DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–2893–N]

Medicare Program; Deductible Amount for Medigap High Deductible Options for Calendar Year 2000

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice announces the annual deductible amount of $1,530.00 for the Medicare supplemental health insurance (Medigap) high deductible options for 2000. High deductible options are those with benefit packages classified as F or J that have a high deductible feature. The deductible amount represents the annual out-of-pocket expenses (not including premiums) that a beneficiary who chooses one of these options must pay before the policy begins paying benefits.

EFFECTIVE DATE: January 1, 2000.

FOR FURTHER INFORMATION CONTACT: Kathryn McCann, (410) 786–7623.

SUPPLEMENTARY INFORMATION:

I. Background

Medicare Supplemental Insurance

A Medicare supplemental, or Medigap, policy is the principal type of private health insurance that a beneficiary may purchase to cover costs that Medicare does not cover. Medicare beneficiaries are responsible for certain deductibles and coinsurance amounts for both Part A (hospital insurance) and Part B (supplementary medical insurance) of the Medicare program. In addition, Medicare generally does not cover custodial nursing home care, eyeglasses, dental care, and most outpatient prescription drugs. Beneficiaries must either pay the full cost of these services themselves, or they may purchase additional private health insurance to help pay these costs. Medigap policies offer coverage for some or all of the deductibles and coinsurance amounts required by Medicare. Additionally, Medigap policies may provide coverage for some services that are not covered under Medicare.

Section 1882 of the Social Security Act (the Act) establishes, among other things, standards for Medigap policies. This section of the Act states that no Medigap policy may be issued in a State unless the policy meets the following criteria: (a) It has been approved by the Health Care Financing Administration as meeting federal standards, or (b) it complies with State laws established in accordance with section 1882(b)(1) of the Act.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) amended the Act by standardizing Medigap benefits and requiring that no more than ten Medigap benefit packages, Plans A through J, be offered nationwide. [1] Plan A is the basic benefit package. It includes Medicare Part A hospital coinsurance plus coverage for 365 additional days over the beneficiary's lifetime, Medicare Part B coinsurance (generally 20% of Medicare-approved expenses), and coverage for the first 3 pints of blood per year. Medigap Plans B through J contain this basic benefit package, as well as different combinations of coverage for some or all of the following benefits: Medicare Part A inpatient hospital deductibles, skilled-nursing facility coinsurance, foreign travel health emergencies, at home recovery, preventive care, some prescription drug coverage, and Medicare Part B excess charges protection.

B. High Deductible Medigap Standard Policies

Section 4031(c) of the Balanced Budget Act of 1997 (BBA) added high deductible versions of two of the standard Medigap policies, or their counterparts in the waivered states. [2] Unlike the regular versions of Plans F and J, however, the high deductible versions of these policies will not begin paying benefits until the deductible amount is met. Amounts included in this deductible are the expenses that would ordinarily be paid by the regular version of the policy, including Medicare deductibles for Parts A and B. The Plan F deductible does not include the separate foreign travel emergency deductible of $250. The Plan J deductible does not include the plan's separate $250 prescription drug deductible or the plan's separate $250 deductible for foreign travel emergencies.

II. Provisions of This Notice

In 1998 and 1999, the high deductible amount was statutorily defined as $1,500.00 in section 1882(p)(11)(C)(i) of the Act. For 2000, the high deductible amount is increased by the percent increase in the Consumer Price Index (CPI) for all urban consumers (all items, U.S. city average) for the 12-month period ending with August of the preceding year. The percent increase in the CPI for all urban consumers (all items, U.S. city average) for the 12-month period ending in August 1999 was 2.26%, according to the Division of Labor Statistics, Department of Labor. A 2.26% increase in $1,500.00 is $1,533.90. Section 1882(p)(11)(C)(ii) of the Act stipulates that this amount ($1,533.90) be rounded to the nearest multiple of $10 to find the high deductible amount for the subsequent year. Rounding $1,533.90 to the nearest $10 multiple, the 2000 deductible for the Medigap high deductible options is $1,530.00.

This figure can also be found by dividing the August 1999 CPI (167.1) by the August 1998 CPI (163.4), which equals 1.022643819. Multiplying this number by the 1998/1999 deductible ($1,500.00) equals $1,533.97 which, rounded to the nearest $10 multiple, is $1,530.00.

III. Unfunded Mandates and Executive Orders

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in any one year. This notice will not have an effect on the governments mentioned, and the private sector costs will not be greater than the $100 threshold.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

We have reviewed this notice under the threshold criteria of Executive Order 13132 of August 4, 1999, Federalism, published in the **Federal Register** on August 10, 1999 (64 FR 43255). The Executive Order is effective November 2, 1999, which is 90 days after the date of this Order. We have determined that the notice does not significantly affect the rights, roles, and responsibilities of States.

Authority: Section 1882 of the Social Security Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance, and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

[1] Three states (Wisconsin, Minnesota, and Massachusetts) experimented with standardizing benefits prior to enactment of federal standards. These states were granted a waiver and permitted to keep their alternative forms of Medigap standardization.

