CBO TESTIMONY

Statement of
Douglas Holtz-Eakin
Director

Estimating the Cost of the Medicare Modernization Act

before the
Committee on Ways and Means
U.S. House of Representatives

March 24, 2004

This statement is embargoed until 1:00 p.m. (EST) on Wednesday, March 24, 2004. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Thomas, Congressman Rangel, and Members of the Committee, I am pleased to be here with you today. I understand that one purpose of this hearing is to discuss the Trustees' 2004 reports for Social Security and Medicare that were released yesterday and to assess the impact of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) on Medicare's long-term financial condition. To help provide a basis for that assessment, I will focus my remarks on the Congressional Budget Office's (CBO's) estimate of the MMA's cost over the next 10 years and on the differences between that estimate and the Administration's estimate for that same period. The MMA was a very complex piece of legislation containing many provisions, and CBO's modeling of its costs was correspondingly complex. Rather than try to explain the scoring for all of its provisions, I will concentrate on the two sections of the act that account for nearly all of the net difference between those two estimates: the new prescription drug benefit and the revised payment system for managed care plans under Medicare.

CBO's Cost Estimate

CBO has estimated that the MMA will increase mandatory outlays by $395 billion over the 2004-2013 period. Anytime a complex and substantially new program is created, predicting the outcome precisely is difficult, but CBO's estimate was the result of extensive analyses of the pharmaceutical market, the Medicare program, the costs of managed care plans, and the likely responses of potential enrollees. To date, CBO has not received any additional data or studies that would lead the agency to reconsider its conclusions. Therefore, CBO believes that its budgetary estimate is sound and has no reason to revise it.

Table 1 shows the major components of CBO's 10-year cost estimate. The provisions of the MMA that established a prescription drug benefit under Part D of Medicare were estimated to increase mandatory spending by $409 billion on net. Title II of the act, which altered the payment system for managed care plans under Part C of Medicare—and also changed the name of that program from Medicare+Choice to Medicare Advantage—was estimated to cost $14 billion through 2013. (The net costs of providing the new drug benefit to enrollees in Medicare's managed care plans were included in the $409 billion estimate for the Part D provisions.) All of the legislation's other provisions, which primarily involve the traditional Medicare fee-for-service (FFS) program, were estimated to reduce net outlays by $28 billion.

Although Table 1 shows the MMA's impact on mandatory spending, a complete estimate of the overall budgetary impact of the legislation must also consider its effect on revenues. CBO estimated that the various revenue effects of the MMA's provisions were largely offsetting. According to the Joint Committee on Taxation, the law would reduce revenues by about $7 billion over 10 years, primarily as a result of provisions to allow qualified taxpayers to establish health savings accounts. At the same time, CBO estimated that the Medicare drug benefit provisions would have the effect of increasing revenues by about $7

Table 1.

Major Components of CBO's Cost Estimate for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(Billions of dollars)

	Mandatory Spending, FY 2004-2013
Prescription Drug Benefit Provisions[a]	409
Medicare Advantage Provisions	14
All Other Provisions	-28
Total	**395**

Source: Congressional Budget Office.

a. Includes mandatory spending for administration of Part D (in title X of the MMA) and interactions with the Hatch-Waxman Act and importation provisions in title XI; excludes the interaction of Part D with Medicare spending for benefits under Parts A and B (which is included in the estimate for "All Other Provisions"). Those factors account for the difference between the $409 billion estimate for the prescription drug benefit provisions shown above and CBO's $410 billion estimate for title I of the MMA.

billion, as businesses would reduce expenditures on nontaxable health benefits and increase them on taxable forms of compensation. By contrast, the Administration estimated that the health savings account provisions would result in a revenue loss of about $17 billion over the 2004-2013 period and to date has not estimated an indirect effect on revenues resulting from the Medicare drug benefit. While the overall assessment of the MMA's impact on federal deficits or surpluses must take into account all of its effects on spending and revenues, the focus today is on CBO's outlay estimates and how they differ from the Administration's estimates as developed by the actuaries at the Centers for Medicare and Medicaid Services (CMS). Accordingly, I will devote the remainder of my testimony to the main factors affecting estimated outlays for the new prescription drug benefit and for the revised payment system for managed care plans.

Costs for the Part D Prescription Drug Benefit

CBO's $409 billion estimate for the net costs of providing the prescription drug benefit under the MMA can be separated into several components, as shown in Table 2. Under the law, CBO projected, stand-alone prescription drug plans and

Table 2.

Components of CBO's Cost Estimate for the Medicare Prescription Drug Benefit

(Billions of dollars)

	Mandatory Spending, FY 2004-2013
Payments to Medicare Drug Plans for Basic Benefits	507
Beneficiary Premium Payments	-131
Employer and Union Subsidies	71
Low-Income Subsidies	192
Federal Medicaid Spending	-142
Transfers from State Medicaid Programs	-88
Effects on Other Federal Programs	-2
Total	**409**

Source: Congressional Budget Office.

