NLWJC - Kagan

DPC - Box 029 - Folder 021

Health - Medicare Proposals

Health -
Medicare

Medicare
Question and Answer
June 8, 1999

Q: Can you confirm that your prescription drug benefit will be between $10 and $25 , as reported in today's *New York Times?*

A: We are not going to discuss details on this or any other aspect of the President's Medicare proposal other than to say that this story is wrong. It would be impossible to provide for a meaningful benefit for a $10 premium without a fiscally imprudent expenditure of Federal dollars. As the Chief of Staff indicated on Sunday, we are designing the Medicare prescription drug benefit to be significantly less costly than what is available in the Medigap market – about $90 per month.

Q: What will the design of the drug benefit be? How will it be financed and administered?

A: We are not releasing any information on the design of the drug benefit or any other aspect of the President's Medicare reform proposal. There are still final policy decisions that need to be made, and no one in the Administration will release this or any aspect of the reform proposal until the President makes his announcement.

Q: Is anyone in the Administration attempting to pressure the Medicare actuary to produce savings projections?

A: Such a suggestion is ridiculous. No one in this Administration has or would pressure the Medicare actuary to do anything. Rick Foster is respected throughout the Administration, the Congress, and the health policy and academic community.

Q: What are the secret documents mentioned in the *New York Times* story today, and do they outline the design of the President's drug benefit?

A: The documents that appear to have been cited in this story are materials that have been produced as background information on the need for a prescription drug benefit and recent trends in coverage. They have been available to the media, the Congress, and throughout the Administration for a number of weeks. They are not secret, and they do not provide any information about the design, cost or administration of the drug benefit.

Health - Medicare proposals

PRESIDENT CLINTON ANNOUNCES NEW MEDICARE PREVENTIVE BENEFITS
December 27, 1997

President Clinton announced today that starting January 1, Medicare will cover a host of new preventive benefits for the program's 39 million beneficiaries. These new benefits will: guarantee affordable coverage for annual mammograms for all Medicare beneficiaries over forty; provide regular pap smears and pelvic exams; and guarantee regular colorectal cancer screening. The President fought for the inclusion of all these benefits in the Balanced Budget Act he signed earlier this year. The new preventive benefits starting January 1 include:

Making Mammography Screening More Affordable. Medicare will waive the deductible for mammograms, making annual screenings more affordable. Although mammography screening can significantly reduce mortality rates, about half of women over 65 have not had a mammogram in the past two years. Studies show that costs are the most significant reason women do not get mammograms. Although Medicare has covered mammography screening since 1991, only 14% of eligible beneficiaries without supplemental "Medigap" insurance, which often helps offset the cost of screening, receive mammograms.

Covering Annual Mammograms for All Women Over Forty. Medicare will now cover annual mammograms for women age 40 and over. Previously, Medicare covered mammograms only every other year for some age groups and not at all for others. This new change ensures that all Medicare-eligible women are covered for yearly mammograms. It also makes Medicare consistent with the National Cancer Institute's (NCI) recent recommendations that women over forty undergo regular mammography screening.

Helping Women Prevent Cervical Cancer. Medicare is also expanding coverage to pay for pap smears and pelvic exams every three years and annually for women who are at risk for this type of cancer. Medicare will cover lab tests, annual deductibles, and the clinical breast exams that frequently accompany these services. Survival rates for cervical cancer are almost 100% when this cancer is detected in the earliest stages and followed by appropriate services. In some areas, up to 75% of women have not had a pap smear in the last 5 years.

Preventing and Detecting Colorectal Cancer. For the first time ever, Medicare will now cover regular colorectal cancer screening tests. Under current law, these screening tests are covered only when patients have symptoms that indicate they may have cancer or another disease. Colorectal cancer is the second leading cause of cancer-related deaths, causing over 54,000 deaths each year. When diagnosed in localized stages, the survival rate for colorectal cancer is over 90%, but when detected in advanced stages, the rate drops to 7%. Today, only 37% of colorectal cancer is diagnosed at the localized, more treatable stage.

THESE NEW PREVENTIVE BENEFITS ARE ONLY ONE ASPECT OF RECENT IMPROVEMENTS IN MEDICARE. The recent balanced budget passed by Congress contained many of the President's proposals to strengthen and modernize the program including:

- **Extending the life of the Medicare Trust Fund until at least 2010;**

- **Modernizing Medicare by including new market-oriented reforms that have proved successful in the private sector such as:** (1) giving beneficiaries more choices in health plans, including Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs); (2) implementing new payment reforms to provide incentives for hospitals, home health proivders, and nursing homes not to overbill; and (3) providing incentives for rural communities to provide more choices of health plans for Medicare beneficiaries.

- **Ensuring New Premium Protections for Low-Income Medicare Beneficiaries.** The budget agreement invests $1.5 billion over five years to pay the premiums for beneficiaries with incomes up to 135% of poverty. Beneficiaries with incomes as high as 185% of poverty will also get assistance.

- **Fighting Fraud and Waste in Medicare.** Since 1993, the Clinton Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240%, saving more than $20 billion in health care claims. The Balanced Budget Act armed law enforcement with new weapons to keep scam artists and fly-by-night health care out of Medicare and Medicaid. Most recently the President proposed legislation to stop the Medicare program from overpaying for the drugs it covers.

Health- Medicare proposals

Draft 12/23/97 12:00pm

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON MEDICARE CANCER SCREENING
December 27, 1997

Good morning. The holidays are a time when families come together to celebrate the season with love. And they remind us of our bonds of duty to care for one another. Today, I would like to talk to you about how we are enlarging the blanket of Medicare protection to honor our parents and grandparents in important new ways in the new year.

Looking back over 1997, it's clear that we achieved major reforms of the Medicare system that will help Americans live healthier, happier, and longer lives. This year's bipartisan balanced budget agreement reaffirmed our commitment to preserving and strengthening Medicare. We extended the life of the Medicare Trust Fund until at least 2010. We made Medicare protection more affordable for low-income Americans. We modernized the Medicare system by expanding choice, injecting competition, and controlling costs. And we created a blue-ribbon commission that will examine ways in which we can ensure that Medicare will serve baby boomers and our children as well as it has our parents.

Now, we will begin the New Year by implementing expanded Medicare benefits so that they provide greater protection to Americans in our fight against cancer. That's why, on New Year's Day, we will introduce a series of changes in Medicare that will make screening, prevention, and detection of cancer more affordable and frequent. We are ringing in the New Year resolved to take new steps in our battle against cancer -- one of mankind's oldest foes.

