DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

April 16, 2004

The Honorable Henry Waxman
U.S. House of Representatives
2204 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Waxman:

Secretary Thompson has referred your letters dated February 3, 2004, March 2, 2004 and March 17, 2004 to me for response. As you may be aware, I was Acting Administrator of CMS at the time your letters arrived and Secretary Thompson thought that I would be in the best position to respond to your request.

We welcome your views on the Medicare Modernization Act (MMA). There has been a fair amount of confusion surrounding the cost estimates of this landmark legislation, and I welcome this opportunity, on behalf of the Department, to help clarify that confusion.

As you know, the Congressional Budget Office (CBO) estimated that the legislation "would result in direct spending outlays totaling $395 billion over the 2004-2013 period," and has recently expressed continued confidence in that estimate.[1] It was of course understood during the debate on the Medicare legislation that Congress views CBO estimates as definitive for legislative purposes. Senator Baucus made this point expressly at a June 6, 2003 Senate Finance Committee hearing on Medicare improvement: "Clearly there are differences of opinion [between HHS and CBO regarding the cost-efficiency of PPOs], but in some sense that is irrelevant because we go by CBO. That is the organization that decides what these costs are or are not."[2]

As this statement makes clear, CBO's estimates were not the only estimates being developed during the debate on the Medicare bill. While HHS did not have a final estimate of the complete

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[1] See *The Financial Outlook for Medicare under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Hearing on Board of Trustees 2004 Annual Reports Before the House Committee on Ways and Means*, 108th Cong., 2nd Sess. (March 24, 2004) (statement of *Douglas Holtz-Eakin*, Chief Actuary, CBO Director), (available at http://waysandmeans.house.gov/Hearings.asp?congress=16) ("To date, CBO has not received any additional data or studies that would lead the agency to reconsider its conclusions. Therefore, CBO believes that its budgetary estimate is sound and has no reason to revise it.").

[2] *See also Statement of Senator Max Baucus Regarding Medicare* (June 5, 2003) ("The proposal Chairman Grassley and I are working on is still very much dependant on the CBO score") (available at http://finance.senate.gov/press/Bpress/2003press/prb060503a.pdf).

bill until after it was enacted, given that the bill was rapidly and frequently changing during the legislative process, HHS's Chief Actuary projected that various provisions of or proposed amendments to the Medicare bill would cost substantially more than CBO estimated. This difference of opinion is not surprising, given that such cost estimates require assumptions about future conduct in response to complex legislation not yet finalized and economic, demographic, and other conditions not yet realized. CBO and the Actuary simply reached different conclusions about the appropriate assumptions, even though both had the same information at their disposal.[3]

Although there is no legal requirement that the Actuary's estimates must be provided to Congress, the disparity between the Actuary's estimates and those of CBO was well known during the legislative debate. Contemporary press accounts make clear that the differences between the two estimates were well known.[4] In one very public instance regarding PPO participation in the program, CBO scored the option of unlimited participation at $200 million over 10 years while the CMS Actuary scored the choice as costing between $40 and $60 billion over that same period of time. Despite this knowledge of the cost differences, Congress chose to allow unlimited participation. Secretary Thompson has explained that HHS made conferees aware that HHS expected its final scoring to be higher than CBO's final scoring.[5] Indeed, Rep. Nancy Johnson has confirmed that "[a]bsolutely, we knew about these numbers."[6]

Moreover, while the President and the Administration pushed for greater cost controls at every stage of the legislative process, many Members who are now expressing concern over the cost of

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[3] See *The Financial Outlook for Medicare under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Hearing on Board of Trustees 2004 Annual Reports Before the House Committee on Ways and Means*, 108th Cong., 2nd Sess. (March 24, 2004) (statement of Richard S. Foster, F.S.A., Chief Actuary, Centers for Medicare & Medicaid Services) (available at http://waysandmeans.house.gov/Hearings.asp?congress=16) ("The estimates differ principally because the future is uncertain, and this uncertainty is reflected in somewhat different assumptions regarding the numerous costs and behavioral factors that will affect future costs. . . . I believe CBO has prepared competent, good-faith estimates for the Medicare modernization act.").