Note: Numbers may not add up to totals because of rounding.

integrated health plans under Medicare would incur costs of $507 billion through 2013 to provide the basic statutory drug benefit. Those costs would be partially offset by $131 billion in premium payments made by or on behalf of enrollees. Separate payments to employer-sponsored and union plans providing qualified drug coverage to Medicare-eligible retirees would amount to an additional $71 billion. The law also subsidizes additional drug coverage for certain low-income enrollees, and CBO estimated that those subsidies would cost $192 billion over the 2004-2013 period (including about $1 billion to provide assistance with drug costs in conjunction with the drug discount card program that will operate from mid-2004 through December 2005).

CBO also estimated that the Part D prescription drug benefit provisions would reduce other federal outlays in a number of ways. Transferring responsibility for the prescription drug benefits of "dual eligibles" from Medicaid to Medicare would save the federal government an estimated $152 billion in Medicaid spending through 2013. (Dual eligibles are Medicare beneficiaries who are also eligible for full Medicaid benefits.) Those savings would be partly offset by an

additional $10 billion in federal outlays for Medicaid resulting from the new law's drug benefit provisions—largely owing to additional spending on benefits for Medicare beneficiaries who would enroll in Medicaid as a result of applying for the low-income drug subsidy program. Thus, net federal Medicaid savings were estimated at $142 billion over 10 years. In addition, the MMA contains a provision that will recapture a portion of the corresponding savings for states on Medicaid drug expenditures, which CBO estimated would reduce federal costs by $88 billion. Finally, the Medicare drug benefit will on net reduce mandatory spending for the Federal Employees Health Benefits (FEHB) program and other federal programs that pay for prescription drugs by about $2 billion.

CBO's cost estimates for prescription drug benefit proposals were based on an analytic structure and a microsimulation model that projects how those proposals would affect a representative sample of Medicare beneficiaries. CBO has used that basic approach to estimate the costs of proposed Medicare prescription drug benefits since 1999, updating it each year to account for new data and refining it to address new provisions. The microsimulation model contains detailed information about beneficiaries' spending for prescription drugs, their supplemental insurance coverage (both public and private), their health status, and their income. The information on drug spending used by CBO is based on data from the 1999 and 2000 Medicare Current Beneficiary Survey, projected forward using CBO's March 2003 economic and technical assumptions—including projected growth rates for drug spending that reflected the most recent CMS estimates for national health expenditures.

Costs and Premiums for Medicare Drug Plans. Estimating the costs of providing the basic drug benefit under Medicare involved three basic steps: (1) estimating the number of beneficiaries who would enroll in a Medicare drug plan; (2) estimating the average costs of providing those enrollees with covered benefits (including the administrative costs of doing so); and (3) using the resulting estimate of gross costs to calculate the offsetting premium receipts that would result from the statute's subsidy formulas. Because of the myriad provisions in the law that could affect each of those steps—particularly the costs per enrollee—CBO had to develop a relatively sophisticated modeling capability. Even so, the primary drivers of federal costs remain the drug benefit's design and the premium subsidy (with that subsidy not only determining how gross costs are allocated between enrollees and the government but also affecting participation in such a voluntary program).

In large measure, CBO based its estimates of program enrollment for the drug benefit on the experience of Medicare Part B. Part B is a voluntary program that has a 75 percent premium subsidy and a substantial penalty for late enrollment; as a result, most but not all Medicare beneficiaries who are eligible for Part B enroll in it. Part D's provisions are quite similar—it is a voluntary program with a 74.5

percent average premium subsidy and significant late-enrollment penalty—and the provisions strongly encourage beneficiaries to enroll when they are first eligible to do so, even if their drug spending is relatively low at the time. Nevertheless, CBO assumed that active workers with drug coverage and some federal retirees would not enroll in Part D, even if they were enrolled in Part B, because the value of any additional drug benefits they would receive would be less than the added premiums they would pay; those projected nonparticipants represent about 7 percent of all Medicare beneficiaries. CBO also assumed that the roughly 6 percent of beneficiaries who are enrolled in Medicare Part A but do not elect to enroll in Part B (some of whom are also active workers) would generally choose not to enroll in Part D. In sum, CBO estimated that 87 percent of all Medicare beneficiaries would participate in the drug benefit in some manner—with about 68 percent enrolling in a Medicare prescription drug plan and the remaining 19 percent receiving drug coverage through a former employer that would be subsidized directly by Medicare.

