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Medicare: The President's Reform Proposal

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Updated August 30, 1999

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ABSTRACT

On June 29, 1999, President Clinton announced the *President's Plan to Modernize and Strengthen Medicare for the 21st Century*. There was no accompanying legislation incorporating the President's proposal. Administration representatives indicated that they expected to work with the Congress in drafting bill language.

The President's plan contained several key components. It would establish a new optional outpatient prescription drug benefit under a newly established Medicare Part D. It would create a new competitive defined benefit (CDB) program that would change the way Medicare+Choice managed care plans are paid. The plan would also make some benefit modifications and provide for the modification and extension of certain policies incorporated in the Balanced Budget Act of 1997 (BBA 97). Further, the proposal would incorporate a number of changes in the traditional fee-for-service (FFS) program which are designed to make the program more efficient. This report provides a summary of the President's plan. It will be updated as additional information becomes available.

Medicare: The President's Reform Proposal

Summary

On June 29, 1999, President Clinton announced the *President's Plan to Modernize and Strengthen Medicare for the 21st Century*. On July 2, 1999, the White House issued a detailed description of this plan prepared by the National Economic Council and the Domestic Policy Council. There was no accompanying legislation incorporating the President's proposal. Administration representatives indicated that they expected to work with the Congress in drafting bill language.

The President's plan contains several key components. It would establish a new optional outpatient prescription drug benefit under a newly established Medicare Part D. In general, all therapeutic classes of drugs would be covered. There would be no Part D deductible. The plan would pay 50% of drug costs beginning with the first prescription filled, up to a specified maximum. Beneficiaries would be liable for the remaining 50%. The program would be phased in over the 2002-2008 period. In 2002, the federal government would pay up to a maximum of $1,000 per person per year (accounting for the first $2,000 in spending). In 2008, it would pay up to $2,500 (accounting for $5,000 in spending). Beneficiaries would pay a premium equal to 50% of program costs; the remaining 50% would be paid by the federal government. The Administration estimates that the premium for 2002 would be $24 per month, rising to $44 per month in 2008.

The President's proposal would create a new competitive defined benefit (CDB) program that would change the way Medicare+Choice managed care plans are paid. Instead of receiving a fixed payment, and varying benefits so that payments equal costs, the new program would fix benefits and allow costs to vary. Each plan would determine its cost of providing coverage for a defined set of Medicare benefits, including the subsidized prescription drug coverage. Medicare beneficiaries would then select among plans based on cost and quality. Beneficiary premiums for Medicare coverage could vary. If a beneficiary chose a managed care plan with a price lower than average traditional Medicare costs (including the cost of drugs if the beneficiary has elected coverage of drugs under the new Part D), the beneficiary's premium obligation would be reduced. If the beneficiary chose a plan with a price that was higher than traditional Medicare costs, the beneficiary's premium would be higher. If a beneficiary chose a managed care plan with a price about equal to the average traditional program costs, the beneficiary's current premium would remain unchanged.

The President's plan would make a number of additional changes. It would make some benefit modifications and provide for the modification and extension of certain policies incorporated in the Balanced Budget Act of 1997 (BBA 97). Further, the proposal would incorporate a number of changes in the traditional program which are designed to make the program more efficient. According to the Administration, the net 10-year (FY2000-FY2009) cost of its plan is $45.7 billion. CBO estimates the net 10-year cost at $111.1 billion. The major difference between the two estimates is the cost of the prescription drug proposal; the Administration estimate is $118.8 billion; the CBO estimate is $168.2 billion. This report provides a summary of the President's plan based on the July 2, 1999 document. It will be updated as additional information about the President's plan becomes available.

http://wikileaks.org/wiki/CRS-RL30279

Contents

Introduction 1

Medicare Benefit Expansions 2
Prescription Drug Benefit 2
Benefit Design 2
Financing 3
Enrollment 3
Management, Payments, Beneficiary Protections 3
Assistance for Low Income 4
Incentives to Retain Employer-Provided Drug Benefits 4
Improving Preventive Benefits 5
Eliminating Preventive Services Cost-Sharing 5
Information Campaign on Prevention 5
U.S. Preventive Services Task Force Study 5
Demonstration of Smoking Cessation and Counseling 5
Changes in Cost-Sharing and Medigap 5
Coinsurance for Clinical Laboratory Services 5
Part B Deductible 6
Updating and Expanding Medigap Options 6
Report on Policy Options for Supplemental Coverage 6
Access to Medigap 6
Medicare Buy-In for Certain People Ages 55-64 7
Medicare Buy-In for Persons Ages 62-64 7
Medicare Buy-In for Displaced Workers Ages 55-62 7
Access to Coverage for Retirees Whose Employers Terminate Coverage 7

Competitive Defined Benefit 7
Beneficiary Premiums Based on Choice of Managed Care Plan 8
Government Payments Based on Plan Prices 9
Risk and Geographic Adjustment 10

Modification and Extension of Policies Incorporated in the Balanced Budget Act of 1997 (BBA 97) 11
Modifying Balanced Budget Act Policies 12
Quality Assurance Fund 12
Administrative Actions 12
Disproportionate Share Payments 13
Constraining Medicare Spending/Extend BBA Provisions 13
Hospitals 13
Ambulance, Prosthetics and Orthotics, and Hospice Services 14
Ambulatory Surgical Centers 14
Clinical Laboratory Services, Durable Medical Equipment and Parenteral and Enteral Items 14

Program Management Improvements 15
Private Sector Purchasing and Quality Improvement Tools 15
Promoting Use of High-Quality, Cost-effective Providers 15

http://wikileaks.org/wiki/CRS-RL30279

Primary Care Case Management and Disease Management 15
Information and Coordination of Care for Medicare/Medicaid Dual Eligibles 16
Purchasing Tools and Contracting Reform 16
Changing Medicare's Management Structure and Personnel Practices . . . 17
Public/Private Advisory Boards 17
Increasing Personnel Flexibility 18

Financing Provisions 18
Extending Life of the Part A Trust Fund 18
Financing the Prescription Drug Benefit 18

Cost Estimates 18

Appendix A 21

List of Tables

Table 1. Example of Beneficiary Premiums and Government Payments 10
Table 2. Comparison of the Administration's and CBO's 10-Year Estimate of the President's Reform Proposal 19
Table A1. Example of Beneficiary Premiums and Government Payments 23
Table A2. Example of Beneficiary Premiums and Government Payments in Low-Cost Area* 23
Table A3. Example of Beneficiary Premiums and Government Payments in High-Cost Area* 24

http://wikileaks.org/wiki/CRS-RL30279

http://wikileaks.org/wiki/CRS-RL30279

Medicare: The President's Reform Proposal

Introduction

Medicare is a nationwide health insurance program for 39 million aged and disabled persons. Total program outlays in FY1999 are estimated at $216.1 billion; net outlays (after deduction of beneficiary premiums) are estimated at $194.6 billion. The program consists of two distinct parts - Part A (Hospital Insurance program) and Part B (Supplementary Medical Insurance program). Part A is financed by payroll taxes paid by current workers and their employers. Part B is financed by a combination of monthly premiums levied on current beneficiaries and federal general revenues; beneficiary premiums account for 25% of Part B costs.