[4] *See, e.g., Senators To Use Favorable Medicare Scoring To Shrink 'Gap,'* Congress Daily/AM (June 10, 2003) (reporting differences between CBO and CMS estimates on percent of beneficiaries who would opt for PPOs and noting "fundamental disagreement" between CBO and CMS about how PPOs work); *David Rogers, Varying Medicare-Cost Analyses Dog House-Senate Negotiators, Wall Street Journal,* Sept. 30, 2003 (describing the differences between HHS and CBO estimates).

[5] Press Release, U.S. Department of Health & Human Services, Remarks By: Tommy G. Thompson (Feb. 2, 2004), *available at* http://www.hhs.gov/news/press/2004pres/20040202.html.

[6] *New York Times,* Mar. 18, 2004.

the Medicare bill Congress passed have supported legislative proposals concerning Medicare that would have cost significantly more than the bill signed by the President.

Finally, as to the allegation, to which you allude in your March 17, 2004 letter, that the former CMS Administrator threatened to fire the Actuary if he provided certain cost estimates to Congress; this allegation appeared in the press last June and has resurfaced recently. It bears mention that, as we understand it, this allegation relates to a purported direction that the Actuary should not respond to a request made by a staff member to provide an impact analysis of a section of the bill that passed the Ways and Means Committee but was changed before floor debate commenced. In the end, the analysis was done on the new version of the provision and it was provided to the ranking member of the Ways and Means Committee. In any event, the HHS Inspector General is conducting an inquiry into the facts surrounding this allegation.

You also asked that we release to you estimates and analyses of the legislation in various phases of the legislative process, and you specifically requested that information pursuant to a statute codified at 5 U.S.C. § 2954. I would like to turn now, briefly, to that request.

The statute that you cite, of course, gives you no right to these documents. That statute was enacted in 1928 and, as its legislative history makes clear, merely repealed a requirement that the Executive Branch submit certain reports to Congress. However, concerned that these reports still be available to the Legislative Branch, the predecessor to the Committee on Government Reform and Oversight inserted language into the statute allowing members of that Committee access to the 128 reports that were no longer being submitted to Congress in 1928. The statute has nothing to do with the material that you are requesting, and we can find no legal basis or support – other than an unpublished district court decision that was later vacated – that would interpret the statute more broadly.

The Congressional Research Service shares our view that 5 U.S.C. § 2954 cannot be read as broadly as you apparently believe that it can. CRS has recognized that "the purpose of the 1928 Act was not to assert a sweeping right of Congress to obtain any information it might desire from the Executive Branch."[7] As CRS explained, "the scope of 5 U.S.C. § 2954 appears closely tied to the 128 reports abolished by ... the Act of May 29, 1928."[8] Since the information you are seeking is not a report that was abolished by Congress in 1928, we do not read the statute as requiring that we provide that information to you.

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[7] Investigative Oversight: An Introduction to the Law, Practice and Procedure of Congressional Inquiry, CRS Report No. 95-464A (April 7, 1995) at 24-25. *See also* Memorandum from American Law Division to Senate Government Operations Committee (Jan. 15, 1975) at 2.

[8] *See* Investigative Oversight, *supra* n. 2.

All that said, we are responding to a request under the Freedom of Information Act for certain documents related to the cost estimates of the MMA. We are responding to that request by providing four documents to the requestor:

1.) A spreadsheet dated June 11, 2003 which shows the CMS Actuary's estimates of the costs of titles I and II of S.1, then under consideration by the Senate Finance Committee.
2.) A memorandum to Congressman Thomas, the Chairman of the House Ways and Means Committee, dated June 21, 2003, showing the estimates of the number of Medicare beneficiaries who would purchase drug coverage under the draft version of H.R. 1, then under consideration by the House Ways and Means Committee.
3.) A memorandum to Congressman Rangel, the ranking member of the House Ways and Means Committee, dated June 26, 2003, showing the estimated impact of H.R. 1 on premiums for fee-for-service beneficiaries.
4.) A memorandum from Richard Foster, the CMS Actuary, to me, dated February 5, 2004, that summarizes the differences between the CMS Actuary and CBO on the cost estimates of Pub. L. No. 108-173.

In the spirit of comity, we are also releasing these documents to you. We are releasing these documents under FOIA because the Department had previously released them to the public.