To estimate costs per enrollee, CBO started with a projection of total outpatient drug spending by the Medicare population in the absence of a new Medicare benefit. That total was then adjusted by several discrete factors:

- a "price effect" to reflect the likelihood that average drug prices will be slightly higher because beneficiaries who currently lack drug coverage will become insulated from those prices;

- a "use effect" to capture changes in demand for drugs resulting from changes in beneficiaries' cost-sharing liabilities (so that their total drug use would increase somewhat if their own out-of-pocket costs fell);

- an adjustment to reflect the degree to which Medicare drug plans will manage the costs of their enrollees (discussed further below); and

- a slight decrease in spending due to the fact that prices negotiated by Medicare drug plans will be exempt from the Medicaid "best price" provision—an exemption that gives those plans more leeway to negotiate steeper price discounts from manufacturers because they will not have to pass on the same discount to Medicaid.

It is important to emphasize that, although CBO sought to model each of those factors separately, they have offsetting impacts and the net effect on drug spending or its components will reflect all of them simultaneously.

In estimating the degree of cost management that Medicare drug plans would achieve on average, CBO focused on three main considerations: the incentives that plans would have to control costs (based on the degree of financial risk they

would face); the "tools" that they could use to control spending (such as preferred drug lists and pharmacy networks); and the degree of competition they would face (as expressed through differences in beneficiary premiums and cost-sharing levels among drug plans). Plans bearing meaningful financial risk would lose money if their costs of providing benefits exceeded expectations and thus would have strong incentives to limit those costs as much as possible while still attracting enrollees—but CBO assumed that they would also have somewhat higher administrative costs as a result. A plan's ability to act on those incentives will depend on what mechanisms it can use to secure price discounts and to encourage beneficiaries to use less costly therapeutic alternatives, though trade-offs could arise between the steps they take to control costs and the ease with which enrollees can obtain the drugs of their choice. The extent to which beneficiaries save on their premium by joining a less expensive drug plan is also an important consideration: it provides an incentive for plans to keep their costs low over time to attract and retain enrollees, and it encourages beneficiaries to consider whether the extra premium of a more costly plan is worth paying.

To summarize the effects of incentives and tools on cost management, CBO estimated the "gross drug savings" that would be expected, on average, for a given proposal. Those gross drug savings represent the degree to which costs would be reduced compared with an unmanaged benefit (such as a traditional indemnity insurance plan), and they combine three types of savings from management: savings due to price discounts or rebates from manufacturers and pharmacies; savings from controlling overall drug use; and savings due to changing the mix of drugs used. For the MMA, CBO estimated that drug plans bearing the full level of financial risk as specified by the statute would achieve average gross savings of 20 percent initially, growing to 25 percent over the budget window. That path reflects the gradual widening of the statute's "risk corridors," which will expose plans to greater financial risk over time.[1] For beneficiaries whose current drug spending already reflects some degree of cost management, however, that spending was adjusted only to capture the incremental savings that would be achieved. CBO also assumed that there was some probability that beneficiaries would be enrolled in reduced-risk or "fallback" drug plans as specified by the law; in those cases, CBO estimated lower gross savings owing both to the reduced financial risk those plans would face and to the less competitive environment in which they would operate.

After applying those adjustments to determine total drug spending by enrollees, CBO estimated the gross costs of providing the drug benefit by applying the

1. Under the MMA's risk-corridor provisions, prescription drug plans whose costs turn out to be somewhat higher than expected will see an increasing share of those costs covered by additional federal payments, while plans with actual benefit costs that are below expected levels will essentially have to reimburse Medicare for a corresponding share of the savings.

statute's benefit-design provisions and adding an estimate of the administrative costs that drug plans would incur. Rather than review all aspects of the benefit design, let me focus on two key features. First, with certain exceptions, the benefit's catastrophic threshold—above which about 95 percent of drug costs are covered—is determined by out-of-pocket costs actually incurred by enrollees. That feature, which is often referred to as the "true out-of-pocket" provision, has the effect of targeting federal assistance to those who lack additional drug coverage. By the same token, though, such coverage is implicitly penalized because the costs that it covers do not count toward reaching the catastrophic threshold.[2] As a consequence, federal costs will depend in part on the extent and sources of any supplemental drug coverage that enrollees may have.

A second key determinant of federal costs is that the standard benefit's deductible, initial coverage limit, and catastrophic threshold are indexed to the projected growth rate in per capita drug expenditures for the Medicare population. As a result, that benefit will, on average, cover about the same share of enrollees' drug costs each year. Table 3 shows CBO's projections for each of those benefit parameters through calendar year 2013 as well as the associated levels of beneficiaries' cost-sharing liabilities or total drug spending. As the table suggests, CBO estimates that per capita drug spending for Medicare beneficiaries will increase at an average annual rate of nearly 9 percent from 2006 to 2013.

