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First Bipartisan Medicare Reform Bill

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LEGISLATIVE WATCH

First Bipartisan Medicare Reform Bill

The proposed Breaux-Frist plan will establish a Competitive Premium System that offers integrated health care benefits and prescription drug coverage, while maintaining Medicare entitlement.

By Senator John Breaux

Senator John Breaux (D.-La.), serving his third term in the U.S. Senate, is the ranking Democrat on the Special Committee on Aging. In January 1998, he was selected by the White House and House and Senate leaders to chair the National Bipartisan Commission on the Future of Medicare. Senator Breaux also cochaired the National Commission on Retirement Policy that produced legislation to help reform Social Security.

On November 9, 1999, Senator Bill Frist (R.-Tenn.) and I were pleased to introduce the first bipartisan Medicare reform bill in final legislative language. The Medicare Preservation and Improvement Act of 1999 (S. 1895), also known as the Breaux-Frist plan, is designed to improve Medicare for 38 million Americans today and 77 million baby boomers tomorrow. We have introduced this legislation to seek wide public debate on our competitive premium system, a reform proposal supported by a majority of the Medicare Commission earlier this year. A summary of the 80-page Breaux-Frist legislative proposal appears below. We seek to change a federal program that now requires more than 132,000 pages of regulations, three times larger than the IRS code. We all share a common goal of preserving and improving Medicare for future generations.

Medicare Competitive Premium System

Establishment of Competitive Medicare Premium System

Beginning January 1, 2003, a new title (Title 22) will establish a Medicare Competitive Premium System. Title 18 (the current Medicare title) is preserved to the extent it does not conflict with new provisions in Title 22. Beneficiaries will continue to be entitled to benefits under Title 18 through enrollment in a Medicare plan.

Medicare Board

The President, with the Senate's advice and consent, will appoint a seven-member Medicare Board. The board will administer the competitive environment and will be responsible for coordinating and determining beneficiary eligibility and enrollment; negotiating contracts with entities offering Medicare plans, including the Health Care Financing Administration

(HCFA); and disseminating information to beneficiaries respecting benefits, costsharing, and quality indicators under Medicare plans.

According to current law, HCFA operates the fee-for-service and Medicare+Choice programs and controls the terms of competition between private plans. With the establishment of the board, HCFA will be responsible for administering its own standard and high-option plans while the board oversees competition between HCFA plans and private plans.

The first board appointees will serve staggered terms, with all appointees limited to two terms on the board. Following the first set of staggered terms, each term will run seven years.

Benefit Package

All Medicare beneficiaries will at a minimum continue to be entitled to the same benefits they are entitled to today. Beneficiaries may choose from varied plans, including private standard plans, private high-option plans, the HCFA-sponsored standard plan, or HCFA-sponsored high-option plans. The board will not approve any plan unless it covers at least the same Medicare benefits that beneficiaries have today. The board may not approve any benefit package designed to result in favorable selection of beneficiaries.

Standard and High-Option Plans

All entities offering Medicare plans must also offer a high-option plan. High-option plans include the standard core Medicare benefits plus outpatient prescription drug coverage and stop-loss protection for standard benefits. Outpatient prescription drug coverage must meet an actuarially equivalent value of $800 in 2003 (adjusted annually for increases in reasonable drug costs). In any given year a beneficiary's out-of-pocket costs for current Medicare benefits cannot exceed $2,000.

HCFA-sponsored Standard and High-Option Plans

HCFA will offer a nationwide standard plan to include all Title 18 benefits currently available under the Medicare fee-for-service program. HCFA will submit premium information for this plan to the board as other plans do. Current payment and coverage rules and regulations applicable under the fee-for-service program will also apply to the HCFA-sponsored standard plan. HCFA will bear the full financial risk for its standard plan offering.

Beginning in 2003, HCFA will offer one or more high-option plans, in addition to the standard plan, through partnerships with private entities. Insurers, pharmaceutical benefit managers, chain pharmacies, Medigap insurers, groups of independent pharmacies, or other qualified private entities may partner with HCFA to offer drug coverage as part of an HCFA-sponsored high-option plan. The HCFA-sponsored high-option plan must meet the same minimum actuarial value of drug benefits as private high-option plans. HCFA may not exclude qualified private entities offering to partner with HCFA to form a high-option plan, as long all requirements established by the board are met.

Only beneficiaries enrolled in the HCFA-sponsored standard plan will continue to be able to purchase Medicare supplemental insurance.

