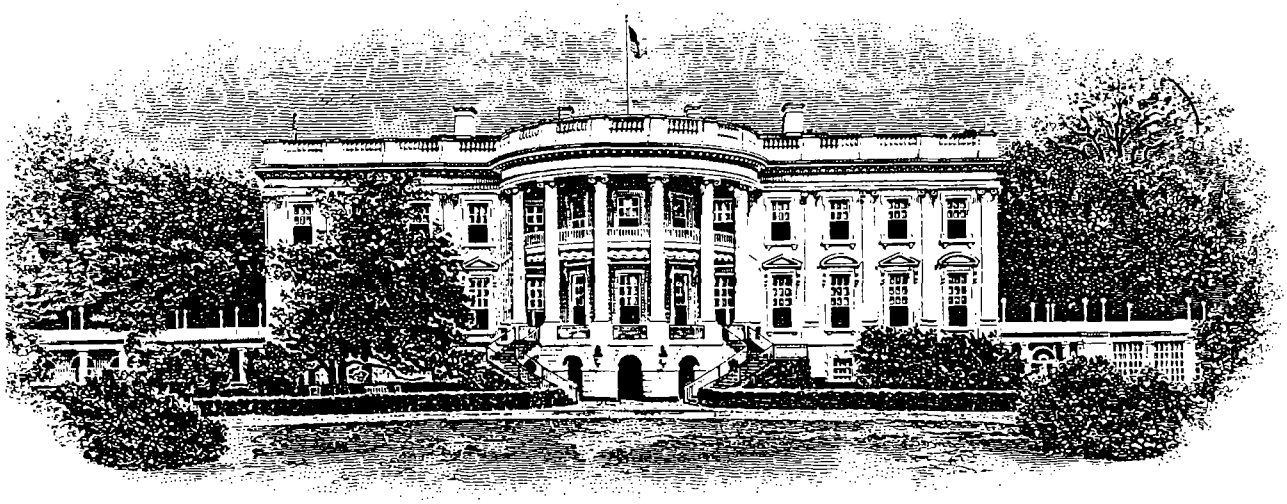
The White House



NEW REVENUES AND THE SURPLUS

NEED FOR NEW REVENUE

- **Massive cuts would be needed**. For the Hospital Insurance (HI) Trust Fund to be solvent only through 2022, it would take an 18 percent reduction in baseline spending in each year (all else held constant). To give an example of what that means, in 2000, this would amount to about $26 billion -- more than Medicare pays for all of outpatient services or home health care.

- **Growth would have to be slowed to below general inflation**. Even if Medicare per capita cost growth were constrained to general inflation in every year -- unprecedented in health care and less than half projected private spending growth rate -- the Trust Fund would only be extended to 2016.

EFFECTS OF THE SURPLUS

- **Reserving remainder of the surplus for Medicare**. The President's plan would include a provision that automatically sends to the Medicare Trust Fund a set dollar amount from the surplus annually for the next 15 years. These funds would be prohibited from being used for any other purpose, thus preventing the Trust Fund from being raided for other priorities.

- **Part of a broader Medicare reform initiative.** The President strongly urged the Medicare Commission and the Congress to include his proposal as part of a broader reform initiative. Medicare reform is about more than solvency -- it should also improve Medicare's efficiency, equity, and adequacy in terms of benefits. Medicare has fewer management tools and less ability to use competition than private health plans. Moreover, its benefits are outdated. Unlike virtually every employer health plan, Medicare does not pay for prescription drugs, for example. Thus, structural reforms as well as funds are needed to strengthen Medicare.

- **Ensuring that Medicare is financed for the next two decades**. Even in the absence of broader reforms, the President's plan would ensure that Medicare can continue to provide its critical health services. His proposal would double the life expectancy of the Medicare Trust Fund to 2020, making its outlook better than it has been in the last quarter of a century.

ADVANTAGES OF THE SURPLUS

- **Baby boom generation created the surplus -- and will need it when they retire.** In fact, the same generation -- the baby boomers -- that has helped create this surplus is going to need it when they retire and are covered by Medicare. By taking this action, the President is ending the need in the foreseeable future to look for new revenues from younger generations.

- **More progressive than a payroll tax increase.** The payroll tax, which is the main source of financing for the Medicare Trust Fund, is not progressive. It imposes a constant tax rate on earnings and does not tax other types of income at all, such as income from stocks. The budget surplus is primarily funded by the income tax. This is not a "flat tax" – it imposes somewhat higher tax rates on those with higher incomes, who have more ability to pay. Thus, even without further Medicare reforms, the proposed commitment of the surplus will make Medicare more progressive right away.

- **Enhances the likelihood of a reform package**. To meet the goals of Medicare reform, a proposal must: (1) make Medicare more efficient; (2) modernize and rationalize its benefits; and (3) add new revenues. This proposal to add new revenues improves the prospects for a bipartisan reform plan.

PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED FOR COVERAGE

- **Prescription drugs are a growing part of health care in the U.S.** In the past 10 year, spending on prescription drugs has risen as a percent of total spending, by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.

- **Medicare does not pay for prescription drug coverage.** Although virtually all private health insurance plans cover prescription drugs, Medicare does not.

- **The elderly and people with disabilities have a greater need for prescription drugs.** Over 80 percent of Medicare beneficiaries use at least one prescription drug. Although the elderly comprise 12 percent of the population, they use one-third of all prescription drugs. This reflects the greater prevalence of conditions like arthritis and high blood pressure that require daily medicines.

- **Higher spending on drugs.** About half of Medicare beneficiaries have more than $500 per year in expenditures on prescription drugs; over one in ten have more than $2,000.

- **Fall back on expensive Medigap insurance, former employers, or Medicaid.** Low-income beneficiaries rely on Medicaid to pay the costs of drugs. Others either turn to former employers or pay for Medigap coverage. Medigap premiums range from $402 to $7,196, depending on the state and type of coverage. The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. In 4 years, the percent of large firms offering employer-sponsored coverage for Medicare eligibles dropped about 20%.

- **Millions of beneficiaries have inadequate coverage**. About 13 million Medicare beneficiaries have no coverage at all. Millions more have drug coverage through Medicare managed care plans, but the amount of that coverage is increasingly low. For example, about one-third of beneficiaries' managed care plans pay less than $1,000 for drugs annually.

- **Older Americans pay more.** A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs.

- **Difficult choices**. According to one survey, one in eight older Americans had to choose between buying food and buying medicine.

MEMORANDUM May 14, 1998

From: Richard S. Foster
Solomon M. Mussey
Elliott A. Weinstein
Office of the Actuary
Health Care Financing Admin.

Subject: Actuarial Evaluation of Illustrative Approaches for Improving HI Solvency Through Expenditure Reductions or Payroll Tax Increases—Update Based on 1998 Trustees Report

The long-range solvency of the Medicare Hospital Insurance (HI) program remains the subject of considerable discussion. Most of the discussion has focused on the reductions in HI expenditures that would be required to meet certain financing or budgetary goals. This memorandum provides an analysis of the effects on the HI trust fund of various illustrative approaches for reducing future HI expenditures or raising payroll tax rates.

The analysis presented here should not be interpreted as advocating a particular approach to addressing the projected financial imbalance for the HI trust fund; nor should a negative inference be made from the absence of other analyses. Our purpose is to help provide a framework for analysis by the program's policymakers. Also, in the case of the illustrative proposals to reduce expenditures, this memorandum provides no information as to how such reductions might be accomplished. In other words, these estimates illustrate the financial impact of various theoretical changes in expenditure levels or growth rates—development of legislative provisions that would result in such changes is rather more challenging.

The illustrations presented in this memorandum are based on the intermediate financial projections from the 1998 HI Trustees Report. Under different economic and demographic conditions, such as the Trustees' "low cost" or "high cost" assumptions, the steps required to reach financial balance can differ significantly from those based on the intermediate assumptions. Equivalently, a legislative package designed to restore balance under the intermediate assumptions could ultimately result in too much or too little savings, depending on actual future economic and other conditions.

I. Background

Under section 1817(b) of the Social Security Act, the Board of Trustees for the HI program is required to report to Congress annually on the financial status of the HI trust fund. In keeping with the program's long-term financial obligations, the law requires both a short-range and a long-range evaluation of the trust fund's actuarial status. The latest Trustees Report was issued to Congress on April 28, 1998.

The Balanced Budget Act of 1997 was designed in part to postpone the imminent exhaustion of the HI trust fund, which was expected to occur in 2001 in the absence of corrective legislation. The Act included numerous provisions to (i) implement new prospective payment systems for most HI services not already reimbursed on a prospective basis, (ii) reduce payment updates for all HI providers, and (iii) shift payment for the majority of home health care services from the HI trust fund to the SMI trust fund. Under the BBA, and based on the intermediate assumptions in the 1998 Trustees Report, the HI trust fund is estimated to be depleted in 2008. Although not designed to address the program's long-range financial imbalance, the Balanced Budget Act also had the important effect of reducing the 75-year actuarial deficit by about one-half, from 4.32 percent of taxable payroll to 2.10 percent in the 1998 Trustees Report.

The 1998 Trustees Report projections still show that the program faces a serious imbalance between projected income and expenditures in the long range, in part due to the demographic changes that will occur with the retirement of the post-World War II "baby boom" generation. To bring HI into actuarial balance for the next 25 years under the intermediate assumptions would require that expenditures be reduced by 18 percent or revenues increased by 22 percent or some combination thereof. Alternative combinations of such measures are shown in the table below. Over the full 75 years of the Trustees' projection, substantially greater changes would be required.

Alternative combinations of revenue increases or expenditure reductions for actuarial balance during 1998-2022 (1998 intermediate assumptions)

Revenue Increase	Expenditure Reduction
0%	18%
5%	14%
10%	10%
15%	6%
20%	2%
22%	0%

The analysis shown in the annual Trustees Report is significantly different in scope and purpose from the financial projections for the HI trust fund shown in the President's Budget or the projections of the Congressional Budget Office (CBO). Budget estimates are generally prepared for at most the next 10 years and are based on somewhat different assumptions concerning future economic growth, inflation rates, medical care utilization, etc. For purposes of evaluating the financial status of the Social Security and Medicare programs, Congress normally relies on the Trustees' projections. Specific proposals to address the current financial imbalance would normally be evaluated using the Trustees' assumptions. Their effects would also be "scored" for budget purposes using Administration and/or CBO budget assumptions.

HI expenditures for benefits and administrative expenses are projected to increase in the future for several reasons. One factor is growth in the number of eligible beneficiaries. Chart 1 shows the projected annual rate of increase in the number of beneficiaries over the next 75 years. Enrollment is estimated to grow around 2 percent or less annually until 2010, around 2-3 percent between 2010 and 2030, when the baby boom generation retires, and well under 1 percent afterwards. While the baby boom represents a serious long-term issue for HI solvency, they are not the cause of the short-range financial problem. In particular, the trust fund is projected to be depleted in 2008 under the intermediate assumptions—just as the first baby boomers near age 65.

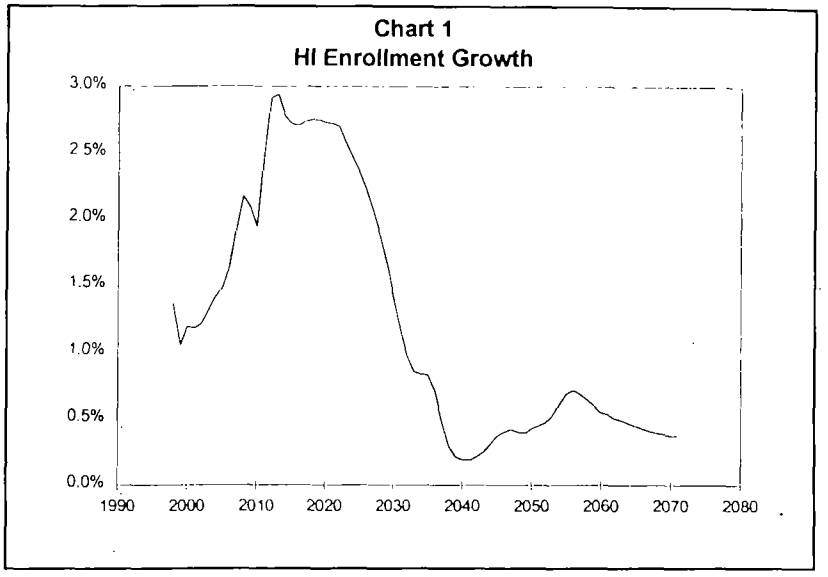
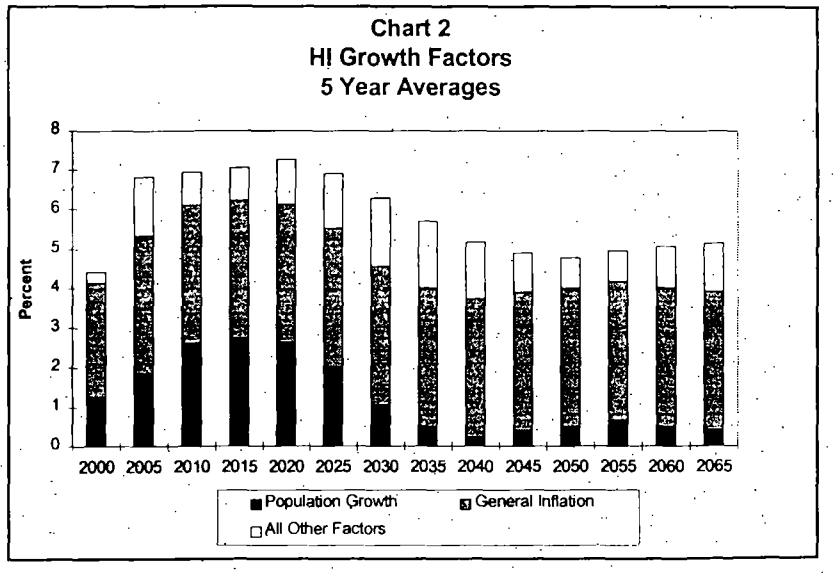


Chart 2 shows projected enrollment growth, general inflation (as measured by the Consumer Price Index), and other cost factors which contribute to HI expenditure growth. Each bar represents the average annual growth rate over the 5-year period beginning with the year shown. During 2005-2009, for example, HI expenditures are expected to increase by about 6.9 percent annually. Beneficiary growth accounts for 1.9 percent of the total and general inflation represents another 3.5 percent. The residual, 1.4 percent, is attributable to all other factors, including assumed additional inflation in the health care sector, increasing utilization and intensity of medical services, and so forth.[1]



[1]A portion of the increasing utilization of services is attributable to projected increases in the average age of beneficiaries. The average residual growth rate shown for 2000-2004 (0.3 percent) reflects the average of substantially slower rates in 2000-2002, attributable to the Balanced Budget Act provisions, and reaccelerating growth thereafter.

As noted above, future growth in the number of beneficiaries will vary considerably. General inflation is assumed to be fairly stable in the range of about 3.5 percent annually throughout the projection period. The residual factors vary somewhat over time (see section II.F of the HI Trustees Report for the specific assumptions). Table 1, attached, lists the components of HI expenditure growth rates.

During calendar years 1999 through 2007, the HI program is projected to spend a total of $1,583 billion under the intermediate assumptions. If growth in program spending were limited to increases attributable to population growth alone, then the resulting reduction in HI expenditures compared to present law would be about $207 billion for those years. If spending growth were constrained to population growth plus an allowance for general inflation, then the reduction in HI expenditures for 1999-2007 would be about $50 billion.