Table 3 also shows CBO's estimate of the average monthly premium per beneficiary for each calendar year (which reflects not only covered benefits but also administrative costs, and thus grows somewhat more slowly than the benefit parameters). Although the MMA's subsidy formulas are complex—specifying both a fixed "direct" subsidy and a reinsurance subsidy that varies with spending above the catastrophic threshold—and beneficiaries' premiums will depend on what drug plan they join, CBO estimated average premiums by applying the 74.5 percent average subsidy to average gross costs.

Finally, by multiplying the average gross cost of providing the drug benefit and the average premium by the number of enrollees, CBO generated estimates of total calendar year obligations and receipts; converting those figures into fiscal year outlays yielded CBO's estimates of $507 billion in payments to drug plans, offset by $131 billion in premium receipts, as shown in Table 2.[3]

---

2. In addition, Medigap policies that cover cost sharing for other Medicare benefits are prohibited from including supplemental drug coverage for Part D enrollees, so enrollees desiring such coverage would have to obtain it from another source (such as a former employer or their Medicare drug plan).

3. CBO's estimate of premium collections assumes that all enrollees have their Part D premiums withheld from their Social Security checks, but net federal outlays would be the same if beneficiaries chose to pay those premiums directly to their drug plans instead since federal payments to those plans and premium receipts would be reduced dollar for dollar.

Table 3.

Standard Drug Benefit Design and Estimated Monthly Premiums

	Calendar Year							
	2006	2007	2008	2009	2010	2011	2012	2013
Annual Deductible	$250	$275	$300	$325	$350	$380	$410	$445
Coinsurance Between Deductible and Initial Coverage Limit (Percent)	25	25	25	25	25	25	25	25
Initial Coverage Limit								
Program spending at limit	$1,500	$1,646	$1,808	$1,946	$2,115	$2,265	$2,460	$2,666
Beneficiary spending at limit	$750	$824	$903	$974	$1,055	$1,135	$1,230	$1,334
Total spending at limit	$2,250	$2,470	$2,710	$2,920	$3,170	$3,400	$3,690	$4,000
Coinsurance Between Initial Coverage Limit and Catastrophic Threshold (Percent)	100	100	100	100	100	100	100	100
Catastrophic Threshold								
Out-of-pocket spending at threshold	$3,600	$3,950	$4,350	$4,650	$5,050	$5,450	$5,900	$6,400
Total spending at threshold[a]	$5,100	$5,596	$6,158	$6,596	$7,165	$7,715	$8,360	$9,066
Coinsurance above threshold (Percent)[b]	5	5	5	5	5	5	5	5
Average Monthly Premium	$35	$37	$41	$43	$47	$49	$54	$58

Source: Congressional Budget Office.

Note: Numbers may not add up to totals because of rounding. Benefit parameters shown here reflect the legislation's rounding rules.

a. Represents total spending at the catastrophic threshold for individuals without other drug coverage.
b. For 2006, cost sharing will be the greater of 5 percent coinsurance or a copayment of $2 (for generic and multiple-source drugs) or $5 (for single-source drugs); after 2006, the $2 and $5 amounts are also indexed.

Participation and Costs for Employer and Union Subsidies. Currently, a substantial share of Medicare beneficiaries receive coverage for their drug costs through a former employer. As I have noted, though, the extent to which enrollees will reach the standard Medicare drug benefit's catastrophic threshold depends on whether they have such supplemental coverage for their Part D cost sharing. If retirees with such coverage enroll in a Medicare drug plan, therefore, their impact on federal costs will depend on the extent to which their former

employer supplements that coverage. The MMA also establishes an additional option for employer and union plans that provide retirees with qualified drug coverage: employers that take that option will receive a tax-free payment directly from Medicare equal to 28 percent of total drug costs in a specified dollar range. To project what federal costs will be, CBO thus had to estimate not only the extent of the drug coverage that those retirees would have but also the mechanism through which that coverage would be subsidized.

Under the MMA, CBO estimated, average federal subsidy payments on behalf of retirees would generally be greatest if they enrolled in a Medicare drug plan and received the basic drug benefit with no supplemental drug coverage. Medicare's average subsidy payment would be reduced if those retirees were instead provided generous wraparound coverage by their former employer; in that case, retirees would not likely reach the basic benefit's catastrophic threshold for out-of-pocket costs. CBO also estimated that the direct payments from Medicare to employer and union plans would be about the same, on average, as the net subsidies that retirees would generate if they enrolled in a Medicare drug plan and retained a generous employer wraparound policy. In other words, those direct Medicare payments to employer and union plans would also be lower, on average, than the net subsidies for retirees who were enrolled in Medicare drug plans and had no additional drug coverage.

