze lab updates, DME updates, and PEN payments
- Reduce ambulatory surgical centers update to CPI minus 2 percentage points

Issues:

- Hospital hits
- On top of President's FY2000 budget
- SNF update issue

COST SHARING PACKAGE

<u>Cost sharing with home health cap:</u>	-\$1 billion over 5 years; +\$1 billion over 10 years
<u>Cost sharing without home health cap:</u>	-\$9 billion over 5 years; -\$20 billion over 10 years
<u>Medigap:</u>	-\$5 billion over 5 years, -\$11 billion over 10 years

Current Law

Preventive Services Copayments:

- **Deductible** applies to hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.
- **Coinsurance** applies to screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.

Cost of buying this down: **\$770 million for 2001-04.**

Medicare Cost Sharing

Benefit	Current Law (1999)	Proposal
PARTS A AND B	--	\$350 deductible indexed to inflation
PART A		
Inpatient Hospital	\$768 deductible No copay: 0- 60th day \$192/day: 61-90th day \$384/day: 60 lifetime reserve days	None
SNF	None: 0- 20 days \$96/day: 21-100th day	20%
Post-institutional HH	None	10% per visit up to 60 visits
Hospice	Nominal copays	20%
PART B	\$100 / yr deductible	None
Physician services	20%	20%
Outpatient Hospital	About 50%	Current law
Ambulatory surgical service	20%	20%
Clinical lab	None	20%
Outpatient mental health	50% for psychotherapy, 20% for medical mngt.	Current law
Home health	None	10% per visit up to 60 visits
DME	20%	20%
PREVENTIVE SERVICES	VARIES	NONE
Screening mammography	20%	None
Pelvic & clinical breast exams, glucose monitoring, diabetes education, bone mass measurement	20%	None
Screening pap smear	None	None
Colorectal cancer screening	Varies	None
Immunizations	None	None

Issues:

- Home health copay: always controversial
- Medigap reform: Is this feasible; should a similar policy be applied to employer-based insurance

PRESCRIPTION DRUG BENEFIT

Low Front

<u>OPTIONS:</u>	<u>2000-04</u>	<u>2000-09</u>
Back-End Coverage (No Cap on Benefit)		
High Option	+84	+253
No cap on benefits, \$3,000 stop-loss		
\$300 deductible, 10% coinsurance		
Premium in 2002: \$41.50		
	<i>Annual Total: \$996</i>	
Low Option	+58	+176
No cap on benefits, no stop-loss		
\$500 deductible, 25% coinsurance		
Premium in 2002: \$28.10		
	<i>\$674</i>	
Front-End Coverage (Cap on Benefit)		
High Option	+51	+141
\$2,000 cap on benefits, no stop-loss		
\$250 deductible, 20% coinsurance		
Premium in 2002: \$28.40		
	<i>\$682</i>	
Low Option	+37	+101
\$1,000 cap on benefits, no stop-loss		
\$250 deductible, 10% coinsurance		
Premium in 2002: \$20.30		
	<i>\$487</i>	

3

For all: Voluntary, 50% premium subsidy, implemented in 2001; for all beneficiaries

INCOME-RELATED PREMIUM

<u>OPTIONS:</u>	<u>2000-04</u>	<u>2000-09</u>
<ul style="list-style-type: none"> • Health Security Act <ul style="list-style-type: none"> Singles: \$90,000 with full payment at \$100,000 Couples: \$110,000 with full payment at \$125,000 <p><u>Beneficiaries affected:</u> About 2 million (5%)</p>	-16 —	-42 —
<ul style="list-style-type: none"> • Chafee-Breaux / Senate 1997 <ul style="list-style-type: none"> Singles: \$50,000 with full payment at \$100,000 Couples: \$75,000 with full payment at \$150,000 <p><u>Beneficiaries affected:</u> About 4 million (11%)</p>	-23 —	-58 —
<ul style="list-style-type: none"> • Breaux / Commission Draft 1999* <ul style="list-style-type: none"> Single: \$24,000 with full payment at \$40,000 Couples: \$30,000 with full payment at \$50,000 <p><u>Beneficiaries affected:</u> About 13 million (33%)</p>	-38	-95

For all: Index income thresholds to inflation; No full phase-out of subsidy; Treasury run

* Phases out at a higher subsidy level than the other options

INCOME-RELATED PREMIUM

Income Cutoff	Share of Single Elderly Above Cutoff (16.3 m)	Share of Elderly Couples Above Cutoff (17.1 m)	Total Elderly (33.4 m)
\$15,000	24.9%	61.4%	44% / 15 m
\$25,000	15.3%	43.9%	30% / 10 m
\$40,000	9.3%	31.1%	21% / 7 m
\$50,000	7.1%	26.2%	17% / 6 m
\$60,000	5.0%	21.3%	13% / 5 m
\$75,000	3.2%	14.8%	9% / 3 m
\$100,000	1.8%	8.5%	5% / 2 m
\$150,000	0.9%	3.9%	2% / 1 m

