



CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

June 28, 2000

H.R. 4680 **Medicare Rx 2000 Act**

As ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000

SUMMARY

The Medicare Rx 2000 Act would:

- Establish a prescription drug benefit for Medicare enrollees and a subsidy program for certain low-income participants;
- Establish a new Medicare Benefits Administration (MBA) to oversee the prescription drug benefit and the Medicare+Choice program, and to administer the low-income subsidy program;
- Establish a disease management demonstration project;
- Modify Medicare's coverage and appeals process;
- Adjust payment rates for Medicare+Choice plans; and
- Expand coverage of certain injectable and infusable drugs under Medicare Part B.

The Manager's Amendment would permit the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, cap participation in the disease management project at 30,000, and extend the deadline for Medicare+Choice plans to announce whether they will participate in the program in 2001. The amendment also contains several technical corrections.

H.R. 4680 would affect both direct spending and revenues; therefore, pay-as-you go procedures would apply. CBO estimates that enacting the bill would increase direct spending by \$0.4 billion in 2001, by \$40 billion over the 2001-2005 period, and by \$159 billion over the 2001-2010 period. The prescription drug benefit and the changes in

coverage and payment rates for medical benefits for Medicare enrollees account for nearly all of those increases in direct spending. We estimate that on-budget revenues and off-budget revenues would each decline by less than \$50 million a year from 2003 through 2010. The bill also would lead to an increase in the market price of prescription drugs, which would result in:

- Slight increases in direct spending for Medicaid and health benefits for retired federal employees,
- Slight increases in discretionary spending for health programs of several federal agencies, and
- A small decrease in federal tax revenues.

Each of those effects would be less than \$50 million in most years.

Subject to appropriation of the necessary amounts, CBO estimates that administering the prescription drug benefit and modifying the coverage and appeals process would cost \$0.2 billion in 2001 and \$6.5 billion over the 2001-2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments. Other provisions in the bill would result in net savings to state and local governments of approximately \$3 billion over the 2001-2005 period and \$19 billion over the 2001-2010 period.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA (\$109 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4680 is shown in Table 1. The bill would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all federal agencies for employee health benefits. It also would reduce federal revenues by a small amount. The bill would have no effect on outlays or revenues in 2000.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By Fiscal Year, in Billions of Dollars									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare Outlays										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	a	a	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	<u>0</u>	<u>0</u>	<u>a</u>	<u>0.1</u>	<u>0.1</u>	<u>0.2</u>	<u>0.2</u>	<u>0.3</u>	<u>0.3</u>	<u>0.3</u>
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid Outlays										
Change to current-law drug spending	0	0	-2.6	-3.7	-4.1	-4.6	-5.1	-5.7	-6.3	-7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	-0.6	-1.3	-1.2	-0.8	-0.3	0	0	0
Administration (net of SMI transfer)	<u>0</u>	<u>0.1</u>	<u>0.2</u>							
Subtotal	0	0.1	-2.7	-4.1	-3.9	-3.8	-3.7	-3.9	-4.4	-4.9
Effect of higher drug prices on outlays by federal programs										
Medicaid	0	0	a	a	a	a	a	a	0.1	0.1
FEHB (for annuitants, on-budget)	<u>0</u>	<u>0</u>	<u>a</u>							
Subtotal, on-budget	0	0	a	a	a	a	a	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	a	a	a	a	a	a	a	a
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	a	a	a	a	a	a	a	a
Social Security payroll taxes (off- budget)	<u>0</u>	<u>0</u>	<u>a</u>							
Total	0	0	a	a	a	a	a	a	a	-0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	<u>0</u>	<u>0</u>	<u>a</u>							
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

SOURCE: Congressional Budget Office

NOTES: SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits

a. Costs or savings of less than \$50 million.

BASIS OF ESTIMATE

Prescription Drug Benefits

H.R. 4680 would create a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. CBO estimates that the Part D provisions would increase direct spending by \$35 billion over the 2001-2005 period and by \$142 billion from 2001 through 2010. Of that 10-year total, \$81 billion represents outlays for federal reinsurance payments to plans offering qualified prescription drug coverage and \$92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by \$31 billion in net federal Medicaid savings associated with the new drug program, because part D would replace Medicaid coverage for some individuals. (States would also accrue additional net Medicaid savings totaling \$3 billion through 2005 and about \$19 billion over the 2001-2010 period.)