The President and this Department have made a commitment to give seniors help with prescription drug costs and to modernize Medicare. We delivered on that commitment, fulfilling a long-standing promise to our seniors. Now is the time to get behind these reforms and make them work. As the President made clear in his State of the Union Address: "I signed this measure proudly, and any attempt to limit the choices of our seniors, or to take away their prescription drug coverage under Medicare, will meet my veto." We look forward to working with you and other Members of Congress as we implement the prescription drug benefit bill and provide America's seniors and people with disabilities much-needed relief from the high cost of prescription drugs.

Sincerely,

Dennis G. Smith
Director, Center for Medicaid and State Operations

Rough estimates of increase in net Medicare and other Federal costs under selected draft Senate Finance proposals

(Based on June 10, 2003 "Chairman's Mark;" amounts in billions)

Proposal	Fiscal year										Total	
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2004-2008	2004-2013
Medicare Advantage (effective 2006):												
HMOs	—	—	$1.4	$1.8	$1.8	$2.0	$2.1	$2.2	$2.3	$2.4	$5.0	$16.0
PPOs	—	—	$2.3	$3.8	$4.1	$4.2	$4.3	$4.4	$4.5	$4.6	$10.2	$32.0
Total for Medicare Advantage	—	—	$3.7	$5.5	$5.9	$6.2	$6.4	$6.6	$6.8	$7.0	$15.1	$48.0
Prescription drug benefit:												
Increase in Medicare costs	$3.6	$5.5	$36.5	$48.7	$53.1	$57.9	$62.7	$68.0	$75.8	$85.2	$147.5	$496.9
Net increase in Fed. Medicaid costs	—	—	$4.0	$5.8	$6.2	$6.7	$7.2	$7.7	$8.2	$8.8	$16.0	$54.6
Total for drug benefit	$3.6	$5.5	$40.5	$54.5	$59.3	$64.5	$69.9	$75.7	$84.0	$94.0	$163.4	$551.5

Notes:

1. Medicare Advantage estimates are very rough and provide only a general indication of the financial effect of this provision. In particular, under the draft legislation, there could be significant shifts in enrollment between HMOs and PPOs, which are not reflected in these estimates.

2. The draft SFC Medicare reform package has other provisions beyond those shown here. Estimates are not yet available for these other provisions.

3. See our June 5, 2003 note on alternative benchmarks for a description of why costs would increase under the Medicare Advantage PPO option. See cover e-mail regarding nature of HMO cost increase.

4. The "increase in net Medicare costs" refers to an increase in benefit expenditures and/or reduction in premium revenues. Estimates do not include impact of proposals on Federal administrative costs.

Office of the Actuary
Centers for Medicare Medicaid Services
June 11, 2003

Senate — June 11, 2003 Version

June 11, 2003 Model Run

FY	Deductible	Initial coverage limit	Coinsurance rate	Catastrophic out-of-pocket threshold	Catastrophic coinsurance rate	Average monthly premium	Federal costs ($ billions): General Premium Subsidy	Rein-surance	Low income subsidy	Rx card and transitional low-income subsidy	Total Medicare	Federal Medicaid	Total
2004										$3.6	$3.6	$0.0	$3.6
2005										$5.5	$5.5	$0.0	$5.5
2006	$275	$3,450	50%	$3,700	10%	$31.80	$17.0	$8.0	$9.2	$2.3	$36.5	$4.0	$40.5
2007	$303	$3,802	50%	$4,077	10%	$34.59	$24.4	$11.2	$13.1	$0.0	$48.7	$5.8	$54.5
2008	$333	$4,174	50%	$4,477	10%	$37.48	$27.0	$11.8	$14.4	$0.0	$53.1	$6.2	$59.3
2009	$364	$4,571	50%	$4,902	10%	$40.48	$29.8	$12.4	$15.7	$0.0	$57.9	$6.7	$64.5
2010	$398	$4,992	50%	$5,353	10%	$43.55	$32.7	$12.9	$17.1	$0.0	$62.7	$7.2	$69.9
2011	$434	$5,451	50%	$5,846	10%	$46.82	$35.9	$13.5	$18.5	$0.0	$68.0	$7.7	$75.7
2012	$474	$5,952	50%	$6,384	10%	$51.21	$40.3	$14.9	$20.6	$0.0	$75.8	$8.2	$84.0
2013	$518	$6,500	50%	$6,971	10%	$55.91	$45.5	$16.8	$23.0	$0.0	$85.2	$8.8	$94.0
2004-2013							$252.5	$101.5	$131.5	$11.4	$496.9	$54.6	$551.5

Notes: Dual-eligible Medicaid beneficiaries will retain their current Medicaid coverage. Medicare will waive the state requirement to pay the Part B premium for beneficiaries between 74% and 100% of the Federal poverty level. **Medicaid dual beneficiaries would not enroll in Medicare drug plans.**

Low-income persons (non dual-eligible Medicaid) will have the following benefit provisions and premium subsidies in 2006.

