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 NOT WOULD
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.

lower of

Fee-for-Service Benefits: Higher

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 10 % 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: ? carving out SNF, HH

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.

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. is expanded to 135%.

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).

outside of Executive jurisdiction

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.

isn't this done under Social Security law?

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.

does the Board oversee Medicare

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.

EVEN IN THE Base

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.

Together? Really? Risk, Selection

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

what if there are no plans.

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.

geographic adjustment

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.

what about limited capacity plans.

Are any groups exempted?

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. No + Budget Neutral

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. ? WHAT Part B

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 No Medigap prob. here.

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.

geographic adjustment

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.

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE

DRAFT: April 12, 1999

PROPOSAL: Increase 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:

- **There has been no improvement in the availability or affordability of health insurance for people in their early 60s that would justify raising Medicare's eligibility age.**

  - **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.

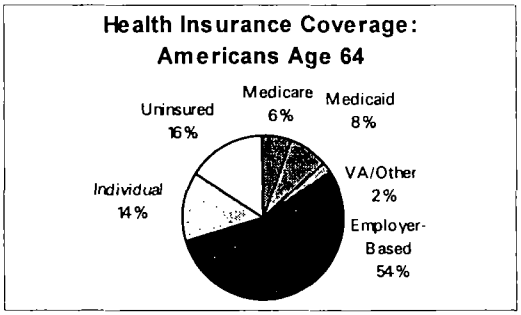
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is most expensive and inaccessible for older Americans. 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.

  Thus, unlike Social Security, where the effects of gradually raising age eligibility to 67 are mitigated by the increased wealth and longer work lives of Americans, there is no comparable improvement in the health insurance system -- making it hard to extend it if the age eligibility for Medicare were raised.

- **More difficult to postpone health care needs than retirement**. Retirement is a fairly predictable event that most families plan for years in advance. Illness and disability, in contrast, are rarely foreseeable and are increasingly likely as people age. 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 take away guaranteed health insurance from people with the greatest risk of health problems and lowest probability of finding affordable private health insurance options.

- **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.** 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. Similarly, it is not clear that all of those who had employer-based insurance when they were 64 could maintain it until they are 67.



  - **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 of these older workers. Costs would result not only from covering workers longer, but from higher premiums for all workers. This is because the older workers would raise the average costs of all employees. The Federal government would also incur costs since employer-based health coverage gets special tax treatment.

  - **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. Applying these rates to the population age 65 to 67, this suggests that only about 185,000 of the 3.7 million who would lose Medicare would opt for coverage through the buy-in.

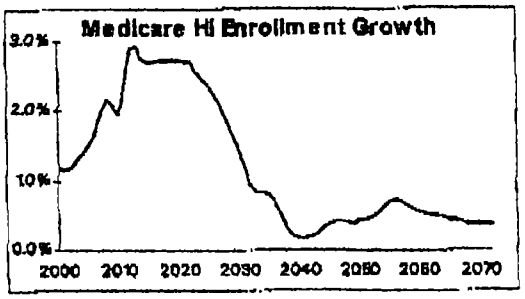
  - **Costs of subsidies for buy-in would reduce savings.** The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about 35 percent of people ages 65 and 66 have income below 200 percent of poverty (about $18,000 for a single, $22,000 for a couple), the savings would be much lower.

DRAFT: BACKGROUND: STRENGTHENING THE MEDICARE TRUST FUND

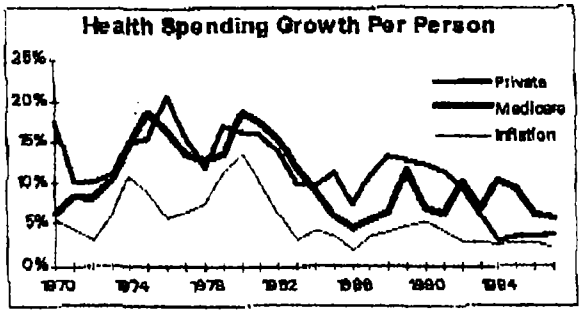
February 15, 1998

CHALLENGES FACING MEDICARE

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



- **Additional challenges of changing health and medicine.** Compounding the demographic challenges are the unique factors that influence health spending -- changing disease patterns, technological advances, and a high value placed on health. As a result, spending growth in health care has almost always exceeded that of general inflation.



In the last 35 years, neither private health nor Medicare spending growth per person has been below general inflation. Recent low growth, in part due to unique trends such as the shift to managed care, is expected to end. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.

- **Improved but still large Trust Fund problem.** In 1993 when President Clinton took office, the Medicare Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent through 2008, in large part because of the historic changes in the Balanced Budget Act of 1997.

  - Medicare spending growth per beneficiary (HI and supplemental medical insurance, Parts A and B) is projected to grow at 5.8 percent between 2000 and 2020. This compares to an average per beneficiary growth rate of 10.8 percent between 1970 and 1996.
  - Medicare spending in 1998 was 2 percent -- its lowest rate since the program began. If Medicare growth in 1999 remains low, Medicare will have broken its record of three consecutive years of single-digit growth.

Despite this improvement, Medicare will ~~become~~ insolvent in 2008, just as the baby boom generation begins to retire.

ACTIONS NEEDED WITHOUT NEW REVENUE

- **Unsustainable, low growth rates.** Competition, efficiency and traditional savings alone cannot secure Medicare. If reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be 2.8 percent per year -- in every year -- to get to 2020. To put this rate into perspective:

  - Medicare growth would have to be over 60 percent below projected private health insurance spending per person (7.3 percent).

  - By 2020, a growth rate of 2.8 percent per beneficiary would result in Medicare spending that is over 40 percent below what is projected to be under current law.

  - Since this growth rate is below inflation, the value of Medicare spending per beneficiary would erode. By 2020, Medicare's spending would be 10 percent below today's level.

- **Removing critical services.** To give a sense of the magnitude of the spending reductions required, taking the following services out of Medicare Part A alone would not be sufficient to preserve the Trust Fund through 2020:

  - All skilled nursing facility plus hospice spending,
  - Part A home health spending, or
  - All graduate medical education and disproportionate share hospital spending.

NEW REVENUE OPTIONS

- **Dedicating 15 percent of the surplus to Medicare.** The President has proposed to dedicate an amount equal to 15 percent of the surplus over the next 15 years to Medicare. This amount is $689 billion over 15 years, $120 billion between 2000 and 2004 alone. This will have the effect of securing Medicare's solvency until 2020 with no other changes.