First, for the first time, we will guarantee the option of annual mammograms for every woman over 40. And, by waiving the deductible, we will make annual breast cancer screenings more affordable. By making mammograms more accessible and detecting cancer earlier, we can significantly increase the likelihood of successful treatment for this disease. And I would like to thank Hillary for alerting us to the barriers that keep nearly half of women from getting regular mammograms and for her long-standing campaign to encourage older women to get these crucial tests.

Second, we are expanding coverage for the early detection of cervical cancer. We have sophisticated tests to pick up early signs of cervical cancer and, from now on, Medicare will pay for regular access to this life-saving technology.

And third, for the first time, we will now cover regular examinations for colorectal cancer. Most Americans don't get this important preventive test, but

when we catch this cancer early, we can beat it more than 90% of the time.

Nearly every family has been touched by the hand of cancer. My own mother passed away because of breast cancer and I miss her dearly -- especially at this time of the year. And that's why these actions are so important. By detecting cancer early on, we offer our loved ones the greatest gifts of all -- the gifts of life, of health, and of many holidays to come.

Thank's for listening. Happy Holidays and have a happy -- and healthy -- New Year.

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health - medicare proposals

SCHEDULING REQUEST December 12, 1997

____ ACCEPT ____ REGRET ____ PENDING

TO: Stephanie Street, Director of Scheduling and Advance

FROM: Bruce Reed, Assistant to the President for Domestic Policy

REQUEST: To announce that the expanded benefits of Medicare, which passed as part of the Balanced Budget Act, are now in effect.

PURPOSE: To highlight the President's leadership in expanding Medicare to cover certain preventative screening practices.

BACKGROUND: New Medicare coverage for annual mammogram screening, pap smears, and colorectal cancer screening will go into effect January 1, 1998. This an opportunity to highlight the impact of the Balanced Budget Act and to demonstrate the Administration's commitment to quality health care for Medicare beneficiaries.

As of January 1, 1998, Medicare coverage will expand to include:
1) annual mammograms for women age 40 and over and a one-time initial mammogram for women age 35-39. Until this time, annual mammograms were only covered for women 50-64 years old, with the exeption of high-risk patients;
2) Pap Smears accompanied by pelvic and breast exams every 3 years for most women and every year for women in high risk categories. Until now, the pap smear was covered, but not the pelvic or breast exam;
3) Colorectal cancer screening including blood tests, colonoscopies, etc. Until now, the tests were only used when symptoms existed. Now the tests will be covered if used for screening purposes.

PREVIOUS PARTICIPATION:

DATE & TIME: Preferably before January 1, 1998, but it could also work the first week in January.

LOCATION: TBD

PARTICIPANTS: POTUS, VPOTUS?, FLOTUS?, Secretary Shalala, health care groups?

OUTLINE

OF EVENTS:	TBD
REMARKS REQUIRED:	Yes.
MEDIA COVERAGE:	Yes.
RECOMMENDED BY:	Bruce Reed/Chris Jennings
CONTACT:	Bruce Reed x6-6515 Christa Robinson x6-5165

Health - Medicare

MEDICARE

Q: DID YOU GIVE IN ON MEDICAL SAVINGS ACCOUNTS?

A: Not at all. I wanted to ensure that Medicare Medical Savings Accounts were a demonstration program and that is exactly what I got. I also fought to ensure that there are important consumer protections in the package that allow beneficiaries to get out of an MSA if they decide soon after that they made a mistake.

Q: WHY DID YOU AGREE ON INCLUDING A PRIVATE FEE-FOR-SERVICE OPTION IN THE FINAL PACKAGE?

A: As was reported today, we have consistently raised concerns about this provision. In fact, we successfully fought for critically important consumer protections. As a result, the final provision is quite different from the one that passed the Senate. There are now a number of consumer protections such as disclosure requirements and other measures that protect beneficiaries from being overcharged by physicians who may participate in this program. Specifically, current law balance billing protections apply to doctors participating in this type of plan. Doctors will not be allowed to charge more than 15 percent over Medicare approved rates. It is worth noting that because of the new consumer protections and many other positive provisions in the Medicare reform, AARP did not raise objections to this option.

Q: ARE YOU READY TO DO REAL MEDICARE REFORM IN A COMMISSION?

A: We actually just passed the largest, single reform of the Medicare program since it was created in 1965. We reformed the managed care payment system, so that beneficiaries have greater choices and we are not overpaying plans. We reigned in the cost of the remaining fee-for-service providers such as home health agencies. We now offer beneficiaries a range of preventive benefits that save costs in the long run. And, we crack down on fraud and abuse in the program.

Despite this enormous accomplishment, we must take the needed, next steps to ensure Medicare's life well beyond the decade locked in by the budget bill just enacted. We look forward to working with Republicans on the bipartisan Medicare commission. This offers the opportunity to thoroughly examine this complex problem and its difficult solutions.

Q: WHO WILL BE ON THE COMMISSION? WHEN WILL YOU DECIDE?

A: This will be a critically important commission so I am not going to rush into any decisions or announcements at this time. In the coming weeks, I will be consulting with Congressional Republicans and Democrats to coordinate the set-up of this commission to ensure its successful commencement.

[NOTE: Do not discuss further details until we have information on personnel and timing options]

Q: CONGRESSMAN ARMEY SUGGESTED THAT SENATOR DOLE SHOULD CHAIR THE COMMISSION. DO YOU AGREE?

A: Senator Dole is among the most able leaders this country has seen. He is most capable of serving in this role. However, it is premature to discuss any commission members at this point.

REFORM IN GENERAL

Q: WHAT DO YOU HOPE TO DO NEXT TO REFORM OUR HEALTH CARE SYSTEM?

A: In December, 1994 I wrote a letter to the Congressional Leadership outlining the next steps I wanted to take to improve our health care system. In that letter I said I wanted to ensure that health care was accessible to more Americans, that more of our children and families obtained affordable health care insurance, that we take steps to strengthen and preserve the quality and efficiency in our Medicare and Medicaid programs, and that we reduce long term deficits. I am proud that with the enactment of this historic balanced budget we have taken significant steps towards achieving all of these goals. Last year I signed into law the Kassebaum-Kennedy legislation that helps families and children keep their health insurance when a family member changes or loses a job. This week I have signed into law a balanced budget which significantly reduces the deficit, which extends the life of Medicare for at least a decade while improving and modernizing the program, and contains the largest investment in children's health care since the enactment of Medicaid in 1965.

