

# Committee on Ways and Means

## Medicare Prescription Drug and Modernization Act of 2003

### *Medicare Modernization*

#### **Medicare Advantage**

##### Stabilization: 2004 and 2005

- Medicare+Choice would be renamed Medicare Advantage.
- Beginning in 2004, a payment option equal to the fee-for-service (FFS) rate (adjusted to include expenditures in VA or DoD facilities for services received by Medicare beneficiaries and indirect medical education costs) would be added.
- Medicare Advantage rate increases would equal *the greater of* the growth in Medicare per capita costs or 2 percent.
- All Medicare Advantage plans would be required to offer disease management one year after date of enactment.

##### Competition in 2006

- Plans would bid against a benchmark, equal to the Medicare Advantage rate.
- If the plan bid is less than the benchmark, the beneficiary would get 75% of the savings, and the government would retain 25%. If the plan bid is greater than the benchmark, the beneficiary would pay the excess to the plan and the government would pay the plan the benchmark amount.
- The Congressional Budget Office assumes that plans will bid their costs. Competitive bidding reduces costs because the government savings, generated when bids are below benchmarks, exceed increased costs from higher benchmarks.
- Beneficiaries in traditional Medicare would be unaffected.

#### **Enhanced Fee-for-Service Option**

- The country would be divided into at least 10 regions in 2006.

- Private enhanced fee-for-service (EFS) plans (preferred provide organizations (PPOs) or FFS plans) would bid to offer the standard Medicare benefit package, and must offer coverage to all beneficiaries in the entire region.
- Plans would bid against a benchmark equal to the *average* of the Medicare Advantage rates in the region.
- Beneficiaries choosing EFS plans with bids below the benchmark would share in the “savings” with the government, with beneficiaries getting 75% of the savings and the government getting 25%. Beneficiaries choosing EFS plans with bids above the benchmark would pay the excess.
- All EFS plans would be required to offer disease management, a single deductible and limit on out-of-pocket expenses. Enrollees would be prohibited from purchasing a Medigap policy.
- All EFS plans would be required to charge a uniform premium and cost-sharing throughout the region.

### **FEHBP-Style Medicare Reform in 2010**

- In 2010, FEHBP-style competition would begin nationwide in competitive areas.
- Entitlement to Medicare’s defined benefit would not be affected in any way.
- Competitive areas would be defined as having at least two private plans offered by different organizations – either two Medicare Advantage or two EFS plans – and private plan enrollment in the area at least as great as private plan enrollment nationwide. Competitive Medicare Advantage areas would be limited to metropolitan statistical areas or areas with substantial numbers of Medicare Advantage enrollees.
- An area that does not meet these criteria would not be affected in any way.
- In competitive areas:
  - Private plans would submit bids for covering standard Medicare benefits. The Medicare Benefits Administrator would calculate the costs of traditional FFS Medicare in the area. All bids and the traditional FFS amount would be adjusted fully to take into account the demographic and health status risk factors for the typical beneficiary residing in the area.
    - The competitive benchmark would be set at the weighted average of all plan bids and the traditional FFS amount in the competitive area. The weight for traditional FFS Medicare would equal the nationwide proportion of Medicare beneficiaries enrolled in traditional FFS Medicare,

or the regional proportion if higher. The weight for private plans would equal the national proportion of beneficiaries enrolled in private plans, or the regional proportion if lower. This policy would provide traditional FFS with a disproportionate influence in establishing the weighted average benchmark. In most cases, the national FFS market share will be greater than the local FFS market share. This would mitigate premium changes.

- For private plans, this competitive benchmark would be blended with the older, pre-2010 benchmark for the area over a 5-year period to provide a transition to a more competitive system.
- Beneficiaries enrolling in plans with bids below the benchmark would receive 75 percent of the savings, and the government would get 25 percent. Beneficiaries enrolling in plans with bids above the benchmark would pay the excess.
- Changes for FFS beneficiary premiums would be phased-in over a 5-year period.
- The traditional FFS beneficiary premium would be unaffected in non-competitive areas. In order to be classified as a non-competitive area, the following criteria must be met:
  - The area lacks two Medicare Advantage or two EFS plans, or plans with lack to meet minimum enrollment standards;
  - The private plans' market share in the area is lower than the private plans' market share nationwide (unless the private plans' market share in the area is 20 percent or higher); or,
  - In the case of Medicare Advantage areas, the area is neither a metropolitan statistical area nor an area with a substantial number of Medicare Advantage enrollees.