Medicare Part A provides coverage for hospital services, post-hospital skilled nursing facility services, and home health care. Part B provides coverage for physicians services, laboratory services, durable medical equipment, and other medical services. Benefits are generally provided under the "traditional Medicare" program (sometimes known as "fee-for-service Medicare"). Under this program, beneficiaries obtain covered services through the providers of their choice and Medicare makes payments for each service rendered (i.e. fee-for-service). The amount of payment per service is generally subject to certain limits. In recent years, the program has been modified a number of times to expand the types of services paid on a prospective rather than fee-for-service basis. Under a prospective payment methodology, a predetermined payment is made for each episode of care, regardless of the scope and mix of services used in each individual case.

Medicare beneficiaries (who are enrolled in both Parts A and B) may elect to receive their Medicare services through a managed care arrangement under the Medicare+Choice program, rather than through the "traditional Medicare" program. Under Medicare+Choice (also known as Medicare Part C), beneficiaries voluntarily enroll with an entity (typically a health maintenance organization) which has agreed to assume the risk for providing all of Medicare's covered services for each enrolled beneficiary. In return, Medicare makes a monthly predetermined payment to the plan; this predetermined payment is fixed and does not vary by the amount of resources used.

Over its 33-year history, Medicare has provided important protections for millions of Americans. However, the program is facing a number of problems. One of the most pressing concerns is the fact that Medicare's financing structure will be unable to sustain it in the long run. Many are also concerned that the program's structure, which in large measure reflects both the health care delivery system as well as political considerations in effect at the time of enactment, has failed to keep pace with the changes in the health system as a whole. A related concern is whether the benefit's structure adequately responds to the health care needs of today's aged and

disabled populations. One of the most notable coverage gaps, is the absence of coverage for most outpatient prescription drugs.

In response to these concerns, a number of observers have recommended significant reforms to the current Medicare program. On June 29, 1999, President Clinton announced the *President's Plan to Modernize and Strengthen Medicare for the 21st Century*. On July 2, 1999, the White House issued a detailed description of this plan prepared by the National Economic Council and the Domestic Policy Council. There is no legislation incorporating the President's proposal. Administration representatives have indicated that they expect to work with the Congress in drafting bill language.

The President's plan contains several key components. It would establish a new prescription drug benefit and make a number of other benefit modifications. It would also create a new competitive defined benefit program that would change the way Medicare+Choice managed care plans are paid. It would provide for the modification and extension of certain policies incorporated in the Balanced Budget Act of 1997 (BBA 97). Further, the proposal would incorporate a number of changes in the traditional fee-for-service (FFS) program which are designed to make the program more efficient. The following is a summary of the President's plan based on the July 2, 1999 document. This summary is limited by the information currently available.

At the conclusion of this report are the cost estimates of the President's proposal made by the Administration and by the Congressional Budget Office (CBO). According to the Administration, the net 10-year (FY2000-FY2009) cost of its plan is $45.7 billion. CBO estimates the net 10-year cost at $111.1 billion. The major difference between the two estimates is the cost of the prescription drug proposal. The Administration estimate is $118.8 billion; the CBO estimate is $168.2 billion.

The proposal also includes a financing provision which is not linked to the reform package. It would dedicate a portion of the budget surplus ($328 billion over 10 years) to Medicare solvency. The Administration estimates this would extend the solvency of the Part A trust fund from 2015 to 2027.

http://wikileaks.org/wiki/CRS-RL30279

Medicare Benefit Expansions

Prescription Drug Benefit[1]

Benefit Design. Medicare currently has a very limited outpatient prescription drug benefit. The proposal would establish a new optional outpatient prescription drug benefit under a newly established Part D. In general, all therapeutic classes of drugs would be covered. (Drugs currently covered under Part B would continue to be paid under the Part B program.) There would be no Part D deductible. The plan

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[1]For further discussion of this issue, see: CRS Report RL30147, *Medicare: Prescription Drug Coverage for Beneficiaries,* by Jennifer O'Sullivan, and CRS Report RL30250, *Medicare: Prescription Drug Proposals*, by Jennifer O'Sullivan.

would pay 50% of drug costs beginning with the first prescription filled, up to a specified maximum. Beneficiaries would be liable for the remaining 50%.

The program would be phased in over the 2002-2008 period. In 2002 and 2003, the federal government would pay up to a maximum of $1,000 per person per year (accounting for the first $2,000 in spending). In 2004 and 2005, the government would pay up to $1,500 (accounting for $3,000 in spending). In 2006 and 2007, it would pay up to $2,000 (accounting for $4,000 in spending). In 2008, it would pay up to $2,500 (accounting for $5,000 in spending). Beginning in 2009, the limit would be increased by the increase in the consumer price index. The Administration estimates that 90% of beneficiaries would not reach the cap when the program was fully implemented.

Financing. Beneficiaries would pay a premium equal to 50% of program costs; the remaining 50% would be paid by the federal government. The Administration estimates that the premium for 2002 would be $24 per month, rising to $44 per month in 2008. CBO, which has estimated a higher overall cost for the drug benefit estimates that the monthly premium would be $25.20 per month in 2002, rising to $52.90 per month in 2008. Premiums would be collected in the same way as Part B premiums; for most persons this is a deduction from monthly social security checks.

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Enrollment. Coverage would be extended to all persons, otherwise eligible for Medicare, who enroll in Part D. Persons would only have one chance to enroll. For current beneficiaries, there would be an open enrollment period for the first year the program is in effect (2002). For other persons, the enrollment opportunity would generally occur when an individual first becomes eligible for Medicare. There would be two exceptions. Beneficiaries who are covered by their employer while still working (or by an employer of a working spouse) would have a one-time enrollment opportunity after retirement (or after retirement or death of the working spouse). Beneficiaries covered under a retiree health plan would have a one-time enrollment opportunity if the former employer drops retiree drug coverage.

Management, Payments, Beneficiary Protections. The Secretary would contract with private entities who would competitively bid to administer the new drug benefit in a geographic region; only one contract would be awarded in each region. Entities that could compete for the contract include pharmacy benefit managers (PBMs), retail drug chains, health plans or insurers, states (through mechanisms established for Medicaid) or multiple entities in collaboration (such as alliances of pharmacies) provided the collaboration is not anti-competitive. The entity administering a benefit for an area would negotiate prices, process claims, and implement drug utilization review programs. All PBMs or similar entities would be required to meet access and quality standards established by the Secretary.

Under the proposal, Medicare would not set prices for drugs. Prices would be determined through negotiations between the benefit managers for an area and drug manufacturers. It is expected that this process would result in discounts. The proposal would require that beneficiaries would continue to have access to prices established by the benefit manager even after they had exceeded the cap.

http://wikileaks.org/wiki/CRS-RL30279

Benefit managers could use various cost containment tools in administering the program, subject to limitations and guidelines set in the contract. They would be permitted to use formularies; these are lists of drugs preferred by a plan's sponsor, in part on the basis of costs. However, beneficiaries would be guaranteed access to off-formulary drugs when medically necessary and have appeal rights when coverage was denied. Private benefit managers would also be authorized to create appropriate incentives for generic substitution.

Benefit managers would be required to enter into contracts with pharmacies that meet a set of qualifications, including having necessary information systems to process electronic point-of-sale transactions and create utilization records. Negotiated dispensing fees would have to be high enough to assure participation by most pharmacies.

The government rather than the benefit manager would bear most of the risk for cost and utilization of services under the benefit. The benefit manager would be paid a fee for managing the benefit, and would have some contractual incentives to control costs and utilization.

