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A Scorecard on the Medicare Reform Bills

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Introduction

The House and Senate began deliberations this week on committee-passed policy recommendations for a balanced budget. The House Ways and Means Committee, the House Commerce Committee, and the Senate Finance Committee have approved legislation achieving $115 billion in savings from the Medicare program over the next five years that will be rolled into the larger budget proposal. All three bills, in varying degrees, make important changes in Medicare that provide a constructive framework for reform.

It is essential to put in place the foundations for future reforms that will be needed to address the deluge of new Medicare beneficiaries entering the system with the retirement of the baby boomers in 15 years. As lawmakers begin considering Medicare reforms, there may be a temptation to let their collective interest in reaching agreement on a balanced budget cloud the end goal, which should be to make real structural reforms in Medicare. Although the House and Senate Medicare bills represent only the beginning of this effort, they should provide the building blocks for future reforms. It is therefore critical that lawmakers be on the right track.

The House and Senate Medicare bills can be improved in key areas to ensure Medicare's long-term structural integrity. Specifically, Congress should:

- Give seniors the same health plan Congress has;
- Allow new types of plans to be made available as future choices;
- Expand the choice of benefits;
- Simplify program administration;

Note: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

- Allow for market-based payments to health plans;
- Establish an annual open season for health plan enrollment;
- Provide comparative health plan information to consumers; and
- Resist enacting complex quality assurance provisions.

IMPROVEMENTS IN MEDICARE

Giving Seniors the Same Health Plan Congress Has

The Senate Finance Committee took a dramatic step to improve Medicare by adopting a pilot program sponsored by Senators John Breaux (D–LA) and Connie Mack (R–FL) to test a Federal Employees Health Benefits Plan (FEHBP) reform model in Medicare. Although many Medicare reform bills are described as expanding choice by offering health plan options to seniors like those available to Members of Congress in the FEHBP, the Breaux–Mack demonstration language comes closer to meeting that goal than any other proposal under consideration.

Adopted unanimously as an amendment during mark-up in the Senate Finance Committee, the Breaux–Mack proposal would test an FEHBP-modeled Medicare program in ten high-cost areas and three rural areas. A variety of health plans meeting broad plan participation requirements, including union and association plans, would compete for seniors' business. Plans could market supplemental benefits, and the Secretary of the Department of Health and Human Services (HHS) would design two benchmark supplemental benefit packages that also could be marketed by health plans.

Rather than create complicated formulas to determine premium rates, the Breaux–Mack plan would have health plans submit bids to the government describing benefits and premiums. A proposed new Office of Competition—separate from the Health Care Financing Administration (HCFA)—would negotiate rates with health plans. The government's contribution to health plans would be 90 percent of the chosen plan's premium, up to a maximum of 90 percent of the weighted average of plans in the area or the average spent for fee-for-service coverage, whichever is lower, thus encouraging beneficiaries to make cost-conscious decisions.

Although the Breaux–Mack demonstration could be improved by increasing the number of demonstration sites and waiving the requirement that all health plans offer the core Medicare benefits in order to allow for more variation in benefits, it represents real progress toward opening the Medicare program to real choice and competition.

What Congress should do: Congress should retain and expand the Breaux–Mack Medicare demonstration proposal in the final budget agreement by increasing the scale of the demonstration project.[1]

Allowing New Types of Plans to Be Made Available as Future Choices

Private health insurance has been evolving over the past 15 years. For years, the standard was fee-for-service, which is the basis of traditional Medicare. Due to unsustainable cost growth, however, the private sector continues to explore new and different ways to

1 Stuart M. Butler, "Giving Seniors the Same Health Plan Congress Has," Heritage Foundation *Executive Memorandum* No. 487, June 12, 1997.

provide health services to employees at lower costs, with varying degrees of success. Most insurance now falls under the rubric of managed care. The original form of managed care coverage was the health maintenance organization (HMO). Today, it has evolved to include a wide range of plans, such as preferred provider organizations (PPOs), physician-hospital organizations (PHOs), independent practice associations (IPAs), point-of-service (POS) plans, and (more recently) provider-sponsored organizations (PSOs), as well as other new types that are being introduced.

