DEVORAH ADLER
Domestic Policy Council

Box 4 of 7

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UARA # 17674

Bruce: FYI, the supposed secret document Gore to the Hill & externally) At least 1 month old

DRAFT: **BACKGROUND ON PRESCRIPTION DRUGS**

Medicare does not pay for outpatient prescription drugs. The number of Medicare beneficiaries with some other source of insurance for drugs is decreasing, primarily because private sources are becoming less accessible and more expensive. Fewer employers are offering retiree health coverage, and Medigap is increasingly scarce and expensive. Even those with coverage are finding that the extent of their coverage is declining (especially in Medicare HMOs). This occurs at a time when prescription drugs are becoming a central component of medical care.

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

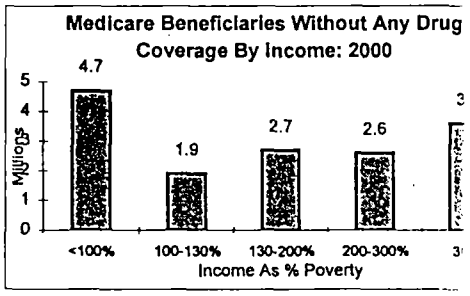
- **Increasing reliance on drugs.** Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery 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 HIV/AIDS). 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.

- **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.

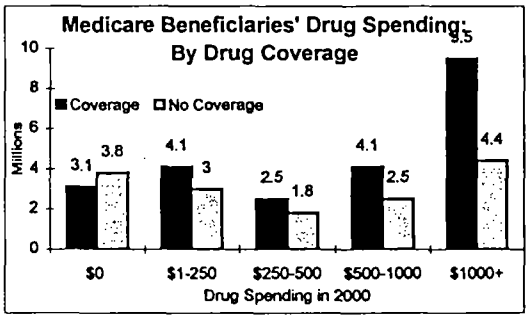
- **Drugs may reduce need for and cost of other services.** Some studies have found that elderly Medicare beneficiaries whose Medicaid drug coverage is limited are twice as likely to enter nursing homes, whose costs are 20 times higher than the savings from the limitation. Stroke patients treated promptly with drugs to thin clots have lower health care costs. And, all experts agree that drug management can reduce complications that lead to costly hospital care. At the same time, drug coverage could add potential new costs due to increases in utilization and possible extension of lives.

BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- **Beneficiaries across the income spectrum lack drug coverage.** About 16 million beneficiaries are projected to have no drug coverage in 2000. Lack of drug coverage 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.



- **Many beneficiaries need drugs but do not use them because they are uninsured.** Most research has found that lack of coverage reduces needed drug utilization. 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. And while some do not receive the drugs they need, nearly half of all beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of $500 or more.



- **Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that are at leaset 15-30 percent higher than large HMOs, employers and the Veterans' Administration. One study found that, for the 10 most prescribed drugs, seniors are charged twice as other payers. A recent General Accounting Office study found that pharmaceutical benefit managers in the Federal Employees' Health Benefits Plan reduced costs by 20 to 27 percent.

- **Larger financial burden**. Elderly with private insurance for drugs have about half the financial burden (out-of-pocket drug spending as a percent of income) as those without drug coverage. The financial burden of drug costs for rural elderly is on average 35 percent higher than urban elderly since they are less likely to have insurance covering drugs. Women have, on average, out-of-pocket costs as a percent of income that are 20 percent higher than men, primarily because many are widowed and have lower income. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed $3,000 - which more than 20 percent of income for at least half of these beneficiaries.

- **Difficult to help only beneficiaries without drug coverage**. The diversity of beneficiaries without drug coverage, along with the instability of coverage for those who have it, makes it difficult and inequitable to target a new drug option only those who are uninsured. Such a policy would either require people paying for expensive Medigap or who joined an HMO only for drug coverage to maintain that coverage or result in substitution.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES

- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private employer-based or Medigap insurance for drug coverage in 2000 according to the Medicare actuary -- down significantly from 1995. Both sources of coverage have been declining as the cost of coverage rises. Therefore, they cannot be relied upon to provide coverage in the future.

    - ***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. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage.

    - ***Medigap***: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. Beneficiaries can be denied coverage if they do not enroll immediately when they are age 65. The premium for a plan with drug coverage is about $1,100 more than a plan without drug coverage ($2,073 v $913 in 1998). Medigap premiums have been rising at double-digit inflation, and coverage has been declining. About 6 percent of beneficiaries are expected to have Medigap drug coverage in 2000.

- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that the potential for "crowding out" private spending are exaggerated.

    - ***Medicare managed care***: The vast majority of beneficiaries in Medicare HMOs have some type of drug coverage. While they typically have no deductibles and relatively low copayments, Medicare managed care plans usually limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to $1,000 or less. Trends and industry reports suggest that benefits are likely to be reduced or dropped in the future.

    - ***Medicaid***: Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.

THE PRESIDENT'S FRAMEWORK FOR MEDICARE
HOW IT WORKS IN THE BUDGET

The President's framework would ensure that we protect and extend the solvency of Social Security and Medicare first. The framework would both lock in our commitment to debt reduction and lock in the benefits of debt reduction for Social Security and Medicare.

Lower Interest Costs: By reducing debt held by the public, the framework would reduce the amount of net interest that the government would have to pay to service debt in the future. This reduction in net interest costs will help free up the resources to make Social Security and Medicare affordable for decades to come.

Like a Thrifty Family: The President's framework is like a family that pays off credit card debt now so that they will not have monthly bills to pay later. When the kids grow older, they can take the money that they would have been spending each month on the credit cards and use it to help with college. In contrast, the Republican budget, with its expanding tax cuts, is like a family that goes on a spending spree on credit that comes due just when their children reach college age.

A Time-Tested Use of Funds: The President's framework would convey bonds to the Medicare Trust Fund. The framework thus uses a traditional means -- increasing Trust Fund balances -- to extend Medicare Trust Fund solvency. These bonds will give Medicare first claim (along with Social Security) on the increasing surpluses that debt reduction and lower net interest costs will bring about.

We Must Meet Our Current Commitments to Medicare: Our existing commitments to future retirees creates the challenge facing Medicare. Like the need for schools in the 1960s, Medicare's challenge is demographic. The number of beneficiaries will roughly double over the next 30 years. One way or the other, the nation must find the resources to meet this need. The President's framework is the right way to begin moving toward long-term solvency.

A Stable Share of the Economy: Social Security and Medicare costs are expected to rise, but the reduction in net interest costs resulting from the President's framework for Social Security and Medicare will offset those rising program costs. As a result, under the President's framework, the sum of Social Security, Medicare, and net interest costs will remain the same (or smaller) share of the economy for decades to come:

Year	The Sum of Social Security, Medicare, and Net Interest Payments as a Share of GDP
1999	9.4 %
2010	8.2 %
2020	9.1 %

Benefits to the Economy in Addition: These results flow from the simple benefits of carrying less debt. They do not depend on improvement in the economy, even though most economists project that a significant improvement will result from reduced federal government borrowing. As the government borrows less (that is, reduces its demand for money), interest rates (the price of money) should come down, private sector investment should become easier, and economic growth should increase, yielding a fiscal dividend in addition to the effects of declining net interest costs.

How It Would Work in the Budget: Budget surpluses would be used to reduce the debt held by the public. The Medicare Trust Fund would receive bonds that would extend its solvency. And new safeguards would protect these funds from being used for other purposes. Here is how the President's framework would work step by step:

Step 1 -- Reduce the Debt: The Treasury would use 15 percent of the budget surpluses we now project to pay down $686 billion in publicly held debt, reducing the government's demands on the credit market.

Step 2 -- Extend Medicare Solvency: The Treasury would then convey to the Medicare Trust Fund special purpose bonds (with the same legal value as all other Treasury bonds), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).

Step 3 -- Lock-Box Protections: Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

Contrast What Would Happen Without the President's Framework: Using the surplus for tax cuts would have the following effects:

Effect # 1:	It would create permanent and growing federal government obligations.
Effect # 2:	It would allow federal debt and interest costs to continue high.
Effect # 3:	It would yield no extension of the life of the Medicare Trust Fund.

We Should Save Medicare Before Tax Cuts: In a radio address response February 7, 1998, Senate Budget Committee Chairman Domenici said, "I believe that we should save Medicare first." In the Senate Budget Committee March 18, 1998, he said, "for every dollar you divert to some other program you are hastening the day when Medicare falls into bankruptcy."

But the Republican Budget Neglects Medicare: The Republican budget fails to extend the life of Medicare by one day, fails to set aside even one penny of the surplus to strengthen Medicare, fails to guarantee any specific allocation for Medicare, and fails to make a rock-solid commitment to debt reduction. While it ignores Medicare, the Republican budget fails to strengthen and extend the life of the Social Security Trust Fund; undermines key investments in our children, the environment, and law enforcement -- forcing cuts of 10 percent in 2000 and more than 20 percent in 2004; and chooses instead large tax breaks targeted to the wealthy.

Without the President's framework, Medicare would have to rely on untenable changes to extend the life of the Trust Fund:

Medicare would need impossibly low growth rates to extend its life through provider payment reductions and efficiency alone: To extend Medicare solvency as long as the President's framework, spending growth per beneficiary would have to be constrained to below inflation in every year. This is well below projected private health insurance spending per person (7.3 percent).

OR

Unsustainable provider cuts: To extend Medicare solvency as long as the President's framework through provider cuts, Part A provider payments would have to be cut by nearly 20 percent -- almost $150 billion over 5 years.

OR

Eliminating major, critical services: Even removing all of the following services would not be sufficient to extend the life of the Trust Fund as long as the President's framework:

All skilled nursing facility plus hospice spending
All Part A home health spending
Graduate medical education and disproportionate share hospital spending.