Although the favorable tax treatment accorded to those direct payments would make that approach somewhat more attractive, CBO nonetheless concluded that the difference in subsidies under the MMA gives employers a new financial incentive to drop prescription drug coverage for Medicare-eligible retirees. In its estimates, CBO did not assume that all employers would respond to that financial incentive but did project that 2.7 million Medicare-eligible retirees who would have had more generous employer drug coverage in 2006 in the absence of a Medicare drug benefit would not see their former employer supplement the basic Part D benefit. In those cases, it would make most sense for those retirees to enroll in a Medicare drug plan (with their former employer potentially choosing to pay their Part D premium as a means of compensation). At the same time, CBO assumed that nearly all of the remaining retirees with employer-sponsored drug coverage—about 8 million individuals in 2006—would see their employer take the direct subsidy payment from Medicare, both because of its tax advantages and for reasons of administrative simplicity. CBO's estimate of $71 billion in direct subsidy payments reflects the share of drug spending by those retirees that is projected to fall in the covered range.

Participation and Costs for Low-Income Subsidies. The MMA established two levels of additional drug benefits for enrollees with sufficiently low income and countable assets: a more generous subsidy for beneficiaries who are either dually eligible for full Medicare and Medicaid benefits or have income below 135 percent of poverty and low assets; and a somewhat less generous subsidy for

those with income below 150 percent of poverty and assets below a slightly higher limit. On the basis of an analysis of both administrative and survey data, CBO estimated that 35 percent of Medicare beneficiaries would be eligible for low-income subsidy benefits under the MMA; about 30 percent would be eligible for the more generous subsidy; and 5 percent would qualify for the less generous subsidy.

At the same time, CBO projected that a significant proportion of the eligible population would not apply for the low-income subsidies. CBO's estimate of the number of people who would sign up for low-income subsidies was based on several factors, including historical participation in the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs. The QMB and SLMB programs pay some or all of the premiums and cost sharing under Parts A and B of Medicare for beneficiaries with incomes below 120 percent of the poverty level and limited assets. In those programs, many beneficiaries who are eligible do not enroll. CBO assumed that participation in the low-income subsidy would be somewhat greater than that for other welfare-related programs, however, because MMA allows individuals to enroll at offices of the Social Security Administration.

CBO also estimated that the share of eligible beneficiaries receiving low-income subsidies would rise gradually after the implementation of the Medicare drug benefit. (Unlike the basic drug benefit, which penalizes individuals for late enrollment, the additional low-income subsidies are available at any time with no penalty to Part D enrollees.) Ultimately, CBO assumed that almost 70 percent of those eligible would receive low-income subsidies under the MMA. About 75 percent of those eligible for the more generous subsidy would receive it, while about 35 percent of those eligible for the less generous subsidy would receive that benefit. Participation rates for the more generous subsidy would be much higher because they would include all dual eligibles, who would participate in the drug benefit by default.

In estimating the costs of the subsidy payments, CBO also assumed that participants would generally have higher average drug costs than beneficiaries who were eligible for those subsidies but chose not to enroll—that is, some adverse selection will occur. The total estimated cost of $192 billion for the low-income subsidies over 10 years also includes the costs of covering the enrollment fees and providing up to $600 of assistance for certain low-income beneficiaries in conjunction with the Medicare drug discount card. For that transitional assistance program, which is scheduled to operate from mid-2004 through December 2005, CBO assumed relatively low take-up—specifically, that about 20 percent of eligible Medicare beneficiaries or about 3 percent of all beneficiaries would enroll—because of its limited benefits and temporary nature. (As an accounting matter, the costs of the low-income subsidies also include the

costs of paying all or a portion of enrollees' Part D premiums, rather than treating those subsidy payments as reductions in the premium receipts specified above.)

Offsetting Federal Savings. Although this testimony has focused on the various costs of providing the drug benefit under Medicare, the MMA's provisions will also generate offsetting federal savings, both implicitly and explicitly:

- Transferring responsibility for the prescription drug benefits of dual eligibles from Medicaid to Medicare will save the federal government an estimated $152 billion in Medicaid spending through 2013. Those savings will be partly offset by an additional $10 billion in federal Medicaid outlays stemming from the new law's drug benefit provisions—largely from additional spending on benefits for Medicare beneficiaries who will enroll in Medicaid or the QMB and SLMB programs as a result of applying for the low-income drug subsidy program.

- Absent other provisions, those federal Medicaid savings would be accompanied by corresponding savings for the states on their Medicaid costs. The MMA's "clawback" provision, however, will recapture a substantial portion of the states' estimated drug savings, which CBO estimated would further reduce federal costs by $88 billion.

- Finally, CBO estimated that some federal retirees will enroll in a Medicare drug plan; as a result, a portion of their prescription drug costs will be indirectly shifted to Medicare (and is included in the figures provided above). Based on that impact, as well as small effects on other federal programs that pay for prescription drugs, CBO estimated that the Medicare law's drug benefit provisions would reduce mandatory federal spending by about $2 billion.