I hope that this fall I can work with the Congress to pass new legislation that improves quality and ensures adequate consumer protections in the nation's rapidly changing health care system. I look forward to working with both Democrats and Republicans to that end.

MEDICAID

Q. IN MEDICAID, WHY DID YOU CONTINUE TO PUSH FOR REWARDS FOR THE VERY STATES THAT SCHEMED TO DRIVE UP THE COSTS OF THEIR DISPROPORTIONATE SHARE (DSH) SCHEMES?

A: I agree that so-called high-DSH states should be targeted for higher levels of cuts than low-DSH states. All of the plans that I have advocated, including the one in the final bill, ensured that this is the case. However, there is also a limit to the extent to which the high-DSH states can sustain large reductions without excessive pain to the programs and people they serve. We believe that the policy we designed with Congress struck an appropriate balance of targeting high-DSH states without causing too much disruption.

Health - Medicare proposals

THE WHITE HOUSE

WASHINGTON

July 4, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

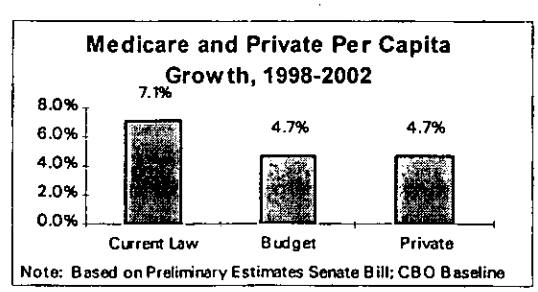
cc: Gene Sperling, Bruce Reed, John Hilley

SUBJECT: The Challenge of Long-Term Medicare Reform

Both the House and the Senate reconciliation bills include a Medicare Commission to address long-term reform. Your policy advisors from NEC, DPC, CEA, OMB, HHS, and Treasury have uniformly concluded that it is highly unlikely that a politically and policy-viable Medicare reform initiative, which comprehensively addresses the program's long-term financing challenges, can emerge from a Commission within the next one or two years. This memo focuses on the underpinnings of this conclusion and supplements the decision memo Gene sent to you yesterday.

BACKGROUND

The Medicare reforms in the budget agreement represent a major restructuring of the program and produce savings that are larger than any enacted in the history of the program. In fact, the Congressional Budget Office (CBO) projects that Medicare spending under the budget would slow from 7.1 percent per capita to 4.7 percent on average between 1998 and 2002 — almost exactly mirroring the projected private premium growth of 4.7 percent. Medicare's Actuaries estimate that the policies we are supporting in the upcoming House/Senate conference would extend the life of the Hospital Insurance (Part A) Trust Fund through 2010.

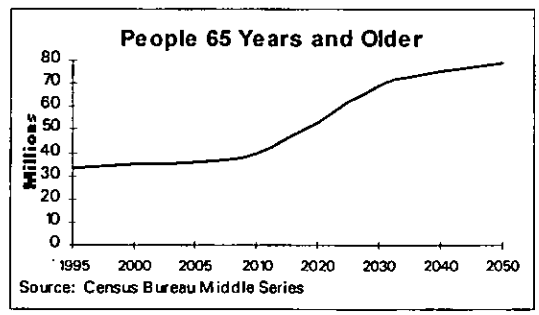


Even more important than the unprecedented level of savings credited to us by CBO are the structural changes to the program that have extraordinary potential to constrain Medicare growth for a much greater time than a traditional 5-year budget would produce. Specifically, your reforms provide for: (1) more managed care plan choices (PPOs and Provider Sponsored Organizations); (2) the authority to develop and implement "risk adjusted" managed care

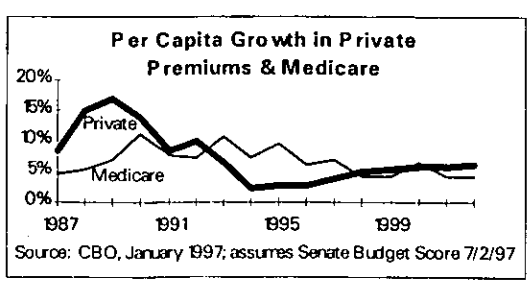
reimbursement reforms; (3) the establishment of prospective payment for nursing homes, home health care, and outpatient departments; (4) the authority to use new "prudent purchasing" techniques (like competitive bidding for the myriad devices and services that Medicare buys); (5) a major set of anti-fraud and abuse initiatives; and (6) the coverage of services and tests that detect diseases before they become severe and expensive to treat. These important provisions could produce savings that would have a significantly positive impact on the state of the Medicare Trust Fund during the next decade and beyond.

Although CBO does not give full credit to the above-mentioned structural reforms as producing significant "scorable" savings, health policy experts agree that they are more important to the program's long-term viability than traditional fee-for-service cuts. The elite media, however, does not define these major changes as "structural reform" because their definition cannot be met unless beneficiaries are directly hit and are complaining about it.

Regardless of all the positive changes to Medicare we hope to make this year, the long-term financing crisis remains constant. Medicare's spending growth, while constrained in the next 10 years due to the budget, will increase thereafter. This growth will be primarily driven by demographics. Beginning in 2010, the baby boom generation begins to turn 65 years old. The number of people age 65 and older is projected to increase from 39 million in 2010 to 69 million in 2030. People aged 85 and older will double by 2025 and increase fivefold by 2050. In 2030, one in five Americans will be elderly compared to 13 percent today. This will have an enormous impact on Medicare although its impact might be mitigated by other trends. For instance, seniors in the 21st century might be wealthier or healthier and have less of a need for health care. Or, if given the opportunity or need, they might choose to extend their working careers and maintain their employer coverage.



Additionally, Medicare's spending growth is inextricably linked to general health inflation. In fact, with the exception of the last several years, Medicare spending growth per beneficiary has paralleled that of the private spending per person over the last 30 years. This is good news as long as the private sector continues to be successful at constraining costs to the levels they have in recent years; unfortunately, the most recent forecasts predict a possible return to higher private sector health care inflation. The unanswerable question in health care these days is can private and public successes in constraining cost growth be repeated for long periods of time OR are we about to witness a new cycle of inflation that will not easily be broke because the excess in the system was squeezed out in the 1990s.



This uncertainty is increased by the nature of health care. The factors that affects its growth — different disease patterns, scientific break-throughs, changes in technology and health care delivery systems — will have profound but as-yet unknown effects on Medicare spending's rate of increase. If, for example, the new age of biology starts producing remarkably successful treatments for extraordinarily expensive diseases, a brand new and positive Medicare Trust Fund cost projection could ensue.