CBO estimates that the cost associated with administering the new Part D benefit and other related activities, subject to the appropriation of the necessary amounts, would total \$2 billion over the 2001-2005 period and more than \$5 billion over the 2001-2010 period.

Two other provisions, which would modify Part B coverage of certain drugs and biologicals and create a disease management demonstration project, would add almost \$2 billion over the 10-year period.

Coverage of the Part D Program. H.R. 4680 would provide federal reinsurance payments to entities offering qualified prescription drug coverage to Medicare beneficiaries. Eligible entities would include sponsors of prescription drug plans (PDPs), Medicare+Choice organizations, and qualified retiree prescription drug plans—all of which would have to offer qualified drug coverage and comply with other requirements under Part D. Either the specified standard coverage or a benefit design that is at least actuarially equivalent to standard coverage would meet the bill's requirements. Such qualified coverage also would have to include access to negotiated prescription drug prices for all of a beneficiary's purchases of covered drugs.

The bill defines standard coverage for 2003 as a \$250 deductible; 50 percent coinsurance—or an actuarially equivalent cost-sharing rate—on the next \$2,100 in total drug spending to reach an "initial coverage limit" of \$1,050; and an annual limit on out-of-pocket spending of \$6,000 (see Table 2). Qualified standard coverage would make the beneficiary responsible for paying 100 percent of drug costs for all drug spending above the \$1,050 benefit maximum but below the \$6,000 out-of-pocket limit. In other words, in 2003 a beneficiary would begin to pay 100 percent of drug costs after annual drug spending exceeded \$2,350 until a total of \$7,050 was spent in that year. After annual drug spending exceeded \$7,050,

the beneficiary would pay no more for drugs and the plan would pay 100 percent of any additional drug spending in that year. The dollar amounts for the deductible, initial coverage limit, and out-of-pocket limit would be updated annually by the percentage increase in average per capita expenditures for covered outpatient drugs for Medicare beneficiaries.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary ^a	
		Spending in the Interval	Cumulative Spending
\$ 0 to 250	100 percent	\$ 250	\$ 250
\$ 250.01 to 2,350	50 percent	1,050	1,300
\$ 2,350.01 to 7,050	100 percent	4,700	6,000
Above \$ 7,050	0 percent	0	6,000

^aAssumes beneficiary spends the full amount in the interval.

Alternative coverage designs would qualify under Part D as long as:

- The actuarial value of total coverage is at least equal to the actuarial value of standard coverage,
- The unsubsidized value of coverage (after receiving federal reinsurance payments) is at least actuarially equivalent to the unsubsidized value of standard coverage,
- The benefit design provides for payments by the plan under the initial coverage limit to be at least actuarially equivalent to the amount paid under standard coverage, and
- The limit on out-of-pocket spending is the same as the limit required for the standard package for beneficiaries whose drug spending equals at least \$2,350 (in 2003).

H.R. 4680 also would allow third parties (such as Medicaid or employer-sponsored health insurance) to pay a beneficiary's cost-sharing obligation below the out-of-pocket limit and would require that the plan count those third-party contributions toward the beneficiary's out-of-pocket contributions.

The bill would require sponsors of qualifying plans to cover prescription drugs, insulin, and biologicals but would prohibit coverage for a specific list of drugs, such as hair growth

products. Drugs currently covered under Medicare Parts A and B would continue to be covered under current law rules.

Qualifying PDPs would assume full financial risk for costs not subject to federal reinsurance subsidies but would be permitted to obtain insurance to cover that risk. The bill would permit insurers to coordinate with other entities to manage the pharmacy benefit. CBO assumes that most insurers would administer the benefit through pharmacy benefit management (PBM) companies.

