

**The President's Plan  
to Strengthen and  
Modernize Medicare  
for the 21st Century**



**"We have not just the opportunity, but a solemn responsibility, to fortify and renew Medicare for the 21st century."**

**-President Bill Clinton  
June 29, 1999**

## **The President's Plan**

- \* Modernizes Medicare's Benefits, including a Prescription Drug Benefit and Preventive Care**
- \* Makes Medicare More Competitive and Efficient**
- \* Strengthens Medicare's Financing for the 21<sup>st</sup> Century**

## **Modernizes Medicare's Benefits.**

### **Offers a New Voluntary Prescription Drug Benefit.**

**\* Three Out of Four Older Americans Lack Decent, Dependable Private-Sector Prescription Drug Coverage.** At least 13 million Medicare beneficiaries have no prescription drug coverage. Millions more have unreliable Medigap or limited Medicare HMO drug coverage. Only one in four Medicare beneficiaries has retiree drug coverage, which is the only meaningful form of private coverage.

**\* New Drug Benefit Option Makes Prescriptions Available and Affordable for All Beneficiaries.** The Clinton-Gore Administration is taking a long-overdue step to ensure that all Medicare beneficiaries can have access to affordable prescription drugs.

**\* Provides Meaningful Coverage.** Medicare would cover half of the beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending (fully phased-in by 2008).

**\* Affordable Premiums and No Deductibles.** The drug benefit would have no deductible and will cost about \$24 per month beginning in 2002 and \$44 per month when fully phased-in. This is one-half to one-third of the typical cost of private Medigap premiums.

**\* Majority of Drug Benefit Costs Offset by Savings.** This benefit would cost \$118 billion over 10 years – less than 10 percent of total Medicare spending. Over 60 percent of the costs are offset by the proposal's savings. The rest comes from the federal budget surplus – representing less than one-twentieth of the available surplus.

### **Ensures Access to Essential Preventive Services.**

**\* Preventive Services Are Important to the Well-Being of Seniors and Americans with Disabilities.** Older Americans are the fastest growing age group in the U.S. and carry the greatest risk of developing chronic disease and disability. About 88 percent of those over the age of 65 have at least one chronic health condition, many of which are preventable, if detected early.

**\* Makes Preventive Services Much More Affordable.** The President's Plan eliminates existing copayments and deductibles for every preventive service covered by Medicare, including:

- ✓ annual mammograms for all beneficiaries,
- ✓ cervical cancer screening and pelvic exams,
- ✓ tests to help detect osteoporosis (bone mass measurements),
- ✓ colorectal cancer screening,
- ✓ prostate cancer screening,
- ✓ flu and pneumonia vaccinations, and
- ✓ diabetes self-management.

**\* Ensures Access to Latest Preventive Services.** The Plan does not stop at removing financial barriers. It invests in a nationwide education campaign to address the lack of knowledge about the importance and availability of preventive services. Finally, it launches studies of the cost-effectiveness and scientific merits of additional preventive services.

IV Strengthening  
Medicare

7 Proposed New Comp.  
Plan to Strengthen +  
Modernize Medicare

**THE CLINTON-GORE ADMINISTRATION HIGHLIGHTS THE IMPORTANCE OF  
THEIR PLAN TO STRENGTHEN AND MODERNIZE MEDICARE TO WOMEN**

**July 27, 1999**

Today, at the White House, President Clinton and First Lady Hillary Rodham Clinton joined the Older Women's League (OWL) in releasing a report entitled "*Medicare: Why Women Care,*" which includes a new analysis documenting why strengthening and modernizing Medicare is particularly important to women of all ages. The President and the First Lady also underscored the importance of taking advantage of the historic opportunity to dedicate a significant portion of the surplus to secure the life of the Medicare trust fund for a quarter century. In releasing this report, OWL stated its strong support for the President's vision of dedicating the surplus to strengthen Medicare, adding a prescription drug benefit, and improving preventive services.

The Vice President later joined the Democratic leadership and released a new analysis on the greater challenges that beneficiaries in rural America face in accessing prescription drug coverage. He pointed out that, although representing fewer than one-fourth of the Medicare population, beneficiaries living in rural areas account for over one in three of all beneficiaries lacking prescription drug coverage. Today, the Clinton-Gore Administration:

**UNVEILED A NEW REPORT BY THE OLDER WOMEN'S LEAGUE.** Nearly 60 percent of Medicare beneficiaries are women and this proportion rises with age – over 4 in 5 people over age 100 are women. Moreover, older women tend to have more chronic illness and lower incomes, making Medicare even more important as a health and financial safety net. Since it was created in 1965, Medicare has contributed to lengthening older women's lives by 20 percent and reducing their poverty rate dramatically. Yet, the 21<sup>st</sup> century brings with it challenges that will affect all beneficiaries.

**Key findings of the report include:**

- **In the next 30 years, the number of Medicare beneficiaries will double – most of them will be women.** In 2035 alone, there will be nearly 40 million elderly women and fewer than 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund by 2015 and in the need for more revenue to avoid devastating cuts to the program.
- **Total prescription drug spending for women on Medicare averages \$1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about \$12,750 for a single, \$17,000 for a couple), despite older women's lower average income.
- **Medicare's preventive benefits are underused by older women.** Financial and information barriers prevent older women from using critical preventive services. In recent years, just 1 in 7 women have taken advantage of Medicare-covered mammograms.