  The surplus is probably the most fair and appropriate source of new revenue for Medicare. It was created largely by the people who will soon become Medicare beneficiaries -- the baby boom generation and those nearing retirement -- whose contributions to the economy have increased revenues. Medicare spending reductions also were a major contributor towards deficit reduction and now the surplus. Together with Medicaid, Medicare accounts for over 40 percent of the Federal spending reductions between 1992 and 2002.

- **Alternatives would hurt lower wage workers and vulnerable beneficiaries.** The two major alternative sources of new revenue are an increase in the payroll tax and a new beneficiary premium targeted for the Medicare Trust Fund. To get to 2020:

  - **An increase in the payroll tax of 2.5 percent** for both employees or employers would be needed. For a worker earning $30,000 a year, this is $750 a year.

  - **A new beneficiary premium equal to $37 per month in 2000** would be needed to equal the amount transferred to Medicare from the surplus under the President's proposal.

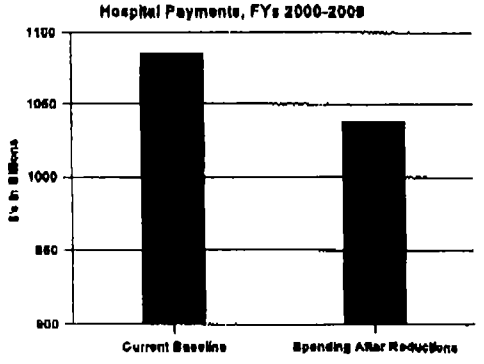
The Medicare Part A Trust Fund has enough resources to remain solvent until 2008. The President's proposal would transfer 15 percent of the Federal government's projected surpluses to the Part A Trust Fund to extend solvency until 2020. As a result, $686 billion would be transferred over the next 15 years. This transfer will help the following groups:

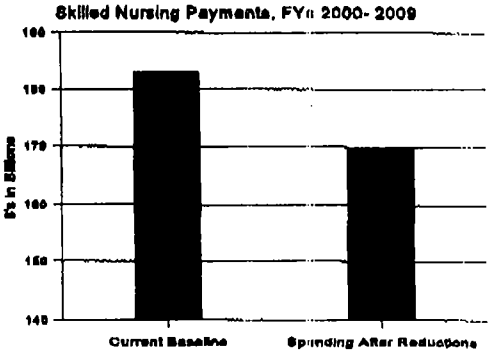
Payers of the Part A Payroll Tax. The Medicare Part A payroll tax is 2.9 percent, evenly split between employees and employers (self employed individuals pay the full 2.9 percent). Without the transfer of the surplus, the Part A payroll tax would have to be increased by 18 percent to 3.46 percent--starting in 2000-- to extend solvency until 2020 (assuming no other change in law).

Transferring 15 percent of the surplus into the Part A Trust Fund helps working Americans and their employers who would have to pay higher payroll taxes to keep the Medicare program solvent. In addition, the payroll tax is a more regressive form of taxation than other taxes (e.g., income taxes) because it imposes a constant tax rate on all income levels.

Providers of Medicare Services. The Part A Trust Fund provides direct funding to providers of inpatient hospital care, post-acute care (e.g., skilled nursing, home health), and hospice care. The Trust Fund also provides direct funding to Medicare managed care organizations for the provision of these Part A services to their enrollees. Medicare benefit payments to providers are projected to grow at an average annual rate of 6.6 percent over the next 20 years. Without the transfer of the surplus, *average annual growth* in Medicare payments to providers would have to be reduced by 1.3 percentage points to 5.3 percent in order to extend solvency until 2020. This growth rate reduction would reduce total Part A provider payments by an overall 10 percent.

Applying this growth rate reduction to the budget baseline illustrates the impact on hospitals and skilled nursing facilities over the budget window (FYs 2000-2009). Hospitals' total Part A payments would be reduced by $47 billion, or 4.5 percent, over FYs 2000-2009. Skilled nursing facilities' Part A payments would be reduced by $13 billion, or 6.9 percent, over the same time period.





In addition, the Medicare Part A Trust Fund provides funding to teaching hospitals for the costs of graduate medical education and to hospitals that serve a high percentage of low-income individuals. Growth in the funding of these programs would also have to be reduced by 1.3

percent to extend the life of the Trust Fund. This reduced funding would significantly diminish the Federal government's ability to support physician training and to preserve access to medical services for low-income individuals.

Current and Future Medicare Beneficiaries. Without the transfer, the Part A Trust Fund will run out of money in 2008 when a projected 44.4 million beneficiaries will be enrolled in the Medicare program. An estimated 25.6 million additional beneficiaries will become eligible for Medicare by 2020. Without the transfer of the surplus, more than 70 million eligible beneficiaries could face a much reduced package of benefits. In 2009, for example, Medicare per-capita Part A spending would have to be decreased $600 from $4,900 to $4,300, potentially requiring beneficiaries to pay the difference through higher copayments, deductibles, and premiums. Such changes would hurt the oldest and sickest Medicare beneficiaries who require a greater share of health services than the relatively younger and healthier beneficiaries. Alternatively, Medicare could change the eligibility for the program (i.e., eligibility age increases).

A Medicare Fee-for-Service Drug Benefit Is Bad Medicine

Proposals to add a government administered drug benefit to the Medicare fee-for-service program are fatally flawed on five specific fronts:

1. Such proposals would displace the outpatient prescription drug benefits that at least 65% of Medicare beneficiaries currently own (Source: Davis study). In addition, these proposals would greatly reduce employers incentives to offer such coverage and discourage individuals from purchasing such coverage.
2. The quality and level of the proposed fee-for-service benefit is significantly less than those currently enjoyed by seniors under employer provider retiree health plans, Medicare+Choice plans, Medigap plans with drug benefits, and the Medicaid program;
3. The cost of establishing a new Medicare benefit is exorbitant, costing the American taxpayer in excess of $267 billion over the next 9 years. Drug costs are already the fastest growing component of health care and adding a prescription drug benefit would significantly exacerbate the already serious solvency problem facing the program;
4. The proposals inappropriately target the entire Medicare population, rather than focusing on the legitimate needs of the small segment of the Medicare population without access to drug coverage today, largely low-income beneficiaries; and
5. The price controls associated with such a government run benefit would significantly disrupt the pharmaceutical market and jeopardize the long-term viability of innovative research into new treatments and cures.