OR

Making beneficiaries pay more: Without the President's framework, policy-makers might consider having beneficiaries pay for more of the cost of care.

But nearly two-thirds of elderly households have incomes below $20,000 and beneficiaries already pay for almost half of their health care costs.

OR

Raising Payroll Taxes: To extend Medicare solvency as long as the President's framework through tax increases would require increasing the payroll tax immediately by almost 20 percent, lifting the tax from 2.9 percent to 3.46 percent.

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

MYTH: The President's framework increases the future obligations of the government.

FACT: We already have a commitment to pay benefits to current workers when they retire. The President's framework does not increase these benefits. Instead, it pays down debt and frees up resources so that we can meet our existing obligations.

MYTH: By providing additional funds to the Medicare Trust Fund, the framework creates a commitment to pay benefits after 2015.

FACT: We now have both the legal obligation and the fiscal resources to pay benefits through 2015; after that we have resources to pay part of the benefits for many years to come. The President's framework provides the additional resources to pay benefits for roughly another decade after that.

MYTH: The bonds in the Medicare Trust Fund will be merely IOUs, just an unenforceable paper promise.

FACT: Treasury bonds convey the soundest promise in the world -- the full faith and credit of the United States. The federal government has never failed to honor Treasury bonds. One can imagine no better guarantee of paying a debt. As well, the framework creates the fiscal soundness and additional resources that will help make it easier to honor those obligations when they come due.

MYTH: The President's framework will have no effect on the unified budget surpluses or the on-budget surpluses and therefore have no effect on the debt held by the public.

FACT: The President's framework would lock in $686 billion from the unified surplus which, under the Republican plan, would go for tax cuts, not debt reduction or Medicare. Merrill Lynch praised the President's overall strategy: "Allocating a portion of the budget surpluses to debt reduction, as the President proposes, is a conservative strategy that makes sense. Reduced debt will result in increased national savings, lower interest rates, and stronger long-term economic growth than would otherwise be the case." (Merrill Lynch, February 10, 1999).

MYTH: Because the President's framework gives a dollar in bonds to the Trust Fund for every dollar of debt reduction, it does not really pay down the total government debt.

FACT: The President's framework pays down debt held by the public exactly as much as paying down the debt without crediting the trust fund. Thus, it creates the same economic benefits of lower net interest payments, higher savings, higher incomes, and additional revenue. The difference is that the President's framework gives Social Security and Medicare first claim to the benefits of debt reduction. The President believes we must meet our existing commitments to these programs before we think of allocating the benefits of debt reduction to other purposes.

MYTH: The money devoted to Medicare is already committed to the Social Security Trust Fund.

FACT: Over the next 15 years, the President's framework devotes to Social Security an amount equivalent to the Social Security surplus over that period. By 2014, the President's framework would just about double the balances that the trust funds would have under current law. The 15 percent that the framework devotes to Medicare represents funds in addition to those.

MYTH: The President's framework does not devote 15 percent of the budget surpluses to the Medicare program, as the federal budget process does not provide a mechanism for setting aside current surpluses for future obligations.

FACT: The President's framework would dedicate $686 billion to debt reduction and the Medicare trust fund. The independent career Medicare actuary -- repeatedly cited by Republicans in 1995 -- confirmed that this proposal would extend the life of the Trust Fund by roughly a decade. Paying off debt and reducing future interest costs is a real way to create the resources we will need to pay Medicare benefits in the future. For example, even in 2020, net interest savings under the President's framework will more than offset the anticipated increase in Social Security and Medicare payments.

MYTH: Transferring IOUs will require raising taxes, cutting benefits, or increased gross debt to pay for Medicare in the future.

FACT: OMB projects that there will be a surplus well into the middle of the next century even after making full payment of currently promised Social Security and Medicare benefits. By paying down

the publicly held debt, the President's framework reduces net interest costs to the federal government and increases economic growth. Thus, even after using the surplus to pay for Medicare and Social Security, there will still be a budget surplus and therefore no requirement to cut benefits or raise taxes to meet our Medicare obligations. In contrast, if the nation were to use the surplus for tax cuts and still meet our future obligations to Medicare, then we would be forced to raise the payroll tax, make tough benefit cuts, or take other difficult measures.

ADDRESSING MEDICARE'S CHALLENGES

April, 1999

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ADDRESSING MEDICARE'S CHALLENGES

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans:** About 34 million elderly and 5 million people with disabilities receive Medicare.

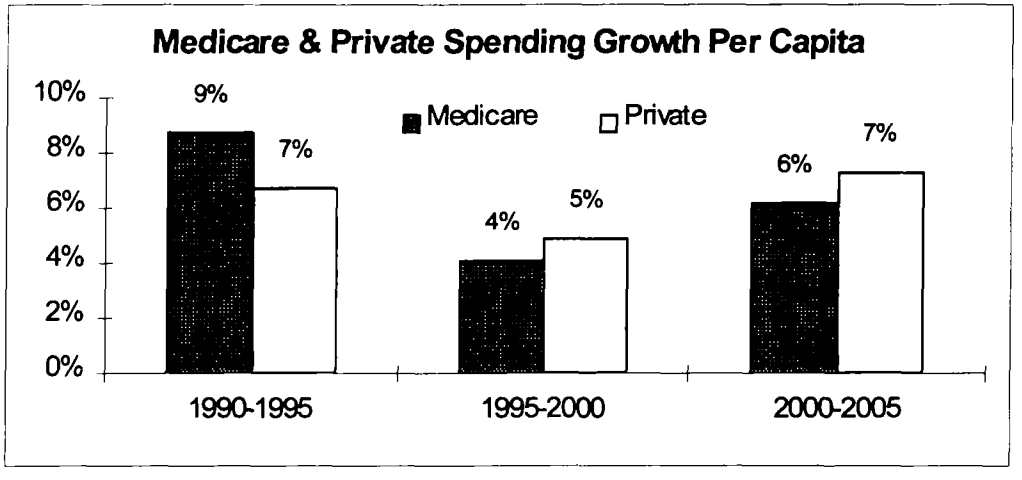
- **Helps those who would otherwise be uninsured:** Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty:** Since 1965:
  - Life expectancy of people at age 65 has increased by 20 percent (79 to 82 years)
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

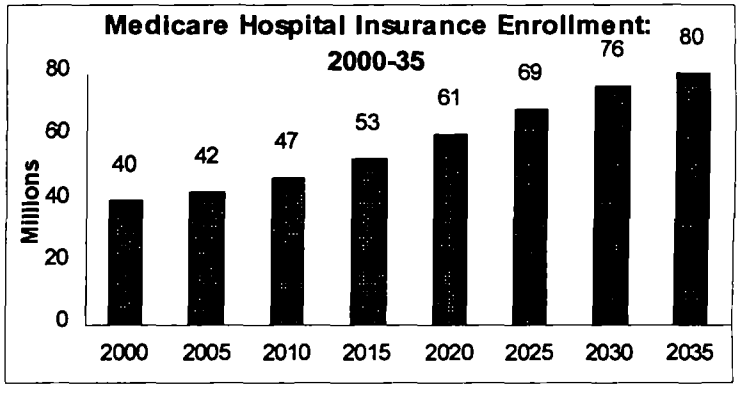
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999. Through commitment to a strong economy, coupled with actions that improve Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015.

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 – from 14 percent to about 22 percent of the population.



- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare trust fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits**: Medicare's benefits are not very generous. In particular:

  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.

  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.

  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.

  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.

- **Insufficient private tools for reducing costs**: Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:

  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). These savings are less than:

  - One-third of BBA savings proposals; and
  - One-third of amount from committing 15 percent of the surplus to Medicare.

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
*BUDGET SAVINGS**	+6	-66

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare**: The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

- **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 Medicare adopt many of the competitive management tools that are used in the private sector.

  - Rationalizing Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid 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.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries:** The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should one plan enter the area.

- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries would not be protected against higher traditional program premiums and would pay more for private plans, since private plans would only get partial payment for their higher costs under the Breaux-Thomas proposal.

- **Unclear commitment to defined guarantee of benefits:** Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** States would face a significant increase in costs since Medicaid pays for premiums for beneficiaries with income below 135 percent of poverty.

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

- **Not a Medicare benefit.** One of Medicare's strengths is that it provides all beneficiaries, regardless of their residence, income or health status, with basic health services. The Breaux-Thomas proposal to extend Medicaid to beneficiaries with incomes below 135 percent of poverty (about $11,000 a year for a single senior) does not constitute a Medicare drug benefit.

    - **Helps only a fraction of beneficiaries without drug coverage:** Nearly 60 percent of beneficiaries without drug coverage would not qualify. For example, a widow with $11,500 in income would not be eligible for assistance for coverage.

    - **Fewer people enroll in Medicaid programs:** Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program.

- **Medigap and unsubsidized options are unworkable.** The Breaux-Thomas proposal would also require all Medigap plans, private managed care plans, and traditional Medicare to offer drug coverage. However, without premium assistance, the costs would likely be high, so that only those who really need the coverage would sign up. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or it would become impossible to offer the coverage altogether.

OTHER SHORTCOMINGS OF THE BREAUX-THOMAS PLAN

- **Does not address Medicare's long-term solvency:** The Breaux-Thomas proposal ignores the need for new revenues to finance the care of the growing numbers of new beneficiaries. The plan's net Medicare savings of around $100 billion over 10 years are not nearly large enough to meaningfully address the long-term shortfall. 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.

- **Raises the age eligibility for Medicare:** The most rapidly growing group of the uninsured is ages of 55 to 65. Raising the Medicare eligibility age without a policy to prevent even more uninsured would exacerbate this problem.

- **Includes an unlimited home health copay:** Beneficiaries would be charged 10 percent coinsurance for all home health visits. For the over 1 million beneficiaries who have more than 60 visits per year, this copay would represent a large financial burden.

- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. This does not produce Federal budget savings and does not assure that teaching hospitals are funded to continue their important mission.

- **Creates new bureaucracy:** A separate Board would oversee premium support, using new staff to approve benefits packages and rates in every single plan, decide on service areas, enforce financial and quality standards among other activities. Not only is this new bureaucracy unneeded, but could remove billions of taxpayer dollars from traditional government oversight, since it is not subject to executive branch rules.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare:** Neither the President nor his four appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conforms to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;

  - Maintaining and improving Medicare's guaranteed benefits, including a prescription drug benefit; and

  - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare:** Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:

  - Competitive pricing for services like medical supplies; and

  - Selectively contracting with lower-cost, high-quality providers.

- **Examining other policies to reduce overpayment and increase competition:** The Administration will also examine specific options to reduce fraud, constrain costs and make both the traditional program and managed care payments more competitive and efficient.

MAINTAINING AND IMPROVING MEDICARE'S GUARANTEED BENEFITS

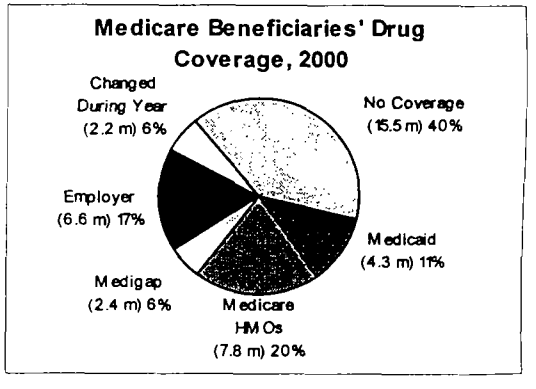
- **Ensuring that Medicare's guarantee is strong:** Medicare protects some of our most vulnerable citizens -- the elderly and people with disabilities -- from excessive health care costs. Proposal to strengthen Medicare must not do so at the expense of this guarantee to a defined set of benefits.

- **Providing a long-overdue prescription drug benefit:**

  - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.

  - Existing coverage is unstable and expensive: Those beneficiaries who have private coverage are vulnerable, since employers are dropping retiree coverage and Medigap is becoming more costly and less accessible.

  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable.



DEDICATING PART OF THE SURPLUS TO MEDICARE

- **Providing new financing by dedicating part of the surplus to 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. This amount would equal $686 billion over the period and extend the life of the trust fund for another decade.

  - Investing now prevents larger problem later. Even though the Medicare shortfall is projected to accumulate to over $1 trillion over the next quarter century, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing later.

  - One-time, fixed contribution: The plan does not create an unlimited tap on general revenues. Instead, it invests a fixed proportion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees.

  - Funded by the baby boom generation -- not tomorrow's workers: The surplus was largely created by the baby boom generation, and makes sense as a one-time funding source for Medicare. In contrast, waiting until future generations are faced with raising taxes to support Medicare would shift this burden to younger and low-income workers.

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE

April 13, 1999

PROPOSAL: The Breaux-Thomas proposal increases the Medicare age eligibility from 65 to 67, one month per year, parallel to Social Security. Some proposals include an unsubsidized Medicare buy-in proposal, similar to what the President has proposed for certain people ages 55 to 65.

ISSUES:

- **The availability and affordability of health insurance for people in their early 60s has not improved -- and in fact has deteriorated.**

  - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups.

  - **Fewer have employer-based health insurance.** Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.

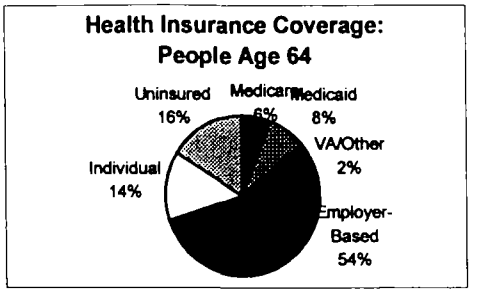
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.

- **Different than Social Security because it is more difficult to postpone health care needs than retirement.** Unlike preparation for income security in retirement, illness and disability are rarely foreseeable. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would affect people with the greatest risk of health problems and lowest probability of finding affordable private health insurance.

- **Breaux-Thomas proposal does not conform to Social Security.** Even under current law, Social Security provides the option for a partial benefit at age 62. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62. Thus, it does not accurately conform to Social Security policy.

- **Raising Medicare's age eligibility could have serious consequences.** Although the Federal government and Medicare Trust Fund would save from raising Medicare's eligibility age, it could create other costs and problems.

  - **Increase the uninsured.** Nearly one in ten Medicare beneficiaries today is either age 65 or 66. In 1998, 16 percent of people age 64 were uninsured. If the 3.7 million people age 65 and 66 were to lose Medicare, it could be assumed that 16 percent of this group would also be uninsured -- nearly 600,000. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance.



  - **Cost shift to employers.** About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage if these older people continue to work. Costs would result not only from covering workers longer, but from higher premiums for all workers since this older group would raise the average costs of all employees. The few firms that offer retiree coverage would pay more as well, since their insurance would be the primary source of coverage, not a wrap-around to Medicare. This could accelerate the trend of dropping retiree coverage. Finally, the Federal government would lose revenue as employers deduct additional cost of premiums.

  - **Unfunded mandate to states.** State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.

- **No viable policy has been offered to prevent the elderly uninsured from increasing.**

  - **Medicare buy-in cannot replace Medicare.** Some proponents of raising the age eligibility of Medicare have suggested that the President's Medicare buy-in proposal as a health insurance alternative for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in.

  - **Costs of subsidies for buy-in would reduce savings.** The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about $27,000 for a single), the cost of subsidies would be high, lowering savings.

DESIGN PARAMETERS FOR A PRESCRIPTION DRUG BENEFIT

Designing a prescription drug benefit is one of the more complicated health policy challenges. Not only are there a large number of decisions involved, but each decision has a cost and/or political tradeoff. This memo describes a number of major design features that affect the costs and coverage of a Medicare prescription drug benefit. Specific options will be presented in forthcoming meetings.

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. In addition, although there was consideration of a benefit for all beneficiaries, Congressman Thomas did not want to respond to a Democratic priority without greater support for his version of premium support. Thus, the Breaux-Thomas proposal included 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 (described later).

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. It also pays for cost sharing for beneficiaries up to 100 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 would 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 to 17 percent by 2000, and with Medigap declining to 6 percent. This has mostly resulted from rising costs of drug coverage, and health coverage for the elderly in general. Similarly, managed care plans report that they are also facing higher costs for drugs and are increasingly limiting their benefit. Thus, the lack of drug coverage is not just a low-income problem.

There are also other problems associated with a Medicaid drug benefit. Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program. The issues of Federal-state matching rates and "unfunded mandates" also emerge. States are reluctant to take on more Medicare-related obligations, even if adequately funded.

For these reasons, Laura Tyson, Reischauer, Aaron and other economists argue that the only efficient – albeit expensive to the Federal government -- 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 drug 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 (note: we are working on transition rules to help beneficiaries with legitimate reasons for postponing enrollment). 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), then all beneficiaries will participate in an optional benefit.

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.

In addition to its low-income proposal, described earlier, the Breaux-Thomas proposal included the requirement that all Medigap and Medicare plans offer some type of prescription drug coverage – without rate restrictions or premium subsidies. However, without premium assistance, the costs would be high, so that only those who really need the coverage would

enroll. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or inaccessible as few plans participate in Medicare.
One option that could address concerns about premium subsidies 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.

In general, there is a desire that the monthly premium for prescription drug coverage is in the $20 to $30 per month range. This is about half of the current Part B premium, and is low enough that we think that there would be nearly 100 percent participation. To put this in context, the typical Medigap premium for drug coverage is about $90 per month. In all of Maine, New Hampshire and Vermont, only three managed care plans offer prescription drug coverage. In Maine, its plan pays up to $800 (with copays) for a $67 premium; in New Hampshire, beneficiaries pay $45 per month for up to $300 in plan payments for drugs, and in Vermont, a beneficiary can pay $36 per month for unlimited coverage with a 50 percent copayment.

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. As with most health expenditures, most people have relatively low expenditures, while a few have very high expenditures. As the attached chart shows, 17 percent of beneficiaries account for over half of all drug spending for beneficiaries. At the same time, over half of beneficiaries have over $500 in drug spending in a year – suggesting that it is not only the sickest who face high costs. A comprehensive policy that covers both up-front and catastrophic drug spending is not affordable in the context of our reform plan. Thus, there are tradeoffs. Policies with high deductibles that protect against catastrophic costs will help fewer beneficiaries, but those with the greatest need. Policies with low deductibles and low limits on plan payments help a much larger proportion of beneficiaries, but could leave the sickest vulnerable.

The attached tables show the illustrative effects of Medigap and two policies. As can be seen in the "Illustration of Medigap Cost Sharing" table, the premiums and cost sharing are so high that only beneficiaries with greater than $2,500 in spending benefit from this coverage.

The table entitled, "Illustration of How Cost Sharing Affects Beneficiaries," shows two different policies. Option 1 has no deductible, 50 percent coinsurance, and a cap on the amount that the plan pays at $5,000. With a 75 percent premium subsidy, this policy would cost about $81 billion over 5 years, $242 billion over 10 years, with a monthly premium of $16. Option 2 has a $100 deductible, 20 percent coinsurance, and a cap on benefits at $2,000. Its estimated costs are $94 billion over 5 years, 281 billion over 10 years, with a monthly premium of $20.

As this table shows, Option 1 helps the people with higher expenditures more, since its cap is higher. The person with $5,000 or more in annual savings would prefer Option 1. Option 2 kicks in earlier, helping the 60 percent of beneficiaries with spending between $500 and $2,500 annually. These illustrations assume that the beneficiary is not now paying for Medigap or Medicare managed care – such beneficiaries would benefit more from these options.