The federal health care program for Members of Congress, federal employees, retirees, and dependents shows why it is important to encourage the development of new, innovative plans. The range of choices must not be restricted to plans currently thought to be the most efficient. The FEHBP allows entities other than commercial insurers—such as unions, employee groups, and various associations—to band together to offer health insurance products. This unique mix of different health coverage models, with a wide variety of health plan sponsors all vying for the business of 9 million FEHBP enrollees, creates a fiercely competitive—and, above all, constantly evolving—consumer-oriented health program. This is a model well suited to the need for Medicare reform.

The House and Senate Medicare bills move in the right direction. The House bill is more limited, offering a PPO and PSO choice in addition to the traditional HMO coverage currently available to many seniors. The House bill also includes a limited demonstration project for up to 500,000 seniors to take advantage of Medicare medical savings accounts (MSAs). The Senate bill provides more health plan options, including a private fee-for-service plan, a POS plan, and "any other types of health plans" meeting plan participation requirements. This language is critical. As already noted, because health insurance is a dynamic product, it is impossible for Congress to know today what new or different models of health coverage will be available tomorrow. Thus, policymakers should not try to make that judgment by placing limits in law on the types of plans that can compete in the market for seniors.

What Congress should do: Congress should adopt the Senate language on choice of competing health plans, ensuring that the market remains open to different health care models in the future. Plan participation standards such as state licensure, solvency, and certain consumer protection requirements must apply to participating plans. However, inflexible statutory limits on the number or types of health coverage options will only inhibit competition and deny seniors a complete menu of choices similar to those Congress enjoys today.

Expanding the Choice of Benefits

If seniors were given a check from the government and told to sit down with an insurance agent to design a benefits package to satisfy their own health care needs, they would be likely to end up with a health plan significantly different from today's Medicare. Illustrating this point is the fact that one of the health benefits most desired by seniors is an outpatient prescription drug benefit not provided by the current Medicare program. This single benefit is often cited as a determining factor when beneficiaries switch to Medicare HMO coverage.

Medicare also does not provide catastrophic coverage for seniors in the event of protracted and costly illness. In fact, the incentives are backwards in Medicare: Outside of the initial deductible for hospital services, a Medicare patient has the first 60 days of hospital

coverage free. However, from the 61st through the 90th days, a patient is charged co-insurance of $179 per day. From the 91st to the 150th days, a patient must use "lifetime reserve days," only a fixed number of which is allotted to each Medicare patient at a cost of $358 per day. Higher out-of-pocket costs are incurred by patients when they are least able to afford them.

Neither the House nor the Senate bills makes any changes that would guarantee seniors more choice and flexibility in type and scope of benefits. They require private plans serving seniors to offer at least the basic Medicare benefits, so other benefits preferred by enrollees typically would cost more: They could not be substituted for any existing benefit. In fact, the bills exacerbate problems created by standardized benefits by adding additional preventive health benefits to the basic package that private insurers contracting with Medicare would be forced to pick up. The more benefits that private Medicare health plans are forced to cover, the less opportunity they have to attract beneficiaries with additional coverage beyond the Medicare basic package at a reasonable price or to substitute a desired benefit for one less needed.

Standardized benefits limit flexibility and consumer choice by forcing a rigid, one-size-fits-all coverage on individuals with different needs. Moreover, when politicians set specific benefits in statute, they invite unrelenting lobbying by special interests vying for a piece of the Medicare pie and make decisions on what treatments and procedures are most appropriate that they have neither the training nor the knowledge of individual needs to make. The practice of legislating health benefits often holds the patient's best interests hostage to the political process, which often takes months or years to make the minor changes or updates needed to reflect the ever-changing and innovative science of medicine.

What Congress should do: Congress should get out of the business of determining specific benefits altogether. Instead, it should establish a broad set of core services that health plans must be required to meet and leave specific benefit design up to a negotiating process between private insurers and government representatives. This is how the Office of Personnel Management (OPM) negotiates benefits and premium rates for FEHBP plans. Core service categories defined in law include coverage for hospital and physician services and catastrophic coverage, but specific type and scope of benefits are left up to the OPM negotiating process.