**Other key findings include:**

## **MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.**

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans. The proportion of the elderly who are women rises with age; about 71 percent of people age 85 or older are women. Eighty-three percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.
- **New revenue is necessary to ensure that the Medicare trust fund is solvent when women in the baby boom generation retire.** Since most women turning 65 today are expected to live through 2018, the projected insolvency of the Medicare Trust Fund will occur within their lifetime.
- **Women have greater health care needs and lower income.** Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

## **WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS.** As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** The combination of greater health problems and lower income results in women on Medicare spending 22 percent of their income on health care compared to 17 percent for men. Lower income women spend an even greater share of their limited incomes on health care – 53 percent for the poorest.
- **Total prescription drug spending averages \$1,200 for women on Medicare – 20 percent more than that of men.** Older women tend to have more chronic illnesses that require medication to manage.
- **For most women, existing coverage is unstable, unaffordable and declining.** Medigap routinely increase premiums with age – at age 85, premium for a Medigap plan with drug coverage up to \$1,250 costs from \$300 to \$400 per month -- \$3,600 to \$4,800 per year. This discriminates against women, who comprise nearly three-fourths of people in this age group. It also charges more at a time where income has declined.
- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Despite their lower average income, fully half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In recent years, just one in seven women without supplemental insurance used Medicare-covered mammograms. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

**EMPHASIZED GREATER PROBLEMS FACING RURAL BENEFICIARIES IN ACCESSING PRESCRIPTION DRUG COVERAGE.**

The Vice President also released new facts on the challenges facing rural beneficiaries. Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries. This reflects the lower access to Medicare managed care and retiree health coverage for these beneficiaries. The Vice President also released information documenting that lack of access to prescription drug coverage occurs throughout the income spectrum – 45 percent of rural beneficiaries with income above \$50,000 lack prescription drug coverage compared to 25 percent of all beneficiaries.

**HIGHLIGHTED THE IMPORTANCE OF INVESTING IN THE FUTURE OF THE MEDICARE PROGRAM.**

Today, the President, First Lady and Vice President underscored the fact that there will not be a debate about how to strengthen Medicare or how to provide a prescription drug benefit if all of the surplus is invested in a large tax cut. They stated their strong belief that the Congress and the American public face an important decision: to invest in a stronger Medicare program for our mothers and grandmothers or give away the entire surplus on a risky and irresponsible tax scheme.

**OVERVIEW:**  
**PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE  
FOR THE 21<sup>ST</sup> CENTURY**

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

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

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: \$25 billion over the next 10 years.
- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: \$8 billion over the next 10 years, starting in 2003.
- **Constrains out-year program growth, but more moderately than the Balanced Budget Act (BBA) of 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates, but are more modest than those included in the BBA. These proposals along with the modernization of traditional Medicare would reduce average annual Medicare spending growth from an estimated 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: \$39 billion over next 10 years (including interactions and premium offsets).

- **Takes administrative and legislative action to smooth out the BBA provider payment reductions.** The proposal includes a 7.5 billion “quality assurance fund” to smooth out provisions in the BBA that may be affecting Medicare beneficiaries’ access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers’ ability to deliver quality services to beneficiaries. Finally, it contains a legislative proposal to better target disproportionate share hospitals. Cost: \$7.5 billion over 10 years.

**MODERNIZING MEDICARE’S BENEFITS.** The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President’s plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the FY 2000 President’s Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare “Part D” prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:
  - Have no deductible and pay for half of the beneficiary’s drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2008.
  - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the \$5,000 limit is reached.
  - Cost about \$24 per month beginning in 2002 (when the coverage is capped at \$2,000 in spending) and \$44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)
  - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$15,000 single/couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.
  - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: \$118 billion over the next 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost \$3 billion over 10 years and would:
  - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
  - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.
  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.
- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save \$11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:
  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.
  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.
- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).
- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The \$1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

**STRENGTHENING MEDICARE'S FINANCING FOR THE 21<sup>ST</sup> CENTURY.** The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus (\$794 billion over 15 years) to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2027, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.
- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about \$118 billion over 10 years. Its budgetary impact would be fully offset by:
  - Savings from competition and efficiency. About 60 percent of the \$118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.
  - Dedicating a small fraction of the surplus. About \$45.5 billion of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:
    - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and
    - Less than the reduction in the Medicare baseline spending between January and June, 1999.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently stated their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success creating a strong economy and in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

**PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE  
MEDICARE FOR THE 21<sup>ST</sup> CENTURY**

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21<sup>st</sup> Century
- **Reduces Medicare spending for current services by \$72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.
- **Adds an optional prescription drug benefit.** This benefit would cost \$118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009 (net of premiums).
  - Over 60 percent of the costs are offset by the proposal's savings.
  - The remaining \$45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the \$374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.
- **Extends the life of the Medicare Trust Fund to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the estimated life of the Medicare Trust Fund for a quarter century from now, through at least 2027.