II. Measures used to evaluate financial effect of proposals

In the budget context, most attention is focused on the dollar amount of expenditure reductions over a given period of time. To evaluate trust fund solvency, however, several key factors are considered. For each of the illustrative proposals to reduce HI expenditures or increase taxes, we show the following results:

A. The "actuarial balance" for the next 25, 50, and 75 years. This amount is expressed as a percentage of the total wages, salaries, and self-employment earnings subject to the HI payroll tax. It represents the net difference between future HI income and expenditures over the period in question. Positive figures are surpluses and negative figures are deficits.

B. The dollar reduction in HI expenditures or increase in tax revenues for various years. (Estimates are shown only for the next 10 years since such amounts are difficult to interpret for long periods of time, due to the changing value of the dollar.)

C. The "trust fund ratio," which is the ratio of HI trust fund assets at the beginning of the year to HI expenditures for that year. The Board of Trustees has recommended that HI assets be maintained at the level of one year's expenditures, to serve as an adequate contingency reserve against temporary economic downturns or other adverse circumstances.

D. The year the trust fund is depleted.

E. The results of the Trustees' tests for short-range financial adequacy and long-range close actuarial balance.[2]

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[2]These tests are complex. See the Glossary in the 1998 HI Trustees Report for complete definitions.

It is important to note the extreme sensitivity of measures based on trust fund assets (i.e., the trust fund ratio and the year of trust fund depletion described in C and D above). As can be seen in the attached tables, seemingly minor differences in expenditure growth rates can result in major changes in the projected level of assets. For this reason, evaluation of the long-range financial status of the HI program (and Social Security) has generally focused more on the actuarial balance, which is a more stable measure of the program's financial status. Conversely, short-range analysis is generally based on the trust fund ratio.

III. Reducing future expenditures by an overall percentage (Table 2)

Four general approaches to reducing HI expenditures are illustrated in this memorandum. The first would reduce outlays by the same overall percentage in all years, compared to current law projections. For example, under present law HI expenditures are projected to increase from $139 billion in calendar year 1997 to $221 in 2007 (see chart 3). If policymakers wished to address the actuarial deficit in the first 25 years by uniformly reducing HI expenditures in all years, then as noted previously expenditures would have to be reduced by about 18 percent in each year. Such a reduction is illustrated in chart 3. (Mathematically, this approach is equivalent to reducing outlays in the first year by the desired percentage and then allowing subsequent expenditures to increase at the same rates as projected under current law.)

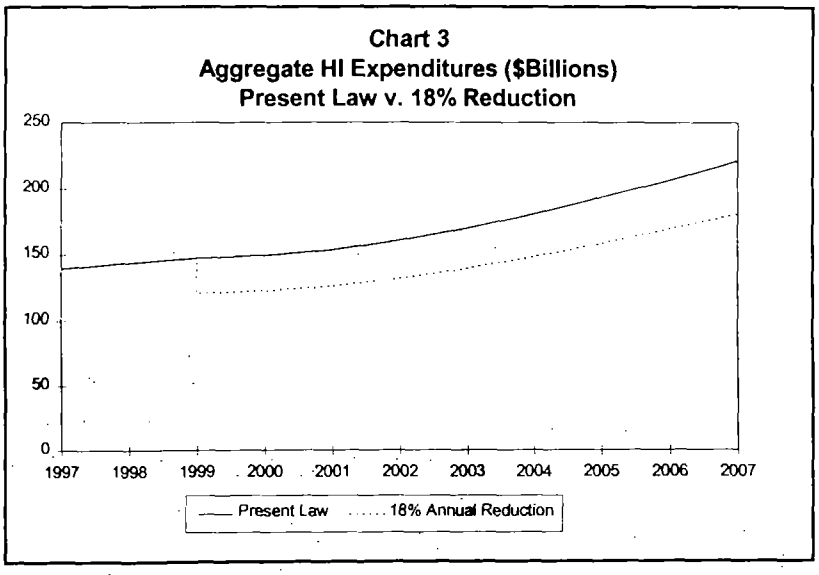


Table 2 shows the effects on the financial status of the HI trust fund of alternative proposals to reduce outlays in all future years by 10, 20, 30, or 40 percent relative to the levels projected under present law. These results indicate that a 10-percent reduction would delay trust fund depletion by 9 years; a 20-percent reduction by 20 years. A 20-percent reduction would also result in an actuarial balance of 0.03 percent for 1998-2022 (i.e., almost exact balance between future income and expenditures for the period), but an overall reduction of close to 40 percent would be required to achieve a zero balance over the full 75-year projection period.

As noted previously, these examples are intended to illustrate the nature of the financial imbalance facing the HI program and the impact of theoretical general approaches to closing the imbalance. In practice, developing legislative packages that would result in overall expenditure reductions of the magnitude illustrated here would be very challenging.

IV. Reducing annual growth in expenditures by a specified percentage (Table 3)

Another approach would be to reduce the rate of growth by a fixed percentage each year. Under present law, for example, HI expenditures are projected to increase at about 4.5 percent annually during 2000-2004. Under this category of proposals, an attempt would be made to reduce annual growth rates by a specified amount, such as 1 percentage point each year (i.e., to about 3.5 percent during 2000-2004). Similarly, growth rates in subsequent years would also be reduced by 1 percentage point. Over time, the effects of these lower growth rates would accumulate.

The effects of alternative reductions in growth rates are shown in table 3. To achieve solvency over the full 75-year projection period, growth rates would have to be reduced by about 2 percentage points in every year, relative to the intermediate projections. The effects of such a reduction are illustrated in chart 4. As can be seen by comparing charts 3 and 4, a reduction in growth rates would produce a different pattern of savings than would an overall percentage reduction.

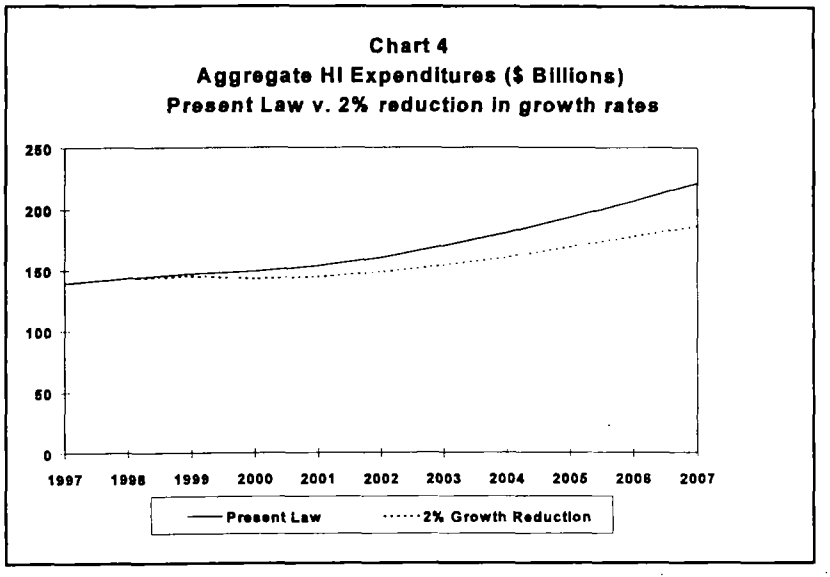
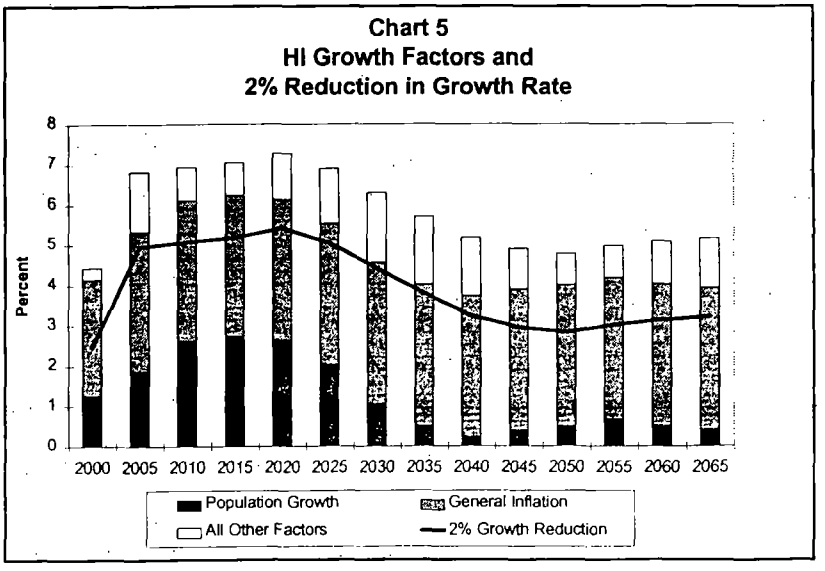


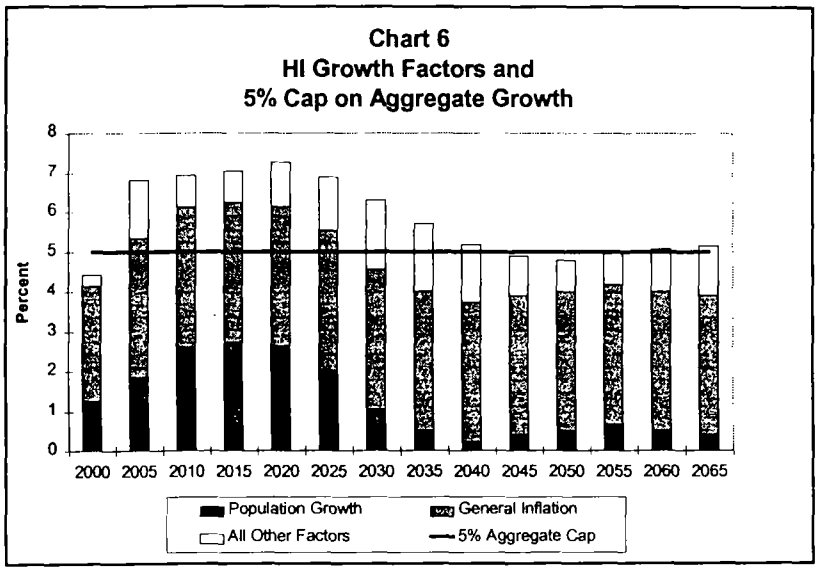
Chart 5 illustrates the nature of proposals to reduce expenditure growth rates. Growth rates under present law would be reduced by the same amount in each period (in this illustration, 2 percentage points). It is also apparent from chart 5 that achieving a 2-percentage-point reduction would necessitate growth rates below the level associated with population growth plus general inflation.



V. Limiting annual growth in aggregate expenditures to a specified maximum percentage (Table 4)

A variation of the approach described in the previous section would be to cap aggregate expenditure increases at a targeted level. If annual program growth fell below the target, the cap would have no effect; however, if expenditures grew faster than the target, then growth would be limited to the target level. For example, under the 1998 Trustees Report assumptions HI expenditure growth is projected to be 3.6 percent in 2000 and 7.1 percent in 2007. A 6-percent cap would not affect growth in 2000 but would reduce 2007 growth by 1.1 percentage points.

The financial effects of alternative caps on aggregate spending growth are shown in table 4. A 5-percent cap would fall a little short of bringing the program into exact actuarial balance throughout the long-range projection period.[3] Chart 6 compares a 5-percent cap with the projected expenditure growth rates under present law. As indicated, most of the reduction in growth rates under such a proposal would occur in the first half of the projection period.



VI. Limiting annual growth in per capita expenditures to a specified maximum percentage (Table 5)

Since Medicare population growth will not be constant (as indicated in the introduction), capping aggregate growth at constant levels would result in arbitrary fluctuations in per capita growth. Accordingly, some analysts have considered a cap on per capita expenditure growth rather than a cap on aggregate growth rates.

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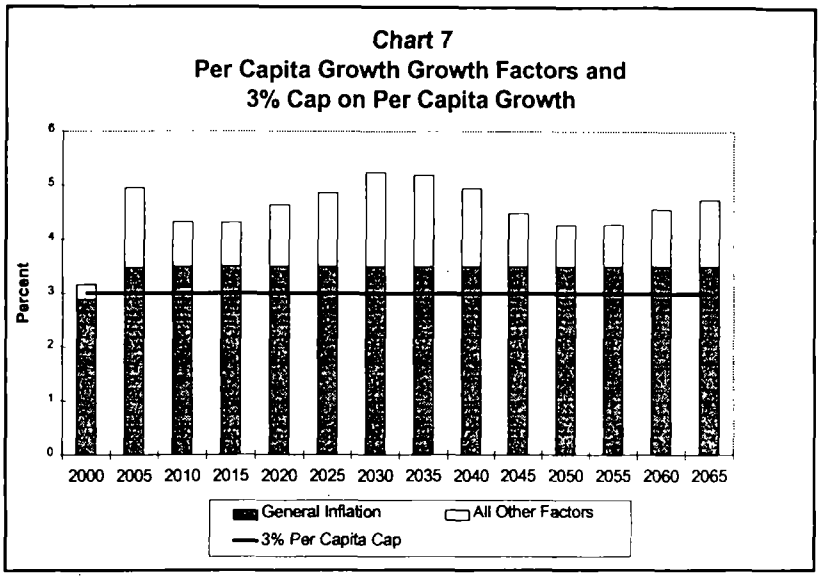
[3]Under the intermediate assumptions, HI tax revenue is projected to increase at around 5 percent per year. Most of this increase is due to assumed increases in average earnings subject to the HI payroll tax; a small portion is attributable to growth in the number of covered workers. Thus, if annual expenditure growth could be reduced to below 5 percent, then income and outgo would remain in approximate balance indefinitely.

Table 5 presents the estimated financial effects of alternative caps on per capita HI expenditure growth. The results indicate that a 3-percent per capita cap would fall somewhat short of bringing the program into balance for the first 25 years. Chart 7 illustrates the 3-percent per capita growth limitation in comparison to the projected per capita growth rates. As indicated, such a cap would require restricting growth to less than the levels required to keep pace with projected general inflation.



VII. Increasing the employer/employee tax rate by a specified percentage (Table 6)

Section I of this report illustrated the combination of expenditure reductions and/or revenue increases necessary to achieve actuarial balance over the first 25-year projection period. The scenarios in this report have so far considered the effects of reductions in HI expenditures. Alternatively, the effects of increasing the HI employer/employee tax rate by a specified percentage can be considered. Currently, the HI payroll tax rate is 1.45% for employers and employees, each, for a total of 2.9%, and this tax rate will remain in effect in all future years unless legislation is enacted to modify the rate. Table 6 illustrates the financial effects of alternative proposals to increase the employer/employee tax rate by a specified percentage. For example, a 0.25% increase in the tax rate for employers and employees, each, yielding a combined 0.5% increase and hence a new total payroll tax rate of 3.4%, would result in an exhaustion date of 2020 (close to the end of the first 25-year projection period). A 1% employer/employee tax increase, increasing the combined tax rate from 2.9% to 4.9%, would nearly maintain solvency over the full 75-year projection period and would just meet the Trustees' long-range test.

In each of these tax illustrations, an increase in the tax rate would initially result in an accumulation of trust fund assets while tax income exceeded expenditures. Subsequently, as expenditures increased as a percentage of taxable payroll to a level in excess of the combined tax rate, income would be inadequate to cover costs and trust fund assets would be drawn down to cover the shortfall. This financing pattern is very similar to the projected financial operations for the Social Security program and has generated considerable debate over the advantages and disadvantages of accumulating large trust fund reserves invested in Treasury securities. A discussion of these issues exceeds the scope of this memorandum.

VIII. Conclusion

The results here indicate that substantial reductions in future HI expenditures or expenditure growth rates and/or increases in payroll tax rates would be required to address projected deficits. The illustrations also show that the year-by-year patterns of savings can vary substantially among the different approaches.

As a final illustration, table 7 shows the year-by-year expenditure reductions or payroll tax revenue increases that would be required to exactly balance income and outlays and to maintain trust fund assets at the level of one year's expenditures. The results indicate that a reduction in expenditures of about $149 billion or about 10 percent of present-law expenditures would be required during 1999-2007, with steadily larger reductions necessary in later years. The corresponding increases in HI tax revenues are slightly larger in the short range, and considerably larger in the long run.