- For premiums imposed at \$25,000+, the total number of beneficiaries affected would be about 7.1% higher if disabled beneficiaries were included. For premiums imposed at \$40,000+, the total number would be about 6.7% higher. For premiums imposed at \$50,000+, the total number would be about 5.5% higher. For premiums imposed at \$75,000+ or higher, the total number would be only slightly higher.
- Income-related premiums imposed between around \$20,000-\$40,000 lead to high marginal tax rates, because they interact with the phase in of taxability of Social Security benefits.
- In general, phase-ins over larger income ranges are less likely to affect the financial actions of the elderly, because they amount to smaller additional “taxes” on income. For a 25% income-related premium (beneficiary payments going from 15% of the combined premium to 40% of the combined premium), phase in over at least a \$20,000-25,000 income range would keep the incremental rate low enough that little distortion would occur. A \$25,000 range for phase in of a 25% premium is equivalent to around a 6% increase in the income tax rate in that range. A \$10,000 phase in range is equivalent to around a 15% higher rate.
- The 1997 analysis of income-related premiums concluded that approximately:
 - 2.5% of affected beneficiaries would drop Part B if required to pay 50%,
 - 7.5% would drop Part B if required to pay 75%, and
 - 15% would drop if required to pay 100%.

Comparable income-related premiums for combined Parts A and B would probably not lead to any substantial opting-out, because beneficiaries would still be receiving 50-60% subsidies for the combined program.

PREMIUM SUPPORT

<u>OPTIONS:</u>	<u>2000-04</u>	<u>2000-09</u>
<ul style="list-style-type: none"> • Breaux Plan <li style="padding-left: 20px;">Assuming 2000 implementation <li style="padding-left: 20px;">Fee-for-service premium higher than current law <li style="padding-left: 20px;">Partial geographic adjustment; limited benefits flexibility 	-26	-75
<ul style="list-style-type: none"> <li style="padding-left: 20px;">Assuming 2002 implementation 	-13	-62
<ul style="list-style-type: none"> • Competitive Defined Benefit <li style="padding-left: 20px;">Assuming 2002 implementation <li style="padding-left: 20px;">Fee-for-service premium no higher than current law <li style="padding-left: 20px;">Full geographic adjustment; limited benefits flexibility 	-8	-30
<ul style="list-style-type: none"> • Phased-In Competitive Defined Benefit <li style="padding-left: 20px;">Assuming 2004 implementation. <li style="padding-left: 20px;">Fee-for-service premium no higher than current law <li style="padding-left: 20px;">Full geographic adjustment; limited benefits flexibility 	-1	-20

- Issues:
- 1- FFS Premium: Even w/ Reforms, 10-20% + Current Law
 - 2- Geo. Adj / Risk Adj: Need to ensure that benes. do not pay for local costs or health risk
 - 3- TRANSITION
 - 4- 15 Risk North Savings

SUMMARY OF COMMISSION PROPOSALS

OPTIONS:

2000-04

2000-09

Base*	-21	-85
Income-Related Premium		
Health Security Act (\$90 / 110,000)	-16	-42
Chafee-Breaux (\$50 / 75,000)	-23	-58
Premium Support		
Competitive Defined Benefit	-8	-30
Phased-In Competitive Defined Benefit	-1	-20
DRUG OPTIONS		
High Uncapped Option (\$250 deductible)	+84	+253
Low Uncapped Option (\$500 deductible)	+58	+176
High Capped Option (\$2,000 cap)	+51	+141
Low Capped Option (\$1,000 cap)	+37	+101

* Could go higher if willing to forego President's Budget proposal, or could add other policies

ILLUSTRATIVE OPTIONS

<u>OPTIONS:</u>	<u>2000-04</u>	<u>2000-09</u>
Option 1: No Competitive Defined Benefit		
Base Plan	-21	-85
<u>Income-Related Premium (\$90/110,000)</u>	<u>-16</u>	<u>-42</u>
Subtotal	-37	-127
<u>Drug Benefit: Front-End, \$1,000 Cap</u>	<u>+37</u>	<u>+101</u>
<i>Net Savings:</i>	<i>0</i>	<i>-26</i>
 Option 2: Phased-In Competitive Benefit / Aggressive Income-Related Premium		
Base Plan	-21	-85
Income-Related Premium (\$50/75,000)	-23	-58
<u>Phased-In Competitive Defined Benefit</u>	<u>-1</u>	<u>-20</u>
Subtotal	-45	-163
<u>Drug Benefit: Front-End, \$1,000 Cap</u>	<u>+37</u>	<u>+101</u>
<i>Net Savings:</i>	<i>-8</i>	<i>-62</i>
 Option 3: Competitive Defined Benefit / Aggressive Income-Related Premium		
Base Plan	-21	-85
Income-Related Premium (\$50/75,000)	-23	-58
<u>Competitive Defined Benefit</u>	<u>-8</u>	<u>-30</u>
Subtotal	-52	-173
<u>Drug Benefit: Front-End, \$2,000 Cap</u>	<u>+51</u>	<u>+141</u>
<i>Net Savings:</i>	<i>-1</i>	<i>-32</i>