

**Testimony of Jeff Lemieux  
Senior Economist  
Progressive Policy Institute**

**United States House of Representatives  
Committee on Government Reform and Oversight  
Subcommittee on Civil Service**

**Hearing on FEHBP and Medicare Reform  
Saturday, May 22, 1999**

Thank you for this opportunity to testify on the Medicare Commission's efforts to use the Federal Employees Health Benefits Program (FEHBP) as a model for Medicare reform. This presentation includes a brief overview, a more detailed explanation of the proposal advanced by Senator Breaux and Representative Thomas, a discussion of some of the issues that divided the Medicare Commission, and a commentary that argues for a step-by-step process for Medicare reform using the Medicare Commission's work as a guide.

**Summary--The Breaux/Thomas Proposal for Medicare Reform**

The federal employees' health system has been successful in controlling the growth of enrollees' premiums and taxpayers' obligations. It has also successfully balanced innovation and standardization in health benefits. Each year, federal employees choose from a wide variety of plans, ranging from fee-for-service plans to HMOs to everything in between. They receive clear comparative information about the available plans. If they choose expensive plans, they pay more. Inexpensive plans have lower premiums both for the enrollee and the government.

Senator John Breaux (D-La.) and Representative Bill Thomas (R-Ca.), the co-chairmen of the National Bipartisan Commission on the Future of Medicare, propose to use the Federal Employees Health Benefits Program (FEHBP) system as a model for the future of Medicare. On the 17-member Commission, the proposal received 10 yes votes--all from members of Congress and Congressional appointees. That was one short of the eleven-vote supermajority needed for a formal recommendation and report.

The intention of the Breaux/Thomas proposal is to get the basic design of the Medicare program right, not for the next year or two, but for the coming decades. It is a broad conceptual proposal that does not prescribe every specific rule in advance. All plans serving Medicare beneficiaries, including the traditional fee-for-service plan, would compete under the supervision of a new entity, dubbed the Medicare Board. The Board would have some latitude to adapt Medicare to changing times, and the proposal would allow the Health Care Financing Administration (HCFA) additional flexibility in operating the traditional fee-for-service plan.

The proposal is designed to encourage all types of plans--national, regional, or local, HMO, fee-for-service, or everything in between, and public or private--to serve Medicare beneficiaries. Recognizing that the plans of the future may be different from those available now, the proposal envisions a fair and even-handed system, called premium support, under which all types of plans could compete.

The premium support system in the Breaux/Thomas proposal is based on these principles:

- fair competition between the government-run fee-for-service plan and private plans
- minimal disruption for current beneficiaries in either the fee-for-service plan or private plans
- fair competition between local, regional, and national plans
- real opportunities for national and other wide-area plans to enter the Medicare market
- enhanced stability in the service areas and benefits of private plans
- a competitive fee-for-service plan

The Breaux/Thomas plan would create a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries. The drug benefit proposal would:

- ensure drug coverage for beneficiaries up to 135 percent of poverty,
- allow more reasonably priced drug coverage for all beneficiaries via high option and Medigap plans, and
- limit the substitution of government-paid benefits for privately-paid benefits.

The goal of the Breaux/Thomas plan is to create a more flexible and modern Medicare program. For beneficiaries it offers more reasonably-priced drug coverage, a reduced need for supplemental coverage, and the promise of lower premiums. For the government (and by extension, the taxpayer) it would aid the budget and gradually reduce the need for federal micromanagement. For health plans, it offers greater stability and a more businesslike atmosphere, with fairer, but tougher, competition. For hospitals and health providers, it would bring a less heavy handed approach to cost control than has been used in the past.

The proposal would minimize disruption to current beneficiaries even as it remakes Medicare and its incentives. That means that beneficiaries remaining in the fee-for-service system or in a current Medicare HMO would not notice a dramatic change when the proposal was implemented. That also means that the proposal does not attempt to answer every question or rectify every perceived inequity in Medicare. Important operational questions would be left to future Boards and the political and oversight responsibilities of future Congresses would certainly not disappear.