Qualifications to Offer a Medicare Plan

In order to offer a Medicare plan, a plan must meet the requirements currently applicable to Medicare+Choice plans and organizations, including the offering of benefits and protections for Medicare beneficiaries. Plans must submit to the board a description of benefits, a bid for the package of benefits, and the proposed service areas. The Board will review the information submitted and negotiate premium and benefit design with the plans.

Payments to Medicare Plans and Computation of the Beneficiary Premium

Step 1. The Medicare Board publishes, with reasonable notification to plans, geographic and risk adjusters.

Step 2. An entity submits a bid for a package of benefits to the board.

Step 3. The board computes a premium for core benefits (by carving out the core benefits plus any de minimis additional benefits).

Step 4. The board calculates a premium schedule based

on computation of the national weighted average (NWA) premium. The NWA premium is equal to the weighted average of the premium for core benefits, with the weight for each plan being equal to the average number of beneficiaries enrolled in that plan in the previous year.

Step 5. Beneficiary premiums are determined for both standard and high-option plans (as described below).

Step 6. The payment amount to a Medicare plan per enrollee is equal to the premium for the plan as approved by the board. The portion of the premium associated with core benefits is subject to geographic and risk adjustment.

Computing Beneficiary Premiums

The beneficiary pays no premium if the premium for the plan selected is less than 85 percent of the NWA premium. If the premium for a plan exceeds 85 percent (but is less than 100 percent) of the NWA premium, the beneficiary premium will be equal to 80 percent of the amount by which the plan premium exceeds 85 percent of the NWA premium.

If the premium for a plan equals or is greater than 100 percent of the NWA premium, the beneficiary premium is equal to 12 percent of the NWA premium, plus the amount, if any, by which the plan premium exceeds the NWA premium.

Premium collection for low-income beneficiaries would occur in the same manner as under current law, so that a beneficiary's share of the premium for Medicare benefits is deducted from his or her Social Security check. Medicare plans are not responsible for collection of premiums.

Premium Discount for Drug Benefits Under High-Option Plans

Low-Income Protection Package

Beneficiaries at or below 135 percent of poverty will pay a zero premium for enrollment in the lowest cost high-option plan in their area. Beneficiaries qualifying for this subsidy include dually eligibles, qualified low-income Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and certain qualifying individuals (QI-1s). The Medicare Board will establish an arrangement with each state to determine eligibility for these beneficiaries.

A beneficiary whose income is above 135 percent of poverty but less than 150 percent of poverty will receive a discount for drug benefits, phasing down from a 50 percent discount at 136 percent of poverty to a 25 percent discount at 150 percent of poverty.

States must maintain their current level of premiums, cost sharing, and deductibles, as required under current law, for beneficiaries at or below 135 percent of poverty. States maintain their premium contributions for low-income beneficiaries by contributing the lower of 12 percent of the NWA premium for core benefits or the beneficiary premium for the HCFA-sponsored standard plan.

If a qualified low-income beneficiary chooses a higher cost high-option plan, the beneficiary will receive a discount based on the premium for the lowest cost high-option plan.

Beneficiaries Above 150 Percent of Poverty

Beneficiaries above 150 percent of poverty choosing a high-option plan will receive a 25 percent discount off the premium for that high-option plan (based on the minimum actuarial value of the high-option drug benefit). The value of the discount for drug premiums will be treated as taxable income for beneficiaries so that the discount is income-related.

Guaranteed Access Provisions

Under the Competitive Premium System, beneficiaries are protected from higher premiums in areas where there is no competition. If the only standard Medicare plan offered in an area is the HCFA-sponsored standard plan, the beneficiary premium for the HCFA-sponsored standard plan may not exceed 12 percent of the NWA premium or the beneficiary premium for the HCFA-sponsored standard plan, whichever is lower.

If the only high-option Medicare plan offered in an area is the HCFA-sponsored high-option plan, the beneficiary premium may not exceed the sum of 12 percent of the national weighted average premium plus

the difference between the beneficiary premium for the HCFA-sponsored standard and high-option plans.

The Medicare Board will also guarantee all beneficiaries a drug benefit package meeting the actuarial equivalence of drug benefits offered in high-option plans, regardless of where the beneficiary resides.