At a minimum, short of making these kinds of changes, Congress should resist the temptation to continue adding new benefits to the Medicare program and begin instead to explore other, non-political administrative entities with limited authority to make determinations about the benefits and services Medicare will reimburse.

Simplifying Program Administration

The HCFA currently employs 4,100 full-time employees (FTEs) to manage and regulate Medicare and Medicaid, with personnel costs of $325 million in FY 1997. Within the HCFA's Office of Managed Care, which manages the Medicare HMO contracting program, 120 employees are working full-time to manage private contracts for approximately 4.9 million Medicare beneficiaries in private Medicare HMOs. Contrast this with the OPM, which runs the FEHBP. In 1996, the OPM employed about 150 FTEs to administer and negotiate health plan contracts for approximately 9 million federal employees, retirees, and dependents on a budget of $20 million.

Congress has encumbered the HCFA with a complicated and expansive mandate to regulate the Medicare program, down to minute details of diagnostic codes and fee schedules. This in turn requires the employment of many bureaucrats who must try to figure out what and who to pay. These officials try to "clarify" rules by producing more and more regulations. In 1993, there were 1,050 pages in the U.S. Code on Medicare but only 26 pages on the FEHBP, as well as 1,156 pages on Medicare in the Code of Federal Regulations but only 83 on the FEHBP.[2]

What Congress should do: Neither the House nor Senate Medicare reform legislation proposes to simplify the administration of traditional Medicare or the expanded Medicare choice programs. Ideally, Congress should propose major changes in the administrative oversight of Medicare by creating a new, semi-independent board to operate the traditional fee-for-service program. The board would consist of private-sector and public-sector health experts and consumer advocates appointed by the President and Congress. They would operate within an annual appropriated budget and would be charged with making determinations about new benefits, premium amounts, and other operational decisions. In this way, detailed decision making regarding traditional Medicare could occur in an expedited and depoliticized manner. Congress would continue to have authority to approve or reject board decisions by up-or-down vote.

Short of making this kind of change, Congress should expand the mandate of the new Office of Competition proposed in the Breaux–Mack Medicare demonstration and give it administrative authority for the entire Medicare private contracting program.

Allowing for Market-Based Payments to Health Plans

The success or failure of expanding private choices for seniors, both in terms of broadening individual choice and in terms of slowing the growth of Medicare costs, depends on the ability of the government or government-appointed administrators to gauge the cost of a health plan in a given market and to make the appropriate government contribution to the cost. This is no easy task. The irrational payment formula used to pay Medicare HMOs shows how not to pay health plans. Today, an HMO contracting with Medicare receives from the government a premium payment of 95 percent of the local Medicare fee-for-service costs. In areas in which there are large numbers of senior citizens with ample access to health services, such as southern Florida, the high utilization of Medicare fee-for-service tends to drive up the Medicare HMO payment, with the opposite being true in areas with few seniors or health centers. This formula creates huge disparities in the amount of payments the government makes to private health plans. This payment methodology in no way reflects local market conditions or the actual costs of managed care health services. The result is that some health plans contracting with Medicare receive huge windfall payments based on the pricing formula. Studies suggest the obvious: Medicare is not saving money through its HMO contracting program.

The House and Senate Medicare bills address this problem by creating new formulas for payments to private health plans, attempting to blend local market health care costs with national average costs to come up with a more rational payment that reflects actual costs rather than merely a discounted fee-for-service cost. The House Commerce Committee and House Ways and Means Committee bills differ in the ratio of national to local payment rates: The Commerce bill advocates a blend of 70 percent local rates and 30 percent

2 Will Marshall and Martin Schram, eds., *Mandate for Change* (New York, N.Y.: Progressive Policy Institute, 1993).

national; the Ways and Means and Senate Finance bills create a 50–50 blend of local and national rates. The Senate Finance and House Commerce Committee bills also would phase out payments for graduate medical education (GME) and disproportionate share hospitals (DSH), which currently are included in Medicare HMO payments, even though most health plans provide no physician training or are subject to DSH. All proposed changes in plan payments would include differing allowable annual growth rates.