Exhibit 1 summarizes the proposal and compares it with current Medicare law.<sup>1</sup> The following sections highlight the key elements of the proposal and discuss some issues of concern to Commissioners.

## **Proposal Basics**

**Premiums.** The Breaux/Thomas proposal would change the Medicare entitlement from the government paying 100 percent of Part A (mostly hospital care) and 75 percent of Part B (mostly outpatient and physician services) to the government paying 88 percent of a combined Medicare. The 88 percent figure approximates the government's share of overall program costs under current law when the new system would be implemented.<sup>2</sup> The combined Medicare spending would grow at the average rate of growth in the premiums of plans beneficiaries chose, including the traditional Medicare fee-for-service plan and private plans. By contrast, current Medicare spending is based only on the fee-for-service program.

Each year, beneficiaries would have significant financial incentives to choose efficient plans. On average,

beneficiaries would pay 12 percent of the premium for a standard plan. But beneficiaries choosing costlier-than-average plans would pay the full extra cost themselves and beneficiaries choosing plans with premiums less than 85 percent of the average would pay no premium at all.<sup>3</sup> Currently, all beneficiaries must pay at least the Part B premium. (This year, 25 percent of Part B is equal to about \$500. When the transfer of home health spending from Part A to Part B under current law is completed, the Part B premium will be about \$700 annually.)

Exhibit 2 shows an example of a Breaux/Thomas premium support schedule. In the example, the average premium for standard benefits is about \$5,700. Therefore, a beneficiary would pay an annual premium of about \$700 (12 percent) for a plan priced at the national average.

**Benefits.** Parts A and B would be combined, but Medicare's standard benefits would not change. The current Part A per-admission hospital deductible (currently \$768) and the annual Part B deductible of \$100 would be replaced by a combined annual deductible of \$400. Coinsurance of ten percent would be charged for home health and laboratory services. No coinsurance would be charged for inpatient hospital stays and preventive care.<sup>4</sup>

The standard benefits specified in law would consist of all services covered under the existing Medicare statute. As under current law, private plans could establish their own rules on exactly how the benefits would be provided. Board approval would be required for all benefit design offerings and changes.

Every plan (including the fee-for-service plan) would offer a high option that would include Medicare's standard benefits plus drug coverage.<sup>5</sup> Drug benefits would be fully subsidized for beneficiaries under 135 percent of poverty.

The minimum drug benefit for high option plans would be based on standards and examples set by the Board. In the fee-for-service plan, HCFA would contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would create a public/private high option plan or plans, with HCFA providing coverage for the standard benefits and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, the proposal allows HCFA to contract more completely with private plans for its standard benefits as well, although no transition steps or timetables are specified and HCFA is not necessarily required to pursue that option.

**Competition.** Under current law HCFA runs the fee-for-service plan and controls the terms of competition between that plan and private plans. Under the Breaux/Thomas proposal, the Board would administer the competitive environment. HCFA's role in Medicare would be focused on administering the fee-for-service plan, and the fee-for-service plan would be treated as any other plan by the Board.

As under current law, the fee-for-service plan would set a national premium and its enrollees would pay one flat amount, regardless of where they live or move. The fee-for-service plan's large enrollment guarantees that its premium would be very close to the national average when the premium support system was implemented. Therefore, in both method and amount, the initial fee-for-service premium under the Breaux/Thomas proposal would be similar to the Part B premium under current law.

Payments to all plans would be adjusted for the demographics, risk, and geographic location of their enrollees. The payment adjustments are needed to ensure that plans serving more or less expensive enrollees are paid fairly, and that in their premiums reflect real value differences. The geographic adjustments would allow fair competition between local and national or wide-area plans.<sup>6</sup> If early versions

of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

Under current law, HCFA sets reimbursement rates for private plans by county. Private plans decide whether or not to offer Medicare options at that rate. If the rate is insufficient, they may collect an additional premium from beneficiaries. Because many hesitate to charge additional premiums, plans sometimes adjust to changes in costs or HCFA reimbursements by changing their service areas or benefits.