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: (1) HCFA-administered benefit, using its power as the largest purchaser of drugs to get discounts; and (2) a 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. Both use of a rebate program and formulary have served as effective price controls for drugs.

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 However, questions that arise with this approach to a Medicare benefit are more complicated (e.g., how much liability does the PBM and/or beneficiary bear; how would the PBM be selected).

During the Medicare Commission, strong arguments were made against a HCFA-administered benefit -- in particular, the adverse market effects if HCFA engaged in rate setting and regulation. Others argued that it would be irresponsible to not use the leverage to get the best discounts. This is a complicated issue that staff will continue to examine.

Not yet fixed

MEDICARE BENEFICIARIES: PRESCRIPTION DRUG USE & SPENDING, 2000

	No Spending	$1 - 500	$500 - 1,000	$1,000 - 2,000	$2,000 - 5,000	$5,000 +	TOTAL
TOTAL							
Beneficiaries (millions)	6.8	11.4	6.6	7.4	5.4	1.1	**38.8**
Percent	*18%*	*29%*	*17%*	*19%*	*14%*	*3%*	***100%***
Expenditures (billions)	$0.0	$2.4	$4.8	$10.6	$16.6	$8.6	**$43.0**
Percent	*0%*	*6%*	*11%*	*25%*	*38%*	*20%*	***100%***
COVERED							
Beneficiaries (millions)	3.1	6.6	4.1	4.8	3.8	0.8	**23.3**
Percent	*13%*	*29%*	*18%*	*21%*	*16%*	*4%*	***100%***
Expenditures (billions)	$0.0	$1.4	$3.0	$6.9	$11.6	$6.5	**$29.4**
Percent	*0%*	*5%*	*10%*	*24%*	*40%*	*22%*	*100%*
NO COVERAGE							
Beneficiaries (millions)	3.8	4.8	2.5	2.6	1.6	0.3	**15.5**
Percent	*24%*	*31%*	*16%*	*16%*	*11%*	*2%*	***100%***
Expenditures (billions)	$0.0	$1.0	$1.8	$3.7	$4.9	$2.2	**$13.6**
Percent	*0%*	*7%*	*13%*	*27%*	*36%*	*16%*	*100%*
< 100% of Poverty							
Beneficiaries (millions)	2.5	2.6	1.5	1.7	1.3	0.3	**9.9**
Percent	*25%*	*26%*	*15%*	*17%*	*13%*	*3%*	***100%***
Expenditures (billions)	$0.0	$0.5	$1.1	$2.4	$4.0	$2.1	**$10.2**
Percent	*0%*	*5%*	*11%*	*24%*	*39%*	*21%*	***100%***
100 - 200% of Poverty							
Beneficiaries (millions)	1.7	2.9	1.8	1.8	1.3	0.3	**9.8**
Percent	*17%*	*30%*	*18%*	*19%*	*13%*	*3%*	***100%***
Expenditures (billions)	$0.0	$0.6	$1.3	$2.6	$3.9	$2.0	**$10.4**
Percent	*0%*	*6%*	*12%*	*25%*	*38%*	*19%*	***100%***
200% + Poverty							
Beneficiaries (millions)	2.7	5.9	3.3	3.8	2.8	0.6	**19.1**
Percent	*14%*	*31%*	*17%*	*20%*	*15%*	*3%*	***100%***
Expenditures (billions)	$0.0	$1.2	$2.4	$5.5	$8.6	$4.5	**$22.3**
Percent	*0%*	*5%*	*11%*	*25%*	*39%*	*20%*	***100%***

Based on HHS, HCFA Office of the Actuary, estimated 2000 baseline

ILLUSTRATION OF MEDIGAP COST SHARING

OPTION	SPENDING					
	$0	**$250**	**$500**	**$1,000**	**$2,500**	**$5,000**
Distribution 100% (38.8 million)	18% (6.8 m have $0 spending)	18% (7.1 m spend $1-250)	11% (4.4 m spend $250-500)	17% (6.6 m spend $500-1000)	24% (9.2 m spend $1000-2500)	12% (4.7 m spend > $2500)
MEDIGAP PLAN H						
Plan Payment:						
Copay Up to $1,250 Cap	**$0**	**$0**	**$0**	**$250**	**$1,000**	**$1,250**
Beneficiary Payment:						
$500 Deductible	$0	$250	$500	$500	$500	$500
50% Copay	$0	$0	$0	$250	$1,000	$2,250
Amount above $1,250 Cap	$0	$0	$0	$0	$0	$1,000
Total	**$0**	**$250**	**$500**	**$750**	**$1,500**	**$3,750**
Premium Payment:	**$1,000**	**$1,000**	**$1,000**	**$1,000**	**$1,000**	**$1,000**
Spending (+)/ Savings (-)	***+$1,000***	***+$1,000***	***+$1,000***	***+$750***	***+$0***	***-$250***

* According to one study, the Medigap premium for Plan H for an average 65-year old was $2,073 in 1998, compared to $913 in Plan D, which is virtually the same except for drug coverage. This premium reflects both adverse selection and high administrative costs typically associated with Medigap.

ILLUSTRATION OF HOW COST [illegible]ARING AFFECTS BENEFICIARIE

OPTION	SPENDING					
	$0	**$250**	**$500**	**$1,000**	**$2,500**	**$5,000**
Distribution 100% (38.8 million)	18% (6.8 m have $0 spending)	18% (7.1 m spend $1-250)	11% (4.4 m spend $250-500)	17% (6.6 m spend $500-1000)	24% (9.2 m spend $1000-2500)	12% (4.7 m spend > $2500)
Option 1 ($81 b / 5) **Plan Payment:**	**$0**	**$125**	**$250**	**$500**	**$1,250**	**$2,500**
Beneficiary Payment:						
$0 Deductible	$0	$0	$0	$0	$0	$0
50% Copay	$0	$125	$250	$500	$1,250	$2,500
Amount above $5,000 Cap	$0	$0	$0	$0	$0	$0
Total	**$0**	**$125**	**$250**	**$500**	**$1,250**	**$2,500**
Premium Payment:	**$192**	**$192**	**$192**	**$192**	**$192**	**$192**
Spending (+)/ Savings (-)	***+$192***	***+$67***	***-$58***	***-$308***	***-$1,058***	***-$2,308***
Option 2 ($94 b / 5) **Plan Payment:**	**$0**	**$120**	**$320**	**$720**	**$1,920**	**$2,000***
Beneficiary Payment:						
$100 Deductible	$0	$100	$100	$100	$100	$100
20% Copay	$0	$30	$80	$180	$480	$980
Amount above $2,000 Cap	$0	$0	$0	$0	$0	$1,920
Total	**$0**	**$130**	**$180**	**$280**	**$580**	**$3,000**
Premium Payment:	**$240**	**$240**	**$240**	**$240**	**$240**	**$240**
Spending (+)/ Savings (-)	***+$240***	***+$120***	***-$80***	***-$480***	***-$1,680***	***-$1,760***

* Cap on plan payment: a person with $5,000 has plan payments that exceed the $2,000 cap, so the beneficiary pays all additional costs.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

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MEMORANDUM

To: The Director
From: Dan Mendelson
Re: Using Budget Savings for the Medicare Reform Package
Date: April 13, 1999

This memo seeks your guidance on whether the Administration should use some of the Medicare savings proposals and the tobacco excise tax increases proposed in the FY 2000 Budget to finance the President's Medicare reform plan (e.g., prescription drug benefit). This topic has been raised repeatedly by DPC, NEC, OVP, and HHS, and I expect that it will be raised at an upcoming Medicare principal's meeting. As I noted to you yesterday, I expect that Senator Kennedy's bill will finance virtually the entire drug benefit through tobacco taxes and use of surplus revenues.

Recall that the Budget proposed $7.7 billion in net Medicare savings over FY 2000-04 ($3.9 billion of this amount is the inpatient hospital freeze that has been extremely controversial). In addition, the Budget proposed a $0.55 increase in the tobacco excise tax and accelerated the BBA's $0.15 tobacco excise tax increase, generating $34.5 billion in savings over five years. The FY 2000 Budget uses most of the Medicare savings and all of the tobacco tax increases to offset FY 2000 discretionary spending.

A prescription drug benefit could cost in the range of $50 to $90 billion over five years. While we are developing options that would generate revenues by extending BBA policies, there is mounting criticism against extending many of the BBA savings policies (as proposed by the Medicare Commission), and a desire by some authorizers to undo selected BBA policies in the short term. And while we will also have some options that generate revenues by modestly increasing beneficiary payments (e.g., through an income-related premium), none of the principals will advocate for heavy reliance on such savings.

Below we give the pros and cons of using Medicare and tobacco savings for Medicare reform. Of course, we could temper this policy by only using a portion of such revenues for this purpose, or by proposing additional tobacco revenues that are not contained in the budget. Addendum I below gives more detail on our FY 2000 tobacco tax policies. Addendum II below summarizes revenue available from different tobacco tax policies.

We should meet briefly to discuss this issue before the upcoming principal's meeting.

Pros:

- Helps the Administration avoid using BBA extenders that have been the subject of recent criticism. It is likely that the authorizers will reverse or curb some of the Medicare BBA savings policies as opposed to extending them as envisioned by the Commission and in the Administration's current Medicare reform base package.

- Could generate new momentum for the Administration's tobacco policies by linking a tobacco tax increase to a popular prescription drug benefit initiative. Similarly, the BBA CHIP program was partially financed through an increase in the Federal tobacco excise tax.

- The President has already established a link between tobacco and Medicare by announcing that some of the proceeds from a Federal lawsuit against the tobacco industry would help shore up the Medicare trust funds.