<b>PRESIDENT'S PROPOSAL</b>		
<i>(Dollars in Billions, Trustees' Baseline)</i>		
	<u>00-04</u>	<u>00-09</u>
<b>COMPETITION &amp; EFFICIENCY</b>		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
<b>Total</b>	<b>-5</b>	<b>-64.5</b>
<b>MODERNIZING BENEFITS</b>		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
<b>Total</b>	<b>+27</b>	<b>+110</b>
<b>DEDICATING FINANCING</b>		
Contribution to Solvency	-28	-328.5**
<b>Surplus for Drug Benefit</b>	<b>-22</b>	<b>-45.5</b>
<b>Surplus Allocation</b>	<b>-50</b>	<b>-374</b>
*Includes \$5.7 billion in interactions/premium offset		
** Does not count toward package		

**PRESIDENT'S PLAN TO  
MODERNIZE & STRENGTHEN  
MEDICARE**

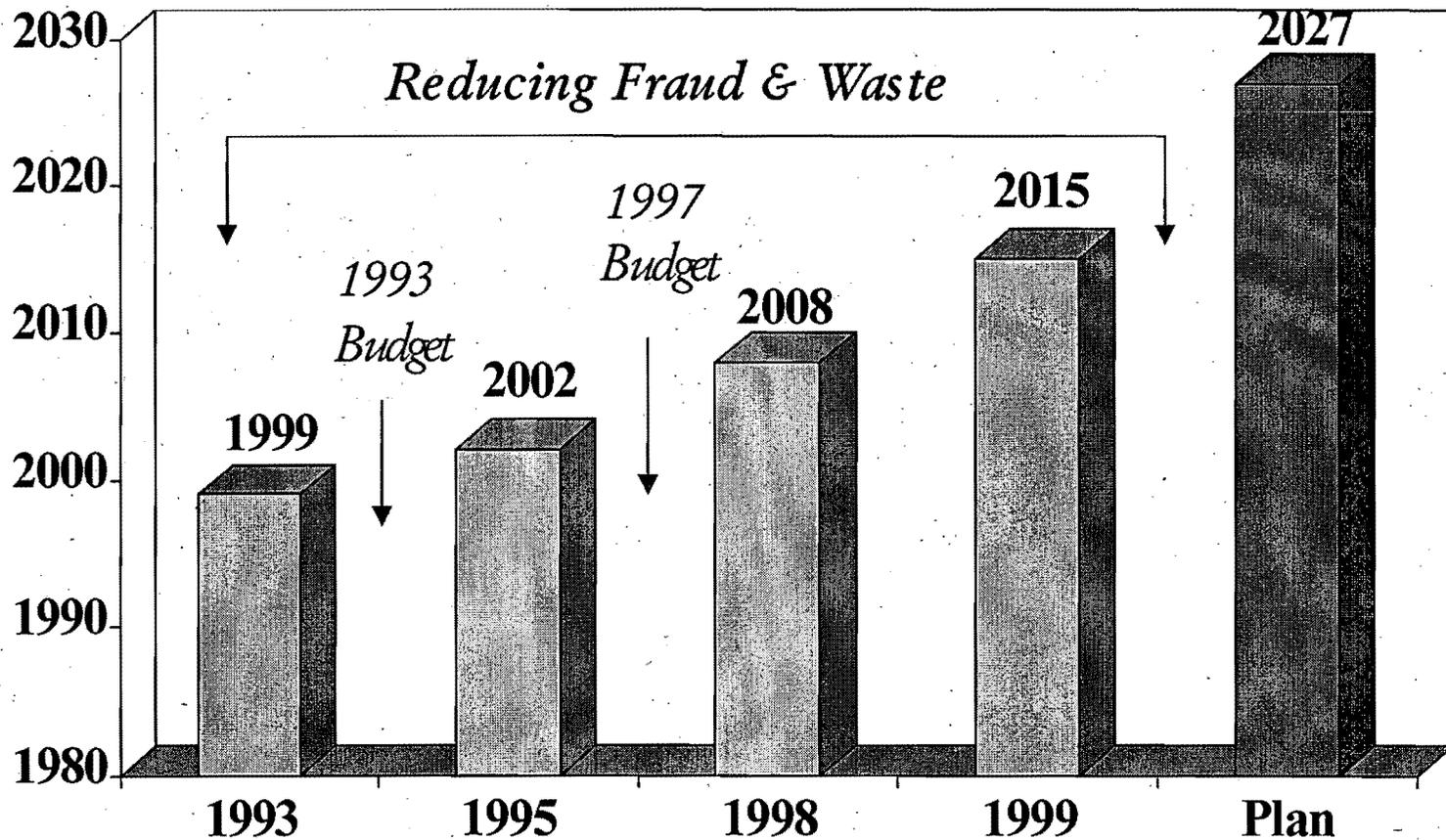
July 16, 1999

# President's Plan To Modernize and Strengthen Medicare

- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21st Century

# Modernizing and Strengthening MEDICARE

*Extending The Solvency Of Medicare To 2027*

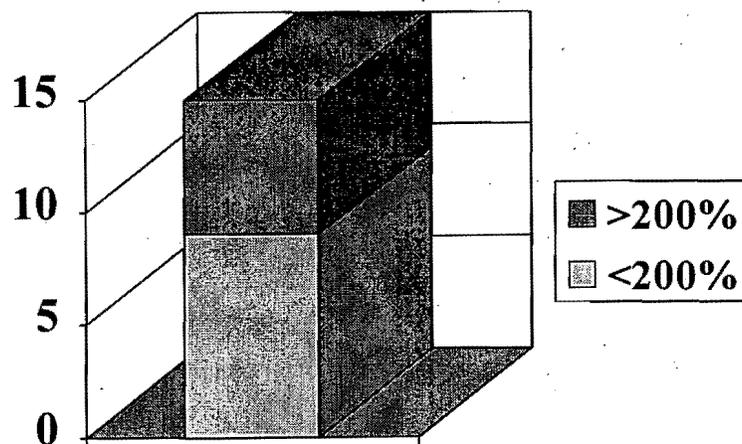


# President's Proposal For Medicare Prescription Drug Coverage

- **Meaningful coverage.** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50% copay with access to discounted prices
  - Benefit limited after \$5,000 in costs (phased-in)
- **Affordable premiums:** \$24/month, rising to \$44/month when fully phased in. Includes low-income protections
- **Private management,** and incentives for retaining retiree health coverage