Once again, these estimates are illustrative and do not represent an expression of desired policy by the Office of the Actuary or the Health Care Financing Administration. Moreover, the implications of any effort to reduce HI costs or increase HI taxes deserve careful consideration and analysis extending well beyond these illustrations.

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Attachments: 7

Table1--Projected growth of factors affecting future HI expenditures, based on the intermediate set of assumptions from the 1998 Trustees Report

Period	Average annual percentage increase in... No. of HI beneficiaries	General inflation 1/	All other factors 2/	HI expenditures Aggregate	HI expenditures Per Capita
1998-1999	1.21%	1.90%	-0.40%	2.72%	1.49%
2000-2004	1.26	2.88	0.28	4.47	3.17
2005-2009	1.86	3.48	1.48	6.96	5.01
2010-2014	2.61	3.50	0.83	7.08	4.36
2015-2019	2.73	3.50	0.81	7.19	4.34
2020-2024	2.63	3.50	1.14	7.43	4.68
2025-2029	2.03	3.50	1.36	7.04	4.91
2030-2034	1.05	3.50	1.74	6.41	5.30
2035-2039	0.51	3.50	1.69	5.79	5.25
2040-2044	0.23	3.50	1.45	5.24	5.00
2045-2049	0.40	3.50	0.99	4.94	4.52
2050-2054	0.50	3.50	0.77	4.82	4.30
2055-2059	0.67	3.50	0.78	5.01	4.31
2060-2064	0.51	3.50	1.06	5.13	4.60
2065-2069	0.41	3.50	1.24	5.21	4.78
1998-2019	2.03	3.21	0.75	6.09	3.98
2020-2044	1.29	3.50	1.47	6.38	5.03
2045-2069	0.50	3.50	0.96	5.02	4.50

1/ As measured by the Consumer Price Index.

2/ All other factors include "excess" wage and price increases in the health sector, relative to the CPI, and increases in the average volume and intensity of services per beneficiary. After 2010, much of the variation shown in the all-other category is related to change in the utilization of services as the baby boom generation moves into and through the beneficiary population.

Office of the Actuary
Health Care Financing Administration
May 14, 1998

Table 2 -- Estimated financial effects of alternative proposals to reduce future HI expenditures by an overall percentage in all years, relative to present law ("overall reduction")

	Present law	Reduce present-law expenditures in each year by... 10%	20%	30%	40%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022	-0.73%	-0.35%	0.03%	0.41%	0.79%
1998-2047	-1.61%	-1.14%	-0.66%	-0.19%	0.29%
1998-2072	-2.10%	-1.57%	-1.04%	-0.52%	0.01%
B. Reduction in HI expenditures (in billions)					
1999	-	$11	$22	$32	$43
2000	-	15	29	44	59
2001	-	15	30	46	61
2002	-	16	32	48	64
2003	-	17	34	50	67
2004	-	18	36	54	72
2005	-	19	38	57	77
2006	-	20	41	61	82
2007	-	22	44	66	88
1999-2003	-	74	147	220	294
1999-2007	-	153	306	458	613
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999	73%	81%	91%	104%	121%
2000	68%	88%	111%	141%	182%
2001	63%	93%	129%	177%	240%
2002	58%	98%	148%	213%	299%
2003	53%	103%	166%	248%	356%
2004	46%	105%	181%	278%	408%
2005	37%	106%	194%	307%	457%
2006	27%	106%	205%	333%	503%
2007	16%	104%	215%	357%	547%
2010	(*)	90%	234%	418%	664%
2015	(*)	37%	228%	473%	801%
2020	(*)	(*)	176%	472%	868%
2025	(*)	(*)	77%	414%	863%
2030	(*)	(*)	(*)	318%	819%
2035	(*)	(*)	(*)	200%	762%
2040	(*)	(*)	(*)	65%	703%
2045	(*)	(*)	(*)	(*)	644%
2050	(*)	(*)	(*)	(*)	583%
2055	(*)	(*)	(*)	(*)	515%
2060	(*)	(*)	(*)	(*)	433%
2065	(*)	(*)	(*)	(*)	334%
2070	(*)	(*)	(*)	(*)	220%
D. Year of trust fund depletion	2008	2017	2028	2042	Never
E. Board of Trustees tests:					
Short range test	No	Yes	Yes	Yes	Yes
Long-range test	No	No	No	No	Yes

* Fund is depleted.

Notes:
1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
2. Illustrative proposals are assumed to take effect starting in 1999.
3. All years shown are calendar years.
4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1998 HI Trustees Report.

Office of the Actuary
Health Care Financing Admin.
May 14, 1998

Table 3 -- Estimated financial effects of alternative proposals to reduce annual growth in HI expenditures ("growth rate reduction")

	Present law	Reduce expenditure growth rate in each year by... 1%	2%
A. Actuarial Balance (percentage of taxable payroll)			
1998-2022	-0.73%	-0.28%	0.09%
1998-2047	-1.61%	-0.60%	0.15%
1998-2072	-2.10%	-0.61%	0.36%
B. Reduction in HI expenditures (in billions)			
1999	-	$1	$2
2000	-	3	6
2001	-	4	9
2002	-	6	12
2003	-	8	16
2004	-	10	20
2005	-	12	24
2006	-	15	29
2007	-	18	35
1999-2003	-	22	45
1999-2007	-	77	153
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)			
1999	73%	73%	74%
2000	68%	71%	74%
2001	63%	68%	73%
2002	58%	66%	75%
2003	53%	64%	78%
2004	46%	62%	82%
2005	37%	60%	86%
2006	27%	57%	90%
2007	16%	53%	95%
2010	(*)	38%	112%
2015	(*)	0%	145%
2020	(*)	(*)	176%
2025	(*)	(*)	196%
2030	(*)	(*)	211%
2035	(*)	(*)	239%
2040	(*)	(*)	299%
2045	(*)	(*)	411%
2050	(*)	(*)	597%
2055	(*)	(*)	876%
2060	(*)	(*)	1254%
2065	(*)	(*)	1745%
2070	(*)	(*)	2369%
D. Year of trust fund depletion	2008	2015	Never
E. Board of Trustees tests:			
Short range test	No	No	No
Long-range test	No	No	Yes

* Fund is depleted.

Note 1. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.
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Table 4 -- Estimated financial effects of alternative proposals to limit annual growth in aggregate HI expenditures to a specified maximum percentage ("aggregate cap")

	Present law	Cap annual growth in aggregate expenditures at... 4%	5%	6%
A. Actuarial Balance (percentage of taxable payroll)				
1998-2022	-0.73%	0.10%	-0.16%	-0.43%
1998-2047	-1.61%	0.37%	-0.17%	-0.81%
1998-2072	-2.10%	0.54%	-0.22%	-1.08%
B. Reduction in HI expenditures (in billions)				
1999	-	$0	$0	$0
2000	-	0	0	0
2001	-	0	0	0
2002	-	1	0	0
2003	-	3	1	0
2004	-	8	4	1
2005	-	13	7	3
2006	-	20	12	5
2007	-	27	16	8
1999-2003	-	4	1	0
1999-2007	-	72	40	17
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)				
1999	73%	73%	73%	73%
2000	68%	68%	68%	68%
2001	63%	63%	63%	63%
2002	58%	58%	58%	58%
2003	53%	54%	53%	53%
2004	46%	49%	47%	46%
2005	37%	46%	40%	38%
2006	27%	44%	35%	30%
2007	16%	43%	30%	21%
2010	(*)	49%	15%	(*)
2015	(*)	84%	(*)	(*)
2020	(*)	151%	(*)	(*)
2025	(*)	252%	(*)	(*)
2030	(*)	388%	(*)	(*)
2035	(*)	566%	(*)	(*)
2040	(*)	792%	(*)	(*)
2045	(*)	1068%	(*)	(*)
2050	(*)	1397%	(*)	(*)
2055	(*)	1787%	(*)	(*)
2060	(*)	2243%	(*)	(*)
2065	(*)	2775%	(*)	(*)
2070	(*)	3391%	(*)	(*)
D. Year of trust fund depletion	2008	Never	2013	2009
E. Board of Trustees tests:				
Short range test	No	No	No	No
Long-range test	No	No	No	No

* Fund is depleted.

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Table 5 -- Estimated financial effects of alternative proposals to limit annual growth in per capita HI expenditures to a specified maximum percentage ("per capita cap")

	Present law	Cap annual growth in per capita expenditures at... 2%	3%	4%	5%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022	-0.73%	0.10%	-0.20%	-0.50%	-0.70%
1998-2047	-1.61%	0.37%	-0.21%	-0.93%	-1.53%
1998-2072	-2.10%	0.68%	-0.03%	-1.04%	-1.98%
B. Reduction in HI expenditures (in billions)					
1999	-	$0	$0	$0	$0
2000	-	0	0	0	0
2001	-	1	0	0	0
2002	-	2	0	0	0
2003	-	6	2	0	0
2004	-	12	6	3	1
2005	-	18	11	5	1
2006	-	25	15	8	2
2007	-	33	20	10	2
1999-2003	-	9	2	0	0
1999-2007	-	97	54	26	6
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999	73%	73%	73%	73%	73%
2000	68%	68%	68%	68%	68%
2001	63%	63%	63%	63%	63%
2002	58%	59%	58%	58%	58%
2003	53%	56%	53%	53%	53%
2004	46%	54%	48%	46%	46%
2005	37%	53%	43%	37%	37%
2006	27%	54%	40%	32%	28%
2007	16%	57%	36%	25%	18%
2010	(*)	73%	28%	(*)	(*)
2015	(*)	114%	8%	(*)	(*)
2020	(*)	164%	(*)	(*)	(*)
2025	(*)	224%	(*)	(*)	(*)
2030	(*)	311%	(*)	(*)	(*)
2035	(*)	468%	(*)	(*)	(*)
2040	(*)	739%	(*)	(*)	(*)
2045	(*)	1161%	(*)	(*)	(*)
2050	(*)	1757%	(*)	(*)	(*)
2055	(*)	2557%	(*)	(*)	(*)
2060	(*)	3599%	(*)	(*)	(*)
2065	(*)	4988%	(*)	(*)	(*)
2070	(*)	6815%	(*)	(*)	(*)
D. Year of trust fund depletion	2008	Never	2016	2009	2008
E. Board of Trustees tests:					
Short range test	No	No	No	No	No
Long-range test	No	No	No	No	No

* Fund is depleted.

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2. Illustrative proposals are assumed to take effect starting in 1999.
3. All years shown are calendar years.
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Table 6 -- Estimated financial effects of alternative proposals to increase the HI tax rate for employers and employees, each, by a specified percentage

	Present law	Increase the employer/employee payroll tax rate by ... 0.25%	0.50%	0.75%	1.00%
A. Actuarial Balance (percentage of taxable payroll)					
1998-2022	-0.73%	-0.25%	0.23%	0.71%	1.18%
1998-2047	-1.61%	-1.13%	-0.64%	-0.15%	0.33%
1998-2072	-2.10%	-1.61%	-1.12%	-0.64%	-0.15%
B. Increase in payroll tax revenues (in billions)					
1999	-	$16	$32	$49	$65
2000	-	23	45	68	90
2001	-	24	47	71	94
2002	-	25	49	74	98
2003	-	26	51	77	103
2004	-	27	54	81	108
2005	-	28	57	85	113
2006	-	30	60	90	119
2007	-	31	63	94	126
1999-2003	-	114	224	339	450
1999-2007	-	230	458	689	916
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
1999	73%	73%	73%	73%	73%
2000	68%	84%	99%	115%	130%
2001	63%	94%	125%	156%	187%
2002	58%	104%	151%	198%	245%
2003	53%	114%	176%	238%	301%
2004	46%	121%	198%	275%	352%
2005	37%	127%	218%	309%	400%
2006	27%	131%	236%	341%	446%
2007	16%	134%	252%	371%	489%
2010	(*)	133%	290%	447%	605%
2015	(*)	97%	310%	524%	737%
2020	(*)	20%	279%	538%	797%
2025	(*)	(*)	195%	490%	784%
2030	(*)	(*)	73%	402%	730%
2035	(*)	(*)	(*)	292%	659%
2040	(*)	(*)	(*)	166%	582%
2045	(*)	(*)	(*)	27%	502%
2050	(*)	(*)	(*)	(*)	415%
2055	(*)	(*)	(*)	(*)	319%
2060	(*)	(*)	(*)	(*)	208%
2065	(*)	(*)	(*)	(*)	81%
2070	(*)	(*)	(*)	(*)	(*)
D. Year of trust fund depletion	2008	2020	2032	2045	2068
E. Board of Trustees tests:					
Short range test	No	Yes	Yes	Yes	Yes
Long-range test	No	No	No	No	Yes

* Fund is depleted.

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2. Illustrative proposals are assumed to take effect starting in 1999.
3. All years shown are calendar years.
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Table 7--Estimated reductions in HI expenditures or increases in payroll tax revenues required to maintain HI trust fund assets at 100% of annual expenditures ("actuarial balance")

	Reduction in HI expenditures...		Increase in payroll tax revenues...	
CY	In billions of dollars	As a % of present law expenditures	In billions of dollars	As a % of present law payroll taxes
1999	$9	6%	$19	15%
2000	20	14%	31	24%
2001	26	17%	7	5%
2002	8	5%	10	7%
2003	10	6%	12	8%
2004	13	7%	16	10%
2005	16	8%	20	12%
2006	22	11%	25	14%
2007	25	11%	28	15%
2010	(*)	15%	(*)	22%
2015	(*)	23%	(*)	34%
2020	(*)	31%	(*)	52%
2025	(*)	39%	(*)	73%
2030	(*)	44%	(*)	92%
2035	(*)	48%	(*)	108%
2040	(*)	50%	(*)	115%
2045	(*)	51%	(*)	121%
2050	(*)	52%	(*)	125%
2055	(*)	52%	(*)	128%
2060	(*)	53%	(*)	132%
2065	(*)	54%	(*)	140%
2070	(*)	56%	(*)	149%
1999-2007	149	10%	168	13%
1999-2070	(*)	51%	(*)	120%

* Estimates of the dollar expenditure reductions and payroll tax increases and their totals are shown only through 2007, since inflation and interest cause such amounts to lose their meaning over long periods.

Notes: 1. Currently, the trust fund ratio is slightly under 100%. Under these scenarios, the ratio would reach 100% in the year 2001, after which the necessary reductions or increases would maintain the ratio at 100% every year thereafter. This would result in a slightly negative actuarial balance over the entire period beginning from 1999, and a zero actuarial balance beginning from 2001. Both the short-range and long-range tests of the Trustees would be satisfied over the entire period.

2. The above estimates are based on the intermediate set of assumptions from the 1998 Trustees Report.

Office of the Actuary
Health Care Financing Administration
May 14, 1998

PRESIDENT CLINTON UNVEILS PRINCIPLES FOR MEDICARE REFORM AND UNDERSCORES NEED TO DEDICATE THE SURPLUS TO MEDICARE

February 3, 1999

Today, in his speech to the American Association of Retired Persons (AARP), President Clinton underscored the need to dedicate 15 percent of the budget surplus to secure the Medicare Trust Fund until 2020. He stressed his preference for bipartisan Medicare reform that is necessary to modernize Medicare and achieve additional savings to strengthen the program, and outlined four main principles that he believes any such plan should meet. The President:

- **Highlighted the Need to Dedicate Budget Surplus to Strengthen Medicare.** The President highlighted the fact that, while we need reform to improve competition and efficiency in the Medicare program, these reforms will not produce savings that are sufficient to significantly extend the life of the Trust Fund. In fact, if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be limited to 2.8 percent per year -- in every year -- to get to 2020. This rate is over 60 percent below projected private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. These projections help explain why virtually every independent health analyst agrees that Medicare cannot be significantly strengthened without adding outside financial support such as the surplus.