Enrollees in managed care plans would receive their benefit through the Medicare+Choice plans; for the first time these plans would be paid directly for providing drug coverage.

Assistance for Low Income. Under current law, Medicare beneficiaries with incomes below 100% of poverty have their Medicare cost-sharing and Part B premium charges paid by the Medicaid program (with the federal and state governments sharing in the costs). These persons are known as Qualified Medicare Beneficiaries (QMBs). Persons with incomes between 100% and 120% of poverty have their Part B premium charges paid by Medicaid under the Specified Low-Income Medicare Beneficiary (SLIMB) program. In certain cases, persons below 135% of poverty can qualify for payment of their Part B premiums. Some of these persons may also be entitled to full Medicaid coverage; all states provide prescription drug coverage to persons entitled to full Medicaid benefits. Medicaid prescription drug coverage is not available for the QMB-only or SLIMB-only populations.

The proposal would make available Part D protection for all beneficiaries, including the low income. Medicare would therefore pick up some costs currently paid by Medicaid. Under the proposal, Medicaid would pay the Part D drug premiums and cost sharing charges for beneficiaries up to 100% of poverty, using the current federal/state matching rate. Beneficiaries with incomes between 100% and 135% of poverty would have their Part D cost sharing and premium charges paid 100% by the federal government. Persons with incomes between 135% and 150% of poverty would pay a partial sliding scale premium based on income; full federal funding would be provided for the remaining cost sharing.

Incentives to Retain Employer-Provided Drug Benefits. The proposal would provide a partial drug premium subsidy to employers whose retiree health coverage for drugs is at least as good as the Part D benefit. The subsidy would equal 67% of the amount that would otherwise be provided to the private benefit manager for Medicare Part D enrollees. The Health Care Financing Administration (HCFA, the

agency that administers Medicare) would make these premium subsidy payments to the health plan or PBM used by the employer.

Improving Preventive Benefits

Eliminating Preventive Services Cost-Sharing. Most services covered under Medicare Part B are subject to a $100 deductible and 20% coinsurance. Some preventive services are exempt from either or both of these requirements. The proposal would extend the waiver of the Part B deductible and 20% coinsurance to *all* preventive services. Therefore, the deductible would be waived for: hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic examinations, hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits.

Information Campaign on Prevention. The proposal would provide for the DHHS to launch a 2-year nationwide education campaign beginning in 2001 to promote the preventive use of health services by older Americans and people with disabilities. The campaign would consist of three parts. *First*, the public and private sector would combine public service and print media campaigns to educate all Americans 50 and over and disabled persons about the importance of preventive care. *Second*, the campaign would provide Medicare beneficiaries with information about the importance of using Medicare's preventive benefits. This would be done in several ways including distributing comprehensive information to all beneficiaries and developing a health status self-assessment tool for beneficiaries. *Third*, DHHS would launch a campaign to prevent falls in the elderly in order to reduce the incidence of injury.

U.S. Preventive Services Task Force Study. The proposal would require the Secretary of DHHS to direct the U.S. Preventive Services Task Force to conduct a series of new studies. These studies would identify preventive interventions that can be safely delivered in the primary care setting that are most valuable to older Americans.

Demonstration of Smoking Cessation and Counseling. HCFA would launch a demonstration project to evaluate the most successful and cost-effective means of providing smoking cessation services to beneficiaries.

Changes in Cost-Sharing and Medigap

Coinsurance for Clinical Laboratory Services. As noted above, most services covered under Medicare Part B are subject to a $100 deductible and 20% coinsurance. However, there are no cost-sharing charges for clinical laboratory services. The proposal would apply the 20% coinsurance requirement to all clinical laboratory services except those which are also preventive services (e.g., pap smears). The requirement would apply beginning in 2002.

http://wikileaks.org/wiki/CRS-RL30279

Part B Deductible. The Part B deductible is $100. When the program began in 1965, the deductible was $50. It was raised to $60 in 1973, $75 in 1982, and $100 in 1991. The proposal would provide for an annual inflation adjustment beginning in 2002.

Updating and Expanding Medigap Options. Beneficiaries can obtain private insurance to supplement Medicare's benefits; these individually purchased policies are known as "Medigap." Beneficiaries with Medigap insurance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from 1 of 10 standardized plans (known as "Plan A" through "Plan J"), though not all 10 plans are offered in all states. Only 3 of the 10 plans (Plans H, I and J) offer some coverage for prescription drugs. BBA 97 added two high deductible plans to the list of 10 standard plans. With the exception of the high deductible feature, the benefit package under the high deductible plan will be the same as Plan F or Plan J.[2]

The proposal would request the National Association of Insurance Commissioners (NAIC) to create a Medigap plan option which would make beneficiaries themselves (rather than Medigap) liable for some of Medicare's cost-sharing charges; at the same time the policy would protect them against catastrophic costs. The proposal would also authorize a review of the 10 standardized policies; particularly the drug benefit provisions.

Report on Policy Options for Supplemental Coverage. The proposal would require the Secretary to prepare a detailed report to Congress on policy options for improving supplemental coverage.

Access to Medigap. The proposal would improve access to Medigap policies as follows:

(1) *Open Enrollment for the Aged and Disabled.* Current law establishes an open enrollment period for the aged. All Medigap insurers are required to offer open enrollment for 6 months from the date a person first enrolls in Part B (generally when an individual turns 65). There is no guaranteed open enrollment period for the non-aged disabled population. The proposal would extend the 6-month guaranteed open enrollment requirement to new disabled and end stage renal disease (ESRD) beneficiaries.

(2) *Special Open Enrollment Period for Certain Beneficiaries*. BBA 97 provided a 63-day open enrollment period for beneficiaries in managed care plans that terminate their Medicare contracts or reduce their service areas. Application of the open enrollment period was first triggered in January 1999; however, not all insurers were able to provide the necessary information to beneficiaries. The proposal would establish a special 90-day open enrollment period for persons who were affected by the January 1, 1999 plan terminations or service area reductions.

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[2]For a further discussion of Medigap see: CRS Report RL30094, *Medicare: Supplementary "Medigap" Coverage*, by Jennifer O'Sullivan.

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(3) *Expanding Choice of Medigap Plans During Special Enrollment Periods*. BBA 97 established special open enrollment periods for Medigap under certain circumstances (including cases where the enrollee's managed care plan terminates the contract). Beneficiaries in these situations are guaranteed enrollment only in plans "A," "B," "C," and "F;" none of these offers prescription drug coverage. The proposal would expand the requirement to include access to all Medigap options.

(4) *Increase in Penalty for Violation of Open Enrollment Requirement*. Currently, issuers who violate the open enrollment requirement are subject to a civil monetary penalty (CMP) of $5,000 for each violation. The proposal would increase the amount to $50,000 plus $5,000 per day per violation.

Medicare Buy-In for Certain People Ages 55-64

Medicare Buy-In for Persons Ages 62-64. Medicare coverage is currently limited to persons who are age 65 and over and persons who are permanently and totally disabled. The proposal would permit persons ages 62-64 (without access to employer-sponsored insurance) to buy into Medicare. They would pay for this early coverage in part during the period they were receiving the early coverage and in part after they turned age 65. Individuals would pay a base premium during the time they received early coverage prior to age 65. This premium is estimated at $300 per month. When they turned age 65 they would no longer pay the base premium. They would, however, pay a premium estimated at $10 to $20 per month for each year of early participation. This premium would be added to the regular Part B premium (which is currently $45.50 per month).