What Congress should do: Congress should break decisively with using formulas to pay for managed care plans. Tinkering with the formula, as the current bills do, may remove some irrationality but will introduce new distortions in the future.

The wiser course would be to move the payment system for managed care plans entirely to a system in which plans offer bids, the bids are fine-tuned through negotiation (preferably through an expanded version of the Breaux–Mack Office of Competition), and Medicare agrees to pay a proportion of the premium up to a maximum. This is the system used in the FEHBP.

Establishing an Annual Open Season for Health Plan Enrollment

Under current law, Medicare-eligible seniors may enroll in and disenroll from a Medicare HMO at any time, either to join another private health plan or to participate in the Medicare fee-for-service program. The Senate Medicare bill continues this practice for beneficiaries, while the House bills allow continuous open enrollment for the first three years and then limits enrollment and disenrollment for everyone except new beneficiaries to the first three months of each year or other special coordinated enrollment periods.

Based on a recent Physician Payment Review Commission (PPRC) survey of Medicare HMO enrollees, only 8 percent left their plans in a given year. As the number of private plans available to seniors grows, however, the propensity for seniors to game the system by enrolling in low-cost, low-coverage plans when they are healthy and switching to more comprehensive coverage when they are sick will only increase. In the long run, allowing open and unlimited switching between private health plans, or back and forth between a private plan and traditional Medicare, will only increase costs, aggravate adverse selection problems, and prevent private health insurers from being able to negotiate fair premium rates for enrollees because they will not be able to measure their risk burdens accurately.

What Congress should do: Congress should reject the Senate's proposal for unlimited open enrollment. Seniors should be able to change health plans or return to traditional Medicare on the same basis that FEHBP participants do during an annual open season. For approximately six weeks, beginning in November and lasting through mid-December, federal employees and retirees each year may shop around for a new health plan under the FEHBP. If they choose a new plan, their coverage begins on January 1 of the following year.

Any problems a senior might face mid-year with an insurer should be remedied through the health plan's grievance and appeals process. As under current law, the House and Senate Medicare bills require that a grievance and appeals process be in place, and a beneficiary may request a formal hearing before the Secretary of HHS if the amount involved in an individual's complaint against the health plan is greater than $100.

Providing Comparative Health Plan Information to Consumers

Medicare beneficiaries cannot be asked to make choices about what health coverage is best for them without access to the necessary consumer information. Currently, information on HMO options available to seniors must be obtained directly from the HMOs, and there is no requirement for standardized reporting or formatting of information. This presents a real challenge for a senior citizen who may be trying to make comparisons among the myriad of health plan options available. The General Accounting Office (GAO) has reported a number of times that the HCFA collects a variety of data from the health plans that consumers may find useful, such as the plans' premium requirements and benefit offerings, disenrollment rates, rates of enrollee complaints, and results of certification visits to HMOs. The HCFA, however, does not make this information available to consumers.[3]

Both the House and Senate bills include requirements that health plans make certain standard information available and that the HCFA compile comparative information in an easily understandable fashion and make it available to all Medicare beneficiaries.

What Congress should do: The Senate bill is preferable because it includes a reference to information made available in a "chart-like" format similar to the format the OPM uses for FEHBP participants. Each year, the OPM publishes the FEHB Guide, which provides in chart format all the plans participating in a given area, their premium rates, benefits, co-insurance and co-pay requirements, consumer satisfaction survey results, and private accreditation status.

Resisting Enacting Complex Quality Assurance Provisions

The issues of measuring and reporting health plan quality are difficult and tend to raise more questions than they attempt to answer. Under current law, Medicare HMOs are required to have an ongoing quality assurance program and are required to contract with a Medicare Peer Review Organization (PRO), which provides external quality review.

The House and Senate Medicare bills require all private contracting Medicare health plans to have ongoing quality assurance programs and to meet health plan quality standards determined by the Secretary of HHS. Health plans would be deemed acceptable by the Secretary if they are accredited by independent private accrediting bodies approved by the Secretary of HHS. In addition, the Senate incorporated provisions from legislation introduced by Senators Joseph Lieberman (D–CT) and Jim Jeffords (R–VT) that would create an independent council to monitor and update quality standards for health plans, would establish minimum federal standards for health plan information to be made available to enrollees, and would allow Medicare to pay plans 0.5 percent more or less based on quality performance.