Costs for Medicare Advantage Plans

The MMA's provisions affecting private health plans under Medicare are also quite complicated, so again I will attempt to summarize the key features that affected their scoring. Currently, those health plans—which are primarily health maintenance organizations (HMOs) participating on a county-by-county basis—are required to provide Part A and Part B benefits and are paid on the basis of a statutory formula. To the extent that Medicare's payments exceed their costs of providing the required benefits, plans must presently give the difference to beneficiaries through some combination of additional benefits and premium rebates. To the extent that plans choose to provide premium rebates, the Medicare program retains 20 percent of the difference and the beneficiaries receive the other 80 percent, but if plans provide additional benefits, no such "tax" is imposed. As a result, very few plans offered premium rebates in 2003 (the first year that such rebates were permitted) or 2004. The past few years have

also seen a number of plans withdraw from the program, reduce their service areas, or lose enrollees; in part that has occurred because plan costs have grown more rapidly than payment rates, making it more difficult for plans that remain in the program to attract enrollees by offering extra benefits. Prior to passage of the MMA, CBO projected that the share of Medicare beneficiaries in private plans would decline from the current level of 13 percent to about 8 percent.

For 2004 and 2005, the MMA largely retained the existing payment system for private health plans but increased the payment rates (and changed the name of the program from Medicare+Choice to Medicare Advantage). Starting in 2006, however, a revised system will be instituted. The statutory payment rate will be relabeled as the "benchmark" amount, and plans will submit bids that reflect the costs they expect to incur in providing Part A and Part B benefits. Medicare will pay plans their bids plus 75 percent of the amount by which the benchmark exceeds the bid. Plans must then return that 75 percent to beneficiaries, either as additional benefits or as a rebate on their Part B or Part D premium. Thus, the essential change from current requirements is that—instead of retaining part (20 percent) of the difference between a plan's cost and the statutory payment rate only if the plan returns that difference to beneficiaries as a premium rebate—Medicare will retain part (25 percent) of that difference regardless of whether the plan provides additional benefits or premium rebates.

The MMA also established new rules for preferred provider organizations (PPOs) that operate on a regionwide level; and to encourage participation by those plans, it set up a stabilization fund with an initial balance of $10 billion. Such plans could be offered starting in 2006, and they will generally be subject to the same rules as county-based plans (though the benchmarks for the regional PPOs will be a weighted average of the benchmarks for county-based plans in their region and the bids submitted by the PPOs). Starting in 2010, the MMA also authorized "comparative cost adjustment" demonstration projects in up to six areas of the country; under those demonstrations, the bids of private plans would affect not only the benchmark for the area but also the Part B premium for enrollees in the traditional fee-for-service program in that area.

In analyzing proposals regarding private health plans in Medicare, CBO focused on three factors: the costs those plans would incur, the payments Medicare would make, and the resulting incentives for beneficiaries to enroll—all of which were compared with the status quo. To estimate private plan costs for providing Medicare benefits, CBO examined data on the experience of existing HMOs in Medicare; data comparing payments to doctors and hospitals by private plans and by the Medicare FFS program; and data comparing commercial HMO and PPO costs. One important consideration was that, even though Medicare payment rates in many areas exceed the local average cost of providing benefits in the traditional FFS program, private plans that must negotiate fees with their providers are not offered in those areas. It thus seemed reasonable to infer that, if

such plans were made available in those areas, their costs would probably equal or exceed both the Medicare payment rate and local FFS costs. CBO also projected that private plan costs would continue to grow somewhat more quickly than costs in the traditional FFS program for the next few years before converging to the same growth rate.

The upshot of CBO's analysis of the MMA's provisions was that regional PPOs would generally have difficulty providing Medicare benefits at costs that were much less than the benchmarks to which they would be compared. Correspondingly, even in the areas where those plans might become available, beneficiaries would not see substantial premium rebates or extra benefits and thus would have only limited incentives to leave FFS programs and enroll in PPOs. While there would also be some additional enrollment in county-based plans because of the immediate increase in payment rates (and the correspondingly higher benchmarks after 2005), CBO estimated only a small increase in the overall share of beneficiaries enrolled in private plans as a result of the MMA's provisions—and did not ultimately distinguish whether those additional enrollees would be in county-based plans or regional PPOs. CBO's final cost estimate reflected not only the additional costs of those new enrollees (relative to their costs in the FFS program), but also the net costs of the higher payment rates and the revised payment system for beneficiaries already enrolled in private plans.