- Would use Medicare savings for Medicare reform, as opposed to funding discretionary programs proposed in the Budget.

Cons:

- It could create a $9.1 billion shortfall in FY 2000 on the discretionary side of the Budget. Using these offsets for Medicare reform could make it much more difficult to reach agreement this year with the Congress on FY 2000 appropriations.

- Because the President's Medicare plan must be released soon, the timing of such a decision would likely conflict with your ongoing negotiations on the Supplemental.

- The tobacco tax is an uncertain revenue source should smokers quit more rapidly than expected. Many states also have acted recently to increase their taxes, which could leave less available revenue for the Federal government to finance prescription drugs and other Medicare reforms in the years ahead.

- The Congress has shown little interest in enacting tobacco price increases as proposed by the Administration in the FY 1999 and FY 2000 Budgets. Linking a popular initiative like Medicare prescription drugs to a tax increase opposed by many in Congress could hinder the motion of a drug benefit.

Addendum I: The FY 2000 Budget Policy on Tobacco Excise Taxes

The Budget included two major tobacco excise policies that provide savings of roughly $35 billion over FY 2000 to FY 2004 (see table below):

(1) A 55 cents per-pack increase to be collected through tobacco excise taxes.
FY 2004-04 Savings: $32.2 billion.

(2) Acceleration of the BBA's 15 cents excise tax. The 1997 Balanced Budget Agreement (BBA) raised the excise tax 10 cents per-pack effective January 1, 2000 and another 5 cents effective January 1, 2002, for a cumulative 15 cents increase. The FY 2000 Budget accelerates the effective date of this entire tax by one year, effective October 1, 1999.
FY 2000-04 Savings: $1.9 billion.

Federal Receipts Raised From Tobacco Excise Taxes (in billions)

Year	1999	2000	2001	2002	2003	2004	00-04
55 cents	.165	6.525	6.426	6.426	6.418	6.400	32.195
BBA 15 cent	.139	1.081	0.679	0.163	-----	-----	1.923
Shift BATF[1]	-.381	.381	----	----	-----	-----	.381
Net Receipts	-.077	7.987	7.105	6.589	6.418	6.400	34.499

The FY 2000 Budget attributed these revenues to tobacco-related health care costs in the following Federal programs.

Federal Program	FY 2000 Tobacco-Related Costs (in billions)
Veterans' Affairs	4.0
OPM FEHB[2]	2.2
Department of Defense	1.6
Indian Health Service	0.3
TOTAL	**$8.0**

[1] This policy is the Bureau on Alcohol, Tobacco and Firearms (BATF) excise shift. Treasury assumes that revenues will be lower than we estimated in 2000 because smokers will stock up in FY 1999, before the 70 cents total price increase takes effect. The stocking up effect reduces 2000 revenues, but increases 1999 revenues by $304 million. To capture the 1999 revenues for use in 2000, Treasury came up with an excise tax shift. The shift loses money in 1999 and gains in 2000, more or less canceling out the stocking up effect. Note that the shift applies to all excise taxes collected by BATF, not just tobacco.

[2] OPM Federal Employee Health Benefits Program figure includes the total premium costs, and is not broken down by enrollee share (28%) and Federal share (72%).

Addendum II.Potential Net Revenues from a Federal Tobacco Tax Increase

The following table estimates revenue that could be derived from various levels of an excise tax increase.

	($ in Billions)					
Increase in Tax	2000[3]	2001	2002	2003	2004	2000-04
55 cents per pack	8.0	7.1	6.6	6.4	6.4	34.5
75 cents per pack	10.3	9.0	8.3	8.1	8.3	43.9
$1.00 per pack	12.8	11.1	10.3	10.1	10.5	54.8
$1.25 per pack	15.1	12.8	12.1	11.9	12.3	64.2
$1.50 per pack	17.1	14.4	13.6	13.4	14.0	72.4

Note: The year-by-year estimates may differ somewhat from Treasury-generated estimates, but the totals from 2000-04 should be close. Treasury is likely to include additional assumptions, such as increased smuggling due to higher per-pack costs, that would drive down the demand and, therefore, reduce the total revenue generated from the tax.

cc: Sylvia Mathews
Josh Gotbaum
Chuck Kieffer
Dick Emery

[3]Includes impact of speeding up BBA97 15 cents tax increase

MEDICARE 1999 TRUSTEES' REPORT

March 30, 1999

SUMMARY: MEDICARE'S FINANCIAL OUTLOOK

- **Life of the HI Trust Fund**:
  Spending exceeds income: Improved from 1998 last year to 2007 this year
  Trust Fund exhaustion: Improved from 2008 last year to 2015 this year

- **Actuarial deficit**: Improved from 2.1 last year to 1.46 this year -- a 30 percent decline

MESSAGE TO THE PUBLIC FROM THE TRUSTEES

"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."

"Despite the improvement in the financial outlook of Medicare, the projected increases in medical care costs still make solutions to Medicare's problems more complex than those for Social Security."

"In this regard, we are encouraged by the high priority the President and the Congress are giving to the resolution of the Social Security program's projected long-range financing shortfall. We strongly recommend that similar urgency be attached to the task of addressing Medicare's long-term financial situation."

1999 ANNUAL REPORT: THE FEDERAL HOSPITAL INSURANCE TRUST FUND

"Finding good solutions to providing medical care for the elderly and disabled will be a continuing and difficult challenge as our population ages and medical care evolves. The legislative action taken in 1997 was a significant first step in meeting that challenge." (Summary of the Annual Reports: p. 9)

"In 1998, HI income exceeded expenditures by $4.8 billion -- the first time in 4 years that the trust fund has experienced a positive cash flow." (P.11)

"These changes, substantial as they are, are only sufficient to enable payment of HI benefits over roughly the next one and a half decades. More far-reaching measures will be needed to prevent trust fund depletion as the baby boom generation reaches age 65 and starts receiving benefits." (P. 16)

"The projections shown in this report, while encouraging in comparison to prior estimates, continue to demonstrate the need for timely and effective action to address the remaining financial imbalance facing the HI trust fund." (P. 17)

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	--	--	na
1974	--	--	na
1975	"Late 1990s"	--	na
1976	"Early 1990s"	--	na
1977	"Late 1980s"	--	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
1994	2001	7	- 4.14
1995	2002	7	- 3.52
1996	2001	5	- 4.52
1997	2001	4	- 4.32
1998	2008	10	-2.10
1999	2015	16	-1.46

Sources: Annual Trustees Reports for 1978 and subsequent years; Reischauer & Aaron, 1995 for early years.
Note: All estimates assume the "intermediary" or, when applicable "intermediary B" assumptions

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.

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:
The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries premiums. Board would approve plan service areas and benefit package designs.

Benefits Package:
The standard benefits package is specified in law and would consist of all services covered under the existing Medicare statute. Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:
Private Plans
All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income
The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Medigap
All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:
Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:
The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. 10 percent coinsurance would be charged for home health, laboratory services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Special Payments:
Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. The proposal would also recommend exploring funding Indirect Medical Education (IME) and other non-insurance subsidies outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program. Any special payments remaining in Medicare would not be included in the calculation of premiums for the government-run fee-for-service plan or private plans.

Retirement Age:
The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. A non-subsidized buy-in would be available at age 65. Congress should develop a special category of eligibility based on specific needs-based criteria (i.e. ADLs) for individuals between 65 and the then-current eligibility age.

Long-Term Care:
Long-term care issues should be separated from Medicare (an acute care program), and long-term care improvements should be made through pension, Social Security, and investment reforms. The proposal would require a study of various long-term care issues.

Financing:
Part A and Part B trust funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare outlays, Congress would be required to authorize any additional contributions to the Medicare Trust Fund. This new test (40% of outlays) would probably not be reached until after 2005. Even if general revenue contributions were limited to 40% of program outlays, this proposal would extend solvency to 2013 (2017 under CBO's new baseline.)

Budgetary Impact:
Between 2000 and 2009, this proposal would save approximately $100 billion. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:
The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries premiums. Board would approve plan service areas and benefit package designs.

Benefits Package:
The standard benefits package is specified in law and would consist of all services covered under the existing Medicare statute. Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:
Private Plans
All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income
The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

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All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:
Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW

I. INTRODUCTION

This recommendation is in three parts:
the design of a premium support system,
improvements to the current Medicare program, and
financing and solvency of the Medicare program.

We believe it is important to address the current program now because of the transition time necessary to implement this premium support system. We assume the enactment of this proposal in 1999 and that the premium support system would be fully operational in 2003.

We believe a premium support system is necessary to enable Medicare beneficiaries to obtain secure, dependable, comprehensive high quality health care coverage comparable to what most workers have today. We believe modeling a system on the one Members of Congress use to obtain health care coverage for themselves and their families is appropriate. This proposal, while based on that system, is different in several important ways in order to better meet the unique health care needs of seniors and individuals with disabilities. Our proposal would allow beneficiaries to choose from among competing comprehensive health plans in a system based on a blend of existing government protections and market-based competition. Unlike today's Medicare program, our proposal ensures that low income seniors would have comprehensive health care coverage.

Because the implementation of a premium support system will take a number of years, we recommend immediate improvements to the current Medicare program. In Section II we outline the incremental improvements to enhance the beneficiaries' security and quality of care now. We recommend immediate federal funding of pharmaceutical coverage through Medicaid for seniors up to 135% of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing.

In reviewing the three parts of this proposal, it is important to keep in mind the different government roles in the premium support system and in current law. We believe the guarantee our society makes to every senior is to ensure that they can obtain the highest quality health care, and that their health care coverage not be allowed to fall behind that available to people in their working years. We believe that our society's commitment to seniors, the Medicare entitlement, can be made ***more secure*** only by focusing the government's powers on ensuring comprehensive coverage at an affordable price rather than continuing the inefficiency, inequity, and inadequacy of the current Medicare program.