# All Types of Beneficiaries Lack Coverage For Prescription Drugs

Over 40% of Beneficiaries Without Drug Coverage Have Income Above 200% of Poverty (Millions of People)

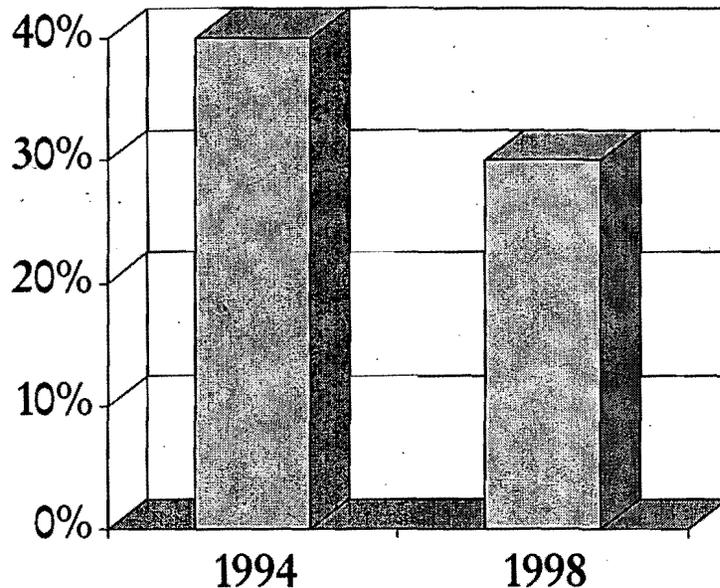


200% of Poverty = \$16,000 for singles, \$22,000 for couples

- Disproportionately affects rural beneficiaries. About half of rural beneficiaries have no coverage
- Older beneficiaries are less likely to have coverage. Over 40 percent of beneficiaries older than 85 pay for their prescription drug costs out-of-pocket, compared to about one-third of beneficiaries ages 65-69

# Prescription Drug Coverage: Private Sources Declining

Firms Offering Retiree  
Health Coverage



- Individual Medigap coverage is becoming even more rare -- and expensive. Premiums for drug coverage through Medigap can be \$90 per month -- and twice as high for older beneficiaries. Only about one in 20 beneficiaries have drug coverage through Medigap.

# Making Medicare Managed Care More Competitive

## Current System

- No price competition
- Plans compete by offering hard-to-compare benefits
- Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer

## Competitive Defined Benefit

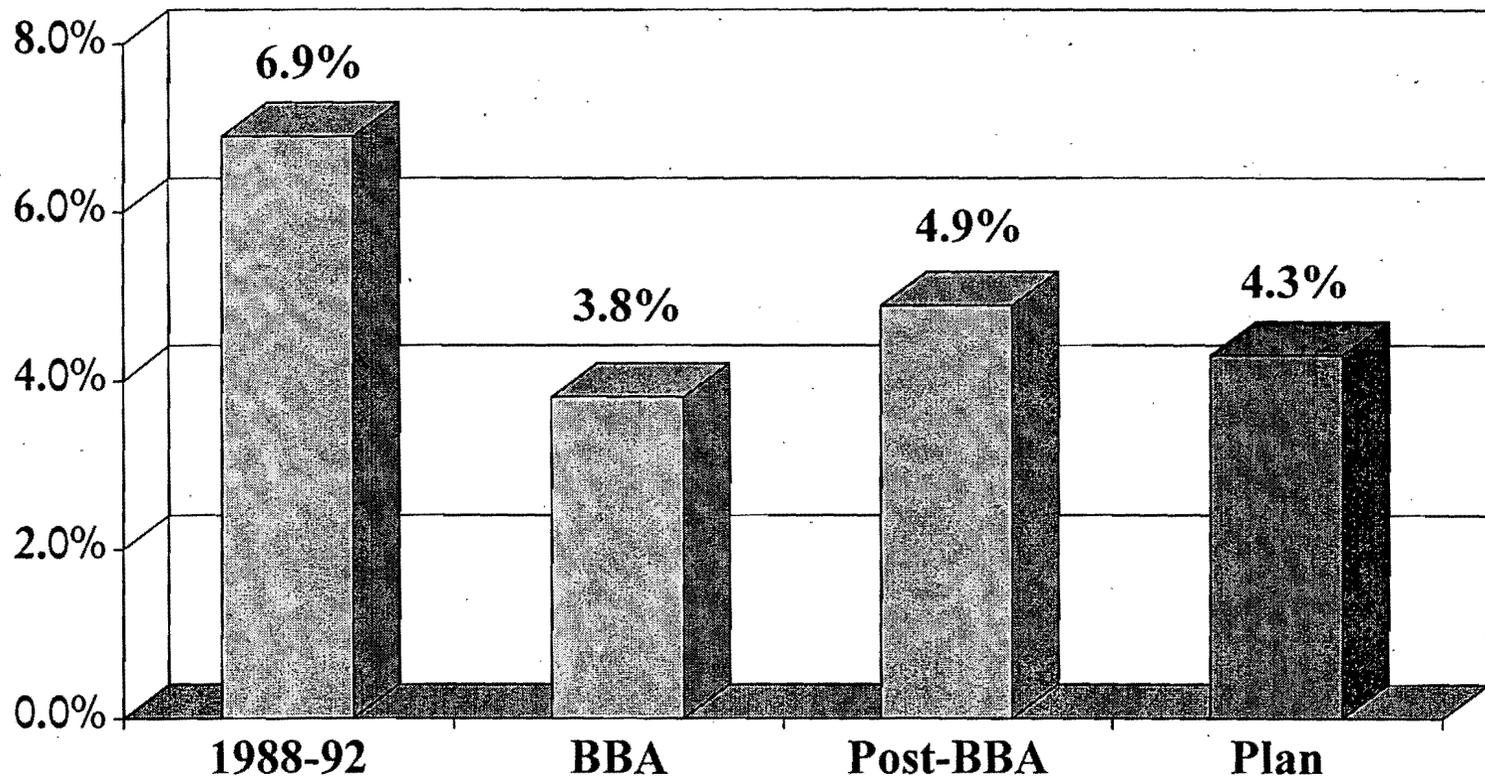
- Plans paid based on price and quality
- Plans compete by lowering premium & cost sharing
- Explicitly pays for drugs in managed care as well as traditional Medicare