Drug Coverage Through Reformed Medigap and Premium Support is a Better Solution

1. Insurance models, unlike statutorily defined benefits, are efficient, low cost mechanisms to aid seniors financing of prescription drug benefits;
2. Providing drug benefits through the premium support model and reformed Medigap policies maximizes the choice individuals have in meeting their health care needs;
3. The premium support model is premised on the delivery of a comprehensive benefit package which will provide beneficiaries electing such coverage improved access to prescription drugs;
4. Updates to benefit design are more rapidly accomplished through private sector mechanisms than government processes;
5. Expanding drug coverage options within a pluralistic system will not displace existing forms of coverage, nor create the adverse incentive for employers, health plans and individuals to drop benefits that a fee-for-service benefit would;
6. Allowing market flexibility will promote rapid adoption of innovative new drugs.
7. For individuals choosing to remain in fee-for-service Medicare and familiar with Medigap products, Medigap should be reformed to adequately meet their prescription drug needs and minimize the potential for adverse selection;

8. Individuals currently unable to afford Medigap policies, should receive assistance toward the purchase of such policies if they choose to remain in fee-for-service Medicare.

Supporting Data

Displacement – 65% of Medicare beneficiaries have some form of drug coverage currently.

- This number may be as much as 5% higher because of the rapid growth in Medicare managed care plans since 1995, the year the most current studies are based upon.
- Existing forms of drug coverage by category:

Type of Coverage	Total	With Primary Drug Coverage	With Secondary Drug Coverage	Percent of Total with Drug Coverage	Percent of Category
All Persons	36,715,848	22,671,434	1,257,223	65.10%	
Medicare Risk HMO	2,507,962	2,383,685		6.49%	95.0%
Medicaid	4,498,400	3,949,139	89,751	11.00%	89.8%
Employer-Sponsored	12,105,893	10,161,803	289,723	28.47%	86.3%
Individually Purchased	10,640,789	3,075,376	743,124	10.40%	35.9%
All other	985,931	773,753		2.11%	78.5%
Switched coverage during year	3,023,291	2,327,678	100,557	6.61%	80.3%

Reduction in Benefits – Available data suggests that the scope of benefits beneficiaries have today is significantly better than the benefits they would receive under a fee-for-service drug benefit. For example, the Lewin study on the scope of available benefits found:

- Employer-sponsored drug coverage was the most comprehensive of all coverage options, generally equal to the coverage seniors enjoyed during their working years, commonly including an uncapped benefit. Additional design features of employer-provided coverage include: nominal copays of $5; use of mail-ordered programs; coverage of brand names drugs, higher reimbursement for generic substitution; and average employer plan payments of $507.
- Medicare+Choice (Medicare Risk Contracts) was the next most comprehensive coverage. Key components include: 73% of plans with prescription drug benefits

do not charge a premium; nominal copayments are the norm, with payments for generic or formulary drugs ranging from $5 to $10; branded and off-formulary products ranging from $10 to $25; 43.2% of beneficiaries in these plans had unlimited generic or formulary drug coverage; average out of pocket expenditures for beneficiaries were $162.

- Medicaid coverage provided access to all prescription drugs (no formulary restrictions, but prior authorization required for certain drugs in certain states), nominal copayments; and average out-of-pocket cost of $135.
- Medigap coverage is available through plans H, I, and J is the one arguable exception. All plans have a $250 deductible and 50% coinsurance. Plans H and I have benefit caps of $1,250 while plan J has a benefit cap of $3,000. Average beneficiary out-of-pocket for Medigap plans is $361.

Any fee-for-service benefit would require increases in beneficiary premiums, and depending on the benefit design, a significant number of seniors will receive worse coverage than the comprehensive coverage they currently enjoy.

Cost – The latest estimates from CBO determined that the cost of a modest fee-for-service drug benefit would run approximately $267 billion dollars over 9 years. This estimate assumed:

- A $250 deductible which is higher than most of the coverage options available to beneficiaries today and equal to the Medigap deductible;
- $2,000 stop loss, again higher than most of the coverage available today;
- 20% coinsurance up to the stop-loss amount;
- an increase in beneficiaries premiums of $15; and
- a mandatory 9% discount imposed on pharmaceutical manufacturers.

Scope of Proposals – The fee-for-service benefit proposals being offered would extend the benefit to all Medicare beneficiaries, ignoring the fact that 65% of seniors have some form of prescription drug coverage. These proposals should more appropriately be targeted to low-income individuals who are at significant financial risk because they rely exclusively on Medicare coverage only. 3,608,000 Medicare beneficiaries are above the poverty level and below 175% of poverty and fall into the category of Medicare coverage only.

In addition, one need not require drugs in Fee For Service to allow middle class seniors to 1) insure against the risk of large pharmaceutical expenditures and 2) benefit from the market-driven discounting common in the under-65 market. A modernized Medigap that minimizes the adverse selection problems in the current H, I, and J Medigap plans is one such way to do this. The pharmaceutical benefit designs required in Medigap today prevent seniors from availing themselves of the modern cost and quality control mechanisms, such as pharmaceutical benefit managers. There is no reason that seniors in employer-sponsored plans pay nominal co-pays and are alerted to potential adverse drug

interactions, while seniors in Medigap must pay 50% of the costs for drugs at retail prices and are not alerted to potential prescribing interaction problems.

Disruption of pharmaceutical markets – If a fee-for-service benefit were established, a significant percentage of the pharmaceutical market would fall under government imposed price controls causing disruptions in cost for private payers and decreasing the resources available for investment in research and development of new drugs.

- Currently 16.4% of the pharmaceutical markets are under price controls – establishment of a fee-for-service benefit would increase this share by 160% to 42.7%.
- It currently takes $500 million and 12-15 years, on average, to bring a new pharmaceutical from discovery to final market approval – imposing mandatory discounts on all manufacturers would greatly reduce the resources available for these extremely risky endeavors, particularly if there are no guarantees on a return.
- The private market has effectively encouraged innovation: between 1993-98, the pharmaceutical industry brought over 200 new drugs to the market, almost half of which are specifically targeted at seniors. New pharmaceuticals are seniors' best hope for treatments to debilitating diseases such as Alzheimer's, arthritis, heart disease. Price controls will only dampen the incentive to produce these new treatments.
- Price controls on 42.7% of the market would likely result in cost-shifting to the private market, where employer-sponsored health plans are already struggling with meeting escalating expenditures on pharmaceuticals.

Questions on Senator Breaux's Mark

A. Administrative Board

Will this Board have too much authority and become another micro-managing regulatory entity? Why not require plans to follow existing state insurance requirements and encourage the creation of private consumer-based entities, rather than create such a Board with such wide powers?

How will the Administrative Board be appointed and structured? Political appointees, civil servants, other?

Will the Board be required to operate according to published rules (e.g., appeals process for excluded plans), civil service restrictions, etc.?