I. PREMIUM SUPPORT SYSTEM TO PROVIDE COMPREHENSIVE COVERAGE

The Medicare Board

A Medicare Board should be established to oversee and negotiate with private plans and the government-run fee-for-service plan. Some examples of the Board's role are: direct and oversee periodic open enrollment periods; provide comparative information to beneficiaries regarding the plans in their areas; transmit information about beneficiaries' plan selections and corresponding premium obligations to the Social Security Administration to permit premium collection as occurs today with Medicare Part B premiums; enforce financial and quality standards; review and approve benefit packages and service areas to ensure against the adverse selection that could be created through benefit design, delineation of service areas or other techniques; negotiate premiums with all health plans; and compute payments to plans (including risk and geographic adjustment).

This Board would operate under a government charter that would describe its responsibilities and operating standards including the ability to hire without regard to civil service requirements and salary restrictions.

Ensuring Plan Performance and Dependability

All plans (private plans and the government-run FFS plan) would compete in the premium support system; all plans would have Board-approved benefit designs and premiums. The Board would ensure that the benefits provided under all plans are self-funded and self-sustaining, determining whether plan premium submissions meet strict tests for actuarial soundness, assessing the adequacy of reserves, and monitoring their performance capacity.

Management of Government-run Fee-for-service in Premium Support

The government plan would have to be self-funded and self-sustaining and meet the same requirements applied to all private plans, including whether its premium submissions meet strict tests for actuarial soundness, the adequacy of reserves, and performance capacity.

Cost containment measures would be necessary. The provisions of the Balanced Budget Act of 1997 should be extended, or comparable savings achieved. In any region where the price control structure of the government run plan is not competitive, the government-run fee-for-service plan could operate on the basis of contracts negotiated with local providers on price and performance, just as is the case with private plans. The government plan would be run through contractors as it is today; contractors in one region would be able to bid in other regions; the Board should have powers to assure that the government-run plan would not distort local markets.

Benefits Package

A standard benefits package would be specified in law. This benefits package would consist of all services covered under the existing Medicare statute. Plans would be able to offer additional benefits beyond the core package and plans would be able to vary cost sharing, including copay and deductible levels, subject to Board approval. Benefits would be updated through the annual negotiations process between plans and the Board, although the Board would not have the power to expand the standard benefit package without Congressional approval. Health plans would establish rules and procedures to assure delivery of benefits in a manner consistent with prevailing private standards and procedures offered to employer groups and other major purchasers.

The Medicare Board would approve benefit offerings and could allow variation within a limited range, for example not more than 10% of the actuarial value of the standard package, provided the Board was satisfied that the overall valuation of the package would be consistent with statutory objectives and would not lead to adverse or unfavorable risk selection problems in the Medicare market.

New benefit to be instituted in the premium support system: Outpatient prescription drug coverage and stop-loss protection

In Private Plans:

Private plans would be required to offer a high option that includes at least Medicare covered services plus coverage for outpatient prescription drugs and stop-loss protection. Plans would be able to vary copay and deductible structures. Minimum drug benefits for high option plans would be based on an actuarial valuation. High option and standard option plans each would be required to be self-funded and self-sustaining.

In Government-run Fee-For-Service Plan:

The government-run fee-for-service plan would be required to offer high option (including outpatient prescription drugs and stop-loss) in addition to standard option plans. The Medicare Board approval process would be the same as for private plans. High option and standard option plans would be required to be separately self-funded and self-sustaining. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Comprehensive coverage for low-income beneficiaries:

Coverage would be provided through high option plans. The federal government would pay 100% of the premiums of the high option plans at or below 85% of the national weighted average premium of all high option plans for all eligible individuals up to 135% of poverty ($10,568 for an individual and $13,334 for a couple) on a fully federally funded basis. This financial support does not limit

these beneficiaries' choice of plans nor restrict plans' design with regard to cost-sharing or other flexibility authorized by the Board. State would maintain their current level of effort, but the federal government would pay 100% of additional costs for these individuals. In this context, Congress should review DSH payments to ensure that double payments do not occur.

Premium Formula Basics

On average, beneficiaries would be expected to pay 12 percent of the total cost of standard option plans. For plans that cost at or less than 85 percent of the national weighted average plan price, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries' premiums would include all costs above the national weighted average.

Only the cost of the standard package would count toward the computation of the national weighted average premium. Plans with a high option, whether private plans or government-run, would separately identify the incremental costs of benefits beyond the standard package in their submissions to the Board, and the government contribution would be calculated without regard to the costs of these additional benefits.

Premium for government-run fee-for-service plans

The government-run fee-for-service plan would be treated the same as private plans.

Government-run plan premium excludes costs of special subsidies in premium calculation

All non-insurance functions and special payments now in Medicare would not be included in calculation of premiums for the government-run FFS plan or private plans.

Guaranteed premium levels where competition develops more slowly

In areas where no competition to the government-run fee-for-service plan exists, beneficiaries' obligations would be no greater than 12 percent of the FFS premium or the national weighted average, whichever is lower. The Medicare Board should periodically review those areas with a fixed percentage premium to ensure that the fixed percentage premium is not anti-competitive.

Medicare's Special Payments in a Premium Support System

Congress should examine all non-insurance functions, special payments and subsidies to determine whether they should be funded through the Trust fund or from another source. For example, payments for Direct Medical Education (DME) would be financed and distributed independent of a Medicare premium support system. Since the Part A and Part B trust funds would be combined and the traditionally separate funding sources of payroll taxes and general revenues would be blurred, Congress should provide a separate mechanism for continued funding through either a mandatory entitlement or multi-year discretionary appropriation program. On the other hand, Indirect Medical Education (IME) presents a unique problem since it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals.

Therefore, for now Congress should continue to fund IME from the Trust Fund as an adjustment to hospital payments.

II. IMMEDIATE IMPROVEMENTS TO THE CURRENT MEDICARE PROGRAM AND OTHER ASPECTS OF SENIORS HEALTH CARE SPENDING

Provide Outpatient Prescription Drug Coverage for 3 million more low-income beneficiaries

Immediately provide federal funding for coverage of prescription drugs under Medicaid for beneficiaries up to 135 percent of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing. All funding obligations related to the coverage under this provision would be federal.

Improve access to outpatient prescription drug coverage for seniors

Revise federal directives to National Association of Insurance Commissioners (NAIC) to develop new Medigap state model legislation immediately. All private supplemental plans would include basic coverage for prescription drugs. One plan would be a prescription drug-only plan.

Combine Parts A and B

Health care delivery changes have blurred the distinctions originally contemplated when Parts A and B of Medicare were enacted. Parts A and B should be combined in a single Medicare Trust Fund. (See Section III on Financing and Solvency.)

Lower deductible for 8 million beneficiaries

The current Medicare program subjects beneficiaries entering the hospital to extremely high costs just at a time when they face the many other expenses associated with serious illness. Virtually no private health plan imposes such costs. We propose to combine the current Part A ($768) deductible and B ($100) deductible, and replace it with a single deductible of $400, which should be indexed to growth in Medicare costs.

Improve utilization of health care services

A fee-for-service plan is best maintained by financial incentives, without which costs spiral out of control or freedom of choice must be restricted. To protect against unnecessary rises in beneficiary Part B premiums, 10% coinsurance would be established for all services except inpatient hospital stay and preventive care, and except where higher copays exist under current law.

Revise federal directives to NAIC to develop new state model legislation to conform to the changes proposed for Medicare cost-sharing. These directives should also be

designed to achieve more affordable and more efficient supplemental insurance and to minimize Medicare outlays. The new single Medicare deductible and coinsurance schedule would be insurable in part or in whole.

Eligibility Age

Medicare eligibility age should be conformed to that of Social Security. A non-subsidized buy-in should be available at age 65. In addition, Congress should develop a special category of eligibility based on specific needs-based criteria, for example selected activities of daily living, for individuals between age 65 and then-current eligibility age.

III. FINANCING AND SOLVENCY

The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms would result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and would enhance our ability to meet our commitment to today's and future beneficiaries. Without these changes, quality of care could suffer, and significantly greater revenues and/or beneficiary sacrifices would be required. Beneficiaries and the taxpayers would not receive the greatest value for the total health dollars spent on seniors' behalf.

Medicare's financing needs would be dictated by the Medicare growth rate achieved under the premium support system. By moving to a premium support system, Medicare's growth rate would be reduced by 1 to 1.5 percentage points per year from the current long-term annual growth rate of 7.6 percent (Trustees Intermediate) or 8.6 (Commission's No Slowdown Baseline.) If this reduction in growth rate can be achieved, the fiscal integrity and Medicare would be significantly improved.

Even if the estimated reduction in growth rate is achieved, Medicare will require additional resources as the percent of population that is eligible for Medicare increases. As revenue is needed, how much should be funded through the payroll tax, through general revenue, and through beneficiary premiums?

The answer to this question is difficult because it would require knowing today the health care system of the future. We do not know what the future holds in terms of the evolution of the health care delivery system, or the impact that technology will have on health care costs.

At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs" Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future "technology cuts both ways with respect to both saving medical expenditures and

potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology--and I could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity."

Notwithstanding the magnitude of uncertainty contained in the task, the statute establishing the Commission directed us to recommend measures to attain the long-term "solvency" of the Medicare program. Because of recent history the meaning of "solvency" has come under question. We believe a new measure of solvency must be developed that couples the uncertainty inherent in the task with the real need for the public to evaluate the cost of Medicare and how we should choose to fund this program over time.

The solvency test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

In addition, the payroll tax supporting the OASDI Trust Funds is limited both by its rate and the wage base on which that rate is applied. No portion of Medicare's funding contains these limitations. In Medicare, there is no cap on the wage base; the Part A Trust Fund is funded by a payroll tax of 2.9% on all earnings, and pays only for the Part A benefits of Medicare. Medicare's Part B benefits are paid 75% by general revenues and 25% by beneficiaries.