Range of Options

Unfortunately, in the proposed Commission's one to two-year time frame, we will not know the real benefit of the new structural reforms. We also will not have any better understanding of possible dramatic positive or negative health spending trends, described earlier, that could change the size and nature of Medicare's long-term problem. As a result, any Medicare Commission would work off assumptions that are fairly close to our current projections — however flawed and temporal they may be. So, for instance, working off of this baseline, even if we could maintain a relatively low per capita cost growth over an extended period of time, the Actuaries suggest it would still be necessary to find hundreds of billions to make the Trust Fund solvent in the long-term. This would require the Commission to consider all or a combination of the following range of options:

Provider cuts. Reducing payment rates to providers is typically the first place that policy makers go to achieve Medicare savings. Both in the recent past and near future, there has been enough excess in the system to generate significant savings from this approach. While there are still ways to improve provider payments, the size of the financing problem will dwarf savings from these changes. Provider cuts that reduce Medicare growth well below private premium growth could potentially cause problems with access, quality, hospital closure, and the general criticism of turning the program into a "second class" system.

Benefits reduction. Another way to reduce costs is to reduce what is covered. Although strong arguments can be made for re-designing certain benefits to have a greater and more traditional copayment structure, such an approach would do little other than to cost-shift to private Medigap plans or the Medicaid program which, taken together, cover 85 percent of the elderly. In so doing, we would not be addressing the over-utilization problem unless we prohibited Medigap plans from offering the first-dollar copayment coverage. While arguably good policy, such an approach does not seem likely to emerge from the current Congress. Finally, and perhaps most importantly, the Medicare benefits package — contrary to its image — is not excessively generous to start with. In fact, because it does not cover prescription drugs or cover catastrophic costs, it ranks in the 20th percentile of plans offered by large businesses. As such, reducing the benefits package is not easy to do when it already has a value well below that of the standard Federal employee package.

PRESERVATION PHOTOCOPY

Beneficiary contribution increases. Last week, the Senate affirmed a growing sentiment that Medicare beneficiaries should shoulder more of the costs of Medicare through both premium and cost sharing increases. While there is undoubtedly some room to do this, particularly for premiums for high-income beneficiaries, it is important to keep in mind that Medicare's benefits pay for less than half of the health care costs of seniors; the average community-based elderly person pays about $2,600 per year for premiums and out-of-pocket health care costs. In addition, increased cost sharing — as mentioned above — has its effect blunted by Medicaid and Medigap. And, lastly, even if we assume the enactment of all of the new beneficiary contributions passed by the Senate, the life of the Trust Fund would be extended by less than 2 years. A separate memo on the three primary issues, , is being submitted

Defined contribution / voucher / private plan approach. During the 1995 budget debate, Republicans proposed to cut $270 billion primarily by putting a cap on Federal Medicare spending. In other words, beneficiaries would be entitled to a fix dollar amount or "defined contribution" rather than a defined benefit. This approach is similar to increased beneficiary contributions in that its effect (if not its goal) is to limit Federal liabilities. And, like beneficiary contributions, it may not slow overall Medicare cost growth. Plans and providers may react to the fixed contribution by reducing their own costs to compete within this cap. Alternatively, they could erode the benefits, quality of care, or bill beneficiaries to make up for losses. If not done extremely carefully, this policy could undermine Medicare's basic promise of health care for the elderly and disabled. Moreover, since the program is already growing at a relatively modest 5 percent per person clip, a defined contribution's growth would have to set well below this amount to achieve the savings needed under today's definition of the Trust Fund problem. In fact, the Medicare Actuaries estimate that this growth would have to be below general inflation (about 1 to 2 percent per capita) to achieve long-term solvency without tax increases. Over time, this could produce access problems as managed care plans avoid the sickest beneficiaries.

Taxes. If there is not a significant downward adjustment in the current long-term financing projections, a bipartisan Commission would likely be forced to suggest a significant increase in the current Medicare payroll tax. For example, even if we assumed success in maintaining per capita growth rates at or below 5 percent through provider payment reductions and structural reform, the Medicare Actuaries project the need for a 2.4 percentage point increase in the Medicare HI payroll tax; it would rise from 2.9 to 5.3 percent, or 1.45 to 2.65 percent per employee. Such an increase would raise $540 billion over 5 years.

Conclusion

Medicare's long-term financing is one of the most important public policy issues of our generation. However, as outlined above, the exact size of the problem depends on health inflation trends, the nature of the demographic changes, and the long-term impact of the structural reforms passed in this year's budget. We are concerned about the potential negative consequences of a Commission that has the almost impossible burden of reviewing a rapidly changing program in an compressed amount of time and, in so doing, developing ill-informed and rushed recommendations.

PRESERVATION PHOTOCOPY

Unlike Social Security, there has been no comprehensive attempt to define problems and new trends facing the program, and to develop thoughtful analysis and options. If we assume current trends and push forward with recommendations on Medicare, we will face a choice of extremely difficult and unpopular options — options that appear unlikely to gain much consensus, particularly in the absence of a perceived crisis. Moreover, attempts to move quickly may well lead to ill conceived and inadequately considered proposals that could undermine rather than strengthen Medicare. Finally, groups such as AARP have quietly indicated to us a great preference for Social Security over Medicare reforms, and are willing to work with us to help educate their Members and younger generations of Americans on this matter.

As a result of our concerns with the Medicare Commission provisions pending in the budget conference, we are recommending that we focus our efforts on redesigning any Commission that emerges from the budget reconciliation bill to be a study-oriented, non-binding body that is not "stacked" against the Administration. Its findings would be used to inform and advance the debate on how to address the long-term financing challenge, but the Commission itself would not be expected to come up with the final resolution(s) to the problem.

Finally, in suggesting a cautious approach with any Medicare Commission, we are not advocating allowing Medicare's problems to go unaddressed. As we better understand the dimensions of the long-term problem, we can take the necessary actions that the problem requires. In the meantime, we should give serious consideration to addressing the policy shortcomings of the income-related premium proposal passed by the Senate to make it acceptable for inclusion in either the budget agreement or some other legislative vehicle that subsequently becomes available. (Clearly, opting for this type of reform in the context of the balanced budget will require a reading by John Hilley and others of how it would affect the votes from our rather shaky Democratic base in the House.) In addition, there are other reforms like postponing Medicare's eligibility age to 67 (with protection to ensure access to coverage), making Medicare managed care more competitive, requiring Medicare managed care plans to offer standardized benefits (e.g., basic coverage and basic plus drugs), and Medigap reforms that could make significant contributions to the long-term financing problem.