- What flexibility will the Board have in preventing a particular plan from participating in the Medicare program? Can a plan be excluded as part of the negotiations process even if it meets state and federal quality requirements?

Will the Board supervise each plan's profit rates and management and overhead expenses? Does this structure merely shift Medicare's price-control focus from providers to private plans?

B. Benefits Package

What does it mean for private plans to be required to offer "benefits at least equivalent to the package offered in the government-run FFS plan?"

- Will the actuarial value of the core benefits of private plans be equal to those offered in the government-run FFS plan? For example, does this preclude high-deductible plans or medical savings accounts?
- Can private plans reduce the generosity of the core benefits in favor of offering more generous supplemental benefits? For example, can private plans cap the number of home health visits, raise the outpatient deductible, and add a prescription drug benefit?
- Doesn't the Board's authority limit the flexibility allowed plans and the choices offered beneficiaries? FEHBP's plans tend to offer benefits more similar than different, e.g., no more than 10% variation in actuarial value. Has the Chairman's plan gone too far in regulating plans to reduce the chance of adverse risk selection?

Does the board have the authority to increase the generosity of the benefits offered through its annual request for bids? Will the government-run FFS plan also be required to modify its benefits package? What is the role of Congress in funding and approving any changes in the core benefits package?

C. Premium Calculation

a.) Government's Contribution

What should be the government's basic contribution (e.g., 88%, 75%?)? Shouldn't the beneficiary share be increased, given the history of the Part B premium?

How much geographic variation will be recognized in the government's contribution?

- How will the government-run FFS plan or other national plans be able to compete in low-cost regions, when local private plans will be able to charge lower premiums?
- Will beneficiaries living in high cost regions, e.g., Boston or Louisiana, face a sudden increase in their premiums?
- Why should beneficiaries living in rural areas and other low-cost areas (e.g., Washington state) subsidize higher medical expenses for beneficiaries living in high-cost areas (e.g., New York City).

What type of risk adjuster will be used in the government's contribution?

- Will any risk adjusters likely to be developed in the near-term predict the variation in beneficiary costs? Why not require all plans (including FFS?) to purchase reinsurance or establish high risk pools instead?

Are there enough incentives for beneficiaries to choose low-cost plans?

- Will the government's contribution be refundable for beneficiaries choosing very efficient/low-cost plans?
- Given the relatively high government subsidy and widespread purchase of supplemental coverage, won't most beneficiaries be tempted to choose higher-costing plans rather than cheaper, more efficient plans?
- Will HMOs and other more efficient plans be more likely to return savings to beneficiaries in terms of more generous benefits rather than lower premiums?

Despite the cap on the government's contribution/new bend points, won't "benefit creep" still eventually occur?

- Won't the government's contribution drift upward over time as some beneficiaries coordinate multiple sources of financing towards the purchase of a single plan?
- Can private plans offer non-acute care services and count these costs as part of their premium bid? For example, can plans offer long-term care, cosmetic surgery, etc.?
- Should the government's base contribution rate (e.g., 88% for low-income beneficiaries, 75% for high income) be tied to the generosity of the average benefits package? As more plans offer more benefits, should the government

reduce the portion of the average plan's premium it covers to avoid the displacement of private dollars?

b.) Beneficiary's Contribution

Isn't the Chairman's proposed means-testing more "progressive" than the current program?

Why should income from means-testing be used to subsidize low-income premiums when this is traditionally a state, not federal, responsibility?

Do the current QMB/SLMB programs make sense in a premium support system?

- Will beneficiaries in these programs be required to stay in the government-run FFS programs to receive subsidies? Will the government subsidies be treated as transferable "vouchers" that can be used towards the purchase of any private plan? Will the Board impose special requirements on plans serving low-income beneficiaries receiving additional government subsidies (e.g., limits on cost-sharing)?
- Can states require beneficiaries receiving subsidies to enroll in private plans, in the same way they require Medicaid beneficiaries?
- Why should any beneficiaries receive 100% coverage of cost sharing, since this removes all utilization-control incentives?
- Would the subsidy function better in a premium support system through a reduced premium contribution from the beneficiary? (e.g., if high income pay 75:25, middle income pay 80:20, and low income pay 88:12, QMBs/SLMBs could pay 95:5)

Modernizing Medicare FFS

Why must we keep HCFA under a premium support system? FEHBP does not have a government-run plan. Can't Blue Cross Blue Shield or some other national fee-for-service plan do a better job than HCFA?

Why should market-oriented conservatives give HCFA more power when it cannot handle its current responsibilities?

What tools will Medicare FFS need to compete with private plans to ensure that premiums do not increase at a much higher rate?

- Won't reducing the growth in the cost of the government-run FFS plan result in substantial savings, given its high enrollment?
- Given its monopsony power, will the government-run FFS plan be in a position to abuse flexible purchasing tools? Will providers be forced to accept unreasonable terms and rates?

- If Medicare FFS is not given more flexible purchasing tools, will its premiums continue to grow quicker than those of private plans and lose enrollment?
- Will the policies listed in the Chairmen's document result in an even greater government and bureaucratic role in defining quality health care?

What does it mean to give HCFA "enhanced demonstration authority, flexible purchasing authority....?"

- What are the specific policies intended?
- What are the limits on HCFA's new powers?
- What prevents HCFA from using its new policies and high enrollment to shift costs to the private sector and prevent private plans from developing?
- Should HCFA transfer additional management responsibilities for the FFS program to regional carriers, i.e., develop local private PPOs?

GME Reforms

Why has the Chairman recommended removing DME payments from Medicare, but not DSH payments? How are DSH payments more directly linked to either payroll tax financing or Medicare utilization?

What kind of multi-year funding or other protections does the Chairman envision for DME funds?

Doesn't this transfer put even more pressure on discretionary spending, even as entitlement spending is already taking over the federal budget?

- If DME funding is shifted from Medicare to discretionary spending, does the Chairman recommend that the discretionary caps be increased or that other discretionary programs be reduced?
- Should the entitlement caps be decreased simultaneously?

Revenue and Financing

Does the premium support system change the program's financing?

Why doesn't the Chairman's document directly address the program's growing dependence on general revenues, even as payroll taxes constitute a declining portion of the program's financing?

Would the separate trust fund structure be maintained in a premium support system?

- How would the government's premium contribution be allocated to the Part A fund?

- How would expenditures be allocated to the Part A fund in the case of a merged deductible? (OACT tells us that today it is difficult for HCFA to know which bill/procedure came in first and thus should be applied towards the deductible)
- How would the current budget discipline of the trust fund be maintained if the two Parts are merged?
- Should Congress be required to appropriate any additional general revenue contributions above GDP growth or some other external variable?