On its face, this may seem like a reasonable requirement, but lawmakers should use caution when they place the government in the role of determining or approving private health plan quality standards. To date, the HCFA has had a mixed record in dealing with quality issues. For example, the GAO has reported that the HCFA has failed to incorporate Medicare PRO findings into its HMO quality monitoring process. The GAO has also raised concerns about the HCFA's ability to implement programs to deal with poorly

3 U.S. General Accounting Office, *Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance,* GAO/HEHS 97–23, October 1996, p. 3.

performing health plans and to encourage better plan performance.[4] In many respects, application of federally imposed quality measures is just another form of government standardization of health plans through the accreditation and certification process that lawmakers should avoid altogether.

The House Medicare proposal makes permanent an HCFA program designed ostensibly to promote quality—the "Centers of Excellence" demonstration program. There is evidence to suggest, however, that this questionable program may not live up to its name. This program solicits providers to enter into contracts to provide Medicare beneficiaries with a specific service (for example, cataract surgery or hip replacement). In exchange, Medicare pays these providers a discounted bundled payment for the procedure instead of individual bills for services rendered. Some physician groups and hospitals have questioned whether this program is about quality or the HCFA is more interested in just saving money.

The private sector has led the discussion on health care quality. The National Committee for Quality Assurance (NCQA), a privately operated quality measurement organization, was created in response to employers' demand for more information on health plan performance. In a competitive environment in which consumers have choice, the market is the best arbiter of health plan quality. For example, FEHBP plans do not require health plan accreditation. The OPM's guide to FEHBP plans notes, however, which plans have received full or partial NCQA accreditation and which ones have been denied, so that individuals may make an informed decision based on that and other information. If health plans without accreditation fail to compete effectively, they will seek accreditation or will not survive in the market. There is no reason why privately competing Medicare health plans could not operate in a similar manner.

What Congress should do. Since the HCFA has not demonstrated its capacity to encourage real improvements in quality beyond those developed by plans, Congress should avoid locking any approach into law. What Congress should do is require the HCFA to make available to elderly associations and consumer organizations the basic information it collects on plans that may be relevant to quality assessments. This information, not questionable government standards, would be the best stimulus to quality improvement.

INTRODUCING GREATER COST CONSCIOUSNESS

The Senate Finance Committee bill includes two additional provisions worthy of support. The first is a requirement that individuals receiving home health services pay a $5 co-pay for each home health visit. The Senate bill also includes a provision, passed with strong bipartisan support, to means-test the Part B premium for upper-income seniors and apply it toward their Part B deductible. The current Part B deductible—at $100 annually—is low by any standard. The Senate provision would require individual seniors earning $50,000 or more ($75,000 for couples) to pay a $540 annual Part B deductible and seniors earning $100,000 or more ($125,000 for couples) to pay a $2,160 deductible.

Even though there are reasons to justify higher co-pays for home health services—in fact, a 20 percent co-pay would be preferable to the prospective payment system proposed

4 U.S. General Accounting Office, *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care*, GAO/HEHS 95–155, August 3, 1995, and *Medicare: Federal Efforts to Enhance Patient Quality of Care*, GAO/HEHS 96–20, April 1996.

in both the House and Senate Medicare proposals—a $5 co-pay moves in the right direction by requiring seniors to recognize a nominal cost for care that currently is provided completely free of charge.

Recent news reports indicate that the Senate may drop the Part B deductible means-test and, instead, apply an income test to the Part B premium. Although income-related Medicare Part B costs represent an important move—there is no justification for continuing to require today's low-income workers to subsidize, through income taxes, 75 percent of Part B costs for a senior with a six-figure annual income—it makes more sense to apply the test to the deductible. By income-relating the deductible rather than the premium, beneficiaries are encouraged to be more cost-conscious about the health care decisions. Means-testing the premium is not likely to affect beneficiary behavior in a positive manner. Means-testing the Part B deductible is a superior policy to means-testing the Part B premium.