We will keep you informed of both developments on the Hill with regard to the Commission and our internal discussions about long-term financing reform of the Medicare program.

PRESERVATION PHOTOCOPY

Health - Medicare

HIGH-PROFILE MEDICARE ISSUES

HOME HEALTH REALLOCATION. Reallocates part of home health expenditures from Part A to Part B over 7 years — rather than immediately reallocating home health but gradually applying the premium.

- **Loses 2 years of Trust Fund solvency** Reallocating home health to Part B has the greatest effect on the Trust Fund if it is done immediately. Phasing in this transfer is no better for beneficiaries and is more difficult to administer.

HOME HEALTH COPAYMENT. Adds a new $5 payment per Part B home health visit, with an annual limit on the copayments equal to the hospital deductible ($760 in 1997).

- **Unlikely to change utilization significantly.** Over three-fourths of Medicare beneficiaries have Medigap or Medicaid and would not directly pay for the visit.

- **Severe impact on low-income beneficiaries.** For the 15 percent of beneficiaries without Medigap or Medicaid, these costs could be high and might reduce access to needed care.

  - Over 60 percent of Medicare's home health users without Medigap have incomes below $10,000. Fully 87 percent have incomes below $20,000.

  - Poor home health users without Medigap protection are more likely to have more than 150 visits per year than less.

- **Unfunded mandate to states.** Medicaid covers cost sharing for millions of low-income Medicare beneficiaries. CBO estimates that state costs could rise by $900 million.

POSTPONE MEDICARE ELIGIBILITY: Extends the eligibility age for Medicare from 65 years old to 67 years old. Phased in one month at time, with full implemented in the year 2027.

- **Increases the number of uninsured.** In 1997, an estimated 1.75 million beneficiaries aged 65 to 67 have income below $25,000. These Medicare beneficiaries may not be able to afford private insurance, possibly increasing the proportion of Americans without insurance by 5 percent, according to a preliminary Urban Institute analysis.

- **No partial benefit or insurance alternatives.** Social Security gives people who retire before eligibility a portion of their benefits; Medicare offers nothing to such beneficiaries.

  There are options to assist these beneficiaries in finding insurance (e.g., Medicare buy-in), but they are costly. The Medicare spending per enrollee — even after the budget agreement — is $7,300 in 2003 when the postponed eligibility begins.

- **Trust Fund effect is less than 1 year.**

HIGH-INCOME PREMIUM. Increases the Medicare Part B premium for high-income beneficiaries, administered by Health and Human Services (HHS) or Social Security (SSA):

Single beneficiaries: Begins at $50,000 with full payment at $100,000
Couple: Begins at $75,000 with full payment at $125,000

- **Creates complex new bureaucracy.** Duplicates the IRS. HHS or SSA would have to use tax returns, ask beneficiaries their income, and bill and collect premiums. Could take as long as 2001 to reconcile premiums for 1998. Would also require recovery of premium payments from deceased beneficiaries' spouses.

  CBO assumes that more than half the revenue from this premium will be lost in its first five years due to inefficiency. If administered by IRS, only about 5% would be lost.

  If administered through the tax system, the high-income premium will appear as an annual tax of $2,400 for singles, $4,800 for couples with the highest income in 2002.

- **Could encourage seniors to leave Medicare.** The policy to completely eliminate any premium subsidy could cause high-income beneficiaries to drop out of Medicare Part B, leaving traditional Medicare with the sicker, more expensive beneficiaries. The HCFA actuaries assume that twice as many beneficiaries will drop out of Medicare if they must pay the full cost of the premium rather than 75% of the premium.

- **Trust Fund effect is 1 to 2 years at most.**

BALANCE BILLING. Allows private fee-for-service plans to charge beneficiaries more than Medicare's allowable payments.

- **Undermines current beneficiary protections against excessive out-of-pocket costs.**

MEDICAL SAVINGS ACCOUNTS (MSAs) DEMONSTRATION. Creates demonstration that allows beneficiaries to choose high-deductible plans.

- **Large demonstration harms traditional Medicare and possibly hurts beneficiaries.** The demonstration should be limited (number of enrollees, geographically, temporary) and should include the current Medicare protections against balance billing.

MEDICAL MALPRACTICE. Includes provisions that are extraneous to the budget agreement.

MEDICARE COMMISSION. Creates partisan (8 Republicans, 7 Democrats) commission to come up with specific recommendations for long-term Medicare reform in one to two years.

- **Likely to produce ill-informed, premature recommendations.**

Health - medicare

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

ADMINISTRATOR
OFFICE OF
INFORMATION AND
REGULATORY AFFAIRS

June 30, 1997

Chris J, EK -
FYI

MEMORANDUM FOR ERSKINE BOWLES

THROUGH: Franklin D. Raines

FROM: Sally Katzen

SUBJECT: Heads-up on HCFA's Proposed Oxygen Rule

We will shortly conclude review of a Health Care Financing Administration (HCFA) proposed rule that would establish new Medicare reimbursement limits for oxygen services. The effect of the rule would be to decrease current oxygen reimbursement by roughly 40 percent.

We anticipate significant opposition to this proposal from oxygen providers and some of their allies. It is also possible that some consumer groups may have been told that any reduction in reimbursement will likely result in restrictions in access or reductions in service. For the most part, those opposing the measure are concerned because while we are proceeding administratively, the Hill is moving in the exact same direction and these opponents fear the inevitable. Incidently, the legislation reducing reimbursement for oxygen has passed both the Senate (decreasing reimbursement by almost 40 percent) and the House (decreasing reimbursement by 10-20 percent). Should the legislation clear conference and be signed by the President, the proposed rule would either be moot or unnecessary.

Please call if you have any questions.

cc: Maria Echaveste
Rahm Emanuel
Kitty Higgins
John Hilley
Ann Lewis
Sylvia Mathews
Bruce Reed
Victoria Radd
Barry Toiv
Michael Waldman
Kathy Wallman
Nancy-Ann Min DeParle
Larry Haas

Health - Medicare proposals

MEDICARE

Q: DO YOU SUPPORT THE INCOME-RELATED PREMIUM PROPOSAL THAT WAS IN THE SENATE FINANCE COMMITTEE MARK?