- **Unveiled Principles to Guide Medicare reform.** The President outlined principles that he will use to evaluate any Medicare reform proposal. Any broad-based reforms should:

  - **Dedicate Surplus to Secure Medicare until 2020.** One of the fundamental goals of Medicare reform is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century. These challenges cannot be addressed solely through making the program more efficient, transferring current liabilities out of the Trust Fund, or increasing payments. The President is proposing to use 15 percent of the projected surpluses over the next 15 years to secure the Medicare Trust Fund until 2020 as part of broader reforms to further strengthen the program.

  - **Modernize Medicare and Make It More Competitive.** Medicare should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with the private spending. Moreover, strong and effective Federal administration of Medicare should be assured.

  - **Guarantee Defined Set of Benefits Without Excessive New Costs to Beneficiaries**. Beneficiaries should still be entitled to an adequate set of health benefits. A modernized, well-defined benefits package is needed to assure that health plans compete on cost and quality rather than price. Reforms should also maintain or strengthen protections for low-income beneficiaries, assure that any new cost burdens are not excessive, and assure that beneficiaries have access to a viable traditional Medicare program.

  - **Use Savings from Reform to Help Fund a Prescription Drug Benefit.** Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. In fact, over half of Medicare beneficiaries pay more than $500 per month for prescription drugs and one in ten pay more than $2,000. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. The President believes that additional savings from making Medicare more efficient should be used to help finance a long-overdue prescription drug benefit for all Medicare beneficiaries.

MEDICARE TRUSTEES' REPORT: 1999

March 30, 1999

*Today, the Medicare Trustees projected that the life of the Medicare Trust Fund has been extended until **2015** -- 7 years longer than projected in last year's report. This report affirms that the President's commitment to strengthening and improving Medicare is paying dividends, but it also underscores the need for additional action to strengthen and improve the program.*

- **The Trustees' Report on the Improved Financial Status of Medicare is Good News and Reflects that the Hard Choices the President Made in 1993 and 1997 Strengthened the Program and Were Justified.** When the President came into office, the Medicare program was projected by the Trustees to go bankrupt by 1999. The Trustees' Report validates the President's economic policies. It reports that: "income exceeded expectations as a result of robust economic growth and expenditures declined due to implementation of the Balanced Budget Act of 1997, low increases in health care costs generally, and continuing efforts to combat fraud and abuse." In the last few years, the life of the Trust Fund has been extended by a full 14 years and the actuarial deficit has been cut by two-thirds.

- **Good News Does Not Delay the Need for Decisive Action.** We are proud of our stewardship of the Medicare program. However, our success does not in any way diminish the challenges facing Medicare. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. As the Trustees' Report points out, "substantially greater changes in income and/or outlays are needed, in large part as a result of the impending retirement of the baby boom generation."

- **The President's Proposal to Modernize Medicare and to Dedicate 15 Percent of the Surplus to the Program is Clearly Necessary to Adequately Extend the Life of the Trust Fund and Add a Long Overdue Prescription Drug Benefit.** While the financial well-being of the Medicare program has improved, its reserves will become exhausted just as the baby boom population begins to retire and long before those of the Social Security program. Moreover, 15 million beneficiaries have absolutely no prescription drug coverage, millions more have totally inadequate coverage, and our nation's elderly are paying excessively high costs for their desperately needed medications. The President's Medicare reform proposal will address these unmet challenges.

- **We Now Face A Historic Fiscal Choice: Do we use the surplus to strengthen and modernize Medicare and keep the program solvent further into the future OR do we use it to provide for an exploding and irresponsible tax cut.** If we choose unwisely and use the surplus to finance tax cuts -- rather than Social Security and Medicare -- we will have made one of the most short-sighted fiscal decisions in our nation's history. Not only will we leave two programs unacceptably weakened, but we will have given up on an unprecedented opportunity to reduce our nation's debt from 44 percent of GDP to 7 percent by 2014 -- the lowest level since 1917. We must use this historic opportunity to strengthen Medicare by devoting 15 percent of the budget surplus to this program over the next 15 years and modernizing Medicare to help fund a prescription drug benefit.

BREAUX-THOMAS MEDICARE REFORM PLAN
March 19, 1999

Medicare Commission has made an important contribution. Thanks to the leadership both of the Commission and the President, the problems facing the Medicare program are getting the attention it deserves.

The Breaux-Thomas proposal has advanced the debate. The plan has recommended a number of ideas worth serious consideration, including:

- **Making Medicare's traditional plan more competitive**: It recommends that the program use the same effective, competitive management tools that are used in the private sector.

- **Simplifying Medicare's complicated, confusing and multiple deductible structure**: It recommends creating a single, simple deductible. It also eliminates cost sharing for preventive services, an Administration priority for years.

- **Recognizes need for expanded coverage of prescription drugs:** By expanding Medicaid prescription drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries. But we can and must do better than providing coverage for fewer than one in ten beneficiaries. The widespread use of drugs in modern medicine, their high cost, and the inaccessibility and unaffordability of drug coverage present problems for all Medicare beneficiaries, not just the poorest.

Despite important contributions, the Breaux-Thomas proposal falls short.

- **It does not address Medicare's financing**: Because it includes no additional commitment for financing, the proposal ducks the economic reality that every independent Medicare expert confirms -- the demographic explosion of the Medicare program will require more financing. No amount of structural reform or cost cutting can compensate for this. The lack of financing makes the problem much larger to solve in the future and shifts more of the burden to our nation's children. <u>This is why the President proposed to dedicate 15 percent of the surplus over the next 15 years to Medicare, to save some of today's prosperity for tomorrow's needs</u>. We cannot waste this historic opportunity.

- **Raises the age eligibility for Medicare**: We are extremely skeptical of any plan that would increase the numbers of uninsured. The most rapidly growing group of the uninsured are between the ages of 55-65; raising the eligibility age of Medicare without a policy that assures that there will not be even more uninsured elderly is simply the wrong thing to do.

- **Includes flawed "premium support" proposal**: The President is committed to adding competition to Medicare, but not at the risk of harming the existing program or its beneficiaries. The current construction of the Breaux-Thomas premium support plan would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to the independent Medicare actuary. Although the plan attempts to address this problem for beneficiaries with no private plan options, those with limited or unattractive private options would be forced to pay more to stay in the system. We believe that this is unacceptable.

MAJOR ISSUES WITH THE BREAUX-THOMAS PLAN

- **No specific plan for Medicare financing**: The plan contains no options for raising new revenue for Medicare -- and does not reference the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding. By waiting, the size of the funding needed becomes larger, and the burden of paying for it increasingly gets shifted to younger generations.

- **Overly optimistic estimates of premium support savings**: The Commission's document uses Commission staff estimates of the impact of premium support on growth -- suggesting that it could reduce Medicare spending by 1 percentage point. This is considerably larger than what the HCFA Actuaries -- who also report to the Medicare Trustees -- project. Their estimates suggest that premium support reduces growth by about 0.2 percentage over time.

- **Vague premium support plan:** The premium support proposal is missing essential information on how it would work-- which, in turn, determines how much it will save and how much it will affect beneficiaries. For example, it is not clear when and how payments will be adjusted for the beneficiaries' risk. There is no mention of geographic adjustment, implying that a beneficiary could end up paying more for a private plan -- not because the plan is more expensive -- but because they live in an urban area. And, since private plans can offer unstandardized extra benefits, possibly at the government's expense, price competition -- the goal of premium support -- could be replace by competition on benefits and risk.

- **No meaningful prescription drug benefit**: Although the proposal would require private managed care plans, Medigap, and Medicare fee-for-service to offer a drug benefit, there appears to be no definition of what this benefit is. Moreover, it would only provide premium assistance for beneficiaries with premiums below 135 percent of poverty through Medicaid. This would move Medicare towards a means-tested, Medicaid-like program. It also would inevitably result in large adverse selection in the unsubsidized Medicare fee-for-service option, especially since beneficiaries would have to purchase stop-loss as well as drug coverage, which attracts sicker beneficiaries.

- **Age eligibility increase without a viable insurance alternative**: Although there is a suggestion that vulnerable sick people ages 65 to 67 would get Medicare, the proposal explicitly states that the Medicare buy-in would be unsubsidized and would not begin at 62 (which is truly conforming to Social Security). This plan would lead to a potentially large increase in the uninsured.

- **Removing direct medical education is the same "gimmick" that the Commission criticizes:** The Commission's report criticizes proposals to transfer liabilities out of Medicare to improve solvency. Yet, the Commission itself proposes to do this. About one-fifth of the "savings" of the Commission is not Federal budget savings, but movement of education spending from Medicare to other parts of the budget.

- **Board could end up being a new bureaucracy**: Although there are legitimate reasons for a new independent board, it appears to have so many functions -- including a negotiation with each and every plan interested in participating in Medicare -- that it would end up being a large bureaucracy -- but one that is exempted from government oversight.

MEDICARE TRUSTEES' REPORT: 1999

March 30, 1999

*Today, the Medicare Trustees projected that the life of the Medicare Trust Fund has been extended until **2015** -- 7 years longer than projected in last year's report. This report affirms that the President's commitment to strengthening and improving Medicare is paying dividends, but it also underscores the need for additional action to strengthen and improve the program.*

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- **We Now Face A Historic Fiscal Choice: Do we use the surplus to strengthen and modernize Medicare and keep the program solvent further into the future OR do we use it to provide for an exploding and irresponsible tax cut.** If we choose unwisely and use the surplus to finance tax cuts -- rather than Social Security and Medicare -- we will have made one of the most short-sighted fiscal decisions in our nation's history. Not only will we leave two programs unacceptably weakened, but we will have given up on an unprecedented opportunity to reduce our nation's debt from 44 percent of GDP to 7 percent by 2014 -- the lowest level since 1917. We must use this historic opportunity to strengthen Medicare by devoting 15 percent of the budget surplus to this program over the next 15 years and modernizing Medicare to help fund a prescription drug benefit.

MAJOR ISSUES WITH THE BREAUX-THOMAS PLAN

- **No specific plan for Medicare financing**: The plan contains no options for raising new revenue for Medicare -- and does not reference the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding. By waiting, the size of the funding needed becomes larger, and the burden of paying for it increasingly gets shifted to younger generations.

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- **Board could end up being a new bureaucracy**: Although there are legitimate reasons for a new independent board, it appears to have so many functions -- including a negotiation with each and every plan interested in participating in Medicare -- that it would end up being a large bureaucracy -- but one that is exempted from government oversight.

BREAUX-THOMAS MEDICARE REFORM PROPOSAL

Senator Breaux has made a constructive contribution toward addressing the challenges facing Medicare. After more than a year of work, the Medicare Commission has helped to focus long-overdue attention on the need to modernize the program and prepare it for retirement of the baby boom generation. Some of its recommendations should be seriously considered by the Congress. The President wants to thank Senator Breaux, Congressman Thomas and all the members of the Commission, particularly his appointees (Laura Tyson, Stuart Altman, Bruce Vladeck and Tony Watson), for all their hard work.

The Breaux-Thomas plan, however, falls short in a number of key areas and therefore the President cannot support it. In January, the President outlined the principles that he would use to evaluate the Commission's work product. This plan does not appear to include elements that are essential to strengthening Medicare and better preparing it for the twenty-first century. In particular, the plan:

- **Does not provide necessary new revenues for Medicare and passes up an historic opportunity to dedicate 15 percent of the surplus to the program.** Every independent Medicare expert agrees that the program cannot provide the baby boom generation with Medicare benefits without substantial new revenue. Unfortunately, the Breaux-Thomas plan does not provide these new revenues. Instead, it recommends waiting to act until Medicare's solvency is at risk. But waiting will make the problem harder to solve and shift more of the burden to our children. This is why the President proposed to dedicate part of the surplus to Medicare immediately, to save some of today's prosperity for tomorrow's needs.

- **Increases Medicare eligibility age without a policy to protect against large increases in the numbers of the uninsured.** As you know, the President is deeply concerned about the increase in the uninsured population, particularly among older Americans. That is why he proposed allowing some people ages 55 to 65 to buy into Medicare. These problems will only get worse under a proposal that postpones Medicare eligibility without providing premium assistance for alternative health coverage.

- **Proposes a premium support model that could adversely affect premiums for the traditional Medicare program.** The President is committed to adding competition and private sector approaches to the Medicare program, but will not risk harming the existing program or its beneficiaries. Senator Breaux's premium support model has the potential to increase premiums for the traditional Medicare program and, as such, make it more difficult to access. The President cannot support this premium support concept until these and other fundamental questions are adequately answered.

- **Provides inadequate coverage of prescription drugs.** While the President recognizes Senator Breaux's leadership in acknowledging the need for prescription drug coverage, the Breaux-Thomas proposal does not provide an accessible, affordable option for all beneficiaries. Most respected health economists agree that the current system's patchwork coverage of prescription drugs is highly inefficient and expensive. Senator Breaux's proposal goes part of the way but not far enough to reform this system.

The President will build on the Commission's work and develop and propose a plan that can go the next step in attracting even greater consensus. He has instructed his health care advisors to take the best ideas from the Breaux-Thomas plan, from members of the Commission not voting for its plan, and from other members of Congress to craft a proposal that can receive bipartisan support and truly prepare Medicare for its future challenges. Medicare is not and should not become a partisan, political issue and the President is determined to work across party lines to strengthen and improve the program this year.

AARP

March 24, 1999

The Honorable J. Dennis Hastert
Speaker of the House
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

AARP believes it is important to protect Social Security's growing reserves and is pleased that the House Budget Resolution provides that protection. Over the next ten years, Social Security is projected to contribute $1.8 trillion of the unified surplus. Preserving Social Security's reserves not only allows our country to better prepare for the impending retirement of the baby boom generation, but also gives us greater financial flexibility to enact long-term reform in both Social Security and Medicare once the options have been carefully considered and their impact understood. In the meantime, maintaining Social Security's trust fund assets helps reduce the publicly held debt, further strengthening the economy.

We are also pleased that the Resolution does not call for reconciliation in the Medicare program. Much work remains to be done to strengthen and modernize Medicare—work that must be taken on judiciously and on a bipartisan basis. Currently, however, the program is still absorbing the impact of the changes enacted in the Balanced Budget Act of 1997. Until such changes are fully understood, we should move cautiously in making additional changes to the program.

The Association remains concerned that the tight constraints on domestic discretionary spending will place an inordinate burden on low-income programs such as elderly housing and home energy assistance. Inevitably, these caps will lead to difficult choices in providing for appropriations for these important programs and may need to be reconsidered in light of pressing needs.

601 E Street, NW Washington, DC 20049 (202) 434-2277 www.aarp.org
Joseph S. Perkins *President* Horace B. Deets *Executive Director*

The Resolution now before the House continues to move this year's budget process forward in a constructive manner. AARP is committed to working with the House on a bipartisan basis to achieve a Budget Resolution that takes advantage of the opportunities that come from a surplus and at the same time continues the course of fiscal discipline that our nation has worked hard to achieve.

Sincerely,

Horace B. Deets

cc: The Honorable Richard Gephardt

email
Woolley

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PRESIDENT CLINTON UNVEILS PRINCIPLES FOR MEDICARE REFORM AND UNDERSCORES NEED TO DEDICATE THE SURPLUS TO MEDICARE

February 3, 1999

Today, in his speech to the American Association of Retired Persons (AARP), President Clinton underscored the need to dedicate 15 percent of the budget surplus to secure the Medicare Trust Fund until 2020. He stressed his preference for bipartisan Medicare reform that is necessary to modernize Medicare and achieve additional savings to strengthen the program, and outlined four main principles that he believes any such plan should meet. The President:

- **Highlighted the Need to Dedicate Budget Surplus to Strengthen Medicare.** The President highlighted the fact that, while we need reform to improve competition and efficiency in the Medicare program, these reforms will not produce savings that are sufficient to significantly extend the life of the Trust Fund. In fact, if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be limited to 2.8 percent per year -- in every year -- to get to 2020. This rate is over 60 percent below projected private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. These projections help explain why virtually every independent health analyst agrees that Medicare cannot be significantly strengthened without adding outside financial support such as the surplus.