Response to President's Proposal to Spend $700 billion of Surplus on Medicare

In the State of the Union address, President Clinton announced that he will devote 16% of the projected surplus – $700 billion – over 15 years to shoring up the Part A hospital insurance trust fund. The proposal raises several concerns and questions:

1) **Adding more tax revenue to Medicare does not alter the escalating spending projections of the current Medicare program; in fact it helps make those daunting predictions more likely.** It fuels the growing rate of entitlement spending as a percent of the economy and the federal budget, squeezing out other priorities.

Trustees Intermediate	1970	2000	2015	2030
Medicare spending as a % of GDP	0.7	2.7	4.4	6.3
Medicare net of premiums as a % of Federal budget	3	12	19	28
No Slowdown	**1970**	**2000**	**2015**	**2030**
Medicare spending as a % of GDP	0.7	2.7	4.5	8.5
Medicare net of premiums as a % of Federal budget	3	12	19	38

2) **The President's proposal does nothing to make the program more efficient.** Medicare is still a program based largely on a 1960s health care delivery structure, with an incomprehensible 110,000 pages of rules and regulations for doctors, hospitals and health plans. Only through fundamental reform and modernization can Medicare purchase beneficiaries better quality and more adequate coverage with the same or fewer (real) dollars.

   Beneficiaries can only be made more secure with reform, not without it. The President's assumption that future generations of taxpayers will shoulder the burden of this notoriously inefficient program makes beneficiaries less secure.

3) **Recognizing that Part A solvency was open to accounting gimmicks and that it does not reflect the fiscal health of the entire Medicare program, the Commission never established solvency of the Part A HI trust fund as its fiscal goal. Instead, the Commission has always been focused on the overall viability of the Medicare program.**

4) **The President's proposal expedites the transition of funding from dedicated payroll tax revenue to general revenue, making fiscal discipline even more difficult.** Under the President's proposal, general revenues as a percent of Medicare spending will increase from 37% today to between 64% (trustee's intermediate) to

70% (no slowdown) by 2030. In 1970, general revenue comprised 20% of the funding for Medicare.

5) **The President's proposal to save Medicare is premised on the prediction that enormous and sustained budgetary surpluses will become reality**. Without fundamental reform, an economic downturn could spell disaster for both beneficiaries and taxpayers.

THE WHITE HOUSE

WASHINGTON

April 6, 1999

BACKGROUND MEMORANDUM ON COMPETITION IN MEDICARE

FROM: Chris J. and Jeanne L.

This memo briefly summarizes the issues and options associated with competition in Medicare. It does not include cost estimates; instead, it provides background information to facilitate an informed discussion of policy options that will be presented at the next principal's meeting.

I. COMPETITION IN THE CURRENT MEDICARE PROGRAM AND PREMIUM SUPPORT

Medicare Today. Medicare spending in 1998 and the first part of 1999 has been very low, and the outlook for Medicare's solvency has improved significantly. In 1993, the Medicare Hospital Insurance Trust Fund was projected to be insolvent in 1999; today, it is projected to become exhausted in 2015. The positive news regarding the trust fund can be attributed in large part to three major factors: the enactment of Medicare reforms and over $100 billion in savings in the 1997 Balanced Budget Act (BBA); the strong economy that has increased revenues and decreased inflation, and success in combating Medicare fraud. The BBA added prospective payment systems to several services and reduced Medicare overpayment.

Despite these successes, Medicare faces the retiring baby boom without many of the tools and competitive incentives that could make the program more capable of meeting this demographic challenge. Under current law, the traditional Medicare program cannot use negotiation, competitive bidding, and other market-oriented approaches to reduce costs. And, although CBO has traditionally not estimated significant savings from these types of policies, our actuaries have estimated that Medicare costs could be reduced by $15 to 20 billion over 10 years if we did.

Medicare managed care payments are also not set competitively. Managed care plans are paid according to a rate schedule (Medicare pays all plans about 96 percent of traditional program costs in the county -- regardless of the plan's premium). Because of the historic overpayments to managed care and the lack of risk adjustment, it is not clear that Medicare saves money from managed care enrollment today. Because of the flat payment rate, the government gets no additional savings if beneficiaries in the traditional program join a lower-cost plan or if they switch from a higher-cost private plan to a lower-cost private plan. However, beneficiaries have an incentive to choose lower cost plans, since they can get 100 percent of the savings back in the form of supplemental benefits (e.g., prescription drug benefit, lower cost sharing). Although the extra benefits offered by managed care are attractive to beneficiaries, the Medicare program does not share in the savings. Competition under the current system, therefore, is based on benefits

rather than price. These extra benefits can be designed to be more attractive to healthier populations, which results in further segmentation of healthy from sick beneficiaries.

Premium Support. Recognizing the limits of competitive incentives in Medicare, Robert Reischauer and Henry Aaron developed a concept called premium support. They described premium support as when "Medicare pays a defined sum toward the purchase of an insurance policy that provided a defined set of services" -- in other words, it maintains the guarantee of a defined set of benefits, but limits the government contribution to create an incentive for beneficiaries to seek care from efficient plans. They suggested that plans, including traditional Medicare, develop premiums for how much it costs to provide the defined benefits and the government sets its contribution based on the average (or median) premium. Beneficiaries choosing plans, including the traditional program, whose premiums are higher than average would pay more -- those choosing lower-cost plans would pay less than under current law.

Premium support comes closer to a traditional voucher program than the current Medicare program since payments for the traditional program would be limited to the government maximum contribution -- beneficiaries would bear the risk of underfinancing of the traditional program. However, there are some critical differences between premium support and a traditional voucher proposal. Premium support includes a guarantee of defined benefits; even if the government contribution is limited, health plans must provide the statutorily-set of Medicare benefits. Also, the government shares with beneficiaries the risk of unexpected health care cost inflation. This is because the maximum government contribution is set as a percent of actual Medicare spending, either for the traditional program, managed care, or both. If Medicare costs go up, so does the maximum government contribution (similar to what happens in Medicare Part B, where the government pays 75 percent of costs). Even though this provides some built-in protection against risk to the beneficiary, the extent of that protection depends on its design.

Savings in premium support are generated in several ways. First, there are direct savings because the government is paying less for lower-cost plans rather than the flat dollar amount under current law. Second, to the extent that the national average premium is reduced over time as people move to managed care, the payment schedule also is reduced and the Federal government saves. And third, increased revenues result from higher premiums for traditional Medicare. Under virtually all premium support models, the traditional plan premium would be higher than the national average, defining it as a "high-cost plan" and resulting in higher premiums. However, the Reischauer-Aaron concept of premium support would provide a richer, better benefits package which would make the inefficient and expensive Medigap market that supplements Medicare either unnecessary or significantly less expensive. The savings that beneficiaries reap would make them more able and willing to finance the choice of a higher-cost traditional program that includes additional benefits.