A: First, what passed the Senate Finance Committee was not an income-related premium but rather an income-related deductible that would allow high-income beneficiaries to pay deductibles beyond the current limit.

The proposal is also outside of what was decided in the Budget Agreement. We decided on what beneficiary savings were in the agreement and all assumed there would be no other beneficiary cost-sharing burdens.

I agree with the former Congressional Budget Office Director, Robert Reischauer that it would be administratively complex and potentially unworkable in a practical context. Regardless, it needs much consideration before we could support it as an addition to the Medicare program.

For this reason, we do not support this proposal in the context of the budget negotiations. However, we would be happy to have discussions with Senator Kerrey and others about this provision in another context.

Q: DO YOU SUPPORT EXTEND THE AGE OF MEDICARE AGE OF MEDICARE ELIGIBILITY OLDER AMERICANS FROM 65 TO 67 YEAR OLD?

A: **Raising the eligibility age for Medicare from 65 to 67 is not consistent with the spirit of the balanced budget agreement.** We do not support this provision in the context of the balanced budget negotiations. It was not thoroughly discussed in the budget agreement, and we believe that it raises a number of issues that have not been thoroughly considered.

Many early retirees would lose their private health insurance if Medicare was not available to them. There 4.1 million retirees between the ages of 55 and 64 -- 24 percent of all retirees. Having no alternative available, many would become uninsured while they were waiting for Medicare.

Health care coverage for early retirees is already dropping. The proportion of all retirees covered by health insurance from a former employer dropped from 37 percent in 1998 to 27 percent in 1994.

The decline in coverage among active workers, which decreases the likelihood of retiree health benefits, is a significant factor in this decline of coverage. The proportion of workers who with coverage from their employer upon reaching retirement declined from 65 percent to 1988 to 60 percent in 1994.

Only 30 percent of early retirees (age 55-64 years i.e. non-Medicare eligible) have health insurance from a former employer.

The cost of health care is also a significant factor for retirees. One-fourth of all retirees who elected not to carry their insurance into retirement reported they made their decision to drop insurance because it was too expensive.

Unlike Social Security, if we raised the age limit for Medicare, beneficiaries who retire early would not be eligible for a portion of benefits.

With Social Security, Americans who retire early are eligible for a portion of their benefits until they reach the age of eligibility. There are no options for partial benefits for Medicare beneficiaries who need access to health care coverage before they reach the age of eligibility.

Q: DO YOU SUPPORT THE HOME CARE COPAYMENT INCLUDED IN THE BILL FROM THE SENATE FINANCE COMMITTEE?

A: No. It is outside the context of the Budget Agreement and it needs further review before preceding further in the legislative process.

We must remember that Medicare beneficiaries who use the home health services tend to be in poorer health. Two-thirds are women, and one-third live alone. Forty-three percent have incomes less than $10,000. We would want to therefore make certain that a copayment would not place excessive burdens on beneficiaries who truly needed the benefit.

While we do not support this proposal in the context of the Budget Agreement, we do believe that proposals like it merit consideration in any serious review of options to address the long-term financing challenges confronting the Medicare program.

Q: THE HOUSE COMMERCE COMMITTEE, THE WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE ALL VOTED TO FORM A MEDICARE COMMISSION. DO YOU SUPPORT THIS AS WELL?

A: We have always indicated our support for a bipartisan process to address the long-term needs of the Medicare program. However, our first goal is to pass the Medicare reforms in the Budget Agreement that will extend the life of the trust fund for at least a decade. We still have lots of work to do on this deal to ensure that we get the provisions agreed to in the Budget Agreement.

A Commission similar to the different approaches outlined in Congress may or may not be the best bipartisan process. We will continue our conversations with the Democrat and Republican Leadership to determine the most advisable course of action.

Health-Medicare proposals

[redacted] 10:34:10 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: See the distribution list at the bottom of this message
Subject: Seniors Medicare Reaction

The following are remaining Medicare concerns of the key senior groups after the Senate Finance Committee Mark last night (in priority order):

AARP:

1. Premium Protections for low income seniors. (AARP's Top Priority)
2. Means Testing
3. Balanced Billing Protection
4. Raising Eligibility Age to 67
5. Home Care Co-Pay
6. Home Health Reallocation

Anticipating that the Congress will move quickly to complete work before the July 4 recess, AARP reports they will move agressively during the next two week, and their field organization will be doing phone-trees and alerts. Their print ads will continue with the theme, "Keep the [Budget Agreement] Promise."

National Committee to Preserve Social Security and Medicare:

1. Means Testing (National Comm's Top Priority)
2. Seek to Eliminate MSA
3. Balanced Billing Protection
4. Premium Protections for low income seniors.

Means testing is the defining issue for the National Committee, and they will oppose legisaltion that includes means testing. Their phone operation will start on Friday, will target House leadership, and will focus on means testing.

National Council of Senior Citizens (Labor)

1. Means Testing (National Comm's Top Priority)
2. Premium Protections for low income seniors.
3. Seek to Eliminate MSA

National Council on Aging

1. Premium Protections for low income seniors.
2. Means Testing (National Comm's Top Priority)
3. Raising Eligibility Age to 67

Health - Medicare proposals

Medicare Beneficiary Provisions in the Balanced Budget Agreement

- **The Balance Budget Agreement includes $18 billion in savings from premiums**
  - About $9 billion comes from extending the current law policy that beneficiaries contribute to 25% of Part B costs. Without this extension, premiums would decline to 20% of program costs by 2002.
  - Another $9 billion comes from gradually including home health in the 25% premium.
- **Of the $18 billion in savings, fully half will be reinvested in new benefits**
  - **Preventive services: $3 to 4 billion**
    All 38 million beneficiaries will benefit from this investment that includes services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.
  - **Protection against excessive hospital outpatient coinsurance: $4 billion**
    Under current law, the coinsurance for the 18 million Medicare beneficiaries who use hospital outpatient departments is 46%. Without a change in this policy, the coinsurance will continue to increase.

    The Balanced Budget Agreement stops this upward coinsurance liability and makes a down payment on eventually bringing it back to the traditional 20%.
  - **Premium assistance for low-income beneficiaries: $1.5 billion**
    About 2.5 million Medicare beneficiaries have incomes between 125 and 150 percent of poverty. Over one-third of them are widows age 75 and older. Elderly between 100 and 150 percent of poverty already spend about 30 percent of their family income on out-of-pocket health costs including Medicare Part B premiums.