The premium support system in Medicare would provide a more stable environment to ensure plan participation. Rather than adjusting to administratively-set reimbursements, they would set their own combination of benefits and premiums through negotiations with the Board. All enrollee premiums would be collected by the Board, freeing plans from collection costs. Although Medicare law now allows private plans other than HMOs, its reimbursements and regulations focus on local areas. PPOs and other types of plans that often serve wider areas are unlikely to proliferate in Medicare under those rules. Like the Federal Employees Health Benefits program, the premium support system proposed by Senator Breaux and Representative Thomas is designed to encourage the full variety of plans to serve Medicare beneficiaries.

The proposal envisions that Congress would prevent payment rates in the fee-for-service plan from increasing to levels that would make its premium uncompetitive with private plans. It would allow HCFA to manage its payments and contracts in areas where its rates were uncompetitive.

**Trust Fund.** The Breaux/Thomas plan would create a combined Medicare trust fund that would include all three sources of funds: payroll taxes, premiums, and general revenue contributions. Without further Congressional action, general revenue contributions would be allowed to grow only as fast as program spending if they otherwise would exceed 40 percent of Medicare's finances.

**Other Items.** The proposal would gradually raise the normal age of Medicare eligibility from 65 to 67. Policies to soften the blow for affected beneficiaries could include adding a new category of eligibility based on need and instituting a voluntary buy-in.<sup>7</sup> Direct subsidies for teaching hospital would be carved out of Medicare; that funding would be placed elsewhere in the budget.

The proposal would significantly remake the Medigap market to conform with the combined Medicare program, to require Medigap coverage or prescription drugs, and to allow varying degrees of coverage of Medicare coinsurance and deductibles. Although the proposal does not address it, the transition policy to a remade Medigap market would be very important, especially with respect to the newly-required prescription drug coverage.

**Items Left on the Table.** One item considered by the Commission, but not included in the Breaux/Thomas proposal, was an income-related premium. For implementation reasons, the income related premium would have been retrospective, handled by or in conjunction with the income tax system. Although that sort of extra premium would have a negligible impact on beneficiaries' health care consumption, it was proposed for fairness reasons and for the savings it would bring.

Also considered in the waning days of the Commission were extra subsidies for high option plans. Those subsidies could have been included in the final premium schedule. An extra subsidy of 10 or 15 percent of the average additional cost of high option plans would have provided an additional incentive for beneficiaries to choose high option plans without greatly affecting the market for employment-based supplemental coverage or too greatly exposing the government to the fast-growing costs of prescription drugs.

## Key Issues in the Medicare Commission

**Premiums in Fee-For-Service and Private Plans.** Some Commissioners expressed concern that if HCFA and Congress could not control the cost of the fee-for-service plan, beneficiaries in that plan could have higher premiums than under current law. That concern is valid since the premium support system would put the fee-for-service plan in direct competition with private plans. Although the average enrollee premium would be pegged at 12 percent of standard option premiums under the proposal, there is no guarantee that the fee-for-service premium will remain at 12 percent. Over time, if its premium grew faster than those of private plans, its enrollees would pay more. That in turn, would put considerable pressure on both HCFA and Congress to keep its costs in line.

Over the next 25 years under current law, however, Medicare Part B premiums are expected to rise to about 14 percent of overall Medicare costs (see Exhibit 3). The baby boom generation will enter Medicare in large numbers beginning in about 2010. In their first 10 or 15 years on Medicare, the baby boomers will be heavy users of Part B (outpatient) services, driving up Part B costs relative to Part A and raising the percentage of overall program costs that the Part B premium represents.