- **Unveiled Principles to Guide Medicare reform.** The President outlined principles that he will use to evaluate any Medicare reform proposal. Any broad-based reforms should:

  - **Dedicate Surplus to Secure Medicare until 2020.** One of the fundamental goals of Medicare reform is to put the program on stronger financial footing to better prepare it for the demographic and health challenges of the next century. These challenges cannot be addressed solely through making the program more efficient, transferring current liabilities out of the Trust Fund, or increasing payments. The President is proposing to use 15 percent of the projected surpluses over the next 15 years to secure the Medicare Trust Fund until 2020 as part of broader reforms to further strengthen the program.

  - **Modernize Medicare and Make It More Competitive.** Medicare should adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with the private spending. Moreover, strong and effective Federal administration of Medicare should be assured.

  - **Guarantee Defined Set of Benefits Without Excessive New Costs to Beneficiaries**. Beneficiaries should still be entitled to an adequate set of health benefits. A modernized, well-defined benefits package is needed to assure that health plans compete on cost and quality rather than price. Reforms should also maintain or strengthen protections for low-income beneficiaries, assure that any new cost burdens are not excessive, and assure that beneficiaries have access to a viable traditional Medicare program.

  - **Use Savings from Reform to Help Fund a Prescription Drug Benefit.** Millions of Medicare beneficiaries have no or inadequate coverage for their medications, limiting their access to needed treatments. In fact, over half of Medicare beneficiaries pay more than $500 per month for prescription drugs and one in ten pay more than $2,000. Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. The President believes that additional savings from making Medicare more efficient should be used to help finance a long-overdue prescription drug benefit for all Medicare beneficiaries.

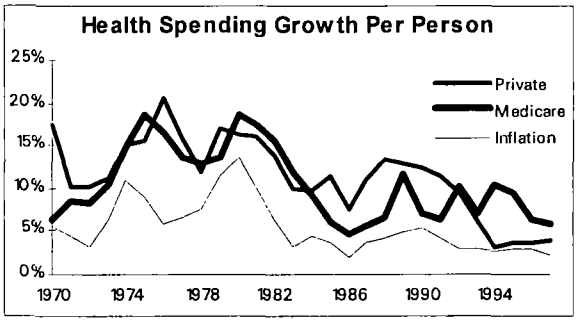
PRESIDENT'S FRAMEWORK FOR STRENGTHENING MEDICARE FOR THE 21st CENTURY

DRAFT: March 15, 1999

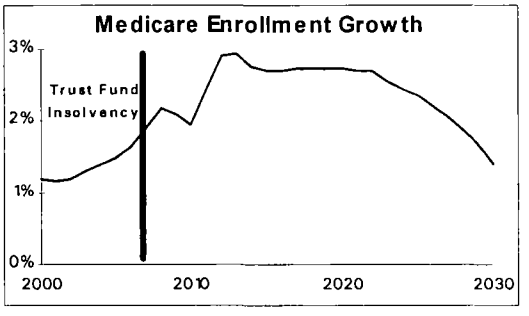
MEDICARE'S PROBLEMS ARE LARGE -- AND SOON

- **Impending "senior boom".** Like Social Security, Medicare enrollment will double between 1999 (39 million) and 2032 (78 million) as the baby boom generation retires. Not only will there be more elderly in the future, but the elderly will live up to 6 years longer on average by the middle of the next century.

- **Additional challenges of health care**. Compounding the demographic challenges are the unique factors that affect health spending -- changing disease patterns, technological advances, and a high value placed on health. For example, the improved ability to prevent and cure diseases, while making tremendous improvements in the nation's health, has also driven up costs. As a result, health spending growth has historically exceeded that of general inflation. These trends are expected to continue into the next century. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.



- **Improved but still large Trust Fund problem.** In 1993 when President Clinton took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent for the next ten years. This is due to the historic changes in the Balanced Budget Act of 1997, aggressive efforts to reduce Medicare fraud and the general health of the economy.



- **Medicare spending outstrips income**. Despite these improvements, Medicare is spending more than its annual income from payroll taxes and other sources. As such, it has begun to use up its assets -- as the baby boom generation begins to retire, these assets will be gone. Although Medicare's prognosis in the Trustees' 1999 report will almost inevitably be better due to strong revenues and continued low spending, the fact remains: current income sources will not be able to finance health care services for the baby boom generation.

- **Over $1 trillion shortfall by 2020.** Once Medicare's Part A Trust Fund runs out of money, it will have to borrow money -- with interest -- to pay for services. The annual shortfall in income plus this interest will build to over $1 trillion by 2020. Also, Medicare's Part B services are growing rapidly, causing the automatic premium increases and general revenue contribution to rise.

OPTIONS FOR ADDRESSING MEDICARE'S LONG-TERM SOLVENCY: A wide range of ideas have been considered to help solve Medicare's fiscal imbalance. These can be categorized as:

- **Reducing provider payments and increasing efficiency**
- **Eliminating or limiting benefits covered**
- **Increasing beneficiary contributions to Medicare** and/or
- **Adding new revenue to Medicare**

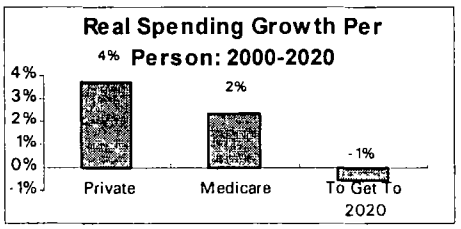
1. Reducing Provider Payments and Increasing Efficiency

Improving Medicare's efficiency and competitiveness and reducing its overpayments and fraud are the focus of most efforts to strengthen Medicare's financial situation.

- **Strong gains in reducing Medicare spending.** Working with Congress, this Administration has reigned in Medicare spending growth. Since 1992, overpayments to health care providers have been reduced, important preventive benefits have been added, and payment systems for services like skilled nursing facilities and managed care have been modernized. Additionally, aggressive efforts to reduce fraud have saved the government billions. As a result, Medicare spending growth per beneficiary is projected to grow at 5.8 percent between 2000 and 2020 -- compared to an average rate of 10.8 percent between 1970 and 1996.

- **Provider payment reductions and improved efficiency alone cannot solve Medicare's long-term problems.** Adopting effective management tools and reducing overpayments undoubtedly contributes towards Medicare long-term solvency. However, by themselves, they cannot solve this problem. if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be constrained to 2.8 percent per year -- in every year -- to get to 2020. To put this rate into perspective:

  - Medicare growth would have to be over 60 percent below projected private health insurance spending per person (7.3 percent). This growth rate is about 1 percent below inflation according to the Trustees, reducing the value of Medicare spending per beneficiary over time. By 2020, Medicare's spending would be 10 percent below today's level.



  - According the actuaries, the Medicare Commission's 2/17 premium support plan would only reduce Medicare per capita growth by 0.2 percentage points.

  - The President's FY 2000 budget proposes about $9 billion in provider payment cuts over the FY 2000-04 period-- these policies have generated intense opposition. To ensure solvency through 2020, Part A provider payments would have to be reduced by almost $1 trillion over this period.

2. Eliminating or Limiting Benefits Covered by Medicare

A second option for addressing Medicare's long-term solvency is to reduce its benefits (e.g., limit coverage for home health care services; eliminate coverage of skilled nursing facility care).

- **Today, Medicare benefits are sub-standard.** Medicare benefits were designed in 1965 to be similar to those offered by the private sector. Since then, however, Medicare benefits have not kept pace with changes, so that Medicare is now less generous than the coverage offered in 80 percent of large employer's health insurance plans.

- **Medicare does not cover prescription drugs**. Drugs have become an essential part of modern medicine, yet 13 million beneficiaries have no health insurance coverage, and millions more have inadequate or unstable coverage.

- **Without other changes, only removing major, critical services could keep Medicare solvent in the long-run** Although Medicare already has a limited benefits package, limiting it even more would not solve its long-term problems. Even removing all skilled nursing facility plus hospice spending or all graduate medical education and disproportionate share hospital spending from Medicare would not be enough to extend its solvency to 2020.

3. Increasing Beneficiary Contributions to Medicare

A third option for addressing Medicare's long-term financing problem is to have beneficiaries pay for more of the cost of health care.

- **Beneficiaries already pay for almost half of their health care costs**. Because of its less generous benefits and higher cost sharing, Medicare only pays 52 percent of the total health care costs of its beneficiaries.

- **Low-income and sick beneficiaries are particularly vulnerable to cost increases.** Despite Medicaid coverage of Medicare premiums and cost sharing for most poor beneficiaries, out-of-pocket health spending consumes over one-third of poor beneficiaries' income.

- **Relying on beneficiaries alone to solve the financing gap would increase Medicare premiums by 75 percent.** A $37 premium per month on top of the current premium would be needed to equal the amount transferred from the surplus in 2000 under the President's proposal. This would be about $890 a year for an elderly couple.

4. **Adding New Revenue to Medicare**

The fourth and final option is adding new revenue to Medicare to assure that its services are adequately funded in the next century. Unlike the previous options, adding new revenues does not change Medicare spending. Instead, it fills in the inevitable, remaining shortfall after some combination of the other options have reduced Medicare spending as much as possible.

- **Increasing the Medicare payroll tax would mean that all workers -- including younger and lower wage workers -- would pay for the shortfall**. Without reducing Medicare spending, nearly a 20 percent increase in the payroll tax for both employees and employers would be needed (from 2.9 to 3.4 percent combined) to fund Medicare through 2020. This includes the 60 million American workers who earn less than $30,000 in income (check).

- **Waiting creates a larger problem**. If funds aren't immediately added to the Medicare Trust Fund, its assets will continue to be used up, making size of the problem even larger. Moreover, this burden would increasingly fall on younger people as the baby boomers retire.

THE PRESIDENT'S FRAMEWORK FOR MEDICARE REFORM

In his State of the Union speech, the President outlined his framework for Medicare: improve Medicare's financial outlook by dedicating 15 percent of the surplus to its depleted Trust Fund, and enact broader reforms that will help pay for a long-overdue prescription drug benefit.

Dedicate Part of the Surplus to Secure Medicare. The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years (2000 through 2014). This amount would equal $686 billion over the period ($120 billion in the next 5 years).

- **Trust Fund solvency for at least another decade.** This early investment in the Medicare Trust Fund prevents it from being used up and allows it to generate income. This has the effect of adequately funding Medicare for at least another decade.

- **Surplus locked into Trust Fund**: Under this proposal, the Treasury would transfer the annual amount of funds to the Medicare Trust Fund. This amount would no longer be considered part of the unified budget surplus. Once these funds are transferred, they would be treated the same way as other HI Trust Fund assets. As such, they would be invested and generate interest income for the Trust Fund to the extent that they are not needed to pay for services. If there is not enough Trust Fund income to pay for HI expenditures, these funds, indistinguishable from other Trust Fund assets, would be redeemed to pay for that shortfall.

- **Investing now prevents larger problem later.** Even though the Medicare shortfall is projected to accumulate to over $1 trillion by 2020, the President's $686 billion investment can fill this hole because it is invested early, earns interest, and prevents Medicare from having to borrow to pay for services.

- **One-time, fixed contribution**. The President's proposal does not create an unlimited tap on general revenue for Medicare. Instead, it takes a fixed proportion of the surplus -- in large part created by the baby boom generation -- and invests it in Medicare to pay for the services when this generation retires. As such, it is similar to pre-funding: putting aside the extra revenues from the strong economy to pay for the temporary but overwhelming influx of retirees beginning in 2010.

Modernize Medicare and Make It More Competitive.

- **Commitment to strengthening Medicare's competitiveness.** The President has proposed many policies that would give Medicare the same tools that the private sector uses to control costs. He is committed to working with Congress on policies to adopt the best management, payment, clinical and competitive practices used by the private sector, to help maintain high-quality services and keep spending growth in line with the private spending.

Guarantee Defined Set of Benefits Without Excessive New Costs to Beneficiaries.

- **Strong, modernized defined benefits must be assured.** As reform proposals are considered by Congress, the President will evaluate them to assure that beneficiaries are entitled to an adequate set of health benefits. A modernized, well-defined benefits package is needed to assure that health plans compete on cost and quality rather than price. Proposals should also maintain or strengthen protections for low-income beneficiaries, assure that any new cost burdens are not excessive, and assure that beneficiaries have access to a viable traditional Medicare program.

Use Savings from Proposals to Help Fund a Prescription Drug Benefit.

- **Prescription drugs are an essential part of modern medicine.** Prescription drugs have become an essential part of treatments and cures, and are expected to play an even greater role in health care in the next century. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children.

- **Medicare does not cover prescription drugs.** About 13 million beneficiaries have no insurance coverage for drugs whatsoever, and millions more have unstable, inadequate or expensive coverage. Lack of coverage can hurt beneficiaries' health. One study found that elderly and disabled beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their drug coverage was limited.

- **Proposals to address Medicare's challenges should include a meaningful, affordable drug benefit for all beneficiaries.** The President believes that any legislation to prepare Medicare for the challenges of the next century must include coverage of prescription drugs. This coverage should be available to all beneficiaries, regardless of where they live or whether they are in a managed care plan. It should be affordable, with a large enough government contribution to the cost of the coverage to assure that all beneficiaries can afford the option. And it should designed and managed in a way comparable to private managed care plan coverage.

- **Paid for in the context of broader reforms.** A well-designed prescription drug benefit for Medicare could be financed in a comprehensive legislative package that both reduces spending through competition and aggressive purchasing and increases financing through dedication of funds from the surplus. The President believes that re-investing Medicare savings in this benefit will have a long-run effect of improving the medical management of Medicare beneficiaries, especially those with chronic illness, and reducing costs associated with underuse of critical drugs (e.g., unnecessary hospitalizations, complications). Adding this benefit would not detracting from the President's goal of making Medicare stable and solvent for another decade.

TALKING POINTS ON TRUSTEES' REPORT ON MEDICARE

- **Trustees' Report on Improved Financial Status of Medicare is Good News.** Today's news from the Trustees that the life of the Medicare Hospital Insurance (HI) Trust Fund has been extended until 2XXX is extremely good news. [INSERT STRONG STAT/QUOTE FROM THE TRUSTEES' REPORT]. The strong economy, the reforms included in the Balanced Budget Act of 1997, our aggressive anti-fraud and abuse enforcement activities, and strong program management have made important contributions to the encouraging new projections of the Trustees.

- **But We Cannot Allow the Positive News To Lull Us Into Complacency.** We are proud of our stewardship of the Medicare program. However, the positive news emerging from the Trustees' Report does not in any way diminish the challenges facing Medicare. The need for more financing within the context of broader reforms is essential to adequately preparing the program for the retirement of the baby boom population. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. [As the Trustees point out, "INSERT RELEVANT QUOTE FROM TRUSTEES' REPORT DOCUMENTING CONTINUING PROBLEM].

- **The President's Proposal to Dedicate 15 Percent of the Surplus to Medicare is Clearly Still Necessary to Confront Overwhelming Demographic Challenges.** [As the Trustees stressed in their report, "more revenues will be necessary unless untenable program reductions are considered (OR ANYTHING THAT APPROXIMATES THIS.] While the financial well being of the Medicare program has improved, its reserves will become exhausted long before those of the Social Security program. We cannot allow this historic opportunity to go by and not invest the surplus for our nation's future retirement security.