Administration and Oversight. The bill would create a new agency in the Department of Health and Human Services called the Medicare Benefits Administration (MBA) to administer the new Part D drug benefit, the low-income subsidy program, and the Medicare+Choice program. The plan oversight function currently within the Health Care Financing Administration (HCFA) would be consolidated within the new agency. Premiums set by plans would be subject to rate review and negotiation with the Administrator of the MBA.

H.R. 4680 would require that each Part B beneficiary have access to at least two qualifying plans, at least one of which is a PDP. The MBA could provide financial incentives to existing sponsors to ensure the availability of two plans. If two plans are not available in an area, the MBA would be required to offer a qualifying prescription drug plan. The MBA could establish such a plan on a regional or nationwide basis. CBO assumes that the MBA would offer coverage through its own plan only to beneficiaries who do not have a choice of two qualifying private plans.

Federal Payments for Reinsurance. Sponsors of PDPs, Medicare + Choice organizations, and qualified retiree prescription drug plans who offer qualified drug coverage would be eligible for federal reinsurance payments. Those federal payments would be based on the lesser of the drug costs per enrollee paid by the plan or the amount that would have been paid by the plan if the coverage offered was standard coverage. Such payments by the plans would be considered "allowable drug costs" for the federal reinsurance subsidy. In 2003, the reinsurance schedule for each enrollee would be:

- 30% of allowable drug costs for total drug spending between \$1,251 and \$1,350;
- 50% of allowable drug costs for total drug spending between \$1,351 and \$1,450;
- 70% of allowable drug costs for total drug spending between \$1,451 and \$1,550;
- 90% of allowable drug costs for total drug spending between \$1,551 and \$2,350,

- 90% of allowable drug costs for total drug spending exceeding \$7,050.

The bill also would require the MBA to adjust the subsidy payments so that the total of such subsidy payments for each year is equal to 35 percent of covered outpatient drug payments made by plans based on standard coverage. CBO assumes it would take at least one year to calculate the amount of the adjustment, so those adjustments would be made with a two-year lag.

Plans would charge beneficiaries a premium to cover drug spending that is not subsidized by the federal government plus the plan's cost of administering the benefit and the plan's profit. CBO estimates that plans would charge beneficiaries an annual premium that would average \$470 in 2003 and would grow to \$809 in 2010.

Enrollment. All Medicare beneficiaries would have a one-time chance to purchase qualified drug coverage from the sponsor of a qualifying plan when they first become eligible for Medicare and during a six-month open enrollment period starting in 2003. During that time, insurers would not be allowed to underwrite their premiums or exclude beneficiaries from coverage based on pre-existing conditions. Rather, the plan would have to charge the same premium to all enrollees in a service area who maintain continuous prescription drug coverage. (Service area is not defined.) Continuous prescription drug coverage refers to prescription drug coverage offered under a PDP, a Medicare+Choice plan, Medicaid, a group health plan, certain Medigap policies, a state pharmaceutical assistance program, or a program of the Department of Veterans Affairs. Beneficiaries would be allowed to change plans each year.

Plans could charge a higher premium to enrollees who did not enroll at the first opportunity or who let coverage lapse for 63 days or longer, except in a few limited circumstances.

Medicare+Choice Drug Benefits. H.R. 4680 would require that all Medicare+Choice plans offering drug benefits meet the qualified prescription drug coverage standards under Part D. However, a Medicare+Choice plan could elect not to offer prescription drug coverage. Medicare+Choice plans that offer qualifying coverage under Part D would be able to charge a separate prescription drug premium and receive federal reinsurance payments.

CBO's Estimating Assumptions for Prescription Drug Benefits

Participation. CBO assumes that Medicare enrollees who have drug coverage under current law that is not federally subsidized would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes that beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit. Of those

who purchase Part B but do not have drug coverage, CBO assumes that 46 percent would purchase a qualified drug plan. In total, CBO estimates that 80 percent of beneficiaries in Part B (equal to 74 percent of all Medicare enrollees) would participate in the drug benefit provided by H.R. 4680.

CBO also expects states to pay the premiums charged by sponsors of qualified drug plans and the cost-sharing obligations of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid benefits, because that would shift some of the costs for drug coverage for those dual-eligibles from the states to Medicare.