Medicare Buy-In for Displaced Workers Ages 55-62. The proposal would offer coverage to persons who involuntarily lose their jobs and health care coverage. Individuals choosing this option would be required to pay the full premium at the time they were receiving early coverage.

Access to Coverage for Retirees Whose Employers Terminate Coverage. The proposal would permit retirees age 55 and older whose employers terminate health insurance coverage to extend COBRA coverage until the Medicare eligibility age of 65. (The COBRA law requires employers to allow certain former employees to buy into the employer-sponsored health plan for up to 36 months.)

Competitive Defined Benefit

Most Medicare beneficiaries obtain covered health services through the original FFS program (also known as "traditional Medicare"). Under the FFS program, beneficiaries obtain covered services through providers of their choice and Medicare pays for each service or package of services rendered. Some Medicare beneficiaries elect to obtain their Medicare services through a managed care arrangement (such as a health maintenance organization) instead of through the FFS program. Managed care arrangements providing services to Medicare beneficiaries are known as

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Medicare+Choice plans. These plans receive a monthly capitation payment from Medicare; in return they have agreed to assume the risk for paying for all of Medicare's covered services for each enrolled beneficiary.

The Administration proposal would create a new competitive defined benefit (CDB) program that would change the way Medicare+Choice (M+C) plans are paid. Under the current M+C program, plans receive payments that are based on a formula contained in BBA 97. Payments are set by county, and equal the maximum of a floor amount, a minimum update amount, or a blended amount, subject to a budget neutrality provision. If the M+C payment rate exceeds the plan's estimated costs of providing Medicare covered services to enrollees, the plan must increase benefits or decrease cost-sharing to cover the difference.[3]

The CDB program would alter the payment mechanism to inject price and quality competition among managed care plans into Medicare. Instead of receiving a fixed payment, and varying benefits so that payments equal costs, the new program would fix benefits and allow costs to vary. Each plan would determine its cost of providing coverage for a defined set of Medicare benefits, including the subsidized prescription drug coverage (described above). Medicare beneficiaries would then select among plans based on cost and quality. Beneficiaries would have the option to choose plans that can offer coverage with no or a lower premium than the traditional Part B premium. According to the Administration, the CDB program would help make beneficiaries more price sensitive, and would encourage them to choose the highest quality, most efficient health plan option that suits their needs.

Beneficiaries would select plans during an open enrollment period each year. Note that government payments to medical savings account (MSA) plans and private FFS plans would remain the same as under current law for the first few years of the new system.

Beneficiary Premiums Based on Choice of Managed Care Plan

Currently, all Medicare beneficiaries, including those who enroll in M+C plans, pay the same Part B premium. Under the CDB program that would be effective in 2003, beneficiary premiums for Medicare coverage could vary. If a beneficiary chose a managed care plan with a price lower than average traditional Medicare costs (including the cost of drugs if the beneficiary has elected coverage of drugs under the new Part D), the beneficiary's Part B premium would be reduced. If the beneficiary chose a plan with a price that was higher than traditional Medicare costs, the beneficiary's Part B premium would be higher. If a beneficiary chose a managed care plan with a price about equal to the average traditional program costs, the beneficiary's Part B premium would remain unchanged. Beneficiaries choosing to stay in traditional Medicare would pay their Part B premium as they do under current law.

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[3]For a discussion of the method used to calculate M+C payment rates, see CRS Report 97-859 EPW. *Medicare: Payments to HMOs and Other Private Plans Under the Medicare+Choice Program*, by Madeleine Smith.

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Assuming a beneficiary opts for managed care, the amount he or she pays in Part B premiums would depend on the plan's price relative to the costs of traditional Medicare. The Part D premium for prescription drugs would also be included in this calculation for participating beneficiaries. Beneficiaries choosing a managed care plan with a price equal to 96%[4] of traditional Medicare would pay the same, current law Part B premium (and Part D premium if applicable). Beneficiaries choosing a plan that is more costly than 96% of traditional Medicare would pay the Part B premium plus the full amount of the difference between the plan's price and 96% of the costs of traditional Medicare. Beneficiaries choosing a plan that is less costly than 96% of traditional Medicare could keep 75% of the savings; the government would retain the remaining 25%. The Administration estimates that beneficiaries choosing a plan that is at or below about 80% of the costs of traditional Medicare would pay no Part B premium. It should be noted that the beneficiary premium is affected by a geographic adjustment as discussed below.

Government Payments Based on Plan Prices

Government payments to managed care plans would be determined in two steps. First, private plans meeting Medicare participation criteria would bid on Medicare's defined set of benefits, including the new prescription drug and prevention benefits. Plans could alter slightly the defined benefits. They could reduce or eliminate cost sharing for Medicare benefits, so long as the value of this reduction does not exceed 10% of the value of the defined Medicare benefits package. They could offer supplemental benefits and charge an additional supplemental premium for these benefits, as is permitted under M+C today. While this practice could continue, the supplements would not count towards the price used to establish the government payment, and thus would not be subsidized.

Second, the plan price would be compared to the cost of traditional Medicare for an average beneficiary. The government payment level would reach its maximum for a plan whose price is equal to 96% of the cost of traditional Medicare. The government contribution would stay at this maximum for plans with prices equal to or greater than 96% of the cost of traditional Medicare. For plans with costs below 96% of traditional Medicare, the government payment would be reduced, by 25% of the difference between the cost of the plan and 96% of the costs of traditional Medicare.

The government's contribution would vary as a percent of total plan price. For plans whose price is below about 80% of the costs of traditional Medicare, the government would pay 100% of the price, and beneficiaries would pay nothing to enroll in the plan. For plans whose price falls between 80% and 96% of the costs of traditional Medicare, the dollar amount of the government contribution would

[4]Under current law, managed care plans would receive about 96% of traditional Medicare costs in 2003. This 4% discount is based on the traditional 5% reduction for managed care savings, the mandatory reductions in the national M+C growth percentage of -.008 percentage points in 1998 and -.05 percentage points each year from 1999 through 2002, and an approximate 4% increase due to lack of re-adjustment for overestimation of cost increases for 1997.

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increase as plan prices increase, but the government contribution would fall as a percent of the total price; beneficiary premiums would increase as well. The government contribution would be capped for plans whose prices are at or above 96% of the costs of traditional Medicare. Increased beneficiary premiums would fund the difference between plan price and 96% of traditional Medicare costs for these high-cost plans. For these higher cost plans, the percent of the price funded by the government would fall as plan prices rise.

Table 1 illustrates beneficiary and government payments for managed care and FFS plans in an area with costs comparable to those nationwide. In this example, beneficiaries who enroll in the FFS plan pay the Part B premium ($720, or 12% of total costs[5]) and the government pays the remainder ($5,280). Beneficiaries who select a managed care plan with a total cost that is equal to 96% of the FFS costs ($5,760) would also pay the Part B premium of $720; the government would pay the remainder ($5,040). Beneficiaries who elect managed care plans with total costs below $5,760 would pay lower Part B premiums, and the government contribution would be lower than $5,040. Those in managed care plans with total costs above $5,760 would pay Part B premiums above $720, but the government contribution would remain at the cap of $5,040. Note that under this program, beneficiaries enrolling in a managed care plan with costs of $5,900, which are lower than FFS costs, would pay $860 in Part B premiums, which are higher than the FFS Part B premium. This result stems from the 4% government discount built into the payment structure and the cap on government contributions (i.e., $5,040 in **Table 1**).