- **The Trustees' Report Simply Means that the President's Proposal Will Provide for a Longer Period of Solvency and a Real Opportunity for Prescription Drug Coverage in the Context of Broader Reforms.** The new projections from the Trustees -- combined with the President's financing and forthcoming reform proposal -- will strengthen and modernize the program even more than previously thought possible. And, when 15 million beneficiaries have absolutely no prescription drug coverage, millions more have totally inadequate coverage, and our nation's elderly are paying the highest costs in the world for their desperately needed medications, it is long past time for a new prescription drug benefit for this population.

- **We Now Face the Choice of the Millennium: To Use the Surplus to Strengthen, Modernize and Lengthen Medicare's Solvency Even More Than Was Previously Thought Possible OR to Use It to Provide for a Politically Attractive, but Dangerous and Irresponsible Tax Cut.** If we choose unwisely and use the surplus to finance tax cuts -- NOT Social Security and Medicare -- we will have made the one of the most short-sighted fiscal decision in our nation's history. Not only will we leave to programs unacceptably weakened, but we will have given up on an unprecedented opportunity to reduce our nation's debt from X% to Y%, thus ....

MEDICARE Q&As RE TRUSTEES REPORT

Q: The President said his goal was to extend the life of the Trust Fund until 2020. Are you now suggesting that you are raising the bar and making the Congress go further than 2020 to meet the President's desires on Medicare?

A: The President always has and will continue to firmly believe that we should dedicate 15 percent of the surplus to Medicare. The fact that the Trustees are now projecting that the program is in better shape does not in any way alter the need for the President's proposal. The demographics and the costs are still overwhelming. It is important to recall that even with the new changes in estimates, Medicare remains in worse financial shape than Social Security (2xxx vs. 2xxx as it relates to projected exhaustion dates). The new projections simply mean that we can use the surplus to extend the life of the Trust Fund longer than 2020 and, in the context of broader reform, help pass a long-overdue prescription drug benefit for some of our most vulnerable the nation's citizens.

Q: FOLLOW-UP: At the State of the Union, the President said that we only needed to make Medicare solvent to 2020. Now that the numbers are better, aren't you just raising the bar to ensure that it is impossible for the Republicans to pay for their tax cut?

A: No. The President has said he is committed to dedicating 15 percent of the surplus to Medicare as part of a broader effort to strengthen Medicare. Even though the Trustees' report's projections have improved, they also underscore the fact that " INSERT SOMETHING FROM REPORT THAT HELPS MAKE CASE." The President does believe, however, that we should not be tapping any part of the surplus until after we have significantly bolstered the financial health of the Medicare program. Adding only 5 years to the life of the Medicare Hospital Insurance program, which is the most that the plan by Senator Breaux and Congressman Thomas produced, is inadequate. We can and must do better; the President's insistence on a 15 percent surplus dedication to Medicare in the context of broader reforms will assure that we do.

Q: Now that you can get to 2020 solvency without using all of the 15 percent of the surplus, are you now going to use some of the surplus for prescription drugs?

A: Our primary goal is to dedicate the surplus to improving Medicare solvency while also taking steps to strengthen and modernize the program. The exact details of the financing we'll be announcing with our plan, and I don't want to say exactly what the financing structure will be until we put our plan out.

Q: FOLLOW-UP. So prescription drugs will be financed at least in part through the surplus?

A: We are not going to get to details of the President's plan before it has been completed. Again, he has made no decisions on this provision -- or any other provision -- at this time.

Q: When is the President going to release his plan?

A: There is no set date, but it certainly will be soon enough for the Congress to have a realistic opportunity to review and consider it this year.

Q. Is it true that raising the age eligibility is off the table?

A. Raising the eligibility age will not be in the President's package. The President believes that raising the eligibility age for Medicare without policies to prevent the uninsured from increasing is going in the wrong direction.

(1) Check out Colors on CHARTS

(2) When do you have time to read revised?

DRAFT: March 29, 1999

BACKGROUND MEMORANDUM ON PRESCRIPTION DRUGS

FROM: Chris J. and Jeanne L.

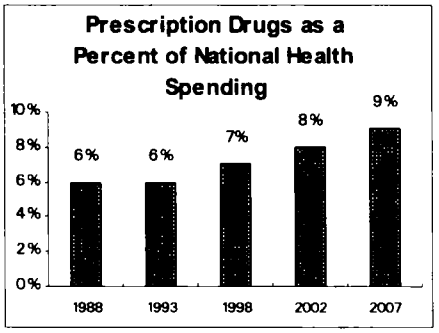
This memo serves as background for our upcoming discussion on a Medicare prescription drug benefit. It describes the need for coverage, expenditure patterns, and the various moving parts of a new benefit. We have also attached an article by Laura D'Andrea Tyson on the topic. Please feel free to call us with questions.

BACKGROUND

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

Increasing reliance on drugs. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for ulcers). Some of the major advances in public health -- the near eradication of polio and measles, and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

Rising share of national health spending. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 year, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.



New drugs and growth in the pharmaceutical industry. Although the need for drugs is growing, the rapid spending increase is also driven by the number of new drugs, which are introduced at high prices when patented. [example] Between 1994 and 1998, the FDA approved nearly 150 new drugs, and one of the leading pharmaceutical associations estimates that over 350 biotechnology medicines are now in development. Also, in the last several years, the industry has been permitted to advertise, increasing demand for drugs. Sales by research-based pharmaceutical companies were $125 billion in 1998, a 12 percent increase over 1997. Profits are expected to grow by 25 percent in 1999.

MEDICARE BENEFICIARIES: GREATEST NEED FOR PRESCRIPTION DRUGS

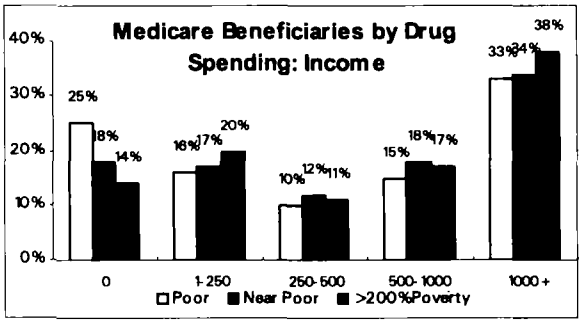
Elderly and people with disabilities rely more on prescription drugs. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.

COMPARISON OF PRICES FOR DRUGS

Drug	Use	Price for Preferred Customers	Regular Price
Prilosec	Ulcers	$56.38	$111.94
Zocor	Cholesterol	$42.95	$104.80
Procardia	Heart	$67.35	$126.86
Zoloft	Depression	$123.88	$213.72

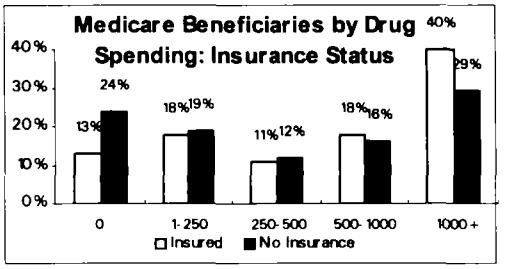
Source: Minority staff report to Committee on Gov't reform

Despite their higher use of drugs, Medicare beneficiaries pay higher prices for them. Beneficiaries without drug coverage pay, on average, twice to three times the price that large HMOs, employers and the Veterans' Administration pay for the same drugs. Moreover, American senior citizens pay higher prices for drugs than citizens in other nations. For example, the average retail price for the top ten drugs for seniors are 72 percent higher in the U.S. versus Canada.



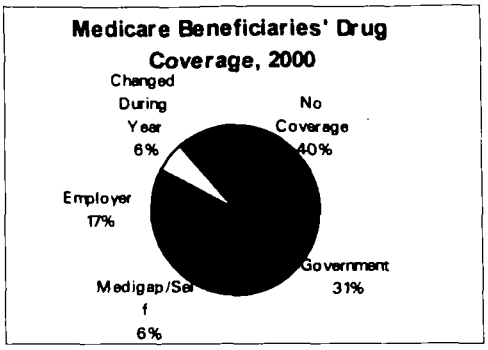
Distribution of beneficiaries' spending on drugs. According the HCFA actuaries' projections for 2000, over 50 percent of beneficiaries will have prescription drug spending of $500 or more -- about 13 million have spending that is greater than $1,000. This expenditure distribution varies somewhat by income. About one in four poor beneficiaries have no drug spending, compared to 14 percent of middle to high income beneficiaries.

Drug spending also varies by whether beneficiaries have insurance coverage. In general, those with some type of insurance coverage (private or public) have higher spending and utilization than those with no insurance coverage for prescription drugs. Although beneficiaries with drug coverage somewhat less healthy and thus may need more drugs, there appears to evidence that the lack of coverage discourages use of prescription drugs.



The distribution of drug spending also varies by what type of insurance coverage beneficiaries have. Nearly half (47 percent) of beneficiaries with employer-sponsored retiree coverage have more than $1,000 in annual expenditures, versus 33 percent of those in Medicare managed care.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES



Private supplemental drug coverage: Only 22 percent of Medicare beneficiaries are expected to have private insurance for drug coverage -- down from 38 percent in 1995. Whereas most people under age 65 have employer-based coverage, only about 17 percent have employer-sponsored retiree coverage. Another 6 percent of beneficiaries have Medigap or other private insurance that pays for prescription drugs. Both sources of coverage have been declining rapidly.

Retiree health insurance: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). The actuaries project that, by 2000, only 17 percent of beneficiaries will have this type of coverage.

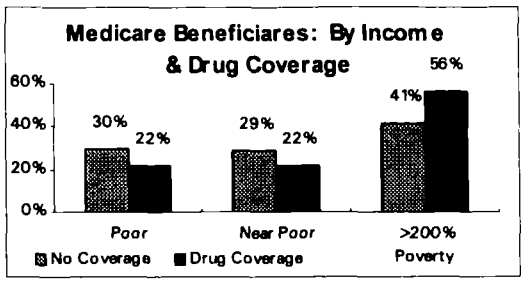
Medigap: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in 3 of its 10 standard plans. The standardized Medigap benefit includes a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive, ranging from $402 to $7,196 per year, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage is well over $1,000 more than a Medigap plan without drug coverage ($2,073 v $913 in 1998). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996. At the same time, Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. The actuaries project that only 6 percent of beneficiaries will have Medigap drug coverage in 2000.

Public coverage: About 30 percent of beneficiaries have some type of government coverage.
Medicare managed care: About two-thirds of plans offer some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, about 40 percent of enrollees are in plans with unlimited benefits; 18 percent in plans with limits greater than $1,000; 17 percent in plans with a limit at $1,000; and 24 percent in plans with limits less than $1,000. Recent trends suggest that the number of plans offering unlimited -- or any drug coverage -- is declining.

Medicaid: Only Medicare beneficiaries who are eligible for Medicaid through the Supplemental Security Income program or a medically needy (spend down) option are eligible for prescription drug coverage. These dual eligibles typically have income at or below 60 percent of poverty.

Beneficiaries without coverage for drugs. About 16 million beneficiaries (40%) are estimated to have no drug coverage in 2000. This is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $17,000 for a single, $23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



CONSEQUENCES OF THE LACK OF DRUG COVERAGE

Less use of needed prescription drugs. The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. Although it is difficult to distinguish appropriate from over-utilization, virtually all researchers acknowledge that the lack of insurance coverage for drugs results in underutilization of drugs, even essential drugs.

Greater institutionaliztion. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. The increased cost of institutionalization exceeded the savings from reduced use of drugs by 20 fold. Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. A different study of stroke patients found that those treated promptly with drugs to thin clots had significantly lower health care costs -- $4 million for every 1,000 patients treated.

Larger financial burden. Even after controlling for health status and income, elderly people with private insurance for drugs have half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent higher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine.

Shorter lives. Given the importance of prescription drugs to modern medicine, it is likely that under-use of them by Medicare beneficiaries can reduce life expectancy. Ironically, some have suggested that adding a prescription drug benefit could raise -- not lower -- costs of hospitalization and other services, since beneficiaries would live longer.

DESIGN PARAMETERS FOR A PRESCRIPTION DRUG BENEFIT

There are a number of major design features that affect the costs and coverage of a Medicare prescription drug benefit. These are outlined below.

Eligibility: One of the basic questions about a new drug benefit is who is eligible. Medicare benefits have never been limited to subsets of beneficiaries or means tested. However, the costs of a new Medicare drug benefit and concerns about substituting for existing private coverage were major reasons why some Medicare Commission members opposed a drug benefit. The Breaux-Thomas proposal did not include a new Medicare benefit. Instead, it recommended a new Medicaid (not Medicare) subsidized benefit for those with income below 135 percent of poverty (about $11,000 for a single, $15, 000 for a couple). It would also require Medicare plans and Medigap to offer an unsubsidized drug option (which, without rate reform, would likely be unaffordable).

Providing low-income beneficiaries with a fully subsidized benefit is important -- and would, in fact, happen automatically if a new Medicare benefit were created. This is because, under current law, Medicaid pays for Medicare premiums for all beneficiaries with income below 135 percent of poverty. Unless this provision is changed, Medicaid would also pay for the Medicare premium for prescription drugs for low-income beneficiaries (note: in our cost estimates).

However, a low-income drug benefit will leave most beneficiaries vulnerable. Nearly 3 out of 5 beneficiaries who lack drug coverage have income above 135 percent of poverty. About 30 percent of these beneficiaries have drug expenditures that exceed $1,000. This represents a considerable expense for beneficiaries with income between $15,000 and $20,000. Moreover, private coverage for drugs is unstable. The actuaries project that the proportion of beneficiaries with retiree coverage will decline from 28 to 17 percent between 1995 and 2000, and with Medigap from 10 to 6 percent. Although these declines are offset by increased enrollment in Medicare managed care, managed care plans are increasingly wary of offering a drug benefit, and in some places are restricting the benefit.

For these reasons, Laura Tyson and other economists argue that the only efficient option is to extend drug coverage to all beneficiaries. Not only does this ensure that beneficiaries that need this coverage get it, but it limits the need for inefficient, expensive supplemental coverage.

Optional versus mandatory: Today, the Part B premium for Medicare is voluntary but, since the government pays 75 percent of the premium, virtually all beneficiaries take this option. In contrast, in 1988, when a catastrophic drug benefit was added to Medicare, all beneficiaries were required to pay the new premium. This mandatory premium was unpopular, particularly with beneficiaries with other, less expensive, and typically more generous coverage. This contributed to the subsequent repeal of this benefit.

Although proponents of a drug benefit would prefer that it be optional, there is one compelling reason to consider a mandatory benefit: costs. As with most insurance, a new optional drug benefit would create a "moral hazard", meaning that beneficiaries with high drugs costs are more likely to purchase the option. This results in a high average cost of the insurance which translates into higher premiums. Over time, healthier beneficiaries will be less willing to pay the higher premiums, causing the risk pool to shrink and the premiums to rise even more.

There are ways to reduce risk selection in an optional drug benefit. The most important would be to subsidize the premium for the benefit. Since nearly all beneficiaries use drugs, a reduced-price premium would encourage healthy beneficiaries to participate. The actuaries assume that even those with employer-sponsored retiree coverage would participate (employers would pay for the beneficiaries' share of the premium, and wrap around the Medicare benefit if their current benefit is more generous). Another way to ensure that an optional benefit is viable is to limit when beneficiaries can enroll. If beneficiaries can wait until they are sick to enroll, even a subsidized option could be subject to risk selection. Our actuaries assume that if there is at least a 50 percent premium subsidy and a one-time option to participate (when a beneficiary enrolls in Medicare), than all beneficiaries will participate in an optional benefit. It may also be possible to create transition rules for beneficiaries who lose their retiree coverage.