# Smoothing Out Balanced Budget Act Policies In The Short Run

- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies
- **Targeting Disproportionate Share Hospital Payments Directly to Hospitals**
- **\$7.5 Billion Quality Assurance Fund**

# Keeping Medicare's Growth In Check

## Spending Growth Per Beneficiary



BBA is for 1998-2002; Post-BBA is for 2002-2009; Plan is for 2002-2009 under the President's plan

**MEDICARE:**

**THE PRESIDENT'S PLAN TO  
MODERNIZE AND STRENGTHEN MEDICARE  
FOR THE 21<sup>st</sup> CENTURY**

July, 1999

# **THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21<sup>st</sup> CENTURY**

## **I. Overview**

- Importance of Medicare
- Challenges Facing Medicare

## **II. President's Plan for Modernizing and Strengthening Medicare**

- Making Medicare More Competitive and Efficient
- Modernizing Medicare's Benefits, Including Adding a Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21<sup>st</sup> Century

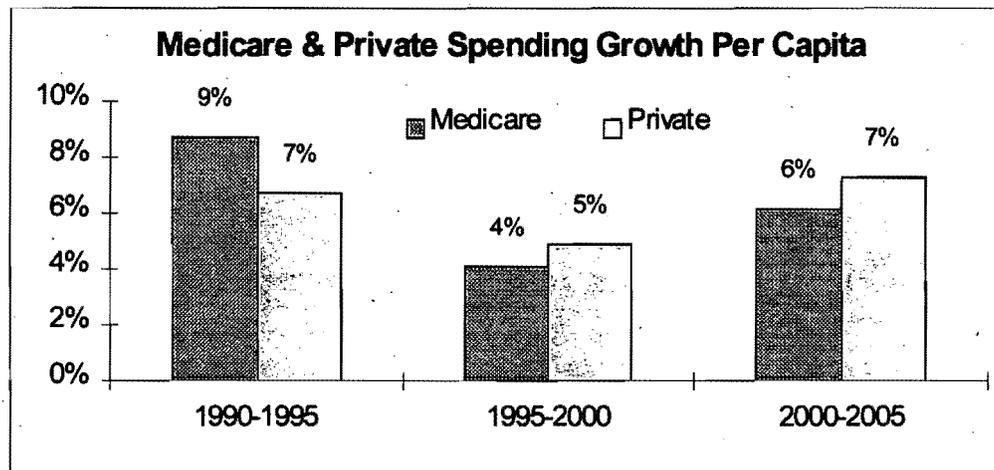
# I. OVERVIEW

## IMPORTANCE OF MEDICARE

- **Medicare now 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 and millions more had substandard coverage. Given the recent rapid rise of the uninsured ages 55 to 65 who are even healthier than seniors, this problem would have been worse today.
- **Improves life expectancy, access to care and reduces poverty:** Since 1965:
  - Life expectancy of people who reach age 65 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%)

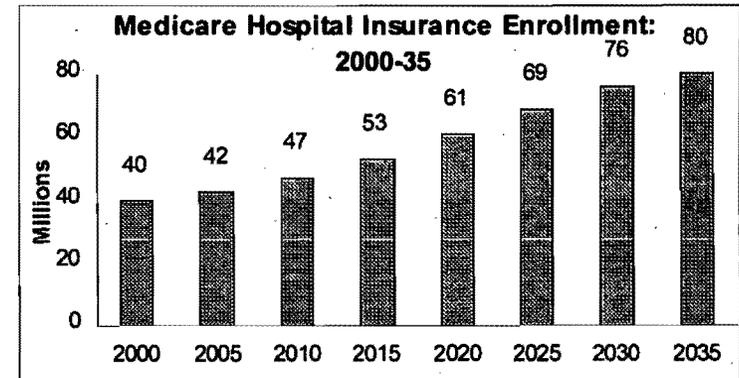
# MEDICARE'S FINANCIAL STATUS HAS IMPROVED