Effectiveness of PBMs. Under H.R. 4680, PBMs would compete against one another for the business of managing the benefit for sponsors of qualifying prescription drug plans. The bill would allow PBMs to use a broad range of current market tools to manage the pharmacy benefits for PDPs, though it would impose certain restrictions on the PBMs' activities.

PBMs would be allowed to negotiate discounts with pharmacies that agree to participate in their networks but would need to guarantee access that is convenient to beneficiaries. PBMs would also be allowed to design restrictive formularies and negotiate rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. However, the bill specifies that the formularies would need to cover all therapeutic classes, which could dilute some of their negotiating power with manufacturers. As long as cost-sharing requirements under a plan are actuarially equivalent to the standard plan for spending under the benefit maximum, the bill would allow PBMs to establish differential copayment requirements that encourage beneficiaries to select lower-priced options, such as generic, preferred formulary, or mail-order drugs.

The appeals process specified under the bill would allow access to off-formulary drugs at a physician's request when the on-formulary drug is considered not as effective as the off-formulary version for the patient or has significant adverse effects for the enrollee. CBO assumes this process would interfere with a PBM's ability to negotiate rebates from manufacturers in certain circumstances. Considering all these factors, CBO estimates that PBMs would be able to reduce spending by an average of about 25 percent from what an uninsured retail purchaser would pay under current law.

Drug Pricing Assumptions and Effects on Other Federal Purchasers. Enrollees whose drug expenses exceed the stop-loss amount would no longer be price-conscious. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 2 percent higher if H.R. 4680 is enacted.

Higher drug prices would also affect spending by other federal programs for prescription drugs. Medicaid, the Federal Employees Health Benefits (FEHB) program, the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the U.S. Coast Guard would all be affected.

CBO estimates that higher drug prices would increase direct spending for Medicaid and for annuitants covered by the FEHB program by less than \$50 million over the 2001-2005 period and by \$0.3 billion over the 2001-2010 period. Subject to the appropriation of necessary amounts, discretionary spending by federal agencies for active workers covered by the FEHB program, DOD, VA, PHS, and the U.S. Coast Guard would increase by \$0.1 billion over the 2001-2010 period. The net impact over the same period for active and retired postal employees would be negligible.

Revenue Impact. As a result of higher drug prices, H.R. 4680 would also lead to a loss of federal income and payroll tax revenues by raising the costs of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the bill would reduce revenues by less than \$50 million over the 2001-2005 period and by \$0.2 billion from 2001 through 2010. Social Security payroll taxes, which are off-budget, account for \$0.1 billion of that 10-year total.

Low-Income Subsidies

A central feature of the bill is the provision of assistance to low-income beneficiaries who participate in Medicare Part D. CBO expects the low-income subsidies, including payments from the SMI trust fund to state Medicaid programs for administrative costs, would increase Medicare spending by \$23 billion over the 2001-2005 period and by \$92 billion over the 2001-2010 period, amounts that slightly exceed the federal reinsurance payments. Because Medicaid currently pays for a share of prescription drug costs for about 13 percent of Medicare beneficiaries who are dually-eligible for both programs, about a quarter of the bill's Medicare Part D spending (the federal reinsurance payment and the low-income subsidies) would be offset by a decline in the federal share of Medicaid spending. The bill also would increase Medicaid spending for prescription drugs for some new enrollees and the U.S. territories, withhold some funds from states, increase other Medicaid benefits for new enrollees, and provide additional Medicaid payments for administration. CBO estimates those provisions would lead to a decrease in net federal Medicaid spending of \$11 billion over the 2001-2005 period and a decrease of \$31 billion over the 2001-2010 period.

Medicare spending on low-income subsidies. Under the bill, Medicare would subsidize spending for premiums and cost sharing under Part D for certain low-income Medicare beneficiaries (except those residing in the U.S. territories). Subsidies would be 100 percent

federally financed. Beneficiaries with incomes below 135 percent of the poverty level and with limited assets would receive a premium subsidy equal to the premium for standard coverage (or its actuarial equivalent). They would also receive a subsidy for cost sharing up to 95 percent of the maximum amount permitted under the initial coverage limit (in 2003, that would be 95 percent of \$1,300, or \$1,235). Individuals with incomes between 135 and 150 percent of the poverty level would receive smaller premium subsidies determined using a sliding scale, but would not be eligible for subsidies for cost sharing.