Pegging the premium at 12 percent, therefore, will lower average beneficiary premiums compared with current law. Whether or not the fee-for-service premium would be higher under premium support than under current law will depend on how well the fee-for-service plan can control its costs.<sup>8</sup> In any case, because the fee-for-service plan will hold a large market share for some time to come, premium changes relative to current law would probably be very gradual. That should give HCFA or Congress ample time to bring fee-for-service payments in line with those of private plans if fee-for-service premiums would otherwise grow too fast.

**Prescription Drugs.** Some Commissioners decried the absence of large government subsidies for prescription drug coverage. The Breaux/Thomas plan would create a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries.

The proposal would explicitly subsidize drug coverage for the poor. In the short run, that coverage would be provided through the Medicaid program. When the premium support system was implemented, the coverage would be provided through special subsidies for high option plans in Medicare. The new drug subsidies would probably increase the participation in subsidies available under current law (for premiums and cost sharing). Ultimately, all such subsidies could be combined into a generous premium support schedule for low-income beneficiaries.

The Breaux/Thomas proposal does not explicitly subsidize drug coverage for those above 135 percent of poverty. The Board would have the power, through risk adjustment and negotiation with plans, to ensure that plans' high option offerings would be available at a fair price. Therefore, additional subsidies would not be necessary to prevent risk selection from driving up the cost of high option plans. Furthermore, large additional subsidies could spur employers to drop retiree wrap-around coverage, which often includes drug benefits. Although employer coverage for retirees will probably continue to weaken, the Breaux/Thomas proposal would not accelerate that trend.

**Financing.** Since most Commissioners agreed that the merger of Parts A and B of Medicare was desirable, the financing question boiled down to how best to create a combined Medicare trust fund. (The Commission did not address the more fundamental question of whether or not trust fund financing should be used for Medicare.)

Trust funds for entitlement programs are created more for political than economic reasons. Economically, trust funds have little meaning. The entitlement alone determines the government spending obligation, and dedicating certain revenues to that obligation does not change the overall federal budget surplus or deficit. Furthermore, all Medicare trust funds, current and proposed, are cash-flow funds. Their balances would not be sufficient to pay benefits for much more than a year if their revenues ceased.

Politically, however, trust funds can send very important signals. A dedicated source of revenue can reassure or comfort future beneficiaries. Dedicated revenues make the program seem permanent--a social or generational contract. Trust funds can also add an important discipline against unrestrained program spending. The impending insolvency of a fund signals the public and Congress that action must be taken.

For reassurance, trust funds work politically only if beneficiaries believe that the government would not "spend" the "fund" on something else. For discipline, a trust fund can only work if the consequences of the fund's insolvency seem serious. Whether or not benefits would be paid without disruption must be murky enough that politicians and beneficiaries alike think that insolvency should be avoided.

Currently, the Medicare Part A fund emphasizes discipline as much as reassurance. Its dedicated revenue is mostly from payroll taxes, which are not expected to rise as fast as Medicare spending in Part A. The Part A fund is expected to go broke soon after the baby boomers begin to retire. The Part B fund is mostly a comfort fund. Its sources of revenue are split between beneficiary premiums (25 percent) and general federal revenues (75 percent). Since neither the premiums nor the general revenue contributions are limited, both will rise indefinitely to match Part B spending. The Part B fund cannot go broke.

The Breaux/Thomas plan is more of a reassurance fund than that current Part A fund, since it would allow general revenue contributions to grow at the same rate as overall program costs, even after the 40 percent cap was reached. But it would impose more fiscal discipline than the current Part B fund because, combined with payroll taxes and beneficiary premiums, the combined fund could still run out of money.

All of the policies in the Breaux/Thomas plan would probably reduce the growth of Medicare spending by about 1 percent a year--enough to squeeze another 4 or 5 years out of a combined trust fund without additional taxes, premiums, or spending restraints.