    The Balanced Budget Agreement extends premium assistance to beneficiaries above today's Medicaid protections (120% of poverty, about $9,500 for a single).
- **The other $9 billion is dedicated directly to extending the life of the Medicare Trust Fund**
  - The reallocation of a portion home health expenditures to Part B of Medicare helps extend the life of the Trust Fund for at least a decade.
  - Because this reallocation is gradually added to the Part B premiums, beneficiaries' premiums contribute directly to those extra years of Medicare solvency.

Note: Total Premium Contributions: About $106 billion over 10 years
New Benefits: About $31 billion over 10 years (30% of premium contribution)
Amount directly dedicated to extending the life of the Trust Fund: About $40 billion over 10 years

Q: THE REPUBLICANS ARE PROVIDING NUMBERS THAT SHOW THAT THE MEDICARE CUTS YOU SAID WOULD DEVASTATE THE PROGRAM IN THE LAST DEBATE ARE ESSENTIALLY THE SAME YOU NOW ENDORSE. DOESN'T THIS PROVE YOUR WERE DEMAGOGING THE ISSUE?

A: **It is true that the Medicare savings in the Balance Budget Agreement meet the Republicans half-way.** The seven-year savings in the Budget Agreement are about $70 billion below the Republican's 1995 budget.

However, there are fundamental differences between the 1997 Balanced Budget Agreement and the Medicare proposal the President vetoed.

1) **Vetoed Budget had premiums that were about $18 more per month than in the 1997 Balanced Budget Agreement.** The monthly premium under the Budget Agreement will be about $69 in 2002. If the policy were a 31.5% premium instead of 25%, this premium would be about $87. On an annual basis, this difference is about $215 for a single beneficiary, $430 for a couple.

2) **Vetoed Budget would have raised the percent of the program funded by beneficiaries by over one fourth.** The 1997 Balanced Budget Agreement keeps the Medicare Part B premium at its current level of 25% of program costs — far below 31.5% the 1995 Republican Budget that the President vetoed.

3) **Vetoed Budget's investments are only 1% of the 1997 Balanced Budget Agreement's investments.** The Budget Agreement includes critical investments:

- **Preventive services: $3 to 4 billion,** including services to detect breast and colon cancer, provide for diabetes self-management, and increase payments for preventive vaccinations.

- **Protection against excessive hospital outpatient coinsurance: $4 billion**

- **Premium assistance for low-income beneficiaries: $1.5 billion**

In contrast, the vetoed Budget included extremely modest investments, **$100 million** for coverage of oral breast cancer drugs.

4) **Vetoed Budget had larger provider reductions.** The vetoed Budget had policies that put much tighter constraints on provider payment growth. For example, the reduction in the rate of increase in Medicare's hospital payments was twice as big as that needed to hit the budget agreement's target.

5) **Vetoed Budget included flawed structural reforms.** The 1997 Balanced Budget Agreement does not sanction the use of balance billing, association plans, and other ideas that put beneficiaries at risk.

DRAFT PRELIMINARY: FOR INTERNAL USE ONLY

Medicare Monthly Premiums

(CBO January 1997 Baseline, Calendar Years)

	1998	1999	2000	2001	2002	1998-2002
Current Law Which Declines to about 20% by 2002*	$45.80	$47.10	$48.50	$50.00	**$51.50**	
Budget Agreement						
25% Premium *	$45.80	$49.50	$52.50	$55.90	**$61.20**	
25% Premium w/ Home Health by 2004						
Based on CBO Scoring as of 5/1/97 **	$46.80	$51.70	$55.90	$60.70	**$67.60**	
HH Component Relative to 25%	*$1.00*	*$2.20*	*$3.40*	*$4.80*	*$6.40*	
Revised Based on New CBO Scoring **	**$47.00**	**$52.10**	**$56.60**	**$61.80**	**$69.30**	
HH Component Relative to 25%	*$1.20*	*$2.60*	*$4.10*	*$5.90*	*$8.10*	
31.5% Premium w/ Home Health by 2004**	$59.20	$65.60	$71.30	$77.90	**$87.30**	
Monthly Difference in 2002 between 25% Premium w/ Home Health and:						
Current Law (about 20% by 2002)	$1.20	$5.00	$8.10	$11.80	$17.80	
25% Premium	$1.20	$2.60	$4.10	$5.90	$8.10	
31.5% Premium	-$12.20	-$13.50	-$14.70	-$16.10	-$18.00	
31.5% Premium Annual Difference	*-$146*	*-$162*	*-$176*	*-$193*	*-$216*	***-$894***
31.5% Premium Annual Difference/Couple	*-$293*	*-$324*	*-$353*	*-$386*	*-$432*	***-$1,788***

* CBO scoring

** Administration staff estimates based on CBO scoring

NOTE: There are several ways to calculate how home health is included; CBO has already produced 3 sets of numbers

The Medicare Actuaries would suggest that none of the 3 CBO methods would be what they would use.

The method recommended by the Actuaries is used in the bolded bank of numbers

The 25% premium is based on CBO's March scoring of the President's budget.

It is likely that it will decrease with additional Part B savings in the $115 b package

5/18/97

MEMORANDUM

February 12, 1997

TO: Bruce Reed

FR: Chris Jennings

RE: Medicare premiums and structural reforms

cc: Elena Kagan

Attached is a Medicare premium chart that illustrates our projections for Part B premiums under our current Medicare proposal as well as projections for premiums under our proposal and the Republican proposal during last year's budget debate. It also includes our current projections of what the Part B premium would be if the home health expenditures that are reallocated to Part B were included in our premium calculations.

As you will note, our current projections show that our Part B premium will be $63.80 in 2002, about $11 more than current law (because it extends current law to maintain the Part B premium at 25 percent of program costs as we did in the last two budgets). This premium is still about $25 less than the CBO projection of the vetoed Republican budget.

In addition, these numbers show that including the home health services reallocated to Part B in the Part B premium, would raise it about $11 in 2002, an amount that is about $14 less per month than the Republican budget that the President vetoed. You should also note that the current additional savings for including the home health expenditures in the Part B premium are projected to be $20 billion (not $17 billion) over five years. None of this information is conceptually new, but I thought that you might find it useful to have it all in one place.

Finally, I am attaching a 3-page document that summarizes the structural reforms in our Medicare plan. This may help make the case that the President's Medicare reform is as much about structural change as it is about achieving savings to extend the life of the Trust Fund. You and other principals might find it useful in discussions to make this point.

I hope this information is helpful. Please call me at 6-5560 with any questions.