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Table 1. Example of Beneficiary Premiums and Government Payments

Plan	Total cost	% of FFS	Beneficiary premium	Beneficiary share	Government contribution	Government share
Private 1	$4,700	78%	$0	0.0%	$4,700	100%
Private 2	$4,800	80%	$0	0.0%	$4,800	100%
Private 3	$5,600	93%	$600	10.7%	$5,000	89%
Private 4	$5,760	96%	$720	12.5%	$5,040	88%
Private 5	$5,900	98%	$860	14.6%	$5,040	85%
FFS	**$6,000**	**100%**	**$720**	**12.0%**	**$5,280**	88%
Private 6	$6,300	105%	$1,260	20.0%	$5,040	80%
Private 7	$6,600	110%	$1,560	23.6%	$5,040	76%
Private 8	$6,900	115%	$1,860	27.0%	$5,040	73%

Source: Table prepared by CRS.

Risk and Geographic Adjustment. The CDB program would not alter the current risk-adjustment mechanism, which is scheduled for full implementation by 2004. However, it would include a new geographic cost adjustment procedure that is intended to adjust the prices of managed care plans to reflect geographic cost differences which affect plan operations and costs in specific geographic locations. This adjustment procedure has the effect of transforming the local managed care plan

[5]Part B premiums are expected to represent about 12% of total costs for Parts A and B in 2003 under current law.

prices into national rates, as illustrated below. This adjusted price is used to determine beneficiary premiums.

Geographic adjustment of government payments helps protect beneficiaries and promotes competition, according to the Administration. Currently, the Part B premium is set nationwide; all beneficiaries pay the same premium regardless of where they reside. Under the CDB program, beneficiary premiums for managed care would vary based on plan prices. Since plan prices would reflect local variations in the costs of delivering care, if the government did not pay for these variations, the plan would pass them along to the beneficiary. Consequently, in high-cost areas, beneficiary premiums for managed care would most likely be much higher than the costs of traditional Medicare, and few beneficiaries would elect managed care coverage. Full geographic adjustment of government payments in high-cost areas was included in the Administration's proposal to make competition between the traditional program and managed care programs equitable, according to the Administration. The Administration's geographic adjustment would retain the current partial adjustment system for low-cost areas, by maintaining the provisions included in the BBA to encourage private plans to enter rural areas.

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Thus, the geographic adjustment procedure would vary between high-cost and low-cost areas. High-cost areas would have the costs of managed care plans adjusted to reflect full local costs. Under the BBA, high-cost areas have seen lower rates of increase in M+C payments over time, due to blending of local and national rates, and to minimum updates. The CDB program would use local rates, instead of the BBA provisions, as benchmarks in these high-cost areas. This would produce lower values for the adjusted (nationally based) costs of managed care in these areas, and lower beneficiary payments to managed care plans, other things being equal.

Low-cost areas would have the geographic adjustments that were implemented under the BBA maintained. The BBA's blending of local and national rates, and establishment of floor payments, has increased relative M+C payments in these areas to amounts above the actual local costs. The goal of this increase was to encourage managed care plans to serve beneficiaries in these areas. **Appendix A** provides a more detailed discussion of the geographic adjustment proposal.

The Secretary of the Department of Health and Human Services (DHHS)would study this two-part geographic adjustment system in its first several years to assure that it produces its intended effect.

Modification and Extension of Policies Incorporated in the Balanced Budget Act of 1997 (BBA 97)

BBA 97 included provisions which were designed to constrain Medicare program growth. At the time of enactment, CBO estimated that Medicare spending would be reduced by $116 billion over 5 years and $394 billion over 10 years. Since then, CBO has revised its total spending projections for Medicare, lowering them from what had been projected at the time of enactment of BBA 97. Most recently, in March 1999, CBO further lowered its Medicare projections by $80 billion over the

next 5 years and $229 billion over 10 years. The revised spending projections are attributable to a number of factors including an improved economic forecast, heightened anti-fraud and abuse initiatives, slowing payments to providers and lower projected enrollment growth in the Medicare+Choice.[6] A number of provider groups contend that the BBA 97 has had a bigger impact than originally anticipated; they have recommended revisions in the legislation to bring spending more in line with the original estimates.

Modifying Balanced Budget Act Policies

Quality Assurance Fund. Under the President's plan, a total of $7.5 billion between FY2000 and FY2009 would be used to address BBA 97 policies that have caused either major access problems for beneficiaries or excessive difficulties for providers. The Administration states that it will work with Congress to develop fiscally prudent policies that would pay targeted providers additional money to resolve specific problems that have impeded beneficiary access to care.

Administrative Actions. HCFA will provide administrative relief in the following four areas:

(1) As mandated by BBA 97, HCFA has implemented a reduction in payments to hospitals when patients in any of 10 diagnoses are transferred to another hospital or hospital unit that is not a prospective payment system (PPS) hospital, skilled nursing facility or home health agency for care.[7] HCFA was authorized to extend the transfer policy to additional diagnoses after October 1, 2000. HCFA will postpone extension of the hospital transfer policy to additional diagnoses for 2 years, to October 1, 2002.

(2) HCFA has proposed a PPS for outpatient hospital care as mandated by BBA and is considering three options that may increase payments to providers that might otherwise suffer large payment reductions under this new payment system. HCFA's proposed outpatient PPS includes a variety of options for controlling the volume of outpatient services. HCFA may delay the implementation of the volume control mechanism to allow affected providers to adjust to the new reimbursement system. HCFA may also adopt the inpatient hospital wage index for its outpatient PPS which

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[6]For a discussion of Medicare spending since BBA 97, see CRS Report RS20238, *Trends in Medicare Spending After the Balanced Budget Act*, by Hinda Ripps Chaikind.

[7]Medicare's PPS for acute care hospitals has always distinguished between *discharges* in which a patient leaves an acute care hospital after completing treatment and *transfers* in which a patient is moved (transferred) to another acute care hospital for related or continued treatment. With some exceptions, the hospital receiving the transfer case is paid a pro-rated amount based on the inpatient days of care provided and total Medicare payment is not to exceed the amount that would have been made if the patient had been discharged without being transferred. BBA 97 provides that qualified discharges from one of 10 diagnostic related groups (DRGs) that are sent to post acute providers will be treated as transfers beginning October 1, 1998. The specific DRGs will be selected by the Secretary based on the disproportionate use of post discharge services.

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would increase Medicare payments for outpatient services to reclassified and redesignated hospitals. Finally HCFA may consider implementation of a budget neutral, 3-year transition period to hospitals, such as low-volume hospitals, teaching hospitals and cancer hospitals, that would suffer from large payment reductions.

(3) HCFA will implement an administrative change that will enable more hospitals to be reclassified to a higher wage area and receive additional Medicare payments. Currently, facilities can be reclassified if their average wage is at least 108% of the average wage in their rural area and at least 84% of the average wage in the nearby urban area. HCFA will change those thresholds.