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. When President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999.
- In response, the President advocated for Medicare reforms in 1993 and 1997, and instituted an unprecedented crack-down on fraud and abuse. These actions, in combination with a strong economy, constrained cost growth and extended the life of the trust fund until 2015.
- The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



## CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires – from 39 to 80 million by 2035 – from 14 percent to about 22 percent of the population.
- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (from 3.6 workers per beneficiary in 2010 to 2.3 in 2030).
- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.
- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 – about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries.



## ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

- **Millions have no coverage for prescription drugs.** Prescription drugs have become central to modern medicine, yet nearly 15 million Medicare beneficiaries have no coverage.
  - About 40 percent of beneficiaries without drug coverage (about 6 million) have income above 200 percent of poverty (about \$16,000 for a single, \$22,000 for a couple).
- **Current prescription drug coverage is unstable and declining rapidly.**
  - Employer-sponsored retiree health insurance is declining. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1998.
  - Medigap, the individually purchased supplemental policies, has grown very expensive and less common. Medigap premiums have been rising rapidly, are often set so to increase with age, and typically cost at least twice as much as the premium as the President's plan.
  - Medicare managed care plans frequently cover drugs, but 11 million beneficiaries do not have access to any managed care plans. Drug coverage is typically limited (e.g., \$1,000 cap), and many plans are dropping or severely limiting coverage.
- **Drug coverage today resembles hospital coverage before Medicare.** Before 1965, 56% of the elderly had insurance, but this coverage was expensive, inadequate and unreliable. Medicare would not have been created if this coverage was considered adequate.

# OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

- **Insufficient flexibility in traditional Medicare to adopt best private sector practices to reduce costs and increase quality.** Medicare is governed by statutory constraints that limit its ability to adopt innovative payment and management strategies.
- **Medicare pays managed care plans a flat rate, set by a complex statutory formula, that has nothing to do with plan prices.**
  - Overpaid. A June 1999 report from the General Accounting Office found that the Balanced Budget Act has not eliminated managed care plan overpayments. For example, managed care plans in Los Angeles can provide the traditional Medicare benefits package for 79 percent of what they are currently paid.
  - No price competition – only competition on providing extra benefits . Managed care plans offer extra benefits with the overpayment – they cannot compete on price.
    - Hard for beneficiaries to comparison shop on benefits
    - Easy to attract healthy or avoid sick beneficiaries by custom-designing benefits
    - Unfairly subsidizes benefits in high-cost / high-payment areas: 75 percent of rural beneficiaries do not even have the option of joining managed care.

## II. PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21<sup>st</sup> CENTURY

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21<sup>st</sup> Century
- **Reduces Medicare spending by \$72 billion /10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition.
- **Adds an optional prescription drug benefit.** This benefit would cost \$118 billion over 10 years, fully financed by the offsets in the proposal.
- **Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027.** This will significantly reduce the need for excessive reductions in Medicare spending when its costs explode as the baby boom generation retires.

<b>PRESIDENT'S PROPOSAL</b>		
(Dollars in Billions, Trustees' Baseline)		
	00-04	00-09
<b>COMPETITION &amp; EFFICIENCY</b>		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
<b>Total</b>	<b>-5</b>	<b>-64.5</b>
<b>MODERNIZING BENEFITS</b>		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
<b>Total</b>	<b>+27</b>	<b>+110</b>
<b>DEDICATING FINANCING</b>		
Contribution to Solvency	-28	-328.5**
<b>Surplus for Drug Benefit</b>	<b>22</b>	<b>-45.5</b>
<b>Surplus Allocation</b>	<b>-50</b>	<b>-374</b>
* Includes \$5.7 billion in interactions/premium offset		
** Does not count toward package		

# I. MAKING MEDICARE MORE EFFICIENT

## Private Sector Purchasing & Quality Improvement Tools for Traditional Medicare

- **Allowing Traditional Medicare to Adopt Best Private Practices.** This proposal would build on the President's commitment to give traditional Medicare the ability to adopt payment and quality improvement tools that are frequently used in the private sector.
  - Promoting the use of high-quality, cost-effective providers. Give beneficiaries a financial incentive (e.g., lower cost sharing) to choose selected providers (like a PPO); pay facilities that meet quality and cost standards a single price (Centers of Excellence).
  - Primary care case management and disease management. Structure payments to promote coordination of services for certain diseases or beneficiaries who have high health costs to reduce hospitalizations.
  - Coordinating care for dual eligibles. The 17 percent of beneficiaries who are Medicare-Medicaid dual eligibles account for 28 percent of spending. Provide information to help coordinate benefits; test models in traditional Medicare to coordinate services.
  - Using competitive pricing, selective contracting, negotiated discounts. These market-oriented practices will make Medicare a stronger negotiator and more efficient manager.