CONCLUSION

Congress has the opportunity to move in a meaningful direction to improve health care options for millions of America's seniors and to rescue Medicare—if only temporarily—from certain financial ruin. With specific improvements in the right places, such as adopting the Breaux–Mack demonstration program broadening health plan choice and spurring a competitive health care marketplace much like the one Members of Congress enjoy today through the FEHBP, lawmakers can make good on their promise to put Medicare on a sound footing for future generations. Congress must ensure that this opportunity is not lost.

Appendix: Comparing the House and Senate Medicare Proposals with Congress's Own Health Plan

	House Medicare Proposal	Senate Medicare Proposal	Congress's Own Health Plan (FEHBP)
Choice of Health Plans	• Expands seniors' choice of health plans to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and a limited number (500,000) of Medicare medical savings accounts (MSAs).	• Includes PPO, PSO, and a more limited MSA option (100,000), and adds private fee-for-service, point-of-service (POS) plans, and "any other types of health plans" that meet required standards.	• In addition to the plan options in the House and Senate Medicare bills, the FEHBP includes union, employer, association-sponsored, and other types of health plans, so long as they meet prescribed solvency and plan participation requirements. The FEHBP, however, currently does not offer an MSA.

Choice of Benefits	• Requires that all health plans contracting with Medicare provide the standard Medicare benefits package. • Requires health plans to offer additional benefits if the government's premium contribution exceeds the health plan's cost of offering those benefits. • Supplemental benefits may be offered if enrollees cover 100 percent of the costs. • Adds new preventive health benefits to the basic Medicare package. • Requires that any additional benefits mandated by Congress for traditional Medicare must also be covered by private contracting plans.	• Same as the House bill.	• Unlike the House and Senate Medicare bills, the FEHBP does not require standardized benefits. • Health plans are required to offer a core set of benefits identified only by category or type, such as hospital and physician services. • Specific benefit levels, treatments, procedures and beneficiary co-payments and deductibles are negotiated by private health plan representatives and the government. Consumer interests and market competition drive the negotiating process. • Federally imposed mandated benefit laws, such as the 48-hour maternity stay law, also apply to FEHBP plans.

Administration	• Currently, approximately 4.9 million of the 37 million Medicare-eligible seniors are in Medicare HMOs. • HCFA employs approximately 4,100 FTEs at an annual cost of $325 million, with 120 FTEs currently working on Medicare HMO contracts in its Office of Managed Care. • As under current law, HCFA would continue to manage and regulate traditional Medicare and the private insurance contracting program with congressional oversight. • Updates in the government-prescribed physician fee schedule, and most benefit changes, would still require congressional action. • Private plans wishing to contract with HCFA would be required to submit necessary information. If plans meet requirements for participation and provide the Medicare basic benefits package at no additional premium cost to the beneficiary and within the federally prescribed capitation rate, they may participate in the program.	• Same as House bill.	• The FEHBP provides health plan coverage for approximately 9 million federal employees, dependents, retirees, and Members of Congress. • In 1996, OPM ran FEHBP with 150 FTEs on a budget of $20 million. • Health plans desiring to contract with the FEHBP submit proposals to OPM including information on financial solvency, state certification as a lawful insurer, service areas covered, the benefits they will offer, description of their delivery systems, and premium rates. • If plans meet basic requirements in these areas, OPM then negotiates benefits and premium rates with the health plans.