Consequently, the historic concept of Medicare's solvency is one that has been partially and inappropriately borrowed from Social Security and has never fully reflected the fiscal integrity, or lack thereof, of the Medicare program. In Medicare, "solvency" has meant only whether the Part A Trust Fund outlays were poised to exceed Part A reserves and collections. That is all.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A "solvency" or rather "insolvency" has been used to shift more program costs to the general fund. An act of Congress shifted major home health expenditures from Part A to Part B in 1997, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A "solvency".

The ever increasing estimates of general fund exposure should be part of any definition of solvency. Absent reform, general fund exposure jumps from 37% of program funding in FY2000 to 43% in FY2005 and 49% in FY2010. General fund demand will increase from $92 billion in FY2000 to $156 billion in FY2005 to $261 billion in FY2010.

Consequently, the "solvency" of the Part A Trust Fund is not useful as a guide to policy making or even as a tool to educate the public on the security and financial condition of the Medicare program.

Therefore, Part A and Part B Trust Funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. This concept should more accurately reflect the implications of the program's financing structure, i.e., the ratio of relative financing burdens on the general fund, the Hospital Insurance payroll tax, and the premiums beneficiaries pay. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. This could be referred to as a programmatic solvency test.

Congress should enact this revised definition of Medicare solvency so that decisions can be made in the context of competing demands for general revenue. Congress should require the Trustees to publish annual projections regarding the ratio in program financing. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent. The Trustees Report should provide for necessary and important public debate leading to potential adjustments to the payroll tax and/or the beneficiary premium as well as any adjustment of the general fund devoted to Medicare. Congressional approval would be required to authorize any additional contributions to the Medicare Trust Fund.

With the reforms contemplated under this proposal, that new test would probably not activated until after 2005. Even if we limit general revenue contributions to 40% of program outlays, however, this proposal would extend the solvency of Medicare to 2013. This calculation, based on the most recent CBO baseline, would indicate that solvency under this test would extend to 2017 or beyond.

Long-term care

The Commission recognizes that its proposal is focused on acute care, and does not address the issue of long-term care. In 1995, Americans spent an estimated $91 billion on long-term care, with 60 percent coming from public sources. Despite these large public expenditures, the elderly face significant uncovered liabilities. The Commission recommends that the Institute of Medicine conduct a study to 1) estimate future demands for long-term care; and 2) analyze the long-term care financing options available to seniors, including long-term care insurance, tax policy and community-based, state and federal government programs.

To: Medicare Commission 3/14/99

From: Jeff Lemieux

Subject: Cost estimate of March 14 proposal

The attached estimate is based on the proposal specified below. The estimate is displayed in annual figures for the 10-year budget window used in the Senate (and slightly beyond). Long-term tables developed by the Modeling Task Force, which display the impact of the proposal using several different measures, are also included. In addition, a simulation of a combined trust fund is attached. The explanation of the basis of the estimate is limited to new items in the proposal. The February 17 estimate of the original Breaux proposal contains a general explanation of the premium support plan. Since the current proposal is similar to the nontraditional estimate on February 17, simulations of the impact on beneficiary premiums from that estimate continue to apply.

DESCRIPTION OF THE PROPOSAL

Medicare Board:

The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries' premiums (collected via Social Security system as with Part B premiums now). Board approval would be required for plan service areas and benefit package designs.

Benefits:

The standard benefits package specified in law would consist of all services covered under the existing Medicare statute (Medicare covered services). Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:

Private Plans

All private plans would be required to offer a high option that included at least the standard benefits package plus coverage for prescription drugs. The minimum drug benefit for high option plans would be based on an actuarial valuation, with standards and examples set by the Board.

Low-Income

The proposal would immediately extend coverage of prescription drugs to qualifying beneficiaries under 135 percent of poverty under Medicaid with full federal funding of the additional cost. That coverage

could be provided through high option plans when the premium support system was implemented. (A special premium support schedule could be used to combine premium and drug subsidies for low-income beneficiaries.)

Fee-For-Service
The Health Care Financing Administration (HCFA) would be allowed to contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would allow a public/private high option plan or plans, with HCFA providing coverage for Medicare covered services and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, HCFA would be allowed to transition the government-run fee-for-service plan to a more private-managed basis overall, possibly with different alternatives available regionally.

Medigap
The National Association of Insurance Commissioners would develop new model plans immediately under a federal directive. All plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:

Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. (An example of this type of premium schedule was included in the estimate from February 17.)

Although all plans would be available on the national premium schedule, only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board for that purpose.

If early versions of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:

The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. Ten percent coinsurance would be charged for home health, laboratory

services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Management of the Government-Run Fee-for-Service Plan:

All plans, private plans and the government-run fee-for-service plan, would compete in the premium support system; all plans would have premiums and would be available on the national schedule. The fee-for-service plan would have a premium like any other plan–it would adjust its premium in subsequent years based on its cost experience.

The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate. The estimate assumes that the growth of fee-for-service spending would be moderated somewhat by a combination of HCFA and Congressional efforts. Without some such ongoing savings, the fee-for-service plan could gradually lose its competitive position with private plans.

Special Payments (Education, Disproportionate Share, Rural Subsidies):

Under the proposal, federal support for Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. Depending on the nature of the replacement program for DME, the federal budget as a whole might not be affected by the carve-out. The proposal would also recommend exploring funding disproportionate share hospitals (DSH) and Indirect Medical Education (IME) outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program.

Any special payments remaining in Medicare would not be included in premiums for the government-run fee-for-service plan or private plans.

Retirement Age:

The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. Congress would develop an exemption process for affected beneficiaries with special needs, such as those unable to work and otherwise get health coverage. Eligibility requirements under that exemption process would not necessarily be the same as the requirements for eligibility based on disability for those under 65, although the waiting period for eligibility based on disability could also be waived or shortened for those affected by the change.

Long-Term Care:

The proposal indicates that long-term care issues should be separated from Medicare (an acute care program). The proposal would require a study of various long-term care issues. The cost estimate

does not include any impact on the budget from long-term care items.

Financing:

The proposal would implement a combined trust fund, with guaranteed general revenue funding to grow at the same rate as overall program costs if it otherwise would exceed 40 percent of the program's cost (without further Congressional approval). The initial balance in the combined fund would equal the balance in the Part A and Part B funds at the time of enactment.

BUDGETARY IMPACT

Table 1 lays out the estimate in the style of an annual Congressional cost estimate. The savings attributed to the individual policies result from a top-down ordering of the estimate. Premium support was estimated first, in the absence of any other policies. Then the subsequent policies were added one by one–the savings represent the incremental impact of that policy on Medicare spending. Because Medicare spending would be reduced compared with current law, premium collections from beneficiaries would be reduced as well. That is why the impact of the proposal on premiums is displayed as a cost item in the table–lower government premium collections reduce the budget surplus (or increase the deficit).

Excluding the optional items, the proposal would be approximately budget neutral in the 5-year budget window between 2000 and 2004. That is because the new assistance for low-income beneficiaries would begin immediately, while the savings provisions would not be implemented until 2003. Over the 10 years between 2000 and 2009, the proposal would save approximately $100 billion.

Tables 2-6 show the detailed cost estimate of the March 14 plan in the format developed by the Modeling Task Force. That format was designed to gauge the impact of proposals using many different measures. Because the Part A trust fund would be replaced by a combined fund, tables 2-6 do not show results for the Part A fund under the proposal. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

Table 7 shows the projected impact of a combined trust fund under the proposal, with general revenue funding growing at the same rate as program costs overall. As noted in the February 17 estimate, the growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30-year baselines

used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short-run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in Table 7 should be extended by 3 or 4 years as well, to 2016 or 2017.

BASIS OF THE ESTIMATE AND DISCUSSION

Premium Support

The basic estimate of the premium support plan is largely unchanged from the February 17 estimate. Tying the national average to the cost of Medicare covered services reduces transition costs by a small amount, increasing slightly the savings attributed to premium support. The provision protecting beneficiaries in areas with only one plan from paying more than 12 percent of the cost of that plan or the national weighted average would add slightly to the cost of the proposal.

Requiring all plans to offer a high option plan and allowing the Board to maintain an appropriate price difference between plans' high and standard options until the risk adjuster was proven over time greatly reduces concerns about adverse selection in high option plans.

Low-Income Subsidies

Currently, state Medicaid programs cover drugs for only so-called dually-eligible Medicare beneficiaries, often limiting such coverage to those well under the poverty line. Medicaid covers Medicare premiums and cost sharing for those between the limit of Medicaid dual eligibility and the poverty line. Between 100 and 135 percent of poverty, Medicaid covers Medicare premiums only. The cost of such Medicaid coverage under current law is split between the states and the federal government. About 50 percent of beneficiaries between the limit of dual eligibility and the poverty line participate in premium and cost sharing subsidies; about 20 percent of beneficiaries between 100 and 135 percent of poverty participate.

This estimate assumes that the federal government would pay 100 percent of the cost of extending drug coverage to qualifying beneficiaries under 135 percent of poverty via the Medicaid program. (States would continue to be responsible for their share of the cost of drug coverage for dually-eligible beneficiaries.) In addition, the federal government would make grants to the states in amounts set to cover 100 percent of the cost of the extra participation in the current assistance programs (for premiums and cost sharing) that the new drug coverage would cause. The estimate assumes that the participation rate for those under 135 percent of poverty, but not dually eligible, would be 60 percent. Thus the federal government would effectively cover the cost of expanding participation for those not dually eligible but under poverty from 50 to 60 percent, and from 20 to 60 percent for those between 100 and 135 percent of poverty.