Medicare Beneficiary Outreach and Education

The board may authorize the establishment of Medicare Consumer Coalitions (MCCs), where a nonprofit organization, composed primarily of Medicare beneficiaries in a given area, is organized to provide for beneficiary outreach and education of Medicare benefit offerings. Specifically, MCCs will conduct programs to prepare and disseminate to Medicare beneficiaries comprehensive, accurate, timely, and understandable information on qualified health plans or Medicare supplemental policies in which beneficiaries are eligible under the Competitive Premium System. All Medicare beneficiaries are eligible to enroll in an MCC.

Unified Medicare Trust Fund: Combining Parts A and B

Effective January 1, 2003, a single trust fund, known as the Medicare Trust Fund (MTF), is created. This unified trust fund will include all three current sources of funds (i.e., payroll taxes, premiums, and general revenue contributions) and any additional fees imposed on plans by the Medicare Board.

The board is responsible for annually reporting to Congress the percentage of total Medicare expenditures from the Medicare Trust Fund through general revenues: the first fiscal year the MTF is determined to be programmatically insolvent; and the first fiscal year in which the fund will be insufficient to pay for the total expenses incurred. In any year in which general revenue contributions otherwise exceed 40 percent of total Medicare expenditures, the MTF will be deemed programmatically insolvent and Congressional approval will be required prior to additional general revenue transfers into the fund.

Division of HCFA-Sponsored Plans

HCFA will be divided into two divisions, the Division of HCFA-sponsored Plans and the Division of Health Programs. The Division of HCFA-sponsored Plans will be responsible for administering HCFA standard and high-option plans under the Competitive Premium System. The Division of Health Programs will maintain all other nonplan and noninsurance functions (e.g., the Medicaid program, the State Children's Health Insurance Program, disproportionate share hospital payments, and graduate medical education payments). Within six months of enactment, a director shall be appointed to oversee each division.

HCFA Business Planning and Administrative Flexibility

Beginning on January 1 of each year, and no later than January 1, 2002, the director of HCFA-sponsored Plans must submit a business plan to Congress. This plan must include a comprehensive payment and management plan for all aspects of offering core benefits, information about partnership arrangements with private entities for prescription drug coverage in high-option plans, and recommendations for benefit coordination and improvements. The plan must include legislative specifications necessary to enact the business plan. The business planning process will be exempt from Office of Management and Budget oversight and Administrative Procedure Act requirements, provided that public comment procedures are established. The Congressional Budget Office, General Accounting Office, and MedPAC must submit reports to Congress evaluating the business plan's impact on cost, providers, and beneficiary access to care.

Each year, Congress must conduct hearings on the business plan. HCFA's business plan will be guaranteed an up-or-down vote by Congress under fast-track procedures by 2005. After 2008, the HCFA-sponsored business plan and recommendations for benefit improvements will take effect without the explicit approval of Congress.

Conclusion

I hope this legislative effort becomes the marker for future discussions and debate on the question of what we do with Medicare. It is absolutely essential that Congress take up the question of how to reform the Medicare program that is currently serving 40 million Americans. The program that the seniors now benefit from is not nearly as good as it should be nor nearly as good as it can be.

QUESTIONS AND ANSWERS: THE BREAUX-FRIST MEDICARE COMPETITIVE PREMIUM PROPOSAL

By: Elizabeth M. Golden
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Q: What is the Medicare Competitive Premium System?

A: The Medicare Competitive Premium System is a new way of delivering health care to our nation's seniors modeled after the Federal Employees Health Benefits Program (FEHBP), a program serving nine million federal employees, including Members of Congress, since the 1950s. The Medicare Competitive Premium System provides an integrated set of health care benefits, including prescription drug and stop-loss coverage, while maintaining the Medicare entitlement for seniors. Through market-based forces, under the Medicare Competitive Premium System, plans offering benefits strive to provide affordable, high-quality health care to beneficiaries.

Q: Is the Medicare Competitive Premium System a voucher?

A: No. The Medicare Competitive Premium System is no more a voucher than the health care program for Congress or the current Medicare+Choice program. Under the Competitive Premium System, the government's contribution is tied directly to the cost of health care and the level of government support is explicitly outlined in statute. Seniors will not be handed a voucher and told to find health coverage on their own. The government will continue to directly reimburse the health plan chosen by the beneficiary.

Q: Does the Competitive Premium System preserve Medicare as an entitlement?

A: Yes. The Medicare Competitive Premium System guarantees all of the same Title 18 benefits currently offered under Medicare today and guarantees the government's commitment to pay 88 percent of the national weighted average premium. This is no different than the way the government contributes toward a beneficiary's Medicare coverage today. Beneficiaries currently pay premiums and cost sharing while the government reimburses a fixed amount for services provided. The Medicare Competitive Premium System operates under this same arrangement.