(4) HCFA is implementing the following changes to help home health agencies adapt to the new interim payment system: (a) extend the repayment period for agencies that have received related overpayments from 1 to 3 years, with interest; (b) postpone the surety bond requirement until October 1, 2000; (c) require agencies to obtain $50,000 surety bonds regardless of the amount of Medicare revenues -- not 15% of the agency's annual Medicare revenues, as originally proposed; and (d) phase in the requirement to report services in 15-minute increments to enable home health agencies to accommodate the competing demands of ensuring Y2K compliance. HCFA has already eliminated the sequential billing rule as of July 1, 1999. (The sequential billing rule meant that claims had to be paid in the same order in which services were provided. Thus, in instances where a claim was held for further documentation or review, no subsequent claims for that beneficiary could be paid until the claim being held was resolved.)

http://wikileaks.org/wiki/CRS-RL30279

Disproportionate Share Payments. Presently, additional payments are made to hospitals that serve a disproportionate share of low-income Medicare or Medicaid patients. HCFA would be authorized to remove disproportionate share payments that are built into the Medicare+Choice rate beginning in FY2001; these payments would be made directly to eligible hospitals based on the services provided to Medicare +Choice enrollees. This budget-neutral change would be similar to the treatment of graduate medical education reimbursement enacted in BBA 97.

Constraining Medicare Spending/Extend BBA Provisions

Most of the BBA 97 provisions affecting provider payments are effective through FY2002.

Hospitals. PPS payment rates are increased each year by an update factor, which is determined in part, by the projected increase in hospital costs as specified in the hospital market basket index. BBA 97 reduced the market basket update for operating costs in *all* hospitals (both urban and rural) by 2.8% in FY1998; 1.9% in FY1999; 1.8% in FY2000; and 1.1% in FY2001 and FY2002. The President's proposal would amend reimbursement policy as follows:

(1) Medicare's PPS reimbursement to urban hospitals for operating cost would be increased by the hospital market basket minus 1.1% from FY2003 through FY2009.

(2) The PPS update for inpatient hospital services in rural hospitals would be the hospital market basket minus .5% in FY2003 with an increasing reduction of .1% each year until the same update applies for both rural and urban hospitals. Thus, the update for rural hospital inpatient services would be the market basket minus .6% in FY2004; market basket minus .7% in FY2005; market basket minus .8% in FY2006; market basket minus .9% in FY2007; market basket minus 1.0% in FY2008 and market basket minus 1.1% in FY2009.

(3) Medicare's PPS reimbursement to acute care hospitals for capital costs would be reduced by 2.1% from FY2003 to FY2009. This continues the existing BBA 97 policy.

(4) The national cost limits and reductions in rate increases for PPS-exempt hospitals established in BBA 97 would be extended from FY2003 to FY2009. Additionally, the 15% reduction in reimbursement for capital costs in PPS-exempt facilities would be extended from FY2003 to FY2009. This continues BBA 97 policies.

http://wikileaks.org/wiki/CRS-RL30279

Ambulance, Prosthetics and Orthotics, and Hospice Services. Under the proposal, Medicare reimbursement policy would be amended as follows:

(1) *Ambulance:* BBA 97 specifies that the reasonable cost and charge limits will apply through 1999, with annual increases equal to the consumer price index for urban consumers (CPI-U) minus 1%. A fee schedule is to be implemented in January 1, 2000 with annual updates equaling the CPI-U increase, except that in 2001 and 2002 there will be a 1% reduction in the update factor. This proposal includes a payment update for ambulance services of the CPI-U minus 1% from FY2003 to FY2009.

(2) *Prosthetics and orthotics*: BBA 97 limited the update to the fee schedule to 1% for each of the years FY1998 through FY2002. This proposal includes a payment update for prosthetics and orthotics of the CPI-U minus 1% from FY2003 to FY2009.

(3) *Hospice care*. BBA 97 reduces the hospice payment update to the market basket minus 1% from FY1998 through FY2002. This proposal includes a payment update for hospice services as the hospital market basket minus 1% from FY2003 to FY2009.

Ambulatory Surgical Centers. BBA 97 includes a payment update for these services of CPI-U minus 2% in FY2002. The proposed payment update for ambulatory surgical centers would be the CPI-U minus 1% from FY2003 to FY2009.

Clinical Laboratory Services, Durable Medical Equipment and Parenteral and Enteral Items. BBA 97 eliminated payment updates for these services from

FY1998 through FY2002. The proposed payment update for these services would be the CPI-U minus 1% from FY2003 to FY2009.

Program Management Improvements

Private Sector Purchasing and Quality Improvement Tools

Promoting Use of High-Quality, Cost-effective Providers. This proposal encompasses two components:

(1) The Health Care Financing Administration (HCFA) would be authorized to contract with existing ***preferred provider organizations*** (PPOs) that meet specified quality and utilization management standards as established by the Secretary. Medicare PPOs would be given advantages such as expedited claims payment and alternative administrative procedures (see subsequent discussion of alternative administrative procedures under Purchasing Tools and Contracting Reform). Beneficiaries who selected preferred providers in the Medicare PPOs would benefit from lower cost sharing.

(2) HCFA would be authorized to contract with ***Centers of Excellence***. These are competitively selected facilities that would receive a global payment for some or all associated services related to a specific surgical procedure; this all-inclusive payment would represent a discount to Medicare. The single fee would cover all of the facility, diagnostic and physician services for designated procedures such as coronary artery by-pass grafts (CABG) and other heart procedures as well as knee and hip replacements. Beneficiaries would not be required to use the facilities, but could be provided incentives by the facility such as reduced cost sharing, private rooms, and reimbursement for travel expenses. This proposal adopts the payment arrangement tested in a generally successful demonstration project that was in place between 1991 and 1998 where four, seven, and finally six participating hospitals received bundled payments for CABGs.

Primary Care Case Management and Disease Management. This proposal has two components:

(1) HCFA would be given the authority to contract with physicians to implement ***primary care case management*** (PCCM) activities that would address patterns of inappropriate utilization or uncoordinated care. Physicians would get case management fees (in addition to FFS payments) and also would receive the PCCM designation to induce participation. Moreover, PCCMs would be marketed to encourage beneficiary participation. Beneficiaries enrolled in a PCCM would receive additional benefits or lower cost sharing in exchange for remaining with the PCCM for a given period of time and receiving all their health care from, or through referral by, the PCCM. HCFA has tested three different case

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management approaches in demonstration projects that were in place between 1993 and 1995.

(2) HCFA would be given the authority to contract with and competitively pay entities to provide physician-directed, nurse-mediated ***disease management services*** to beneficiaries with certain high-cost, chronic health conditions. These services could encompass patient screening and assessment, patient education, medication review, telephone consultations, physician interaction, home nursing visits, and surveillance and reporting for conditions such as congestive heart failure and diabetes.

Information and Coordination of Care for Medicare/Medicaid Dual Eligibles. This proposal has two components:

(1) HCFA would work with states to design and distribute an ***orientation package*** to all new, dually eligible beneficiaries that would provide information on their special status, the Medicare and Medicaid programs, and how to obtain further information from HCFA, other state agencies and relevant offices.