	QMB	SLMB / QI-1	<135% poverty	135-160% poverty
Deductible	$0	$0	$50	$50
Coinsurance to initial coverage limit	2.5%	5.0%	10.0%	10.0%
Coinsurance to catastrophic threshold	5.0%	10.0%	20.0%	20.0%
Coinsurance above catastrophic threshold	2.5%	2.5%	10.0%	10.0%
Premium subsidy	100.0%	100.0%	100.0%	Sliding scale

Low-income Medicare beneficiaries (under 135% of poverty) who apply and are determined to be eligible will receive up to $600 in 2004 and 2005 for the purchase of qualifying outpatient prescription drugs.

States would realize a Medicaid savings of $4.1 billion for the period 2006-2013.

Office of the Actuary
Centers for Medicare Medicaid Services
June 11, 2003

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of the Actuary

DATE: June 21, 2003

FROM: Richard S. Foster
Chief Actuary

TO: Representative William M. Thomas
Chairman
Ways and Means Committee

SUBJECT: Estimated Proportion of Medicare Beneficiaries Who Would Purchase Drug Insurance Coverage under Ways and Means Medicare Reform Package

The Medicare reform legislative package reported earlier this week by the House Ways and Means Committee would provide for a voluntary program of prescription drug coverage for Medicare beneficiaries. Coverage would be offered through insurance companies and health plans, with partial Federal reinsurance for beneficiaries incurring high drug costs and with a Federal premium subsidy. Together, the reinsurance and premium subsidy would cover 73 percent of the average value of the drug benefit, for beneficiaries with annual incomes below $60,000. Beneficiaries could enroll in this program at any time but would face potential higher premium rates or preexisting condition exclusions if they delayed enrollment past their first opportunity.

We estimate that virtually all Medicare beneficiaries (i.e., at least 95 percent) would opt for such drug coverage. In general, we would expect a very high participation rate for any drug benefit with a substantial premium subsidy and potential penalties for late enrollment.

Please let us know if you have any questions about this information or if we can be of additional assistance.

Richard S. Foster, F.S.A.
Chief Actuary

cc: Thomas A. Scully

Final

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DATE: June 26, 2003

FROM: Richard S. Foster
Office of the Actuary

TO: Representative Charles B. Rangel
Ranking Member
House Committee on Ways and Means

SUBJECT: Estimated Impact of H.R. 1 on Premiums for Fee-for-Service Beneficiaries in 2010 and Later

Under H.R. 1, the "Medicare Prescription Drug and Modernization Act of 2003," premiums paid by beneficiaries in traditional fee-for-service Medicare would not be affected by the operations of private health plans prior to 2010. Beginning in 2010, the determination of such premiums for beneficiaries residing in "competitive" areas would be affected by the level of fee-for-service costs in the area compared to private plan costs. (In other areas—that is, those not meeting the criteria defining competitive areas—there would be no change in fee-for-service premiums.) A transition rule would limit year-to-year changes in fee-for-service premiums. This memorandum presents estimates of the changes in fee-for-service premiums under H.R. 1 in 2010 and later, for beneficiaries residing in "competitive Medicare Advantage areas" and "competitive Enhanced Fee-for-Service regions."[1]

It is important to understand that the impact of H.R. 1 on premiums for fee-for-service beneficiaries would vary substantially depending on such factors as:

- The cost of private EFFS and MA health plans relative to fee-for-service cost levels;
- The percentage of Medicare beneficiaries enrolled in traditional fee-for-service, EFFS plans, and MA plans, both for regions and for the nation overall; and
- The number of consecutive years that an area was "competitive," as defined in the bill.

As described below, we generally estimate that premiums for fee-for-service beneficiaries in competitive MA areas or EFFS regions would exceed those under current law. There are plausible situations, however, in which such premiums in some areas could instead be slightly lower than current-law levels.