Premium subsidy: As described above, premium subsidies are important to participation in an optional drug benefit. At the same time, while they reduce the cost per beneficiary, they raise Federal spending in aggregate. The level of the premium subsidy was discussed extensively in the last days of the Medicare Commission. Laura Tyson and Stuart Altman, following logic of the actuaries, argued for at least a 50 percent subsidy. At one point, it appeared that the Commission would agree to a 25 percent subsidy for all beneficiaries, but in the end rejected it -- both on cost grounds and because of a reluctance to subsidize higher income beneficiaries.

One option that could address these concerns is an income-related premium for the optional drug benefit. It would have to be designed carefully, to avoid selection, but could both lessen the cost of the benefit and reduce government assistance for those who could afford it. It would make even more sense if there were an income-related Part B premium, simplifying the administration.

Cost sharing: In additional to the premium subsidy, the cost of a Medicare drug benefit depends on its cost sharing structure. There are four major moving parts of a drug benefit: its (1) deductible, (2) coinsurance or copayments, (3) limits on out-of-pocket spending or stop-loss protection, and (4) cap on benefit payments. The cost sharing for Medicare beneficiaries with drug coverage varies dramatically. Employer-sponsored coverage is probably the most generous. Mirroring coverage for their under-65 workers, it typically has no separate deductible for drugs, low copayments, stop-loss protection, and no limit on benefit payments. Medigap, in contrast, has a separate, $250 deductible, 50 percent coinsurance, and a cap on how much the plan will pay. Medicare managed care usually has low to no deductible and copayments, controlling costs by limiting the amount that plans pay.

EXAMPLES OF DRUG BENEFIT COST SHARING

Option	Deductible	Copay	Stop-Loss	Benefits Cap
FEHBP*	$50	20%	($3,750)	None
Retiree **	($300)	$5/15	($1,750)	None
Medigap	$250	50%	None	$1250/3000
Kaiser DC:	$0	$5/20	None	$1,000

Limits in parentheses are for all services, not just drugs
* Blue Cross/Blue Shield standard option
** Typical retiree plan

These different design features affect who benefits the most from each policy. The table shows the illustrative effects of two policies. It assumes that beneficiaries are not now paying premiums -- those who now pay premiums for drug coverage would see even greater savings. For the most part, the table shows that even with a $250 deductible, the combination of the deductible and the premium suggest that a beneficiary must have a sizable amount of drug spending to benefit from the new coverage. At the same time, capping the benefit at $1,000 versus $2,000 makes a substantial difference for a person with high expenditures. Benefits that help the sickest beneficiaries tend to be the most costly, since most of drug expenditures are associated with high users.

ILLUSTRATION OF DRUG BENEFIT OPTIONS

NO DEDUCTIBLE, 50% COPAY, $1,000 BENEFITS CAP

CURRENT	NEW BENEFIT			
SPENDING	Gov't	Premium	Copays	Change*
$0	$0	$300	$0	-$300
$250	$125	$300	$125	-$175
$500	$250	$300	$250	-$50
$1,000	$500	$300	$500	+$200
$2,000	$1000	$300	$1000	+$700
$3,000	$1000	$300	$2000	+$700

$250 DEDUCTIBLE, 20% COPAY, $2,000 BENEFITS CAP

CURRENT	NEW BENEFIT			
SPENDING	Gov't	Premium	Copays	Change*
$0	$0	$420	$0	-$420
$250	$0	$420	$250	-$420
$500	$200	$420	$300	-$220
$1,000	$600	$420	$400	+$180
$2,000	$1400	$420	$600	+$980
$3,000	$2000	$420	$1000	+$1580

* Current spending minus new beneficiary spending

NEW

Management of the benefit: The last major parameter of a drug benefit is its management. There are a number of ways that a new Medicare benefit could be administered and its costs constrained. The two major options are a HCFA-administered versus privately managed benefit. The Federal government has experience with both models through its health programs. Both Medicaid and the Veterans' Administration purchase prescription drugs for a large number of people. Medicaid has mandated a rebate for drugs. For drugs not covered by patents that prevent generic manufacturing, this discount is 11 percent of the average manufacturer price (AMP); for drugs covered by patents ("innovator drugs"), the discount is the greater of 15.1 percent of the AMP or the difference between a the AMP and a "best price" (defined in regulations). The Veterans' Administration uses a national formulary to negotiate lower prices for its members.

In contrast, most Federal employees get their prescription drugs through private managed care. Pharmacy benefit managers (PBMs) typically use computer networks and electronic card systems to link patients to the plan's formulary or list of drugs that are generic or reduced cost. PBMs also usually get discounts from drug companies for putting their drugs in their formularies and negotiate with pharmacies over the retail prices charged for prescriptions. Some studies suggest that the management tools used by PBMs can save up to 25 percent

During the Medicare Commission debate, strong arguments were made against a HCFA-administered benefit. The primary concern was the potential disruption of the market that would occur if HCFA engaged in rate setting and regulation. The pharmaceutical industry is more concerned about this precedent than about the increased volume of sales that would result from a new benefit. Yet, the ability to leverage the Federal funds gets the best discount could be diffused if HCFA purely contracted out the benefit management. Most proponents of a drug benefit support some combination of HCFA oversight and private management.

Wednesday, March 24, 1999, 11pm

To: Jack Lew
Gene Sperling
From: Chuck Konigsberg
Re: Democrats' unity in today's Budget Resolution votes

cc: Chris Jennings, Sylvia Mathews

Jack/Gene:

Chris Jennings is concerned about an upcoming amendment on Thursday to be offered by Breaux, Kerrey, and Robb on the subject of the Medicare Commission.

Chris asked me to check to verify that Senate Democrats had been able to hold their votes today.

There were two partisan votes on Wednesday:

- Lautenberg amendment to establish a point of order against considering tax cut or spending increase legislation until the Congress first enacts legislation ensuring the long-term fiscal solvency of Social Security and extends the Medicare HI Trust Fund at least 12 years; and

- Conrad amendment to establish a Social Security and Medicare lockbox.

As the attached voting records show, in both cases the Democrats all voted together (i.e. for a budget waiver to waive a germaneness point of order).

I have also attached a summary of all of Wednesday's Budget Resolution votes.

Overview:

Senate Vote 59 ** SCONRES20, Fiscal 2000 Budget Resolution - Social Security and Medicare Solvency. Lautenberg, D-N.J., motion to waive the Budget Act with respect to the Domenici, R-N.M., point of order against the Lautenberg amendment. The Lautenberg amendment would establish a Senate point of order against any measure that would increase spending or reduce taxes without offsets until Congress enacts legislation to ensure the long-term solvency of Social Security and extend the solvency of Medicare by at least 12 years. Motion rejected 45-54: R 0-54; D 45-0 (ND 37-0, SD 8-0). March 24, 1999. A three-fifths majority vote (60) of the total Senate is required to waive the Budget Act. (Subsequently, the chair upheld the point of order, and the amendment fell.)

Date: (03/24/1999)

Positions:

Abraham, Spencer (R-MI)	N	Hutchison, Kay Bailey (R-TX)	N
Akaka, Daniel K. (D-HI)	Y	Inhofe, James M. (R-OK)	N
Allard, Wayne (R-CO)	N	Inouye, Daniel K. (D-HI)	Y
Ashcroft, John (R-MO)	N	Jeffords, James M. (R-VT)	N
Baucus, Max (D-MT)	Y	Johnson, Tim (D-SD)	Y
Bayh, Evan (D-IN)	Y	Kennedy, Edward M. (D-MA)	Y
Bennett, Robert F. (R-UT)	N	Kerrey, Bob (D-NE)	Y
Biden, Joseph R. Jr. (D-DE)	Y	Kerry, John (D-MA)	Y
Bingaman, Jeff (D-NM)	Y	Kohl, Herb (D-WI)	Y
Bond, Christopher S. (R-MO)	N	Kyl, Jon (R-AZ)	N
Boxer, Barbara (D-CA)	Y	Landrieu, Mary L. (D-LA)	Y
Breaux, John B. (D-LA)	Y	Lautenberg, Frank R. (D-NJ)	Y
Brownback, Sam (R-KS)	N	Leahy, Patrick J. (D-VT)	Y
Bryan, Richard H. (D-NV)	Y	Levin, Carl (D-MI)	Y
Bunning, Jim (R-KY)	N	Lieberman, Joseph I. (D-CT)	Y
Burns, Conrad (R-MT)	N	Lincoln, Blanche (D-AR)	Y
Byrd, Robert C. (D-WV)	Y	Lott, Trent (R-MS)	N
Campbell, Ben Nighthorse (R-CO)	N	Lugar, Richard G. (R-IN)	?
Chafee, John H. (R-RI)	N	Mack, Connie (R-FL)	N
Cleland, Max (D-GA)	Y	McCain, John (R-AZ)	N
Cochran, Thad (R-MS)	N	McConnell, Mitch (R-KY)	N
Collins, Susan (R-ME)	N	Mikulski, Barbara A. (D-MD)	Y
Conrad, Kent (D-ND)	Y	Moynihan, Daniel Patrick (D-NY)	Y
Coverdell, Paul (R-GA)	N	Murkowski, Frank H. (R-AK)	N
Craig, Larry E. (R-ID)	N	Murray, Patty (D-WA)	Y
Crapo, Mike (R-ID)	N	Nickles, Don (R-OK)	N
Daschle, Tom (D-SD)	Y	Reed, Jack (D-RI)	Y
DeWine, Mike (R-OH)	N	Reid, Harry (D-NV)	Y
Dodd, Christopher J. (D-CT)	Y	Robb, Charles S. (D-VA)	Y

Dodd, Christopher J. (D-CT)	Y	Robb, Charles S. (D-VA)	Y
Domenici, Pete V. (R-NM)	N	Roberts, Pat (R-KS)	N
Dorgan, Byron L. (D-ND)	Y	Rockefeller, John D. IV (D-WV)	Y
Durbin, Richard J. (D-IL)	Y	Roth, William V. Jr. (R-DE)	N
Edwards, John (D-NC)	Y	Santorum, Rick (R-PA)	N
Enzi, Michael B. (R-WY)	N	Sarbanes, Paul S. (D-MD)	Y
Feingold, Russell D. (D-WI)	Y	Schumer, Charles E. (D-NY)	Y
Feinstein, Dianne (D-CA)	Y	Sessions, Jeff (R-AL)	N
Fitzgerald, Peter G. (R-IL)	N	Shelby, Richard C. (R-AL)	N
Frist, Bill (R-TN)	N	Smith, Gordon H. (R-OR)	N
Gorton, Slade (R-WA)	N	Smith, Robert C. (R-NH)	N
Graham, Bob (D-FL)	Y	Snowe, Olympia J. (R-ME)	N
Gramm, Phil (R-TX)	N	Specter, Arlen (R-PA)	N
Grams, Rod (R-MN)	N	Stevens, Ted (R-AK)	N
Grassley, Charles E. (R-IA)	N	Thomas, Craig (R-WY)	N
Gregg, Judd (R-NH)	N	Thompson, Fred (R-TN)	N
Hagel, Chuck (R-NE)	N	Thurmond, Strom (R-SC)	N
Harkin, Tom (D-IA)	Y	Torricelli, Robert G. (D-NJ)	Y
Hatch, Orrin G. (R-UT)	N	Voinovich, George V. (R-OH)	N
Helms, Jesse (R-NC)	N	Warner, John W. (R-VA)	N
Hollings, Ernest F. (D-SC)	Y	Wellstone, Paul (D-MN)	Y
Hutchinson, Tim (R-AR)	N	Wyden, Ron (D-OR)	Y

Vote Result Key

Overview:

Senate Vote 61 ** SCONRES20. Fiscal 2000 Budget Resolution - Reserve Portion of Surplus for Medicare. Conrad, D-N.D., motion to waive the Budget Act with respect to the Domenici, R-N.M., point of order against the Conrad amendment. The Conrad amendment would reserve 40 percent of the non-Social Security budget surplus to ensure the solvency of Medicare through 2020 and would establish a Senate point of order against spending money reserved for Social Security or Medicare. Motion rejected 45-54: R 0-54; D 45-0 (ND 37-0, SD 8-0). March 24, 1999. A three-fifths majority vote (60) of the total Senate is required to waive the Budget Act. (Subsequently, the chair upheld the point of order, and the amendment fell.)

Date: (03/24/1999)

Positions:

Abraham, Spencer (R-MI)	N	Hutchison, Kay Bailey (R-TX)	N
Akaka, Daniel K. (D-HI)	Y	Inhofe, James M. (R-OK)	N
Allard, Wayne (R-CO)	N	Inouye, Daniel K. (D-HI)	Y
Ashcroft, John (R-MO)	N	Jeffords, James M. (R-VT)	N
Baucus, Max (D-MT)	Y	Johnson, Tim (D-SD)	Y
Bayh, Evan (D-IN)	Y	Kennedy, Edward M. (D-MA)	Y
Bennett, Robert F. (R-UT)	N	Kerrey, Bob (D-NE)	Y
Biden, Joseph R. Jr. (D-DE)	Y	Kerry, John (D-MA)	Y
Bingaman, Jeff (D-NM)	Y	Kohl, Herb (D-WI)	Y
Bond, Christopher S. (R-MO)	N	Kyl, Jon (R-AZ)	N
Boxer, Barbara (D-CA)	Y	Landrieu, Mary L. (D-LA)	Y
Breaux, John B. (D-LA)	Y	Lautenberg, Frank R. (D-NJ)	Y
Brownback, Sam (R-KS)	N	Leahy, Patrick J. (D-VT)	Y
Bryan, Richard H. (D-NV)	Y	Levin, Carl (D-MI)	Y
Bunning, Jim (R-KY)	N	Lieberman, Joseph I. (D-CT)	Y
Burns, Conrad (R-MT)	N	Lincoln, Blanche (D-AR)	Y
Byrd, Robert C. (D-WV)	Y	Lott, Trent (R-MS)	N
Campbell, Ben Nighthorse (R-CO)	N	Lugar, Richard G. (R-IN)	?
Chafee, John H. (R-RI)	N	Mack, Connie (R-FL)	N
Cleland, Max (D-GA)	Y	McCain, John (R-AZ)	N
Cochran, Thad (R-MS)	N	McConnell, Mitch (R-KY)	N
Collins, Susan (R-ME)	N	Mikulski, Barbara A. (D-MD)	Y
Conrad, Kent (D-ND)	Y	Moynihan, Daniel Patrick (D-NY)	Y
Coverdell, Paul (R-GA)	N	Murkowski, Frank H. (R-AK)	N
Craig, Larry E. (R-ID)	N	Murray, Patty (D-WA)	Y
Crapo, Mike (R-ID)	N	Nickles, Don (R-OK)	N
Daschle, Tom (D-SD)	Y	Reed, Jack (D-RI)	Y
DeWine, Mike (R-OH)	N	Reid, Harry (D-NV)	Y
Dodd, Christopher J. (D-CT)	Y	Robb, Charles S. (D-VA)	Y

Domenici, Pete V. (R-NM)	N	Roberts, Pat (R-KS)	N
Dorgan, Byron L. (D-ND)	Y	Rockefeller, John D. IV (D-WV)	Y
Durbin, Richard J. (D-IL)	Y	Roth, William V. Jr. (R-DE)	N
Edwards, John (D-NC)	Y	Santorum, Rick (R-PA)	N
Enzi, Michael B. (R-WY)	N	Sarbanes, Paul S. (D-MD)	Y
Feingold, Russell D. (D-WI)	Y	Schumer, Charles E. (D-NY)	Y
Feinstein, Dianne (D-CA)	Y	Sessions, Jeff (R-AL)	N
Fitzgerald, Peter G. (R-IL)	N	Shelby, Richard C. (R-AL)	N
Frist, Bill (R-TN)	N	Smith, Gordon H. (R-OR)	N
Gorton, Slade (R-WA)	N	Smith, Robert C. (R-NH)	N
Graham, Bob (D-FL)	Y	Snowe, Olympia J. (R-ME)	N
Gramm, Phil (R-TX)	N	Specter, Arlen (R-PA)	N
Grams, Rod (R-MN)	N	Stevens, Ted (R-AK)	N
Grassley, Charles E. (R-IA)	N	Thomas, Craig (R-WY)	N
Gregg, Judd (R-NH)	N	Thompson, Fred (R-TN)	N
Hagel, Chuck (R-NE)	N	Thurmond, Strom (R-SC)	N
Harkin, Tom (D-IA)	Y	Torricelli, Robert G. (D-NJ)	Y
Hatch, Orrin G. (R-UT)	N	Voinovich, George V. (R-OH)	N
Helms, Jesse (R-NC)	N	Warner, John W. (R-VA)	N
Hollings, Ernest F. (D-SC)	Y	Wellstone, Paul (D-MN)	Y
Hutchinson, Tim (R-AR)	N	Wyden, Ron (D-OR)	Y

Vote Result Key

CHARLES KONIGSBERG
03/24/99 09:31:00 PM

Record Type: Record

To: Lisa Zweig/OMB/EOP
cc:
Subject: daily

The Senate today began consideration of S.Con.Res. 20, the Budget Resolution. Consideration will resume at 9am Thursday with stacked votes to begin at 11am. During today's action, the Senate:

Amendments which Passed

--Adopted 99-0 an Abraham amendment stating sense of the Congress that the Budget Resolution assumes the Congress will pass Social Security lockbox legislation which ensures that all Social Security surpluses are reserved for Social Security.