The $14 billion cost estimate for the MMA's title II provisions included several other components as well. CBO projected modest savings ($0.3 billion through 2013) from the comparative cost adjustment demonstration and offsetting modest costs for a set of other provisions (primarily affecting specific types of plans or payments). More significantly, CBO also assumed that the sums available in the PPO stabilization fund would be spent but did not explicitly model the effect of that spending on beneficiary enrollment (since in that case, estimated spending would not be a function of enrollment).[4]

4. Recently, CBO increased its ultimate projection of private plan enrollment from 9 percent to about 13 percent of the Medicare population, but that change has only a negligible effect on federal costs because most of the additional enrollment is projected to occur in areas where the payment rates and benchmarks are based on the local average of costs in the FFS program; in those instances, having an enrollee switch from the FFS program into a private plan does not substantially change federal outlays.

Comparison with the Administration's Cost Estimate

Having laid out the basis for CBO's estimate, I can now discuss how it compares with the Administration's estimate. While the differences between those estimates are of obvious interest to Members, they should not overshadow similarities in some of the assumptions underlying our respective projections. Regarding the drug benefit, both CBO and the Administration have assumed that private drug plans will be generally available to provide benefits starting in 2006. We have both assumed broad enrollment by beneficiaries in the basic drug benefit and lower take-up rates for the low-income subsidies. We have both assumed that a substantial minority of retirees who now have drug coverage through a former employer will see that employer choose not to supplement the basic Medicare benefit. And we have both assumed that the drug benefit and clawback provision will generate significant offsetting federal savings via Medicaid. Nevertheless, because the aggregate level of projected drug spending by Medicare beneficiaries is so large—$1.6 trillion between 2006 and 2013, according to CBO estimates—seemingly small differences in the magnitude of those assumptions can translate into large dollar discrepancies.

Table 4 summarizes CBO's understanding of the differences in outlays between the two cost estimates for the Medicare Modernization Act. As you know, the Administration estimated that the MMA would increase net federal outlays for mandatory spending by $534 billion for fiscal years 2004 to 2013, a difference of $139 billion from CBO's estimate for that period. The Administration's estimate is $101 billion higher than CBO's for the drug benefit provisions, and $32 billion higher for the Medicare Advantage provisions. While the estimates for other provisions may have differed somewhat, the net difference in mandatory outlays for those provisions (about $6 billion) is relatively small.

As shown in Table 4, the difference of $101 billion in estimates for the drug benefit has three major components. First, about one-third of that discrepancy ($32 billion) is due to differences in our estimates of total payments to Medicare drug plans for the basic drug benefit (net of beneficiary premiums) and payments to qualified employer and union plans. CBO estimates that those net payments will sum to $448 billion, while the Administration's estimate (excluding intragovernmental transfers) is $479 billion. (The difference between those numbers rounds to $32 billion.)

One source of that difference is that the Administration assumed higher overall participation in the drug benefit—specifically, that 94 percent of all Medicare beneficiaries would enroll. The discrepancy with CBO's estimate of 87 percent participation would appear to account for the entire $32 billion difference in costs, but the Administration's participation figures include a number of federal retirees who would generate intragovernmental transfers that would not count as outlays (for example, from Medicare to FEHB). If those participants are

Table 4.

Differences Between Cost Estimates for the Medicare Modernization Act

(Billions of dollars)

	Mandatory Outlays, FY 2004-2013		
	Administration Estimate	CBO Estimate	Difference (Administration minus CBO)
Drug Benefit Provisions			
Net payments to drug plans and employer/union subsidies	479 [a]	448	32
Low-income subsidies	239	192	47
Federal Medicaid spending	-123	-142	18
Other provisions and effects	-85	-89	4
Subtotal	510	409	101
Medicare Advantage Provisions	46	14	32
Net, All Other Provisions	-23	-28	6
Total	**534** [a]	**395**	**139**

Source: Congressional Budget Office.

Note: Numbers may not add up to totals because of rounding. The figures shown here exclude effects on federal revenues, which in combination with the impact on outlays determine the total effect of the legislation on federal budget deficits or surpluses.

a. Figures shown here for the Administration's estimate exclude $16 billion in intragovernmental transfers from Medicare to federal employers, which do not count as outlays.

subtracted to get a more comparable measure of enrollment, the difference between CBO's estimated participation rate and the Administration's is smaller—about 3 percent to 4 percent. The principal difference that remains appears to involve Medicare enrollees who decline Part B but are not active workers; CBO assumed they would generally not participate in Part D (for the reasons already outlined), but the Administration assumed that they would enroll.

The Administration also estimated that per capita costs for the basic drug benefit would be about 4 percent higher than CBO's estimates throughout the period. As my testimony has indicated, costs per capita reflect a variety of provisions and assumptions about the effects of those provisions, so it is difficult to isolate any single factor as the basis for that difference—but CBO's understanding is that the

Administration projected slightly lower benefit costs and slightly higher administrative costs. Overall, the differences in number of participants and costs per capita each account for about half of the $32 billion difference in the estimated costs of providing the basic drug benefit.