Participation in the subsidy program would grow over time as beneficiaries become aware of and apply for those subsidies, though some low-income Medicare beneficiaries who would participate in Part D and who would be eligible for subsidy assistance would choose not to participate in the subsidy program. CBO expects that about 8 million Medicare beneficiaries, or one quarter of the enrollees in Part D, would receive subsidy assistance by 2007. Most of those subsidy recipients currently receive full or partial medical assistance under Medicaid. We estimate that Medicare payments for low-income subsidies would total \$23 billion over the 2001-2005 period and \$90 billion over the 2001-2010 period.

The bill would require that state Medicaid programs perform eligibility determinations for the subsidies (see below for more detail) and would offer states a higher federal match rate than the average rate of 50 percent to perform those services. Although the Medicaid program would initially incur the costs of administration, Medicare's Supplementary Medical Insurance (SMI) Trust Fund would ultimately transfer funds to Medicaid to cover some of Medicaid's new administrative costs. CBO estimates that Medicare spending for those administrative costs would total \$0.2 billion over the 2001-2005 period and \$1.4 billion over the 2001-2010 period.

Changes in Medicaid drug spending. In 2007, about 5.5 million low-income Medicare beneficiaries are expected to be eligible for full benefits under Medicaid, which covers prescription drugs for most beneficiaries. Under the bill, the Medicare Part D benefit would become the primary payor for prescription drugs for those beneficiaries. Cost-sharing assistance provided by Medicare to full dual-eligibles under 135 percent of poverty also would replace Medicaid assistance. Thus, savings would accrue to the Medicaid program, and would be shared with the states at the regular federal match rate (57 percent, on average). Medicaid would continue to pay for prescription drug spending not covered by the new Part D benefit and for some cost-sharing subsidies, including spending in the gap between the initial coverage limit and the annual out-of-pocket limit.

CBO anticipates that state Medicaid programs would pay premiums and cost-sharing amounts for full dual-eligibles who are not eligible for subsidy assistance to enroll them in the new drug benefit program. The bill would not allow full dual-eligibles over 135 percent of poverty access to Part D subsidy assistance (except for some dual-eligibles under 150

percent of poverty who might be eligible for premium subsidies). Those beneficiaries would be worse off under the new drug benefit than under current law if Medicaid did not pay for prescription drug spending beyond the scope of the Part D benefit. Although the bill is silent on the question of whether states would be permitted to enroll and subsidize dual-eligibles above the subsidy thresholds, CBO assumes that they would be allowed to do so and would be reimbursed at the regular federal match rate for Medicaid.

Medicaid's savings would be partially offset by new drug spending. Because CBO expects that the new drug program would increase participation of full dual-eligibles in the Medicaid program, Medicaid would be required to pay for their prescription drug spending not covered by the Part D benefit or Medicare subsidies. Finally, federal Medicaid spending in the U.S. territories would increase by additional amounts provided in the bill for prescription drug assistance to low-income Medicare beneficiaries. CBO estimates that net federal Medicaid spending for prescription drugs would decline by \$10 billion over the 2001-2005 period and by \$39 billion over the 2001-2010 period.

Reduction in federal payments to states. The bill would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2006. The amount of the reduction would be based on the amount of low-income subsidies that Part D of Medicare would pay for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 80 percent in 2003 to 20 percent in 2006.

CBO anticipates that the reduction would be difficult to administer because it is likely that states would demand that the federal government document its spending on subsidy payments before withholding funds. CBO's estimate therefore assumes a six-month lag between the time that low-income subsidies are paid and the time that any reductions in federal Medicaid payments are made. CBO also anticipates that potential conflicts between states and the federal government over the amount of the withholding could result in HCFA making less than the full amount of the reduction specified in the bill. Overall, CBO estimates that those reductions would lower federal Medicaid outlays by \$3 billion over the 2001-2005 period and by \$4 billion over the 2001-2010 period.