# Competitive Defined Benefit Proposal

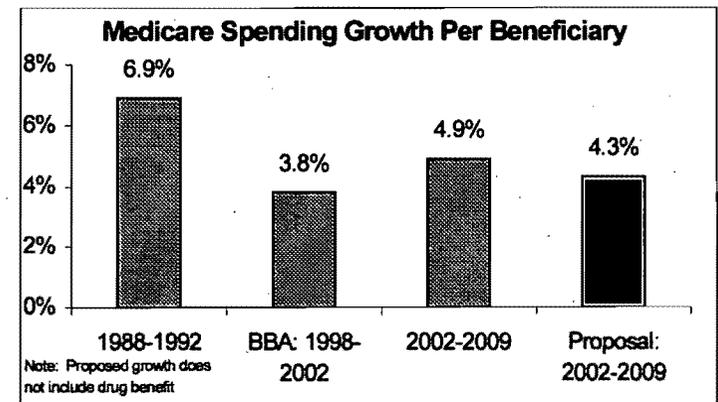
- **Competitive defined benefit proposal.** This proposal would pay managed care plans based on competitive prices, not on fixed rates. If a plan's price is higher than 96 percent of traditional program costs, the beneficiary would pay a higher premium. If it is less, the beneficiary would pay a premium that is lower than the Part B premium.
- **Saves through competition, not rate reductions.** Unlike the current system, Medicare would save money when beneficiaries choose lower cost plans. For each dollar saved, beneficiaries would receive 75 cents, the government 25 cents.
- **Price competition promotes informed beneficiary choice.** By having plans compete over a defined benefit, beneficiaries can make "apples-to-apples" comparisons over price and quality. This eliminates the problem of plans designing benefits to attract healthy enrollees.
- **Plan payments more rational.** Rather than receiving a rate based on a complicated formula, managed care plans would get paid what they bid, although the higher the price, the higher the beneficiary premium. The government payment includes the costs of prescription drugs, risk adjustment and full geographic adjustment in high-cost areas.

**Example: Competitive Defined Benefit Proposal**

Option	Plan Price (monthly)	Split of Plan Payments	
		<i>Beneficiary</i>	<i>Government</i>
Low-Price Plan	\$433.33	\$0.00 0%	\$433.33 100%
Medium-Price Plan	\$490.00	\$42.50 9%	\$447.50 91%
Price Equals 96% Of Traditional Costs	\$500.00	\$50.00 10%	\$450.00 90%
High-Price Plan	\$520.00	\$70.00 13%	\$450.00 87%

## Smoothing Out Balanced Budget Act Policies: Short- and Long-Term

- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this, this plan includes:
  - Administrative actions. The plan includes immediate administrative actions to moderate the impact of the BBA on hospitals, academic health centers, and home health agencies.
  - Better targeting disproportionate share hospital payments. These payments would be removed from managed care payments and paid directly to qualifying hospitals.
  - \$7.5 billion quality assurance fund. This fund would be used to modify BBA provisions that have been determined by the Administration, Congress, and health experts to be severely undermining providers' ability to delivery high-quality, affordable health care.
- **Constraining out-year program growth, but more moderately than BBA 1997.** To moderate program growth after most of the provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates. They are more modest than those included in the BBA 1997 and would result in a growth rate that is 15% higher than it would have been had BBA rates continued.



# Improving Medicare Management

- **Modernizing Medicare management.** The President's plan includes a major modernization reform of the management of Medicare. It would:
  - **Increase accountability through public/private advisory boards.** These include:
    - Management Advisory Council. Panel of public and private sector management experts to identify and recommend best management practices for Medicare.
    - Medicare Coverage Advisory Committee. Experts in medicine and science, consumer and industry representatives would provide advise on coverage policy.
    - Citizens' Advisory Panel on Medicare Education. Experts in consumer education and health policy and health care providers would monitor and evaluate Medicare's consumer education initiatives.
- **Increasing personnel flexibility.** Medicare has taken strides in hiring experts from the private sector to manage its programs. It has contracted with an outside evaluator to determine how best it can prepare its staff for the challenges of the next century.

# MODERNIZING MEDICARE BENEFITS

## Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002.
  - Meaningful coverage. Medicare would cover half of drug costs from the first prescription up to \$5,000 in spending per year (\$2,500 in Medicare payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers.
  - Affordable premiums. Beneficiaries would pay separate premium for Medicare Part D -- an estimated \$24 per month in 2002, and \$44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded (no premiums below 150% of poverty; no cost sharing below 135% of poverty).
  - Private management. Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers or similar entities to manage the benefit. No price controls would be used.
  - Medicare support for retiree coverage. Medicare would pay a reduced premium subsidy for beneficiaries who receive coverage through their employers' health plan.

# Improving Preventive Benefits and Eliminating Cost Sharing

- **Promoting prevention for Medicare beneficiaries.** This proposal would take a number of steps to make preventive services more affordable, as well as to raise awareness of services
  - Eliminating all existing preventive services cost sharing. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. For the rest of the preventive services covered by Medicare, cost sharing is already waived. Cost: \$3 billion over 10 years.
  - Smoking cessation demonstration. A three-year demonstration project would evaluate the cost-effectiveness of smoking cessation services for Medicare beneficiaries.
  - Education campaign. A new, nationwide campaign would be launched to encourage use of preventive services and promote healthy behaviors for all Americans over age 50.
  - U.S. Preventive Services Task Force study. This impartial panel of experts would evaluate preventive services that are appropriate for the elderly, providing guidance for future Medicare improvements.