(2) HCFA would be authorized to implement a demonstration project to test ***coordination models for dually eligible Medicare beneficiaries*** who remain in the FFS sector. Participating beneficiaries would receive an initial clinical assessment of their acute and long term care needs. Those beneficiaries with significant health care needs would qualify for the care coordination benefit provided by a team of clinicians, including a geriatrician, social worker, and nurse. This team would provide general primary care services and would advise beneficiaries about Medicare and Medicaid benefits.

http://wikileaks.org/wiki/CRS-RL30279

Purchasing Tools and Contracting Reform. This proposal has five components as follows:

(1) HCFA would be authorized to use ***competitive bidding and price negotiations*** to set payment rates for Part B items and services (except for physician services). The services and geographic areas to be included in a bidding or negotiation process would be subject to HCFA's discretion, based on the availability of qualified providers and the associated savings potential. However, HCFA would not necessarily select the best price offered, but would be restricted, in some fashion, to accepting the median price offered. Other selection restrictions would include using multiple suppliers, rather than sole source contracts or a winner take all strategy. Other protections for beneficiaries in rural areas would be established as well. HCFA would be given the authority to contract selectively with providers who accept negotiated or bid prices.

(2) HCFA would be allowed to negotiate ***alternative flexible administrative arrangements*** with providers and suppliers who (a) agree to discount prices for Medicare and (b) demonstrate better performance/higher quality.

The administrative arrangements could include simplified claims processing, faster claims payments, and alternative cost settlement processing.

(3) HCFA would be authorized to provide a single, ***bundled payment*** to combinations of practitioners, providers and suppliers for all care delivered at a specific facility or site of care. (See also earlier discussion of Centers of Excellence.) For example, the hospital payment related to a Medicare admission for a given DRG would be combined with all payments for the surgeon, anesthesiologist, attending physician, and physician consultants and paid to one entity. The combined amount is intended to provide incentives for the physicians and hospital to work together and associated cost efficiencies would be shared with Medicare.

(4) HCFA would be authorized to implement a demonstration project where ***bonus payments could be provided to qualified group practices*** that reduce excessive use and document improved patient outcomes. Qualified group practices are those that: meet or exceed certain size and scope criteria; submit acceptable clinical and administrative practice plans; implement acceptable quality improvement plans; submit required performance data; and distribute at least a portion of the bonus payments based on quality performance. Qualified group practices would be given an annual per capita target based on their historic cost experience (combining both Part A and Part B expenditures for Medicare beneficiaries seen by the practice in a base year). Bonus payments could be paid when actual per capita expenditures are lower than the target amount. A separate payment, based on process and outcome improvements, could also be made.

(5) HCFA would be authorized to use entities other than insurance companies as its fiscal agents, would be allowed to use competition to select Medicare's fiscal intermediaries and carriers, and would have greater ***contract flexibility*** in determining which functions should be performed.

Changing Medicare's Management Structure and Personnel Practices

This part of the plan would encompass the following two components:

Public/Private Advisory Boards. HCFA plans to establish three advisory panels:

(1) HCFA would establish a ***Management Advisory Council*** comprised of public and private sector experts who would identify relevant innovations in customer service, purchasing, and management and assist HCFA in their adaptation and implementation.

(2) HCFA would establish a ***Medicare Coverage Advisory Committee*** comprised of experts in medicine and science, consumer advocates, and

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industry representatives who would assist in determining whether new treatments and devices should be covered by Medicare.

(3) HCFA would establish a ***Citizens Advisory Panel on Medicare Education*** comprised of experts in medicine, health policy, and consumer education who would assist in shaping Medicare's beneficiary education program to ensure that beneficiaries are sent timely and useful program information.

Increasing Personnel Flexibility. HCFA seeks the authority to implement the staffing changes that were recommended by the independent experts hired to evaluate personnel needs.

Financing Provisions

Extending Life of the Part A Trust Fund

The proposal includes a financing provision which is *not linked to financing the reform package*. This proposal would dedicate a portion of the budget surplus to Medicare solvency. The contribution would be $328 billion over 10 years; this action (together with other Part A savings) is estimated by the Administration to extend the trust fund solvency from 2015 to 2027. For the amount transferred, the Treasury would buy down the debt and convey to the trust fund special purpose bonds. A Medicare "Lock Box" would prevent these funds from being used for other purposes.

Financing the Prescription Drug Benefit

The federal cost of the proposed drug benefit is estimated by the Administration to be about $119 billion over 10 years. A portion of the costs ($45 billion over 10 years) would be offset from the surplus.

Cost Estimates

Both the Administration and the Congressional Budget Office (CBO) have provided estimates of the President's Medicare reform proposal. According to the Administration, the plan, excluding the prescription drug benefit is estimated to save $73 billion over 10 years (FY2000-FY2009). Federal costs for the prescription drug benefits are estimated at $119 billion over 10 years. (See **Table 2**.)

On July 22, 1999, the Director of the CBO testified before the Senate Finance Committee on the President's reform plan. Included in the statement was an estimate of the President's reform proposal. CBO's estimate of the 10-year cost of the prescription drug benefit is about $49 billion or 42% higher than the Administration's estimate. Its estimate of savings achieved through changes in the fee-for-service (FFS) program are $16 billion or 22% lower than those made by the Administration. CBO's statement said that its estimates of changes attributable to provider payment changes are in line with those made by the Administration. It had not yet completed its review of the combined benefit proposal. (See **Table 2**.)

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Table 2. Comparison of the Administration's and CBO's 10-Year Estimate of the President's Reform Proposal
(In billions of dollars)

	Administration estimate	CBO estimate
Benefit Payments*		
Prescription Drug Benefit	118.8	168.2
Changes to FFS Medicare	-64.2	-48.2
Competitive Defined Benefit**	-8.9	-8.9
Subtotal	45.7	111.1
Transfers from the General Fund***	327.7	327.7
Total	373.4	438.8

Source: Testimony by Dan Crippen, Director of CBO, before Senate Finance Committee, July 22, 1999.

* Includes effect on Medicaid.
** Administration estimate.
*** This is the amount of the actual transfer. Over the 10-year period, cumulative interest would increase this amount to $374 billion (the total of the transfer amount cited in the President's summary). Of this amount, $45.5 billion would be used to finance a portion of the drug benefit.

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Appendix A

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Tables A1, A2 and **A3** illustrate the effects of geographical adjustment on payments to managed care plans under the President's proposal. **Table A1** represents a geographic area with costs comparable to those nationwide. It assumes that the average cost of treating a Medicare FFS beneficiary in this area is the same as the average cost nationwide -- $6,000. Geographic adjustment would not alter the total local costs of private plans in this area.

Table A2 represents a low-cost area. Private plans operating in low-cost areas are able to offer coverage of defined benefits for lower costs than they would be able to offer if they operated in areas with higher input prices. Therefore, in order to compare costs bid by plans in a low-cost area to nationwide FFS costs, the private plan costs must be inflated. **Table A2** assumes that the average cost of treating a Medicare FFS beneficiary in this area is 10% (i.e., $600) below the national average, so the average cost of a FFS beneficiary in this area would be $5,400 (i.e., $6,000 minus $600). Geographic adjustment would *increase* the "local" costs of private plans by 10% of the national FFS cost ($600), in order to make "local" plan costs comparable to "nationwide" FFS costs. The "local" costs are the costs bid by the private plans, and represent what the plan would be paid through beneficiary and government contributions. The geographically adjusted costs are calculated only for the purpose of computing the beneficiary premium. Plans would not be paid geographically adjusted costs.

Table A3 represents a high-cost area. Private plans in high-cost areas offer coverage at costs that reflect their relatively high input prices. In order to compare costs bid by plans in a high-cost area to nationwide FFS costs, these private plan local costs must be deflated. **Table A3** assumes that costs in this area are 10% higher than the national average, so that the average cost of a FFS beneficiary in this area would be $6,600 (i.e., $6,000 plus $600). Geographic adjustment would *decrease* the local costs of private plans by 10% of national FFS costs ($600) for comparison with nationwide FFS costs.