Impact on other Medicaid benefits. In addition to its regular benefits, Medicaid pays for some or all of the premiums and out-of-pocket expenses incurred by certain Medicare beneficiaries with low incomes and limited resources. Medicaid covers Medicare premiums and cost sharing for beneficiaries with incomes below the poverty level, and the Part B premium for beneficiaries with incomes between 100 and 120 percent of the poverty level. However, many of the Medicare beneficiaries who are eligible for this Medicaid assistance are not enrolled in Medicaid; some may not be aware of their eligibility, while others may prefer to avoid the hassle of Medicaid's enrollment process and pay Medicare cost sharing

on their own. Still others may view Medicaid as having the stigma of a public assistance program and may choose not to participate.

CBO believes that the attractiveness of assistance for a prescription drug benefit would boost the number of low-income Medicare beneficiaries enrolled in Medicaid by about 1.5 million by 2006 (a 20 percent increase). The bill would require state Medicaid programs to determine the eligibility of Medicare beneficiaries for the low-income subsidies under Part D of Medicare. Some beneficiaries, while applying for those subsidies in a local Medicaid office, would learn that they are eligible for additional assistance under Medicaid and would enroll. CBO estimates that provision would increase federal Medicaid spending by \$2 billion over the 2001-2005 period and by \$10 billion over the 2001-2010 period.

Administrative Costs for Medicaid. The bill would affect Medicaid spending for administrative costs in a number of ways. As noted above, state Medicaid programs would be required to determine the eligibility of Medicare beneficiaries for low-income subsidies under Part D. The federal Medicaid matching rate for costs related to those determinations would rise from 60 percent in 2003 to 100 percent after 2006. (The current match rate for most administrative costs is 50 percent.) CBO assumes that states would reclassify some of their regular administrative expenses as Part D administrative costs to take advantage of the higher match rate. As noted above, Medicare (SMI) would transfer funds to Medicaid to cover the portion of Medicaid's administrative costs reimbursed above the regular federal match rate.

The bill would also necessitate increased spending on administration as more low-income Medicare beneficiaries enroll in Medicaid, but would yield savings as states would have reduced responsibility for handling prescription drug claims for full-dual eligibles. CBO estimates that net federal Medicaid outlays for administration would increase by \$0.7 billion over the 2001-2005 period and \$1.6 billion over the 2001-2010 period.

Disease Management Project

H.R. 4680 would direct the Administrator of the MBA to conduct a three-year demonstration project to evaluate the impact of disease management services on the costs and health outcomes of Medicare Part B beneficiaries with certain illnesses. Eligible beneficiaries would have to have advanced-stage congestive heart failure, diabetes, or coronary heart disease and would be required to secure the approval of their physicians in order to participate.

Participants would be entitled to additional prescription drug benefits paid through the enrolling disease management organization (DMO). More specifically, the organization

would pay for a beneficiary's premium, deductible, and cost-sharing under Part D plus any amounts not covered by the plan because of the initial coverage limit. The organization would pay for all prescription drug costs for participants who are not enrolled under Part D. CBO expects that offering such highly desirable drug benefits would create strong demand for disease management services among chronically ill beneficiaries.

Given the nature of the contractual agreements outlined in the bill, however, whether disease management organizations would enter into contracts under those conditions is uncertain. Much of that uncertainty involves the interpretation of how the fee would be negotiated between DMOs and the Administrator. The bill would require that the fee paid to DMOs be negotiated in a manner that would guarantee a "net reduction in expenditures under the Medicare program" for participating beneficiaries. However, accurately estimating the benchmark spending against which the savings or costs would be measured would be extremely difficult, particularly because the bill would delay the implementation of improved risk adjustment factors. As a result, CBO believes that there is no assurance that the demonstration project could be implemented so as to reduce Medicare expenditures and that, on the contrary, it would increase costs to the Medicare program overall.