The estimates are highly uncertain, however, and they are far from vital to the Medicare financing debate. The question of the degree of fiscal discipline in a combined Medicare trust fund should be answered politically--it is not fundamentally an economic or estimating issue.

**Estimates.** The staff estimates of the Medicare Commission's plan were based on the assumption that spending in the unrestrained fee-for-service program (which would determine Medicare spending under current law) would grow faster than the blend of fee-for-service and private plan premiums that would determine Medicare spending under premium support.<sup>9</sup> Therefore the premium support plan would slow the growth of Medicare spending. The estimated savings were roughly in line with those used by CBO during the debate on health reform proposals that would have spurred competition among health plans. Exhibit 4 shows the short-term cost estimate I prepared for the Medicare Commission.

The estimates used CBO's projection for the growth of private health insurance premiums as a guide to the likely growth of premiums for private plans under a premium support system for Medicare. CBO assumes that competition among health plans, and careful purchasing by the employers who arrange most private health insurance, will help hold the growth of private premiums to a slower rate than that seen prior to the early 1990s. A premium support system in Medicare would create a competitive purchasing environment similar to that expected in the market for private insurance for workers.

In all probability, the fee-for-service plan will continue to hold a large market share under premium support. In the absence of restraints in the fee-for-service plan, therefore, savings from the premium support system would accrue slowly. A modest sustained reduction in the growth of Medicare spending, however, can compound to significant savings for the program in the long-run.

HCFA's estimates of the premium support plan, which started from a more optimistic (lower) baseline for fee-for-service and a more pessimistic (higher) baseline for the growth of private premiums, showed less savings than the staff estimates in the long run.<sup>10</sup> Based on more aggressive assumptions about beneficiary switching behavior, however, HCFA estimated that the shorter-run savings would be higher than those estimated by the staff.

Some Commissioners argued that the estimates were too optimistic about Medicare savings. In a sense they were disagreeing with other Commissioners who argued that the premium support system would drive fee-for-service premiums above those of private plans. The two effects--Medicare savings and the performance of the fee-for-service plan--are directly linked. If private premiums fell below that of the unrestrained fee-for-service plan under premium support, Medicare outlays would be reduced compared to current law. If the fee-for-service plan found new ways to keep its costs in line with those of private plans, then everybody would win. That, ultimately, is the goal of premium support.

But even if the premium support system did not work to slow the growth of Medicare spending and there were no savings, beneficiaries would be no worse off. The fee-for-service system would still be in place, and its premiums would be no higher than they would otherwise have been.

## **Perspective**

The primary motivation for Medicare reform should be the search for value, not the crisis in Medicare's finances. For significant reforms to work, both political parties and most people, working and retired, taxpayers and beneficiaries, must understand that the reforms are valuable to them. Although economists preach against the undue hope for free lunches, efficiency gains that would offer the hope for both better benefits and lower premium and tax burdens are probably possible in Medicare. Efficiency gains in Medicare could free up national resources for any number of important purposes.

The premium support system proposed by Senator Breaux and Representative Thomas has the potential to unlock efficiencies in the fee-for-service plan as well as in private plans. Fee-for-service beneficiaries in a competitive system, seeing the connection between cost control and lower premiums, could prod HCFA to work more carefully to control costs. Pressure from direct competition could aid HCFA's management, and management successes would help build the political trust necessary for HCFA to gain more and more flexibility from a skeptical Congress.

The Breaux/Thomas proposal can be viewed as a blueprint for a series of reforms. The first steps should be moving the oversight of Medicare's private plans from HCFA to the newly-created Board and launching the prescription drug subsidies for low-income beneficiaries. The Board should then work with Congress and the Administration to transition from the current system to premium support. That work would include performing detailed studies of alternative bidding and payment adjustment techniques and building the logistical capability to run a premium support system. In anticipation of greater administrative flexibility and responsibility, HCFA should begin searching for high-option partners and reporting its plans for a more businesslike management of the fee-for-service plan to Congress in detail. The specific legislative authority for the changes could proceed in stages.