Payments to Health Plans **(government's responsibility)**	**Ways and Means Plan:** • Delinks payments to private Medicare health plans from current Medicare fee-for-service costs. • Establishes a payment formula that combines a blending of national average per capita costs (50 percent) with area-specific average per capita costs (50 percent). • Payments for graduate medical education (GME) and disproportionate share hospitals (DSH) are included in the payments to private health plans. • Payments to health plans would be capped at a growth rate of 2 percent annually. • Payments would be risk adjusted for age, sex, and disability status, and the Secretary would be required to study and report to Congress on an appropriate method of risk adjustment. **Commerce Plan:** • Similar to the Ways and Means plan, but uses a different formula to blend local (70 percent) and national (30 percent) capitation rates; phases GME and DSH out of plan payments; allows for lower annual growth rates in the first two years.	• Uses the 50–50 blend of national and area-specific per capita costs to determine the new Medicare capitation rate. • Phases GME and DSH payments out of payments to private plans. • Allows an annual growth rate of GDP plus 0.5 percent. • Risk adjusts for new enrollees at 5 percent, phasing down one percentage point each year thereafter.	• The federal contribution to FEHBP plans is determined by a formula established in law based on the average premium of the six health plans most representative of those available in the overall health care system (reflecting a combination of indemnity and managed care plans). • This premium average is then multiplied by 60 percent to determine the maximum federal contribution. • The law stipulates that the federal contribution may not exceed 75 percent of premium costs for any plan. • FEHBP plans do not have a formal method of risk adjusting health care premiums.

Payments to Health Plans (beneficiary's responsibility)	• Beneficiaries opting to enter a private health plan would be required to continue to pay the Part B premium, reflecting 25 percent of traditional Medicare's Part B costs. • Health plans could charge additional premiums for supplemental benefits; any premium charged, however, must be the same for everyone in that plan in a given area. Health plans could not charge additional premiums for the required Medicare benefits. • Cost-sharing under this plan could not exceed what would have been paid under traditional Medicare (no "balance billing").	• Same as the House bill. • Includes a means-test for high-income seniors*: Individual seniors with incomes exceeding $50,000 and couples with incomes exceeding $75,000 would pay an annual deductible of $540 (compared to the current $100 deductible for all Medicare recipients). Individuals with incomes exceeding $100,000 annually and couples earning $125,000 or more would pay an annual deductible of $2,160. * Note: *The Senate reportedly is considering dropping the means-test on the deductible and, instead, will propose to means-test premium payments.*	• Beneficiaries are responsible, at a minimum, for 25 percent of premium costs in the FEHBP. • Beyond that, a beneficiary's responsibility depends on the plan chosen and the type and amount of coverage. • FEHBP plans are required to community rate: They must charge every individual participating in a particular plan the same premium regardless of age, sex, or health status.

Election and Enrollment	• Allows for continuous open enrollment and disenrollment for Medicare-eligible individuals from 1998 to 2000; seniors could switch from one health plan to another or back and forth between a private plan and traditional Medicare at any time during this three-year period. • Except for new enrollees, in 2001 and beyond, a senior could enroll or disenroll only during the first three months of the year. • A coordinated "open season" would be required annually.	• Places no limitations on enrollment and disenrollment; seniors may switch at any time. • A coordinated "open season" would be required annually.	• Except for new enrollees, an FEHBP beneficiary may change enrollment once annually during an "open season," usually lasting for approximately six weeks in November and December of each year. • Health plan changes take effect January 1 of the following year.

Consumer Information	• HCFA would be required to make available to seniors, in easily understood language, the following information within 30 days prior to each coordinated enrollment period: 1. A list of plan options; 2. Comparative plan information; 3. Plan premiums; 4. Benefits covered and not covered by traditional Medicare (including cost-sharing); 5. The Part B premium amount; 6. Election procedures and grievance and appeals rights; and 7. Other quality indicators. • In addition, the Secretary would be required to maintain a toll-free number and Internet site for seniors.	Similar to the House bill except: • Requires a description of how plan participating physicians are compensated; • Requires that comparative health plan information be provided in a "chart-like" format and that it be of a "similar level of specificity" as the information distributed by the OPM for FEHBP beneficiaries.	• OPM publishes an *FEHBP Guide* once a year and sends copies to beneficiaries. This guide contains easy-to-read plan information in a chart-like form, describing benefits, premium rates, co-insurance and co-pay requirements, if any, and customer satisfaction data. • Health plans will also advertise directly and send customer representatives to FEHBP health fairs held during open season. • In addition, a detailed plan and consumer satisfaction information guide called *Checkbook's Guide to Health Insurance Plans for Federal Employees* is published annually by a consumer group.