Moreover, the extent to which DMOs would be willing to participate in the project is unclear. CBO assumes that it is unlikely that DMOs would assume full risk for any additional costs associated with the expanded drug benefit unless those costs are reflected in the negotiated fee. Under the bill, DMOs are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, or D. If DMOs must guarantee a "net reduction in expenditures under the Medicare program," with those expenditures defined to include additional premium and cost-sharing assistance paid under the project, CBO assumes that all DMOs would decline to participate. However, if those drug benefit payments are included in the negotiated fee, CBO assumes DMOs would enter into those agreements.

Without any legislative restrictions on the number of qualifying beneficiaries allowed to join the demonstration project, CBO would assume that up to 300,000 of them would enroll, if DMOs decided to participate and offer those benefits. Assuming an equal probability that regulations implementing the project would include or exclude payments for drug benefits from the negotiated fee, CBO estimates that such enrollment in the demonstration project would increase federal spending by about \$1.1 billion over the 2001-2005 period. However, because the Manager's Amendment to the bill would limit participation to 30,000 enrollees, CBO estimates that the demonstration project would increase net federal spending by \$0.3 billion over 2001-2005 period and by \$0.4 billion over the 2001-2010 period.

Medicare Coverage and Appeals Process

H.R. 4680 would modify the current appeals process for the Medicare fee-for-service program to make it similar to the appeals process under the Medicare+Choice program. The bill would allow Medicare beneficiaries the right to an initial determination of coverage before services are provided. The bill would provide for external contractors to independently handle reconsiderations for denied services, impose time limits for the appeals processes, provide rules for the review of local and national coverage decisions, authorize continuing education for reviewers and adjudicators, limit beneficiaries' liability, and eliminate the Secretary's ability to overturn or modify the decisions of the Provider Reimbursement Review Board with regard to appeals by Part A providers. CBO estimates those provisions would increase direct spending by about \$50 million in 2001, \$0.7 billion between 2001 and 2005, and \$3 billion from 2001 through 2010. Assuming appropriation of the necessary amounts, CBO assumes that the appeals and coverage provisions would increase discretionary spending by \$44 million in 2001 and by \$1.1 billion over the 2001-2010 period.

Medicare+Choice Reforms

Under current law, payment rates for Medicare+Choice plans are defined according to plan members' county of residence, and are then adjusted for each beneficiary's demographic and risk characteristics. The geographic payment rates are the highest of three different rates: a minimum floor rate; a blend of the county-specific rates existing before the Balanced Budget Act of 1997 and the national average rate, adjusted for local costs; or the previous year's rate increased by 2 percent. The floor and county-specific rates are updated each calendar year by the expected rate of increase in per-capita Medicare costs, minus specified percentage reductions from that rate of increase over the 1998-2002 period. The updated county rates are used to calculate a new national average and hence the new blended rates. The share of the national average rate in the blend will increase until reaching 50 percent local and 50 percent national rates some time after 2002. Finally, a "budget neutrality adjustment" is applied to the blended rates to ensure that the expected Medicare+Choice payments are the same as if all payments were completely based on local rates. That adjustment may either increase or lower the counties' rates depending upon interactions with other factors in the payment system.

The bill would eliminate the reductions from the national per capita growth rate for 2001 and 2002. In 2002, the bill would increase the floor payment rate from an estimated \$432 to \$450 and would allow plans to choose to be paid a 50:50 blend of local and national rates beginning in 2002. Between 2002 and 2005, the bill would establish a minimum update of 2.5 percent instead of 2 percent for counties served by one or fewer plans. The bill would

eliminate the budget neutrality adjustment beginning in 2003, and in 2004, would allow plans to negotiate a rate of payment with HCFA regardless of the county-specific rate, as long as the negotiated rate does not exceed the national average per-capita cost and does not increase more than the expected rate of increase for private insurance, minus the cost of prescription drugs. Finally, the bill would phase in implementation of improved methods of adjusting payments to reflect differences in health status, with full implementation delayed until 2013. CBO estimates that those provisions would increase Medicare outlays by \$4 billion over the 2001-2005 period and by \$13 billion over the 2001-2010 period.