The challenge for the Board would be to raise the comfort level of current and future beneficiaries, HCFA and the Administration, Congress, health plans, and health providers as the new system takes shape. Medicare is too important to reform in any but the most careful ways; to meet the challenge, the preparations must be rigorous.

**Exhibit 1.**  
**Comparison of Current Medicare Law and the Breaux/Thomas Proposal**

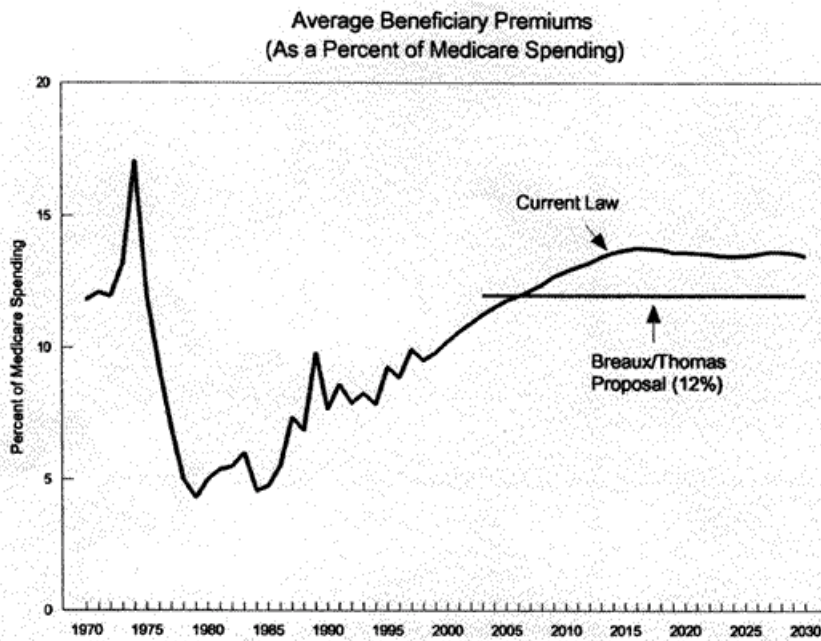
Current Law	Breaux/Thomas
<b>Entitlement:</b> All of Part A benefits, 75% of Part B benefits. Based on fee-for-service.	<b>Entitlement:</b> 88% of combined Parts A and B benefits based on weighted average cost of fee-for-service and private plans.
<b>Premiums:</b> Premium is 25% of Part B. Same premium paid by all. Extra premium for some private plans.	<b>Premiums:</b> 12% of national average premium (combined Part A and B) on average. Inexpensive plans could have no premium; those choosing expensive plans would pay higher percentage.
<b>Prescription Drugs:</b> Only available in certain HMOs.	<b>Prescription Drugs:</b> All plans (including gov't fee-for-service) have a high option with standard benefits plus drugs.
<b>Deductibles and Coinsurance in Fee-for-Service Plan:</b> \$768 hospital deductible (per admission). \$100 Part B annual deductible. Limits on hospital days. No coinsurance for lab and home health.	<b>Deductibles and Coinsurance in Fee-for-Service Plan:</b> \$400 annual combined deductible. No limit on hospital days. 10% coinsurance for lab and home health.
<b>Choice of Plans:</b> Mostly HMOs and gov't-run fee-for-service plan. Locally-based payments and regulations not likely to attract PPOs, POS plans, and private FFS plans.	<b>Choice of Plans:</b> FEHB-style system (with risk and geographic adjustment) would encourage wide-area private PPOs, POS plans, and FFS plans as well as local HMOs.
<b>Assistance for Low-Income:</b> Medicaid pays for Medicare premiums up to 135% of poverty and cost sharing up to 100% of poverty. Dual eligibles (generally well below poverty) get drugs.	<b>Assistance for Low-Income:</b> Full subsidy for prescription drugs up to 135% of poverty, initially through Medicaid. Federal responsibility for all additional cost (incl. higher participation) with state maintenance of effort.
<b>Trust Funds:</b> Part A fund based on payroll tax receipts. Part B fund is 25% premiums and open-ended general revenue for other 75%. Part A and B funds affected by transfer of home health from A to B.	<b>Trust Fund:</b> Combined fund with payroll tax, premium, and general revenue receipts. General revenues cannot grow faster than overall Medicare spending if they would otherwise exceed 40% (without further Congressional action).
<b>Education and DSH:</b> Administered as part of Medicare entitlement.	<b>Education and DSH:</b> Carve out direct medical education; fund that activity through normal appropriations process raise caps on appropriated spending to accommodate. Study long-term appropriation for DSH and IME funding outside of Medicare.
<b>Retirement Age:</b> 65	<b>Retirement Age:</b> Gradually raised from 65 to 67 to conform with Social Security normal retirement age. Possibly new disability or need-based eligibility for those 65-67 or waiting period reduced. "Budget neutral" buy-in for 65-67.
<b>Medigap:</b> A-J plans generally cover deductibles and coinsurance. Drug coverage is an add-on, usually expensive due to self-selection.	<b>Medigap:</b> Federal directive to NAIC to develop new model plans. All plans to include coverage for prescription drugs. One plan drug-only. Plans to vary on the degree they cover Medicare coinsurance.