Q: What will happen to beneficiaries who live in areas where there are no private plans?

A: Beneficiaries everywhere, including those in areas with no private plans, will continue to have access to the traditional Medicare fee-for-service program through an HCFA-sponsored standard or high-option plan. Both plans offer the standard benefits available under Medicare today, and the high-option plan will include a prescription drug benefit. Under the Competitive Premium System, all beneficiaries, regardless of where they live, will have access to the current Medicare benefits and prescription drug coverage.

Q: How is this different from the current Medicare+Choice system, where plans are pulling out of various markets?

A: Under a Competitive Premium System, managed care payment rates are set through competition among plans rather than through a complicated statutory formula as they are under Medicare+Choice today. In addition, payment rates are not tied to Medicare fee-for-service spending, but instead are based on the actual cost of delivering care. Thus, the Competitive Premium System replaces the complicated statutory payment system under current law and provides more appropriate payments to plans.

Q: What benefits will be guaranteed under the Competitive Premium System?

A: All standard plans will be required to offer at least the same benefits that are cov-

ered under Medicare today. In addition, a high-option plan will include standard Medicare benefits plus prescription drug coverage. The Competitive Premium System establishes a new Medicare Board to ensure that all plans offer these benefits as a condition of participating in Medicare.

Q: What prescription drug benefits are offered under this proposal?

A: The proposal, for the first time in Medicare, offers a drug benefit to all beneficiaries, by requiring both HCFA-sponsored plans and private plans to offer drug coverage through a high-option plan. Beneficiaries below 135 percent of poverty who enroll in a high-option play will receive free coverage for all benefits, including prescription drugs. Beneficiaries between 135 percent and 150 percent of poverty who enroll in a high-option plan will receive a discount, ranging from 25 percent to 50 percent, off the part of the high-option premium associated with the new drug benefit. Finally, all beneficiaries above 150 percent of poverty will receive a discount of 25 percent off premiums for drugs within a high-option plan. All prescription drug benefits are offered only through a high-option plan in the context of the Competitive Premium System.

Q: Are there any protections for beneficiaries against large out-of-pocket costs?

A: Yes. The Medicare Competitive Premium System protects beneficiaries from high out-of-pocket costs by requiring all plans, including HCFA, to provide $2,000 in annual stop-loss coverage for current Medicare benefits.

Q: Is the Breaux-Frist proposal the same as the Medicare Commission's proposal?

A: The Breaux-Frist proposal is a logical extension of the Medicare Commission's work, but it is not identical to the commission's proposal released in March 1999. In particular, the Breaux-Frist proposal differs in that it offers drug coverage to all Medicare beneficiaries and covers either all or part of the costs of drugs for beneficiaries choosing a high-option plan. In addition, the Breaux-Frist proposal ensures full coverage of all benefits (core benefits and drugs), at no cost for low-income beneficiaries (under 135 percent of poverty). The Breaux-Frist proposal also eliminates several items included in the Medicare Commission's proposal, including raising the eligibility age, combining deductibles, extending Balanced Budget Act savings provisions, establishing cost-sharing for lab and home health services, reforming Medigap, and carving out graduate medical education. It is important, however, that these provisions are addressed as we move further into the discussions on reform.

Q: How would premiums change under the Competitive Premium System?

A: The Competitive Premium System replaces Medicare's Part B premium (currently about $45 a month for almost all seniors) with a new formula for premiums, which could range down to zero for very efficient health plans. The new formula for premiums is the same as that proposed by the Medicare Commission. Premiums for any Medicare plan, private or HCFA-sponsored, should remain the same for seniors under the Competitive Premium System as they are under the Part B system. Over time, however, the Competitive Premium System provides plans with an incentive to offer the most affordable high-quality health care. Keeping premiums affordable in future years is something the current system cannot manage, as the Congressional Budget Office estimates Part B premiums alone will more than double over the next 10 years.

Q: How does the Competitive Premium System address medicare's solvency crisis?

A: With major demographic shifts in our aging population and the reduction in workers per retiree paying payroll taxes for current Medicare obligations, clearly, more revenue will be needed to pay for Medicare for future beneficiaries. This proposal develops a new definition of solvency that focuses on the

amount of general revenue, beneficiary premiums, and payroll taxes being used to pay for Medicare in a given year. Although recognizing the need for new revenue, the proposal envisions reforming Medicare before committing future general revenues to the program.