Coverage of Drugs and Biologicals under Part B

The bill would expand the Part B outpatient drug benefit to include coverage of certain drug products that are not usually self-administered by the patient but are administered incident to a physician's service. CBO estimates that this provision would increase federal spending by \$0.7 billion over the 2001-2005 period and by \$1.3 billion over the 2001-2010 period.

SPENDING SUBJECT TO APPROPRIATION

The bill would establish the Medicare Benefits Administration to oversee the prescription drug benefit and to assume certain responsibilities of the Health Care Financing Administration. Subject to appropriation of the necessary amounts, CBO estimates those activities would increase federal spending by \$0.2 billion in 2001 and by \$5.4 billion over the 2001-2005 period. With the administrative costs of the coverage and appeals provision and the effect on federal purchasers of higher prices for prescription drugs (both described above), CBO estimates that enacting H.R. 4680 would increase discretionary spending by a total of \$6.6 billion over the 10-year period, assuming appropriation of the necessary amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	390	1,650	9,180	12,800	15,960	18,360	21,080	23,780	26,450	29,440
Changes in receipts	0	0	0	-2	-5	-10	-10	-15	-20	-25	-35

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs). This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs could result in a shift of premium payments away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues to states. CBO cannot estimate the magnitude of those losses because we have no basis for predicting the size of such shifts or the degree to which such plans would have been taxable in the absence of the preemption.

The bill includes a number of preemptions that would be intergovernmental mandates as defined by UMRA, but those preemptions would impose no costs on state, local, or tribal governments. Among the preemptions are protections from civil or criminal liability for certain federal contractors, waivers of state licensing requirements, and preemption of laws establishing minimum coverage requirements.

Other Impacts

CBO estimates that the bill would reduce state Medicaid spending by about \$3 billion over the 2001-2005 period and by \$19 billion over the 2001-2010 period. A number of factors would contribute to that reduction. State Medicaid programs would benefit as coverage responsibility for dual-eligibles shifts from Medicaid to PDPs for prescription drug coverage and to Medicare for cost-sharing subsidies. However, some savings would be offset by prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. As a result CBO estimates that net state spending for prescription drug coverage would decline by \$8 billion over the 2001-2005 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state revenues by \$3 billion over the same period. Additionally, increased

Medicaid enrollment and other changes are expected to increase state spending by \$1.6 billion over the 2001-2005 period.

As a condition of approval for their Medicaid plans, states would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare and would be required to transmit that information to the MBA. However, states have the ability to alter their programmatic and financial responsibilities for Medicaid to accommodate this additional determination requirement; consequently, this requirement would not be an intergovernmental mandate as defined in UMRA. Additional costs would total approximately \$0.3 billion over the 2001-2005 period. Costs would decrease over time because the matching rate from the federal government would increase annually until 2007 when it would reach 100 percent.

State and local governments that provide health insurance to their employees or retired employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in the costs of their health plans. Because CBO cannot predict how states would restructure the prescription drug component of their health plans, we cannot estimate the amount of such savings.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA (\$109 million in 2000, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On June 21, 2000, CBO produced a preliminary analysis of H.R. 4680, as modified in discussions with staff. That analysis concluded the bill would increase direct spending by \$38.6 billion over the 2001-2005 period and by \$155 billion over the 2001-2010 period. The current estimate is \$1.4 billion higher over the first five years and \$4 billion higher over the 10-year period. Two revisions in the committee-approved bill—the addition of the disease management project, and an increase in the updates to rates paid to Medicare+Choice plans in 2001 and 2002—increased the estimate by \$1.5 billion for the 2001-2005 period and by \$3.4 billion for the 2001-2010 period. The remaining differences are due to numerous refinements of estimating assumptions and to differences between specifications discussed

with staff and the legislative language in the reported bill and subsequently modified by the Manager's Amendment dated June 28, 2000.

This estimate includes one significant change in the display of the estimated cost of administering the low-income subsidy. The previous estimate combined the transfer from SMI to Medicaid for administering the low-income subsidy and the administrative spending that is funded through Medicaid. The current estimate displays those components separately.

The estimated impact on revenues is unchanged. The estimate of spending subject to appropriation was incomplete in the previous analysis.

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