**Exhibit 2.  
Premium Support Schedule**

Annual Premium (in dollars)	Premium as a Percent of the National Avg.	Enrollee Share	Enrollee Share (in percent)
4500	79%	0	0%
4600	81%	0	0%
4700	82%	0	0%
4800	84%	0	0%
4900	86%	78	2%
5000	88%	156	3%
5100	89%	234	5%
5200	91%	312	6%
5300	93%	390	7%
5400	95%	468	9%
5500	96%	546	10%
5600	98%	624	11%
5700	100%	702	12%
5800	102%	802	14%
5900	104%	902	15%
6000	105%	1002	17%
6100	107%	1102	18%
6200	109%	1202	19%

**Note:** In this example, the National Weighted Average Premium is about \$5700.

**Exhibit 3.**



**Note:** Part B premium under current law vs. 12 percent of national average under the Breux/Thomas proposal.

**Exhibit 4. Breaux/Thomas Proposal, March 14**  
(by calendar year)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2000-2004	2005-2009
<b>Cost (+) or Savings (-) in Billions of Dollars</b>																
Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 136 Percent of Poverty <sup>11</sup>	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs <sup>12</sup>	2	2	2	3	3	3	3	4	4	4	4	5	5	5	12	30
Cost Sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-7	-8	-4	-24
Removal of DME <sup>13</sup>	0	0	0	-4	-5	-5	-5	-5	-5	-5	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-1	-11
Slowdown of Growth in Gov't FFS plan <sup>14</sup>	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
<b>Total</b>	<b>4</b>	<b>4</b>	<b>5</b>	<b>-6</b>	<b>-9</b>	<b>-11</b>	<b>-16</b>	<b>-20</b>	<b>-24</b>	<b>-29</b>	<b>-34</b>	<b>-41</b>	<b>-48</b>	<b>-55</b>	<b>-1</b>	<b>-102</b>
<b>Average Monthly Premium:</b>																
Government-run FFS plan				\$76	\$80	\$84	\$89	\$93	\$96	\$103	\$106	\$114	\$119	\$125		
Government-run plan in no alternative areas				\$75	\$79	\$84	\$88	\$92	\$95	\$101	\$106	\$111	\$116	\$120		
Private plans				\$75	\$79	\$82	\$86	\$90	\$93	\$97	\$102	\$106	\$110	\$114		
Average of all plans				\$75	\$79	\$84	\$88	\$92	\$95	\$101	\$106	\$111	\$116	\$120		
Monthly Part B Premium under Current Law				\$71	\$77	\$84	\$91	\$98	\$106	\$115	\$123	\$132	\$141	\$151		
<b>Items Not Included (Cost + or Savings - in billion of dollars)</b>																
Premium Subsidies in High Option Plans	0	0	0	1	1	1	1	2	2	2	2	3	3	3	2	10
Option: 10 Percent of Private Drug Cost	0	0	0	3	3	4	5	5	6	7	8	9	10	12	6	33
Option: 25 Percent of Private Drug Cost																
Option: 50 Percent of Private Drug Cost																
Income-Related Premium	0	0	0	-4	-5	-6	-8	-10	-10	-11	-13	-14	-16	-18	-10	-55