Comparisons of beneficiary premiums and government contributions for private plans across the three tables illustrate the effect of geographic adjustments, and the changing relationships of private plans to FFS depending on actual local costs.[8] For example, the first plan in each of the three tables bids $4,700 in its geographic area; $4,700 is the plan's *local* cost. When computing the beneficiary premium, the local cost of plan *1* is unaltered in **Table A1,** because costs in this area are assumed to equal the average nationwide. Private plan *A*'s total local cost is increased by $600, to $5,300, in its low-cost area (**Table A2**), and private plan *a*'s local costs are decreased by $600, to $4,100, in its high-cost area (**Table A3**). When the CDB program rules for beneficiary premiums are applied to the geographically adjusted costs, private plans *1* and *a* have a $0 beneficiary premium in their average and high-cost areas, respectively (**Tables A1** and **A3**), but private plan *A* has a beneficiary premium of $375 in its low-cost area (**Table A2**). The government contribution for

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[8]Note that plans operating in the area represented by **Table A1** are not the same plans as in **tables A2 or A3**.

http://wikileaks.org/wiki/CRS-RL30279

each plan would be the difference between the beneficiary premium and the *unadjusted* cost bid by the plan.

These comparisons illustrate the potentially significant effect of geographic adjustment on beneficiary premiums. With geographic adjustments, a plan offering coverage for $4,700 in a low-cost area is shown to be less efficient than a plan offering coverage for $4,700 in a high-cost area. For example, plan *A's* geographically adjusted cost in a low-cost area becomes $5,300, and plan *a*'s adjusted cost in a high-cost area becomes $4,100. Since beneficiary premiums are based on the geographically adjusted costs, they may vary for plans with identical premiums prior to geographic adjustment.

Another way to think about the effects of geographic adjustment is to consider how costs of private plans would vary if they operated in different areas. For example, if private plan *A* from the low-cost area represented by **Table A2** were to move to an average cost area represented by **Table A1**, private plan *A* would increase its bid to $5,300. Similarly, private plan *a* moving from the high-cost area represented by **Table A3** would decrease its bid to $4,100 if it were to move to an average cost area. Private plan *1*, located in an average cost area, would decrease its costs by $600, to $4,100, if it were to move to the low-cost area represented by **Table A2**, and would increase its costs by $600, to $5,300, if it were to move to the high-cost area represented by **Table A3**.

The relationship between the current M+C payment rates and the Administration's proposed CDB program is complex, and would vary depending upon classification of the geographic area as "high-cost" or "low-cost." The Administration proposes that geographic adjustment in high-cost areas would reflect full local costs. In the example shown here, this policy implies that the high-cost area represented by **Table A3** would have local costs decreased by $600 for purposes of computing beneficiary premiums. Under the BBA formula, payments in high-cost areas are limited by the blending of local and national rates; the effect of blending is mitigated by the minimum update provision, which guarantees that M+C payment rates will increase by at least 2% per year. Under the Administration's proposal, restrictions on rate growth in high-cost areas resulting from the blend would be removed. Other things being equal, payments to high-cost areas would increase over BBA amounts.

On the other hand, the Administration proposes that BBA provisions resulting in higher payments to low-cost areas would be retained. The BBA provides for payments that exceed local costs in low-cost areas, again through blending of local and national rates when computing M+C payment rates. Moreover, the BBA's floor payment rate provision increases M+C rates in the lowest cost areas even more than the blend provision. The Administration's proposal implies that local costs in **Table A2**, which represents a low-cost area, would not be inflated by the full $600. Instead, the BBA provisions would be used to calculate a lower adjustment, perhaps equal to $500. This would make each plan less expensive for beneficiaries and more expensive for the government than would be the case if full geographic adjustment were used. However, other things being equal, payments to low-cost areas would be equal to BBA amounts.

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Table A1. Example of Beneficiary Premiums and Government Payments

Plan	Total local cost	Geograph-ically adjusted cost	% of FFS	Beneficiary premium		Government contribution	
				$	%	$	%
Private 1	$4,700	$4,700	78%	$0	0.0%	$4,700	100%
Private 2	$4,800	$4,800	80%	$0	0.0%	$4,800	100%
Private 3	$5,600	$5,600	93%	$600	10.7%	$5,000	89%
Private 4	$5,760	$5,760	96%	$720	12.5%	$5,040	88%
Private 5	$5,900	$5,900	98%	$860	14.6%	$5,040	85%
FFS	**$6,000**	**$6,000**	**100%**	**$720**	**12.0%**	**$5,280**	88%
Private 6	$6,300	$6,300	105%	$1,260	20.0%	$5,040	80%
Private 7	$6,600	$6,600	110%	$1,560	23.6%	$5,040	76%
Private 8	$6,900	$6,900	115%	$1,860	27.0%	$5,040	73%

Source: Table prepared by CRS.

Table A2. Example of Beneficiary Premiums and Government Payments in Low-Cost Area*

Plan	Total local cost	Geograph-ically adjusted cost	% of FFS	Beneficiary premium		Government contribution	
				$	%	$	%
Private A	$4,700	$5,300	88%	$375	8.0%	$4,325	92%
Private B	$4,800	$5,400	90%	$450	9.4%	$4,350	91%
FFS	**$5,400**	**$6,000**	**100%**	**$720**	**12.0%**	**$5,280**	88%
Private C	$5,600	$6,200	103%	$1,160	20.7%	$4,440	79%
Private D	$5,760	$6,360	106%	$1,320	22.9%	$4,440	77%
Private E	$5,900	$6,500	108%	$1,460	24.7%	$4,440	75%
Private F	$6,300	$6,900	115%	$1,860	29.5%	$4,440	70%
Private G	$6,600	$7,200	120%	$2,160	32.7%	$4,440	67%
Private H	$6,900	$7,500	125%	$2,460	35.7%	$4,440	64%

Source: Table prepared by CRS.

*Assumes geographic adjustment would increase relative FFS costs by 10% ($600). Makes no allowance for increases in government payments in low-cost areas included in the BBA.

Table A3. Example of Beneficiary Premiums and Government Payments in High-Cost Area*

Plan	Total local cost	Geographically adjusted cost	% of FFS	Beneficiary premium		Government contribution	
				$	%	$	%
Private a	$4,700	$4,100	68%	$0	0.0%	$4,700	100%
Private b	$4,800	$4,200	70%	$0	0.0%	$4,800	100%
Private c	$5,600	$5,000	83%	$150	2.7%	$5,450	97%
Private d	$5,760	$5,160	86%	$270	4.7%	$5,490	95%
Private e	$5,900	$5,300	88%	$375	6.4%	$5,525	94%
Private f	$6,300	$5,700	95%	$675	10.7%	$5,625	89%
FFS	**$6,600**	**$6,000**	**100%**	**$720**	**12.0%**	**$5,280**	88%
Private g	$6,600	$6,000	100%	$960	14.5%	$5,640	85%
Private h	$6,900	$6,300	105%	$1,260	18.3%	$5,640	82%

Source: Table prepared by CRS.

*Assumes geographic adjustment would decrease relative costs of FFS care by 10% ($600).

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