Management of the Fee-for-Service Plan

In the short run, the proposal would allow the government-run fee-for-service plan to partner with private plans to offer drug benefits under one high option premium. The estimate assumes that such partnerships would not involve HCFA regulation of that industry.

The estimate assumes that a combination of HCFA and Congressional initiatives would slow the growth of spending in the fee-for-service program somewhat. That slowdown was explained in the description of the nontraditional estimate of February 17. The estimated impact of the specified cost sharing changes in the fee-for-service plan is shown separately.

Financing

The Part A fund covers only part of Medicare spending, and an act of Congress recently aided the fund simply by transferring a portion of its spending out of Part A into Part B (which is funded mostly by general revenues). Current budget proposals would transfer additional funds from the general Treasury to the Part A fund in order to postpone its insolvency date. Because the Part A fund never covered all of Medicare, and because of the recent and proposed transfers of obligations and funds, the Part A fund no longer adequately summarizes the financial condition of the Medicare program. A combined fund could make it more clear who pays for Medicare and would allow a more transparent discussion of how to aid Medicare's finances.

Table 1. March 14 Proposal

(by calendar year)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	00-04	00-09
	Cost (+) or Savings (-) in Billions of Dollars															
Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 135 Percent of Poverty \1	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs \2	2	2	2	3	3	3	3	4	4	4	4	5	5	5	12	30
Cost sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-8	-8	-4	-24
Removal of DME \3	0	0	0	-4	-5	-5	-5	-5	-6	-6	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-5	-1	-11
Slowdown of Growth in Gov't FFS plan \4	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where																
There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
Total	4	4	5	-6	-9	-11	-16	-20	-24	-29	-34	-41	-48	-55	-1	-102
Average Monthly Premium:																
Government-run FFS plan				$76	$80	$84	$89	$93	$98	$103	$108	$114	$119	$125		
Government-run plan in no alternative areas				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Private plans				$75	$79	$82	$86	$90	$93	$97	$102	$106	$110	$114		
Average of all plans				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Monthly Part B Premium under Current Law				$71	$77	$84	$91	$98	$106	$115	$123	$132	$141	$151		

Source: Medicare Commission Staff.

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items.
Estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003.
The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003.
Over time, that percentage would gradually fall; if national private plans developed, it would fall to zero.
In this time period, the results are approximately the same using either of the Commission's baselines.
The premium support schedule is calibrated to Medicare spending after the home health transfer is fully phased in (2006).

\1 Assumes 100% federal funding with a state maintenance of effort for dually-eligible beneficiaries. Participation rate assumed to be about 60 percent.
\2 Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).
\3 Savings to Medicare, but not necessarily to the overall budget.
\4 Follows the method of the nontraditional estimate of Feb. 17, which assumed that the fee-for-service plan would compete to some extent.

Table 2. **March 14 Proposal** **DRAFT**

14-Mar-99

	Medicare Spending Growth Rate, 2000-		Medicare Spending as a Percent of GDP /1/2		Medicare as a Percent of Federal Revenues		Medicare Spending (in billions of dollars) /3		Part A or Combined Fund Insolvency /4	Premiums as a Percent of Beneficiaries' Income		Budgetary Costs (+) or Savings (-) (in billions) /5	
	2015	2030	2015	2030	2015	2030	2015	2030		2015	2030	2015	2030
Baselines													
Trustees Intermediate	8.2%	7.6%	4.4%	6.3%	19%	28%	801	2,212	2008	7%	7%	0	0
No Slowdown	8.3%	8.6%	4.5%	8.5%	19%	38%	817	2,972	2008	7%	10%	0	0
Viability Standard Based on Spending													
Slow Growth of Per Beneficiary Spending to that of Per Capita GDP													
Trustees Intermediate	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-182	-615
No Slowdown	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-195	-1272
Preliminary Estimate													
March 14 Proposal													
Trustees Intermediate	6.9%	6.4%	3.7%	4.5%	16%	20%	676	1,596	~2013	5%	5%	-99	-514
No Slowdown	7.1%	7.4%	3.8%	5.9%	17%	27%	688	2,087	~2013	5%	6%	-101	-740

Policy: The Part B premium and the Medicare+Choice system for private plans would be replaced by a premium support with standard and high options under formula that allowed zero-premium plans. Normal age of eligibility would be gradually increased, but waiting period for eligibility for disabled would be waived or reduced for those affected. Low-income subsidies expanded with drug coverage for qualifying beneficiaries under 135 percent of poverty Benefits package change would include coinsurance for home health and lab services with combined deductible (indexed to program costs). Direct education carved out. HCFA can organize public/private fee-for-service plan, with standard and high option. Premium formula anchored to standard option/Medicare covered services.

SOURCE: Medicare Commission Staff.

1. In 2000, Medicare spending will be 3 percent of GDP and 12 percent of the federal budget (revenues). Total projected Medicare spending will be $247 billion in 2000.
2. Payroll is approximately half of GDP. For example, in 2015 under the Trustees Intermediate baseline, Medicare spending would be 9.0 percent of payroll.
3. All spending estimates after Part A fund insolvency are hypothetical.
4. Updated estimates from HCFA and CBO will probably extend insolvency date by 3 or 4 years under current law. This cost estimate does not include that update.
5. Medicare cost or savings in the year shown.

Table 3.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
Trustees Intermediate Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.4	5.0	5.7	6.3
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.7	4.0	4.3	4.5
Medicare Spending as a Percent of Payroll \1													
Trustees Intermediate Baseline	1	2	3	4	4	5	6	6	8	9	10	12	13
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	8	9	9
Medicare Spending as a Percent of the Federal Budget \2													
Trustees Intermediate Baseline	3	5	6	8	9	11	12	14	16	19	22	25	28
March 14 Proposal	3	5	6	8	9	11	12	13	14	16	18	19	20
Medicare Spending in Billions of Dollars													
Trustees Intermediate Baseline	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
Average Annual Growth in Spending from Previous Year Shown													
Trustees Intermediate Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.1	8.4	7.5	7.0	6.6
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.2	6.4	5.7	5.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
Trustees Intermediate Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.3	6.0	4.9	4.3	4.2
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	4.9	3.8	3.0	3.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
Trustees Intermediate Baseline						3	4	5	6	7	7	7	7
March 14 Proposal						3	4	5	5	5	5	5	5

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP .

Table 4.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
No Slowdown Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.5	5.5	6.9	8.5
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.8	4.4	5.1	5.9
Medicare Spending as a Percent of Payroll \1													
No Slowdown Baseline	1	2	3	4	4	5	6	6	8	9	11	14	17
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	9	10	12
Medicare Spending as a Percent of the Federal Budget \2													
No Slowdown Baseline	3	5	6	8	9	11	12	14	16	19	24	30	38
March 14 Proposal	3	5	6	8	9	11	12	13	14	17	19	23	27
Medicare Spending in Billions of Dollars													
No Slowdown Baseline	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
Average Annual Growth in Spending from Previous Year Shown													
No Slowdown Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.2	8.7	9.0	9.2	8.8
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.6	7.8	7.6	7.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
No Slowdown Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.4	6.4	6.4	6.4	6.4
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	5.3	5.2	4.9	5.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
No Slowdown Baseline						3	4	5	6	7	8	9	10
March 14 Proposal						3	4	5	5	5	6	6	6

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP.

Table 5.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
						Billions of Dollars							
Trustees Intermediate Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	110	156	217	299
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	432	668	992	1,416
Total, Medicare Spending	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	84	114	150	196
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	333	484	666	902
Total, Medicare Spending	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
						Percent Distribution							
Trustees Intermediate Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	13
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	28	25	22
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	54	58	62	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	35	33	31
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	49	53	55	57
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
Trustees Intermediate Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	262	388	607	949	1,450
Net	1	1	1	5	13	-3	1	-10	-40	-109	-258	-517	-914
Balance	3	11	14	21	99	130	110	87	(49)	(438)	(1,388)	(3,411)	(7,090)

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

Part A estimates here computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical.
Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 6.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
							Billions of Dollars						
No Slowdown Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	112	171	263	401
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	445	763	1,285	2,073
Total, Medicare Spending	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	85	124	179	257
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	344	555	868	1,333
Total, Medicare Spending	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
							Percent Distribution						
No Slowdown Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	14
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	26	21	17
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	55	61	66	70
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	32	28	24
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	50	55	60	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
No Slowdown Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	263	397	669	1,159	1,969
Net	1	1	1	5	13	-3	1	-10	-41	-117	-320	-727	-1434
Balance	3	11	14	21	99	130	110	87	(49)	(457)	(1,581)	(4,308)	(9,872)

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

Part A estimates computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical. Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 7. A Combined Trust Fund Under the March 14 Proposal

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
						Billions of Dollars					
Inflows											
Premiums	32	36	39	42	46	50	55	60	65	70	77
Payroll Taxes	149	156	164	171	180	188	197	206	216	226	237
General Revenues	117	128	140	150	161	172	184	198	212	228	245
Interest	9	9	9	9	9	8	7	5	3	0	0
Total, Inflows	307	329	352	373	395	418	443	469	496	525	559
Outflows											
Medicare Spending	307	329	352	376	402	431	461	494	530	570	613
Interest	0	0	0	0	0	0	0	0	0	0	3
Total, Outflows	307	329	352	376	402	431	461	494	530	570	617
Net	0	0	0	(3)	(7)	(13)	(18)	(25)	(34)	(45)	(57)
Balance	150	150	150	147	140	127	109	84	49	4	(53)
Memorandum:											
General Revenue Share of Medicare Financing	38%	39%	40%	40%	40%	40%	40%	40%	40%	40%	40%

Source: Medicare Commission Staff.

Note: The growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30 year baselines used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in this table should be extended by 3 or 4 years as well, to 2016 or 2017.