Breaux-Thomas Proposal. The Breaux-Thomas proposal included a premium support model that loosely resembles a Reischauer-Aaron concept since the government would pay health plans a percent of plan costs up to a limit -- a percent of the national average premium (a dollar amount

based on the per capita costs of the traditional program and the premiums for private plan, adjusted for enrollment). Beneficiaries would pay more for plans above the national average -- including the traditional program -- and less for lower-cost plans (see chart 1). However, it does not explicitly improve the Medicare package and it does not provide a clear guarantee of defined benefits, both of which are central to the concept of premium support.

Of greatest concern is the use of increased premiums for the traditional program as a mechanism to implicitly, financially coerce beneficiaries into managed care options. Our actuaries estimated that the premiums for traditional Medicare would be 18 to 30 percent higher than current law (10 to 20 percent if traditional program savings are included). To fend off the concerns about this premium hike, the final version of the Breaux-Thomas plan allowed beneficiaries in areas without private plan options to pay current-law premiums for traditional Medicare. However, this fix is not given to beneficiaries for whom managed care is not a good option (the very old, beneficiaries with special health need), and those in areas with one limited or substandard plan.

II. Options for Managed Care Competition

The Breaux-Thomas premium support proposal is clearly a politically and policy-flawed design. However, there are options for reforming Medicare managed care payments that reduce Federal costs, improve efficiency, and protect the premium for the traditional program. Most analysts agree that our current system for paying managed care plans is inefficient, with little savings accruing to the government. More importantly, it is harder for beneficiaries to compare choices based on extra benefits than on premiums. Allowing plans to compete on lower premiums would raise the cost consciousness of beneficiaries about their plan choices, creating incentives for them to help reduce program costs. At the same time, it represents a major change from the current system, in which all beneficiaries pay the same, Part B premium.

This section describes assumptions and the key policy parameters in designing a competitive approach to managed care payments. All options are structured to prevent the premium for beneficiaries choosing the traditional program from rising. These options also assume that Medicare benefits are guaranteed and explicitly defined; that plan payments are fully adjusted for risk of the beneficiary and local costs; and that private plans have some flexibility in reducing beneficiary cost sharing. Since risk adjustment under current law will not be fully phased in until 2004, this would probably be the earliest implementation date.

Under these options, the current law premium is $720 per year or 12 percent of total costs which is equivalent to 25 percent of Part B costs. The goal of protecting the traditional program premium is unanimously shared within the Administration because any approach that we adopt should produce savings through competition, not implicitly raising the Medicare premium. However, it should be noted that by protecting the traditional program's premium, it probably would not be considered premium support by those who advocate for it. Not withstanding its potential similarities to the Breuax-Thomas concept, managed care plans will likely oppose since

they are, in most options, but at a competitive disadvantage relative to the traditional program. Additionally, there will be both less private plan enrollment and less savings as a result.

Another major assumption in the options is that the government splits the savings with beneficiaries when they choose lower-cost plans. This does not occur under current law, since the government pays a flat rate for all plans and the beneficiaries gets 100 percent of the savings in the form of extra benefits. It is possible under these options to give beneficiaries 100 percent of the savings back in the form of lower premiums. However, to ensure some direct savings to the government for beneficiaries, the options assume that both the government and beneficiaries pay less for lower-cost plans. Additionally, since we have not yet had any experience with beneficiaries and price competition, there is some concern about providing such large financial incentives to go to managed care. Our actuaries suggest that the government cannot take more than 25 percent of the savings from choosing a lower-cost plan, since taking a higher cut would discourage beneficiaries from choosing private plans.

Setting the Maximum Government Contribution. As stated earlier, the difference between premium support and a voucher proposal is that the maximum government payment is set as a percent of actual Medicare spending, not some arbitrary budget-driven factor that could shift greater risk to beneficiaries. However, exactly how this maximum is designed determines the extent to which competition occurs, beneficiaries choose private plan options, and the government saves. There are three major options for the setting the government contribution, described below.

Option 1: Premium Support-Like Payment Methodology with Explicit Premium Protection for Traditional Program. The first option would set the maximum government contribution based on the national weighted average premium (see chart 2). This is the same basis for payments in the Breaux-Thomas plan with one exception. There would be a special rule that would ensure that the traditional plan premium does not rise above current levels for all beneficiaries, not just those in counties with no private plans.

Pros

- Maintains the savings that result from increased private plan enrollment, but assures that Medicare beneficiaries are not financially coerced into HMOs.

- Assures that private plan premiums are related to traditional Medicare, since traditional Medicare will dominate the national average which serves as the anchor for payments.

Cons

- Because it is the closest to the original Breaux-Thomas model, it is the most vulnerable to being modified into an unacceptable premium support plan.

- Creates odd incentives since a beneficiary would pay more for a private plan that costs the same as the traditional plan because of the special exception.

- Could be perceived as a double standard -- payments to managed care plans are set using competition but the traditional program is exempted from competition.

Option 2: Nationalized Competitive Pricing for Private Plans. The second option would set the maximum government contribution regionally, based on the local weighted average of private plan premiums (see chart 3). This approach not only excludes the traditional premium from being set under the new system, but excludes it from affecting the maximum government contribution. Thus, managed care payments would essentially be de-linked from traditional Medicare, whose premium would be set as under current law.

Pros

- Most straightforward way of protecting the traditional program's premium since it is totally separate from the competition

- This is the one competitive option that even the most liberal of Democrats in Congress could support.

- Would likely pay private plans less than other options because excluding the traditional program, which is usually higher, from the average premium lowers the average.

Cons

- Could create instability in premiums in private plans and has less of an incentive for beneficiaries to join private plans. As such, it has no supporters in the Administration.

- Most likely to result in lowest participation by managed care plans, thus reducing plan options, beneficiary migration to plans, and overall government savings.

- Would likely not be viewed as "real" competition in Medicare since the traditional program would be totally excluded.

- Could be perceived as a double standard. The private payments are set based on competition but the traditional plan is paid separately, and a beneficiary could pay more for a private plan that costs the same as the traditional plan because of the special exception for traditional Medicare.