Medicare Part B Premiums under Current Law and the President's Budgets

	1996	1997	1998	1999	2000	2001	2002	**1998-2002**
Current OMB Baseline	$42.50	$43.80	$47.40	$48.70	$50.00	$51.30	$52.70	
President's 5-Year Balanced Budget 2/6/97 (OMB scoring, 2/97, relative to OMB January 1997 baseline)	$42.50	$43.80	$47.30	$50.90	$54.40	$58.60	$63.80	
President's 7-Year Balanced Budget 12/7/95 (CBO scoring, 12/95, relative to CBO December 1995 baseline)	$42.50	$45.50	$49.50	$53.40	$59.50	$64.60	$70.40	
GOP 7-Year Balanced Budget 12/95 (CBO scoring, 12/95, relative to CBO December 1995 baseline)	$51.40	$54.90	$58.60	$62.80	$70.70	$77.20	$84.60	
Vetoed GOP 7-Year Balanced Budget 11/95 (CBO scoring, 11/95, relative to CBO March 1995 baseline)	$53.70	$57.00	$59.30	$64.10	$73.10	$80.10	$88.90	

Note: These premiums are relative to different baselines; thus, the President's same policy produces different premiums due to the baseline differences.

President's 5-Year Balanced Budget 2/6/97 With the Home Health Transfer Included in Premiums (OMB scoring, 2/97, relative to OMB January 1997 baseline)	$42.50	$43.80	$55.90	$59.90	$63.60	$68.60	$74.60	
Revenue from Premium on Home Health (FY, Billions)			$2.9	$4.0	$4.2	$4.5	$4.9	**$20.5**

2/11/97

The President's FY 1998 Budget:
Medicare Structural Reforms in the President's Budget

The President's Budget modernizes Medicare and brings it into the 21st century through a number of major structural changes.

FEE-FOR-SERVICE PAYMENT REFORM

- **Building on the success of prospective payment for inpatient hospital, the President's Budget would move to prospective payment systems for:**

  - **Skilled nursing facilities (SNF).** Driven primarily by increases in intensity of services, SNF is one of the fastest growing Medicare benefits. The budget would establish a per-diem SNF prospective payment system beginning in 1998, which would reimburse for all costs (routine, ancillary, and capital).

  - **Home health services.** Medicare's retrospective reimbursement rates do not help control volume, contributing to the increasingly high expenditures in this area. The President's budget implements a prospective payment system in 1999, which pays home health agencies based on characteristics of the patients, not on how many services agencies provide.

  - **Hospital outpatient departments (OPDs).**

    Implements prospective payment system. OPDs are still paid, in part, on a per cost basis. To help constrain the costs of OPDs, which are projected to nearly double between FY 1997 and FY 2002, the President's budget would move to a prospective payment system for these services starting in 1999, which for the first time, would create incentives for efficiencies.

    Addresses the current inequity in coinsurance for hospital outpatient fees. Due to flaws in the current reimbursement methodology, OPDs receive a total payment for certain services that exceed the 100 percent Medicare "rate." Since coinsurance is a function of hospital charges and since charges are significantly greater than Medicare's payment rates, beneficiaries pay nearly a 50-percent copayment for outpatient department services, as oppose to the 20-percent rate for other Part B services. The President's proposal assures that by 2007, coinsurance will be reduced to the traditional 20-percent level.

IMPLEMENT SUCCESSFUL PURCHASING APPROACHES

- **Adopts approaches to purchasing health care services that have proved successful in other areas.** These approaches to purchasing health care services have been used successfully by the private sector and other federal and state purchasers that have been tested under Medicare's demonstration authority.

    - **Centers of Excellence.** Since 1991, the Health Care Financing Administration has been conducting a demonstration that pays facilities a single flat fee to provide all diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. Medicare has achieved an average of 12 percent savings for the CABG. This proposal would make the "centers of excellence" a permanent part of Medicare expanding it to include heart procedures, knee surgery, and hip replacement surgery.

    - **Competitive Bidding.** To help implement more competitive strategies in managing payment for durable medical equipment, laboratories, and other items and supplies, the President's proposal would establish competitive bidding for these items.

    - **Purchasing Through Global Payments.** This enables the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services for a specific condition or need of an individual. Providers would be selected on the basis of their ability to provide high quality services, to improve coordination of care, and to offer additional benefits. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such an arrangement.

    - **Flexible Purchasing Authority.** This authorizes the Secretary to negotiate alternative administrative arrangements, excluding changes in quality standards or conditions of participation, with providers who agree to provide price discounts to Medicare. Savings from these arrangements could be given directly to the beneficiaries who use them.

MANAGED CARE PAYMENT REFORMS

The President's Budget would reform the payment methodology for managed care plans.

- **Addresses flaws in payment methodology for managed care.** The reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly in rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will reduce geographical variation in current payment rates.

- **Carves out GME, IME, and DSH payments from managed care.** Eliminates medical education and disproportionate share hospital payments from the HMO reimbursement formula and provide this money directly to teaching and disproportionate share hospitals for managed care enrollees and to academic health centers.

- **Adjusts payment rates to reduce Medicare's current overpayment of managed care.** Currently, this overpayment exists because managed care enrollees are typically healthier than Medicare beneficiaries who remain in fee-for-service. This is a temporary adjustment until we implement a risk-adjusted payment system which is expected to be in place by no later than 2002.

NEW CHOICES FOR BENEFICIARIES

- **Establishes new private health plan options.** The budget increases the number of plans -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities. These options will meet strong quality standards and include consumer protections. The plans would be required to compete on cost and quality, not on the health status of enrollees.

- **Replaces 50/50 rule with quality measurement system.** The Secretary, in consultation with consumers and the industry, will develop a system for quality measurement. Once this system is in place, the current requirement that requires managed care plans to maintain a level of private enrollment at least equal to the public program enrollment will be eliminated.

- **Provides beneficiaries with comparative information to help them choose the plan that best meets their needs.** Similar to the FEHBP program, this proposal would enable beneficiaries to examine and compare all of the information about their coverage options.

- **Develops a process with the National Association of Insurance Commissioners to better standardize benefits.** This proposal creates a process to standardize some of the additional benefits provided by managed care plans and revises standard Medigap packages so that Medicare beneficiaries can make an apples to apples comparison when evaluating their coverage options.

- **Establishes an annual coordinated open enrollment period for all managed care and Medigap plans.** These new Medigap protections would make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to choose managed care plans because they would be assured that they could always go back to fee-for-service.