--Adopted 99-0 an Ashcroft/Brownback amendment stating sense of the Senate that Social Security funds should not be invested in the stock market.

--Adopted 99-0 a Johnson/Wellstone amendment to add $2 billion to the veterans function, offset by across-the board cuts in other non-defense discretionary programs. (Even though Domenici opposed the amendment in principle, he told Members they might as well vote aye since the discretionary assumptions are not binding on the appropriators.)

Amendments which Failed

--Fell on a germaneness point of order: a Lautenberg Amendment to establish a point of order against considering tax cut or spending increase legislation until the Congress first enacts legislation ensuring the long-term fiscal solvency of Social Security and extends the Medicare HI Trust Fund at least 12 years.(The motion to waive the point of order failed 45-54, 60 votes being required.)

--Fell on a germaneness point of order: a Conrad amendment to establish a Social Security and Medicare lockbox; all Social Security surpluses would be reserved for Social Security; and 40 percent of the on-budget surpluses over 10 years would be reserved for Medicare. (The motion to waive the point of order failed 45-54, 60 votes being required.)

--Senate tabled 97-2 a Bond amendment which purported to be the President's budget. (The vote was on a Lautenberg motion to table.)

DISCUSSION OF
COMPETITIVE APPROACHES TO MEDICARE

DRAFT: March 22, 1999

I. Concept of "Premium Support"

II. Issues and Alternatives

III. Policy Pros and Cons

IV. Political Pros and Cons

I. CONCEPT OF "PREMIUM SUPPORT"

- **Current Medicare Managed Care**:

  - Government payments: Medicare pays managed care plans based on a payment schedule. This schedule is set using the local costs of traditional Medicare. All plans in the area get paid the same rate. If a plan can offer Medicare benefits for less than the payment rate, it must use the excess payments to give beneficiaries extra benefits.

  - Beneficiary premiums: All Medicare beneficiaries pay the same premiums regardless of their plan choices or place of residence.

  - Enrollment: Today, about 16 percent or 6 million beneficiaries are enrolled in Medicare managed care. About 70 percent of beneficiaries live in areas where managed care plans operate. Over two-thirds of managed care enrollees receive prescription drug coverage, reduced cost sharing or other supplemental benefits.

- **The Concept of Premium Support**:

  - Government payments: Medicare would pay plans an amount per beneficiary up to a limit. This limit could be a percent up to a cap (e.g., the national average premium) or a regional average premium.

  - Beneficiary premiums: Beneficiaries' premium would vary based on their plan choices. In general, those choosing higher-cost plans would pay more, those choosing lower-cost plans would pay less. In most models, traditional Medicare's premiums would be included in the formula, and could be higher if Medicare is a high-cost plan.

  - Savings: Medicare costs would be reduced if (a) the new payment system pays managed care plans less than they are paid today; and (b) more beneficiaries enroll in private plans.

BREAUX-THOMAS PREMIUM SUPPORT PROPOSAL

- **Flexible Benefits:** Requires that private plans offer at least the same benefits as traditional Medicare, but allows flexibility in how benefits are delivered.

- **Government Payments: Percent to a cap**: Medicare's payments would be based on the national weighted average premium for all plans. The government would pay:

    - 100 percent of the premium if the plan's premium is less than 85 percent of the national average premium;

    - From 100 to 88 percent of the premium if the plan's premium is between 85 and 100 percent of the national average premium; and

    - No more than 88 percent of the national average premium if the plan's premium is above 100 percent of the national average premium.

- **Beneficiary payments**: Beneficiaries would pay the difference between the government payment and the plan's premium -- including all of the additional premium for plans above the national average premium.

EXAMPLE: HOW PLANS WOULD BE PAID

Total Premium		Gov't Payment		Beneficiary Payment	
$	% of Nat'l Average	$	% of Total	$	% of Total
$5,100	85%	$5,100	100%	0	0%
$5,500	92%	$5,180	94%	$320	6%
$6,000 Avg	**100%**	**$5,280**	**88%**	**$720**	**12%**
$6,100 FFS	102%	$5,280	87%	$820	13%
$6,500	108%	$5,280	81%	$1,320	20%

* If beneficiaries in fee-for-service pay 12% of costs, they would pay $732.

II. ISSUES AND ALTERNATIVES
MAJOR ISSUES

- **Most beneficiaries would pay more for traditional Medicare**: The Breaux-Thomas plan would result in Medicare premiums that are 10 to 20 percent above current law, according to the independent Medicare actuary. Although the plan limits the Medicare premium for beneficiaries with no private plan option, it does nothing for people with limited or unattractive plan options.

- **Competition based on benefits, not price**: The proposal would allow private plans to vary their benefits within some limits. This could result in adverse selection as plans tailor their benefits to attract the healthiest beneficiaries.

- **Beneficiaries would pay more or less for private plans, depending on where they live**: Although the final version of the plan included no reference to how it would adjust payments for geographic differences, the previous versions suggested that the government would only pay part of the local costs of care -- in an effort to constrain the current, wide variation in payments. However, the consequences of this approach are that plans will over- or under-charge for their benefits to compensate for the partial geographic adjustment. As a result, beneficiaries will pick up part of the local costs -- paying more in high-cost areas and less in low-cost areas for a typical plan.

- **Somewhat aggressive transition**: The Breaux-Thomas premium support plan would be implemented in 2003. HHS would probably be better able to transition to a change as large as this over a longer period of time.

ALTERNATIVE: MANAGED CARE PAYMENT REFORM

- **Guarantee defined benefits:** Clear, defined guaranteed benefits. Private plans could buy down Medicare's cost sharing, but could not offer extra benefits (note: assuming that prescription drug benefit is added).

- **Protecting the fee-for-service premium and improving adjustments:** Options include: (1) anchoring the Medicare's payments to the national fee-for-service premium (not the national weighted average premium) so that beneficiaries would always pay the same percent premium; or (2) exempting fee-for-service from the private plan payment system..

  The government would pay the full amount of risk adjustment and all (not part) of the geographic adjustment.

- **Lower savings**: Relative to the Breaux-Thomas plan, this approach will save much less money -- in large part, because it does not rely on higher fee-for-service premiums for its savings. It is not clear how much more efficient than current law this would be.

III. POLICY PROS AND CONS

PROS

- **Would likely reduce Medicare costs through competition.** Although there would not be significant savings from a well-designed model, this approach probably saves more than current managed care payment systems.

- **Better aligns Medicare with private health insurance.** Relies less on explicit changes to Medicare reimbursement levels to control program costs. Medicare spending growth would be affected by private plans' ability to achieve efficiency and attract beneficiaries, which should better align Medicare with private spending growth.

- **Gives beneficiaries lower-cost options.** Beneficiaries could lower their Medicare premiums by enrolling in low-cost plans.

CONS

- **Variable and less beneficiary premiums.** Unlike today, all beneficiaries would not pay the same premiums. The Medicare fee-for-service premium would likely be higher than that of private plans -- even if it is protected against being higher than current law. Also, beneficiaries choosing private plans could face premiums that vary considerably from year to year.

- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under competitive approaches, a greater share of the efficiency accrues to the government, reducing the amount that can be provided as additional benefits.

- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- not enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, this policy could have the unintended effects of creating higher premiums for people who are sick and low-income.

IV. POLITICAL PROS AND CONS

PROS

- **Increases the likelihood of bipartisan agreement on Medicare -- and Social Security.** Without some variation of premium support, it is unlikely that Republicans will consider any type of Medicare legislation -- especially a bill that includes the surplus or a prescription drug benefit.

- **A drug benefit and the dedication of the surplus could be worth some version of premium support.** The complexity and controversy surrounding premium support will necessitate it being phased in and otherwise altered to make it more acceptable. However, it is possible that the drug benefit, the surplus transfer and other reforms would begin sooner and remain intact.

- **Confirms willingness to reform Medicare.** Most economist and elite media consider premium support "real" reform. An openness to it would end Republican criticism that we only want an election issue or only more revenues and benefits for Medicare.

CONS

- **Would alienate Democratic base, particularly in the House, who think that premium support undermines Medicare's guarantees.** Base Democrats generally think that the risk of something bad coming out of any negotiation with Republicans far exceeds any potential for a positive outcome -- even if that means a prescription drug benefit.

- **Even if accompanied by a drug benefit and the surplus, the fear of higher premiums and elderly dissatisfaction may outweigh benefits.** High costs and less certainty will always be much more threatening and politically volatile to the elderly than the promise of a new benefit. This is particularly the case given the low odds that a good drug benefit and premium support proposal could emerge from a Republican Congress.

- **Opposition to premium support could unify beneficiary and provider groups.**

THE WHITE HOUSE

WASHINGTON

March 15, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K., Jack L., Dan M. David B., Melanne V., Sarah B., Neera T., Janet M.

FROM: Chris J. and Jeanne L.

RE: BREAUX-THOMAS MEDICARE PLAN

Attached is the final Breaux-Thomas Medicare plan. They released it at a 5pm press conference. Highlights of the plan include:

- **No specific plan for Medicare financing**: The plan contains no options for raising new revenue for Medicare -- specifically it does not include the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding.

- **No meaningful prescription drug benefit**: The plan would require private managed care plans, Medigap, and possibly Medicare fee-for-service to offer a drug benefit, but only provides a subsidy for that coverage for people below 135 percent of poverty. This is troubling because it moves Medicare towards a means-tested, Medicaid-like program, and would probably result in large adverse selection in the unsubsidized Medicare fee-for-service option.

- **Age eligibility increase without a viable insurance alternative**: Although there is a suggestion that vulnerable sick people ages 65 to 67 would get Medicare, the proposal explicitly states that the Medicare buy-in would be unsubsidized and would not begin at 62 (which is truly conforming to Social Security). This plan would likely lead to an increase in the uninsured.

- **No income-related premium:** This was dropped since the last draft -- reportedly because some Republicans considered it too similar to a tax (since it is administered through Treasury).

There are probably other issues that we have not yet noticed; we will be working on a more complete memo of the issues for the morning.

Please call or page with questions.

WHY WE VOTED NO ON THE CHAIRMAN'S MEDICARE REFORM PLAN

STUART H. ALTMAN
LAURA D'ANDREA TYSON

Medicare is among the most important and successful programs developed and run by the federal government. It has allowed tens of millions of American, mostly over age 65, to have access to the best health care our nation offers and provided needed funding to enable the entire US health care system to accommodate its constantly expanding needs for expensive new procedures and technologies. But Medicare has problems, problems which will grow worse in the years ahead. It was to address these long-term issues that the National Bipartisan Commission on the Future of Medicare was established. Unfortunately, we believe the proposal put forth by Chairman Breaux fails to address several of the most important of these issues

Central to the mission of the Commission was the charge that it make recommendations to restore the solvency of the Medicare program. Under current conditions it is projected that the Trust fund which finances hospital and other institutional services for Medicare beneficiaries will become bankrupt around the year 2011 and that the growth in general revenues required to pay for other Medicare services will consume an ever larger portion of the federal budget which pays for all other Federal programs. Unfortunately, that is just the beginning of the problem. With the number of beneficiaries expected to almost double in the next 30 years and spending for medical services continuing to grow faster than our national income, the deficit gap between the existing funding base and projected Medicare spending needs will spiral after 2010. The Chairmen's plan does little to change this situation. While it might move the insolvency date ahead 4 to 5 years, it does so in part by adding a further drain on the existing general revenue fund. How will these additional demands be met? Cut defense spending? Unlikely! Therefore, the country would be forced to either reduce discretionary programs or increase the national debt. Even here the fix is limited by a cap on the proportion of total Medicare spending that can come from general revenues. What is needed is a new revenue source!

The President has proposed dedicating 15 percent of the expected federal surplus to the Medicare program. Some critics argue that the President's plan adds no new money to the Federal coffers. While technically true, if we use the surplus to fund either a tax cut or increase spending for other programs, the government would have even less money available for Medicare.By dedicating a portion of the surplus to the Medicare program, those funds would be restricted from other uses, whether they be a tax cut or spending for other programs and as such it would help to reduce the impending financial crisis. If the Chairmen disapproved of this option, the plan could have recommended other revenue sources. Dare we mention, a tax increase? Of course, that was ruled out from day one by those who support the Chairmen's plan. Thus, the only alternative was to finesse the solvency issue and push it off to the future.

Medicare also suffers from an inadequate benefit package. When the program was passed in 1965, drugs were relatively inexpensive and had limited value in the medical arsenal. Today, they are indispensable for the treatment of many of our most prevalent and serious illnesses. But

they are also very expensive. Ironically, the reason now given for not covering outpatient prescription drugs in the Medicare program is that it is too expensive. Too expensive for the Federal government -- what about for the average Medicare beneficiary? As we think about Medicare for the 21st century, we must find a way to cover prescription drugs in some form. Such coverage need not be totally comprehensive, but it must protect both those who have low incomes and those who face high drug bills. The Chairmen's plan, while offering some help in this area, is, in our view, inadequate and is likely to require premiums for such coverage that would be too expensive for most Medicare beneficiaries. As it stands, plans would be required to offer a high option drug benefit, but the beneficiary premiums collected would have to match the cost of the program. Under such an arrangement, only those with high drug needs or those with high incomes would buy into the plan, thereby creating a spiraling up of the required premium.

We have other concerns about the Chairmen's plan. Raising the age of eligibility would save very little money and add to the number of Americans without health insurance. Those affected would be individuals who are the least likely to be able to secure private coverage. The plan also has the potential to seriously restructure the flow of funds to different geographic sectors of the country. In particular, it would reduce funding in areas with a high concentration of institutions that train the future generation of physicians and provide most of the biomedical research for the country and the world.

These problems are so serious that we cannot support a plan which in other areas has much to recommend it. We have long supported the idea of restructuring the Medicare program in such a way that would allow beneficiaries more choice while permitting the continuation of a more efficient government-run program. Many of the components of the premium support plan outlined by the Chairmen, we believe, should be included in a properly designed Medicare reform plan. We hope that debate over reforming Medicare will not end with the conclusion of this Commission. This problem is too important and must be addressed now. In the end, the financing problems for this critically important program are so significant the we are convinced they will require each of the major stakeholders--Beneficiaries, Health Care Providers and Taxpayers to contribute to the solution. The longer we wait to address these issues, however, the more serious the problems become and the more severe the solutions will have to be.