Source: Medicare Commission Staff.

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items. Estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003. Estimate assumes avg. drug cost in private high option plans was about \$875 in 2003, growing to \$1,890 in 2013. That is consistent with tightly managed drug coverage with \$500 deductible, 25% coinsurance, and \$2,500 out-of-pocket maximum (stop loss). The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003. Over time, that percentage would gradually fall; if national private plans developed, it would fall to zero. In this time period, the results are approximately the same using either of the Commission's baselines.

- <sup>11</sup> Assumes 100% federal funding with a state maintenance of effort for dually-eligible beneficiaries. Participation rate assumed to be about 60 percent.
- <sup>12</sup> Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).
- <sup>13</sup> Savings to Medicare, but not necessarily to the overall budget.
- <sup>14</sup> Follows the method of the nontraditional estimate of Feb. 17, which assumed that the fee-for-service plan would compete to some extent.

## Endnotes

1. Because the proposal contains few details, this paper is at best an interpretation, not a definitive explanation.
2. Based on current projections, all of Part A and 75 percent of Part B would equal 88 percent of Parts A and B combined if the home health transfer (enacted in 1997) was completed. If the projections changed prior to implementation, the percentage could change as well.
3. In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.
4. Although their final proposal does not mention it, I believe the authors' intention was to eliminate the current-law limitation on the number of hospital days covered by Medicare.
5. Private plans in Medicare generally have out-of-pocket maximum projections (stop-loss) for covered services. That would be a requirement for high option plans under the proposal.
6. To minimize disruption to current HMO enrollees, the level and type of geographic adjustments initially would be similar to those anticipated under current law. For illustrative purposes, the Commission used a 50-50 blend of historical fee-for-service payments and an input price index. That was meant to approximate the level of geographic adjustment in current law when provisions of the Balanced Budget Act of 1997 are fully implemented. Geographic adjustment for high option plans could differ from those used for standard option coverage.
7. Although the buy-in was intended to be budget neutral, a budget neutral buy-in policy may be impossible to devise. The cost estimates attached to the Medicare Commission's proposals did not include the cost of a buy-in.
8. My simulations of fee-for-service and private premiums for the Medicare Commission showed that with modest cost control in fee-for-service, premiums remained lower than under current law. With no cost control, however, fee-for-service premiums would exceed those expected under current law by 2020.
9. Staff and other estimates are available on the Medicare Commission's web site: [medicare.commission.gov](http://medicare.commission.gov).
10. For its estimates, HCFA's uses a baseline for Medicare spending that assumes the growth of fee-for-service spending will slow in the future, even absent changes in Medicare law. The Commission used two current-law baselines for fee-for-service spending in Medicare: one more optimistic like HCFA's and one that did not assume the growth of fee-for-service spending would slow in the years ahead. HCFA's baseline for private insurance assumes a growth rate of about 3 percentage points above the growth of nominal GDP. The Commission used CBO's baseline, which assumed a growth rate of one percentage point above GDP. That baseline was adjusted proportionately to be consistent with either baseline for fee-for-service spending.