Option 3: Modified Current Payment Methodology to Assure Savings for Government and Beneficiaries. The third option would set the maximum government contribution based on the traditional program's premium, similar to current law (see chart 4). Rather than basing private plan payment schedule on private plan premiums, it would link them to the traditional program. Specifically, the maximum government payment to the private plans would be set as a percent of the traditional program, guaranteeing the premium for traditional Medicare will be 12 percent. Beneficiaries who choose private plans with premiums below that amount would get a large proportion of the savings as a reduced Part B-like premium -- the government would save by paying the plan less. This is similar to our current managed care payment methodology, that pays for private plans based on traditional program costs, but differs since it allows price, not benefits, competition.

Pros

- Provides financial incentives for beneficiaries to opt for low-cost plans without putting private plans at a competitive disadvantage relative to the traditional program (since there is no special exception for the traditional program).

- Could be described as a next step in our current policy, maintaining the link to the traditional program but rewarding beneficiaries for opting for low-cost plans.

- While it uses the traditional program premium as a benchmark, it does not require special rules to protect the traditional premium, making it less vulnerable to movement towards a voucher proposal.

Cons

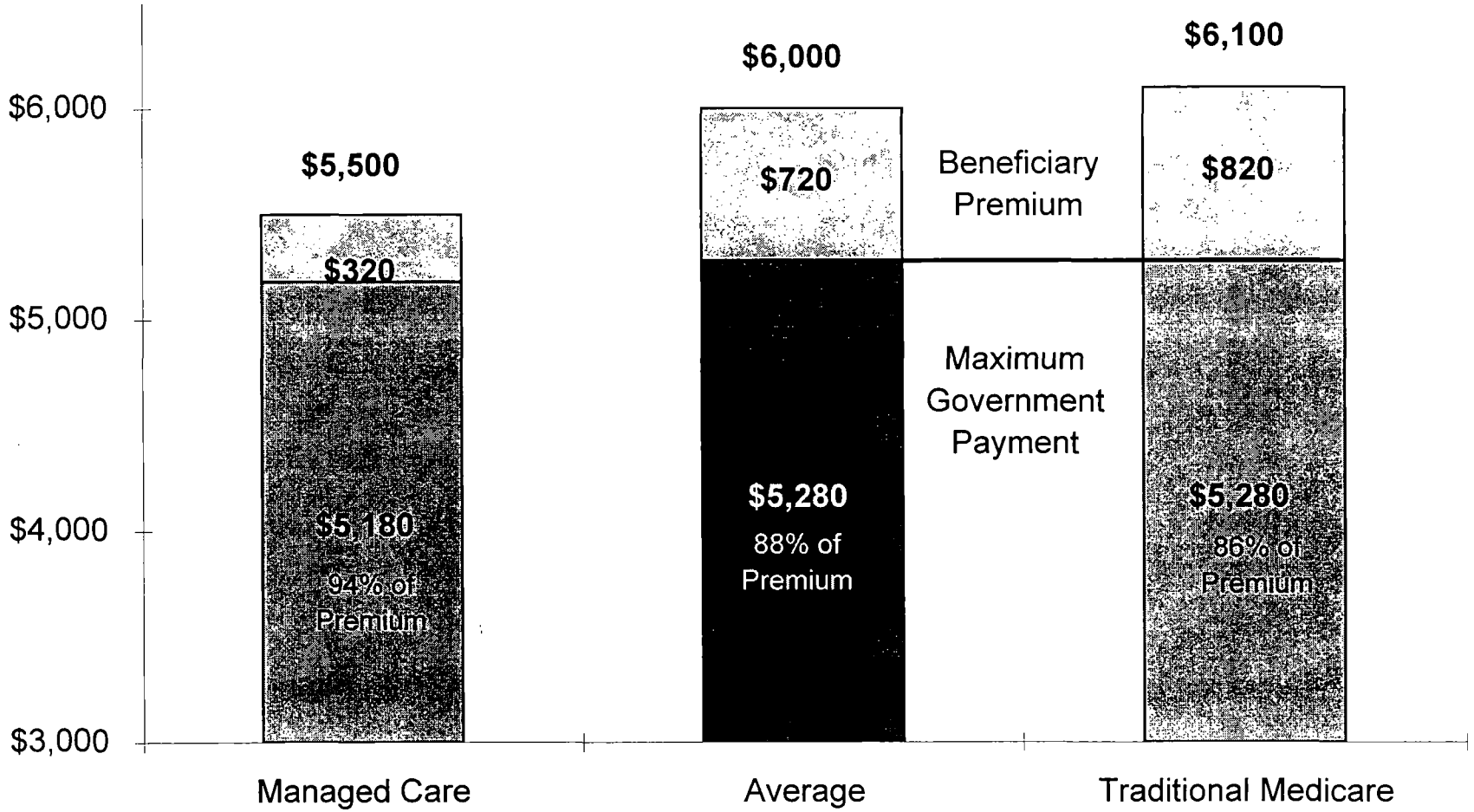
- Maintaining the traditional program at the center of private plan payments could lead to criticism about how efficient this option is -- if traditional program costs skyrocket, private plans are automatically paid more.

- Could be viewed as too incremental and would be most disliked by the managed care industry that has argued for including the traditional program in the competition and against linking payments to the traditional program.

Chart 1.