# Rationalizing Cost Sharing and Medigap

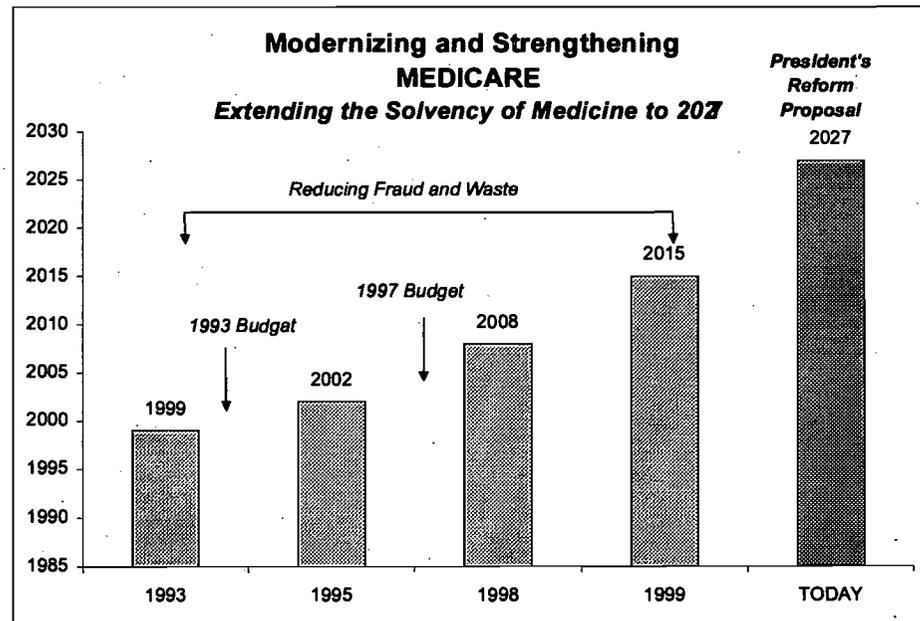
- **Rationalizing Medicare cost sharing.** The plan would change Medicare cost sharing by:
  - Adding a 20 percent clinical laboratory coinsurance. Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform. It also could cut down on fraud and help reduce over-use.
  - Indexing the Part B deductible to inflation. Medicare's Part B deductible of \$100 would be indexed annually to inflation so its value does not decline over time.
- **Reforming Medigap.** The plan would update the private insurance policies called Medigap:
  - Adding a new plan option, with nominal cost sharing. This would better track the coverage for the nonelderly, and could reduce premium costs for Medigap.
  - Updating existing plan options. In light of the new prescription drug policy and other changes proposed in the plan, all of the Medigap plan options would be updated.
  - Reporting to Congress on policy alternatives to Medigap, since access problems are rising.
  - Improving access to Medigap for beneficiaries whose private plans withdraw from Medicare.

## Medicare Buy-In for Certain People Ages 55-65

- **Important insurance option for those nearing Medicare eligibility.** The plan includes the President's proposal to expand health options for people ages 55 to 65. Its costs are offset in the context of the FY 2000 President's Budget submission.
  - People ages 62 to 65 without access to employer-sponsored insurance would have the choice to buy into the Medicare program for approximately \$300 a month if they agreed to pay a small risk adjustment payment once they become eligible for Medicare at age 65.
  - Displaced workers between 55-62 who involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400).
  - Retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.
- All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever. The initiative should help 300,000 to 400,000 people.

### III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21<sup>st</sup> CENTURY Surplus for Medicare Solvency

- The President has renewed the commitment he made in the State of the Union Address to dedicate 15 percent of the surplus to Medicare. Over the 15-year window covered by the President's Framework, \$794 billion would be dedicated to strengthening Medicare and extending its solvency. This amount is more than the \$686 billion from the budget since the surplus has increased.
- Extends the trust fund to 2027. The combined effect of this reform package would extend the life of the Hospital Insurance trust fund to at least 2027 – 12 years longer than its current projected expiration in 2015.



## Financing for the Prescription Drug Benefit

- **Prescription drug benefit designed to be fiscally responsible.** To ensure that it does not result in unsustainable spending growth in the out-years, this proposal's drug benefit's limit is indexed to general inflation. Thus, Medicare offsets are able to keep pace with its growth.
- **Medicare savings are the primary source of funding for the new prescription drug benefit.** About 60 percent of the costs of the prescription drug benefit would come from reducing Medicare cost growth, improving its efficiency, and beneficiary contributions.
- **Small fraction of the surplus used as financing.** The remaining \$45 billion would be financed by using a fraction of the 15 percent of the surplus dedicated to Medicare. To put this amount in context, it is:
  - Less than one-eighth of the amount for Medicare -- 2 percent of the entire surplus.
  - Less than one-fifth of the drop in Medicare baseline from 1998 to 1999.
- **Medicare baseline has dropped, in part because of administrative actions.** Policy experts advising the Congress (MedPAC, CBO, and Medicare Trustees) have credited our success in combating fraud, waste, and abuse as a major reason for the \$241 billion, 10-year drop in Medicare spending from 1998 to 1999. Reinvesting savings that can be reasonably attributed to our anti-fraud and waste activities in a new prescription drug benefit is completely consistent with our precedent of using savings for programmatic improvements.