[1] The beneficiary premium provisions in H.R. 1 for 2010 and later are complex, and a summary of these provisions exceeds the scope of this memorandum. Reference should be made to section 241 of the legislation for the specific definitions, rules, and formulas.

For areas in their fifth consecutive year as competitive MA areas or competitive EFFS regions (which would occur in 2014 at the earliest), the fee-for-service premium adjustment would be fully phased in, and we estimate that:

- For fee-for-service beneficiaries in competitive MA areas, premiums would be roughly 5 to 25 percent greater than under current law. This estimate is sensitive to the average cost of MA plans in the area and to the beneficiary enrollments in fee-for-service versus private plans.[2]

- For fee-for-service beneficiaries in competitive EFFS regions who are not also in competitive MA areas, monthly premiums would be slightly greater than under current law (for example, about 2 to 4 percent greater in 2014). This result is sensitive to the average level of private EFFS plan costs in the region and to the proportion of beneficiaries in fee-for-service compared to private plans.[3]

The transition provision would phase in any adjustments to fee-for-service premiums, based on the consecutive number of years that the area had been competitive. One-fifth of the full adjustment would be applied in the first such year, two-fifths in the second consecutive year, three-fifths in the third year, etc.[4] Consequently, the estimated ultimate premium impacts described above would be proportionally smaller during the initial transition (which would be 2010 through 2014 for many areas) or any later period involving fewer than 5 consecutive years as a competitive area. In addition, there is a possibility that, in some competitive MA areas during the transition, fee-for-service premiums would be adjusted downward rather than upward. This situation could occur if the average cost of HMOs in that area were greater than the fee-for-service cost level. By the final year of the transition, however, after the higher payment benchmarks for private plan premium determinations had phased out, we would expect any such areas to revert to non-competitive status. In this case, fee-for-service premiums would not be affected.

As noted above, these estimates apply only to Medicare beneficiaries residing in competitive MA or EFFS areas. Under H.R. 1, not all areas would meet the competitive criteria, in which case premiums for fee-for-service beneficiaries would not be affected. We have not yet estimated the proportions of beneficiaries who would enroll in fee-for-service Medicare versus MA or EFFS private health plans in 2010 and later. Prior to 2010, we estimate that roughly 57 percent of

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[2] With relatively high private plan enrollment, as we estimate, fee-for-service premium increases would be at the upper end of our estimated 5-25 percent range. With relatively low private enrollment, as estimated by the Congressional Budget Office, the fee-for-service premium increase would tend to be at the lower end of this range.

[3] We estimate that, by 2014, the average cost of the three winning PPO plans in most EFFS regions would be slightly less than the region's fee-for-service cost. If PPO costs were instead significantly greater, as estimated by CBO, then fee-for-service premiums in competitive EFFS regions would tend to be slightly less than current law, depending on the proportion of beneficiaries in the region enrolled in private plans.

[4] If a region or area that had been competitive subsequently became non-competitive, then fee-for-service premiums would revert to their normal, unadjusted level. If in later years the area again became competitive, then the transition would start over and fee-for-service premiums would again follow the pattern described above.

beneficiaries would remain in the fee-for-service program, with a total of roughly 43 percent in MA and EFFS plans.[5]

As suggested by the foregoing discussion, the impact of the post-2010 competition provisions on fee-for-service premiums is complex. In addition, the estimates shown in this memorandum reflect considerable uncertainty due to (i) lack of robust data on private plan costs, (ii) possible changes in beneficiary enrollments in reaction to the premium changes after 2010, (iii) ambiguity in certain of the draft legislative provisions, and (iv) the limited time available for preparation of these estimates, which necessitated simplified estimation methods. Consequently, while we believe that these estimates provide a reasonable indication of future fee-for-service premium levels under the draft legislation, they should be considered preliminary and used only with full awareness of their limitations.

Richard S. Foster, F.S.A.
Chief Actuary

[5] For previous versions of the Medicare reform legislation, as developed in the Ways and Means Committee, we had estimated private plan enrollment at 48 percent prior to 2010. The lower estimate for H.R. 1 results from a change in the calculation of Medicare Advantage payment rates under section 212.