[2] In the three waivered states, high deductible versions of the plans that most closely approximate the benefits contained in Plans F and J are authorized by the Balanced Budget Act.

Dated: March 1, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–1110–FN]

RIN 0938–AJ90

Medicare Program; Sustainable Growth Rate for the Year 2000

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final notice.

SUMMARY: This final notice implements section 211(a)(2)(C) of the Public Law 106–113, the Medicare, Medicaid, and State Childrens Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), that requires us to publish a notice in the **Federal Register** not later than 90 days after the date of enactment. This notice includes, based on the best available data, our determination of (1) allowed expenditures for physicians' services under the Medicare Supplementary Medical Insurance program (Part B) for both the 9-month period of April 1, 1999 through December 31, 1999, and for calendar year 1999, (2) estimated actual expenditures for Part B physicians' services in 1999, and (3) the sustainable growth rate (SGR) for calendar year 2000.

This notice also discusses our plans for making available to the Medicare Payment Advisory Commission and the public, by March 1 of each year beginning with 2000, an estimate of the sustainable growth rate and the conversion factor for the next year and the data used in making this estimate, as required in section 211(a)(2)(A) of the BBRA.

EFFECTIVE DATE: The provisions of this notice are effective April 10, 2000.

FOR FURTHER INFORMATION CONTACT: Marc Hartstein, (410) 786–4539.

SUPPLEMENTARY INFORMATION:

I. Background

A. Medicare Sustainable Growth Rate

Section 1848(f) of the Social Security Act (the Act), as amended by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR). Section 1848(f)(2) of the Act specifies the formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets is intended to control the actual growth in aggregate Medicare expenditures for physicians' services.

The SGR targets are not limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the appropriate fee schedule update, as specified in section 1848(d)(3) of the Act, is adjusted to reflect the success or failure in meeting the SGR target. If expenditures exceed the target, the update is reduced. If expenditures are less than the target the update is increased.

As with the MVPS, the statute specifies a formula to calculate the SGR based on our estimate of the change in each of four factors. The four factors for calculating the SGR are as follows:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real gross domestic product (GDP) per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

Section 211 of the BBRA amended sections 1848(d) and 1848(f) of the Act with respect to the physician fee schedule update and the SGR. Section 211(b) of the BBRA maintains the formula for calculating the SGR, but amends section 1848(f)(2) of the Act to apply the SGR on a calendar year (CY) basis beginning with 2000 while maintaining the SGR on a fiscal year (FY) basis for FY 1998 through FY 2000. Specifically, section 1848(f)(2) of the Act, as amended by section 211(b) of the BBRA, states that— ''* * * [t]he sustainable growth rate for all physicians'' services for a fiscal year (beginning with fiscal 1998 and ending with fiscal year 2000) and a year beginning with 2000 shall be equal to the product of—

(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the applicable period involved,

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare + Choice plan enrollees) from the previous applicable period to the applicable period involved,

(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous applicable period to the applicable period involved; and

(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the applicable period (compared with the previous applicable period) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under section 1834 (d)(3)(B) or (d)(4)(B) of the Act, as the case may be, minus 1 and multiplied by 100.''

Under section 1848(f)(4)(C) of the Act, as added by section 211(b)(3)) of the BBRA, the term ''applicable period'' means—(1) a FY, in the case of FY 1998, FY 1999 and FY 2000, and (2) a CY with respect to a year beginning with 2000.

To make the transition from a FY SGR to a CY SGR in 1999 using the FY 2000 SGR, sections 211(b)(2) and (3) of the BBRA require us to calculate SGRs for both FY and CY 2000. Section 1848(d)(4)(C) of the Act, as modified by section 211(a)(1)(B) of the BBRA, requires us to determine the allowed expenditures for both the 9-month period beginning April 1, 1999 and for CY 1999. The SGR for CY 2000 is then applied to allowed expenditures for CY 1999.

In making the transition to a CY SGR system, the law essentially requires us to use the 2000 SGR twice (both FY and CY) twice to determine 2000 allowed expenditures. The FY 2000 SGR is used to determine allowed expenditures for the April 1, 1999 to December 31, 1999 period and the CY 2000 SGR is used to determine CY 2000 allowed expenditures. Since we are using the FY 2000 SGR to determine allowed expenditures for the April 1, 1999 to December 31, 1999 period, allowed expenditures have been increased for components of the SGR that may not be reflective of the increase that actually occurs over that period. For instance, the FY 2000 SGR includes a portion of the full year effect of the new prostate screening benefit that did not become effective until January 1, 2000. Similarly, other components of the SGR (that is, the increase in physician fees, fee-for-service enrollment, real per capita GDP, and legislative factors other than prostate screening benefit) may have a different rate of increase in the FY 2000 SGR than occurred in the April 1, 1999 to December 31, 1999 period.

The issue described above occurs because the law required mismatched