The second major difference regarding the drug benefit involves the estimates of participation and costs for the low-income subsidies, which account for nearly half ($47 billion) of the overall difference. Here too it appears that the Administration assumed higher take-up of the subsidies, as well as modestly higher costs per participant. Specifically, the Administration estimated that the number of enrollees in the subsidy program after 2009 would be 13 percent to 15 percent higher than CBO projected. The difference is even larger (in percentage terms) for the initial years because CBO assumed that participation would increase gradually to its ultimate level while the Administration used a roughly constant take-up rate. The Administration's estimate of per capita costs is also higher than CBO's, but that disparity shrinks from about 7 percent to 10 percent initially to about 4 percent by 2013.

The third major difference regarding the drug benefit involves savings to Medicaid, which the Administration estimated would be $18 billion lower than CBO's estimate. On net, that difference appears to reflect diverging estimates of what federal Medicaid spending on prescription drugs for Medicare beneficiaries would have been under prior law. In particular, CBO's baseline estimate included $18 billion in federal spending on waiver programs that provide limited drug coverage to low-income Medicare beneficiaries. At the same time, CBO assumed that federal spending on those waiver programs would end once the Part D benefit was implemented—both because Medicaid drug coverage for many of those enrollees would effectively be replaced by the Medicare benefit and low-income subsidies and because Medicaid would generally be precluded from using federal funds to supplement those drug benefits. Consequently, CBO's estimate of the federal savings resulting from the MMA was $18 billion higher than the Administration's estimate.

The other major component of the $139 billion difference in cost estimates—payments to Medicare Advantage plans under title II of the MMA—accounts for $32 billion of the overall difference. That is, CBO estimated that those provisions would increase federal outlays by $14 billion over the period, while the Administration projected a $46 billion increase. As CBO understands it, the basis for the discrepancy lies primarily in differing estimates of the per capita costs that regional PPO plans would incur in providing Medicare's Part A and Part B benefits. The Administration's estimates appear to be based at least in part on a recent PPO demonstration project, in which a number of PPO plans offered to provide those benefits at costs close to the average levels seen in the FFS program for their area. CBO also examined that demonstration project but concluded that those plans would not be indicative of PPO costs generally, in part because the

plans most likely chose to participate in areas where their costs were most competitive (and not in areas where their relative costs would have been higher). The fact that those plans were offered almost exclusively in areas already served by Medicare+Choice plans that have provider networks also suggested to CBO that their experience might not apply in areas where such plans and provider networks were less prevalent.

It may seem counterintuitive that CBO estimated higher per capita costs for PPOs but lower overall federal costs for the legislation—and vice versa for the Administration—but that paradox reflects interactions between those costs, incentives for beneficiaries to enroll, and federal payments under the MMA. As we understand it, the Administration projected that PPO costs in many areas would be noticeably lower than the benchmarks against which those costs would be measured. Beneficiaries, who would receive three-fourths of the difference in the form of premium rebates and extra benefits, would thus have a strong incentive to enroll in those plans. As a result, the Administration estimated that total enrollment in private plans (regional and county-based plans combined) would grow quickly after 2005 and reach 32 percent of the Medicare population by 2013.

At the same time, the Administration apparently estimated that those benchmarks would, on average, exceed the local costs of providing services in the traditional FFS program (which is the baseline against which costs for new enrollees must be measured). Correspondingly, the Administration projected that Medicare's total payments to the PPOs—including the rebates for beneficiaries who enrolled in them—would, on average, exceed the costs in the FFS program, so that federal spending would rise as beneficiaries switched from the FFS program into regional PPOs. By contrast, CBO's estimate that regional PPOs would have higher per capita costs led the agency to conclude that those plans are not likely to be widely available and would have costs close to the benchmarks in those areas where they were offered. Consequently, CBO projected that beneficiary enrollment would be limited and that—even though those enrollees would increase federal costs somewhat—the impact on federal spending would primarily be determined by use of the PPO stabilization fund.

Conclusion

I hope that this explanation of the assumptions and methods used in generating CBO's cost estimate—and this analysis of the differences between that estimate and the Administration's—have been helpful to the Committee. Although CBO stands behind its cost estimate and has chosen to respectfully disagree with some of the assumptions the Administration used in developing its projections, CBO also acknowledges that it is difficult to estimate the outcome of such complex legislation precisely. Throughout this process, CBO has sought to be as open as it could about the approach used in estimating the costs of various proposals, both in previous testimony and in a variety of published studies, cost estimates, and letters. This hearing represents another step in that process, and I look forward to answering any questions the Committee Members may have.