February 5, 2004

NOTE TO: Dennis Smith

SUBJECT: Summary of Differences Between OACT and CBO Cost Estimates for P.L. 108-173, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003"—Updated

As you know, the Office of the Actuary has estimated that the Medicare modernization act would increase net Federal costs by a total of $534 billion through fiscal year 2013.[1] The corresponding estimate by the Congressional Budget Office is $395 billion. OACT and CBO have independently estimated the cost of the modernization act using the best data, assumptions, and methods that each organization could develop. The following points summarize the nature of the differences in the estimates.

- The estimates differ principally because the future is uncertain, and this uncertainty is reflected in somewhat different assumptions regarding the numerous cost and behavioral factors that will affect actual future costs. In this regard, the difference in estimates is a useful reminder of the inherent uncertainty and a rough indication of the sensitivity of future costs to the underlying cost factors.

- Of the total difference of $139 billion between the estimates, approximately $100 billion relates to Title I of the act, the Medicare prescription drug program:

  — OACT estimates that about 94 percent of all Medicare beneficiaries would enroll in (or otherwise benefit from) the Medicare drug benefit,[2] compared to 87 percent for CBO, and we also estimate a slightly higher average, per-beneficiary value for the standard drug benefit. These factors account for $32 billion of the total difference.

  — While OACT and CBO estimate similar numbers of beneficiaries who are eligible for the low-income drug subsidy, OACT estimates a significantly higher enrollment rate by these individuals. In addition, our estimated average cost for the low-income subsidy per beneficiary is slightly greater than CBO's. Of the total difference in estimated drug costs, the low-income subsidy accounts for $47 billion.

  — The cost to Medicare of providing the drug benefit would be partially offset by net Federal savings for Medicaid. (Federal Medicaid drug expenditures would be eliminated, but other Federal Medicaid costs would increase somewhat; as beneficiaries enroll for the Medicare low-income drug subsidy, some will be found to qualify for Medicaid coverage). CBO estimates a greater degree of net Federal Medicaid savings, because their prior baseline projections included a rapidly growing cost for "pharmacy plus" Medicaid waivers. In total, the CBO savings estimate is $18 billion greater than OACT's.

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[1] This estimate excludes Federal administrative costs, other than the $1.5 billion authorized by section 1015 of the act, and the impact on social insurance payroll taxes and general income taxes. An additional Medicare expenditure of $16 billion through 2013 would be made for employer drug subsidy payments to Federal employers.

[2] Beneficiaries in employer-sponsored retiree health benefit programs are included in this percentage.

- $32 billion of the remaining difference in the overall cost estimates is associated with Title II, the Medicare Advantage program. OACT's estimated costs for this title are $46 billion, versus CBO's estimate of $14 billion:

  — CBO's estimate is based on a $10 billion cost for the regional PPO stabilization fund, and $4 billion for the "immediate improvements" in 2004 and later MA payment rates. They estimate that these changes will slow the decline in private plan enrollment, with about 9 percent of beneficiaries ultimately so enrolled. Regional PPOs are estimated to have costs somewhat in excess of the prevailing "payment benchmarks," with the result that few such plans could participate and beneficiary enrollment would be minimal.

  — OACT's estimate includes $12 billion for the stabilization fund and another $34 billion due to the higher payment rates starting in 2004 and the restructured payment formula in 2006 and later. We estimate that HMO enrollment would increase from its current level of about 12 percent to 16 percent and that PPO enrollment would also reach 16 percent in 2009 and later. The latter projection is based on estimated PPO costs that are generally below the payment benchmarks, with the result that beneficiaries could qualify for significant premium rebates and/or additional benefits. Because these estimated PPO costs typically exceed fee-for-service levels, however, Medicare costs for such enrollees would be higher than under prior law.

- Other differences exist between the OACT and CBO estimates for Titles III through IX. These differences tend to be smaller and are also largely offsetting (with CBO sometimes higher and sometimes lower than our estimates).

As you know, it is not uncommon for these two organizations to differ somewhat in their estimates. For example, CBO's estimated Medicare savings for the Balanced Budget Act of 1997 totaled about $116 billion in the first 5 fiscal years. The corresponding OACT estimates were $152 billion. Similarly, the BBA savings estimates over the first 10 years were $394 billion for CBO versus $517 billion for OACT. I believe that CBO has prepared competent, good-faith estimates for the Medicare modernization act. I prefer the assumptions and methods employed in the Office of the Actuary, and stand behind our own estimates, while recognizing that an uncertain future could prove all of us wrong.

Please let us know if you have any questions about this information.

Rick Foster