Breaux-Thomas Plan: Base Payments on Average

Traditional Medicare Premium Not Protected

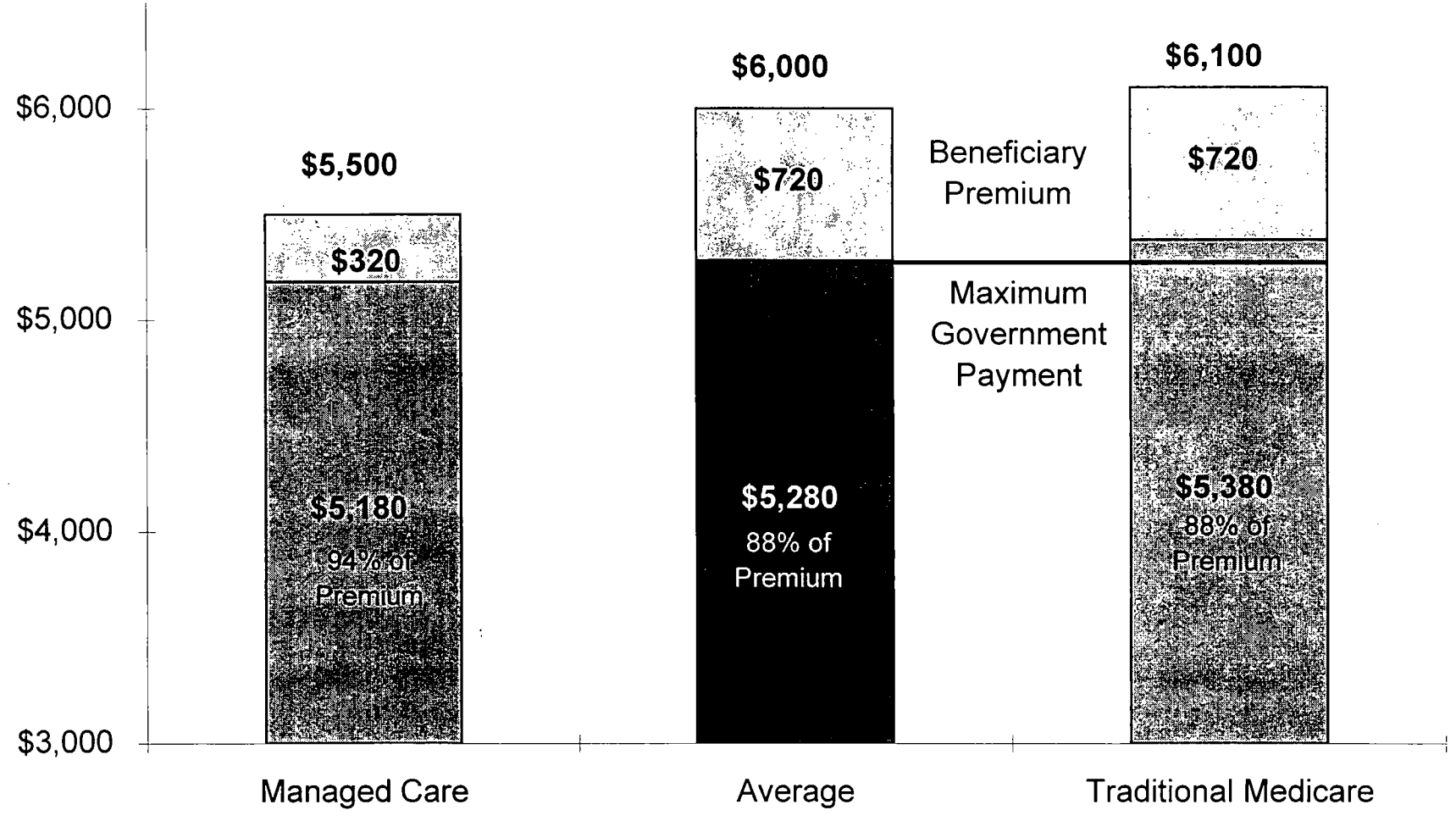


Note: $720 is approximately current law

Chart 2.

Option 1: Base Payments on Average

Traditional Medicare Premium Protected / Private Plans Not

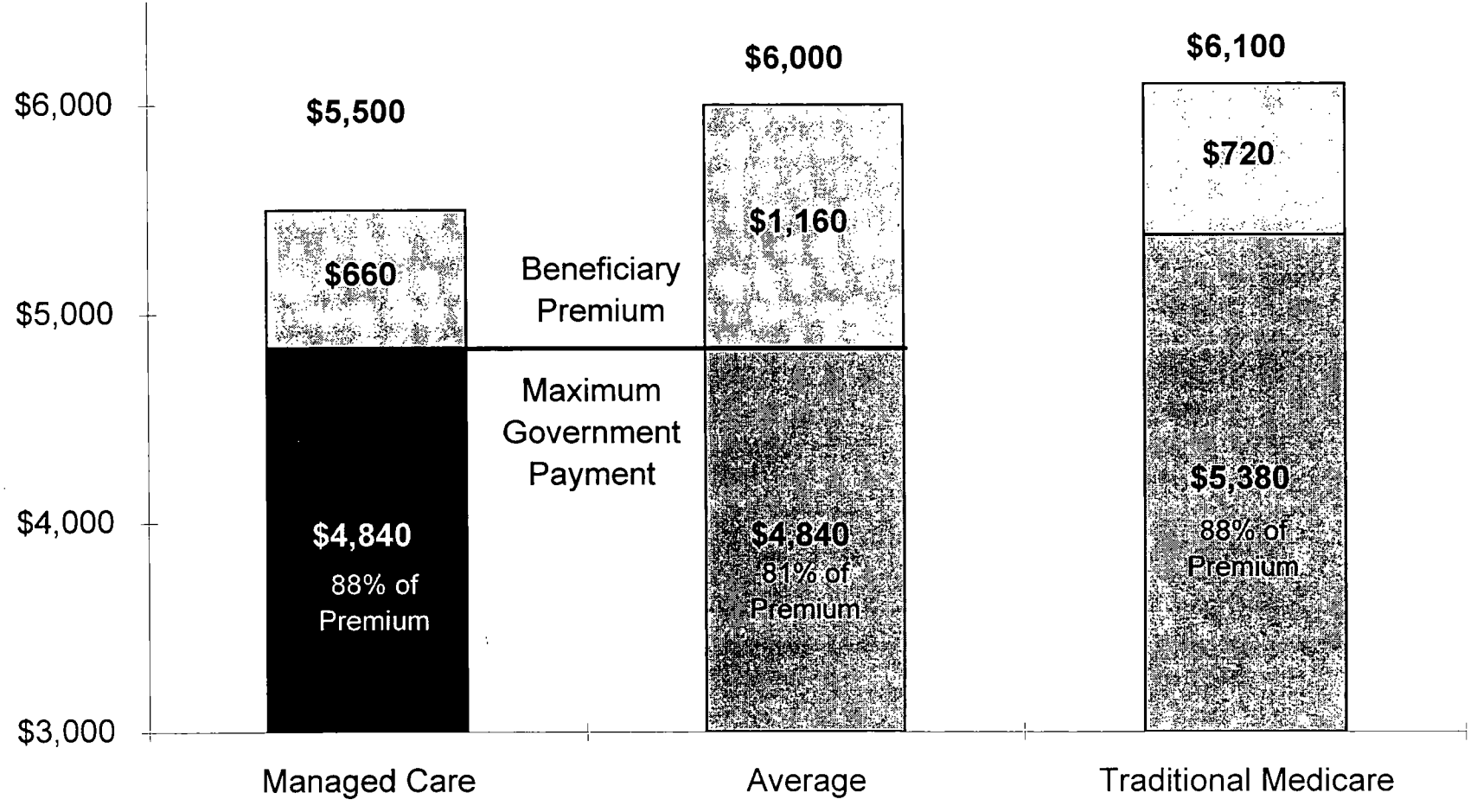


Note: $720 is approximately current law

Chart 3.

Option 2: Base Payments on Managed Care Only

Traditional Medicare Premium Set Separately

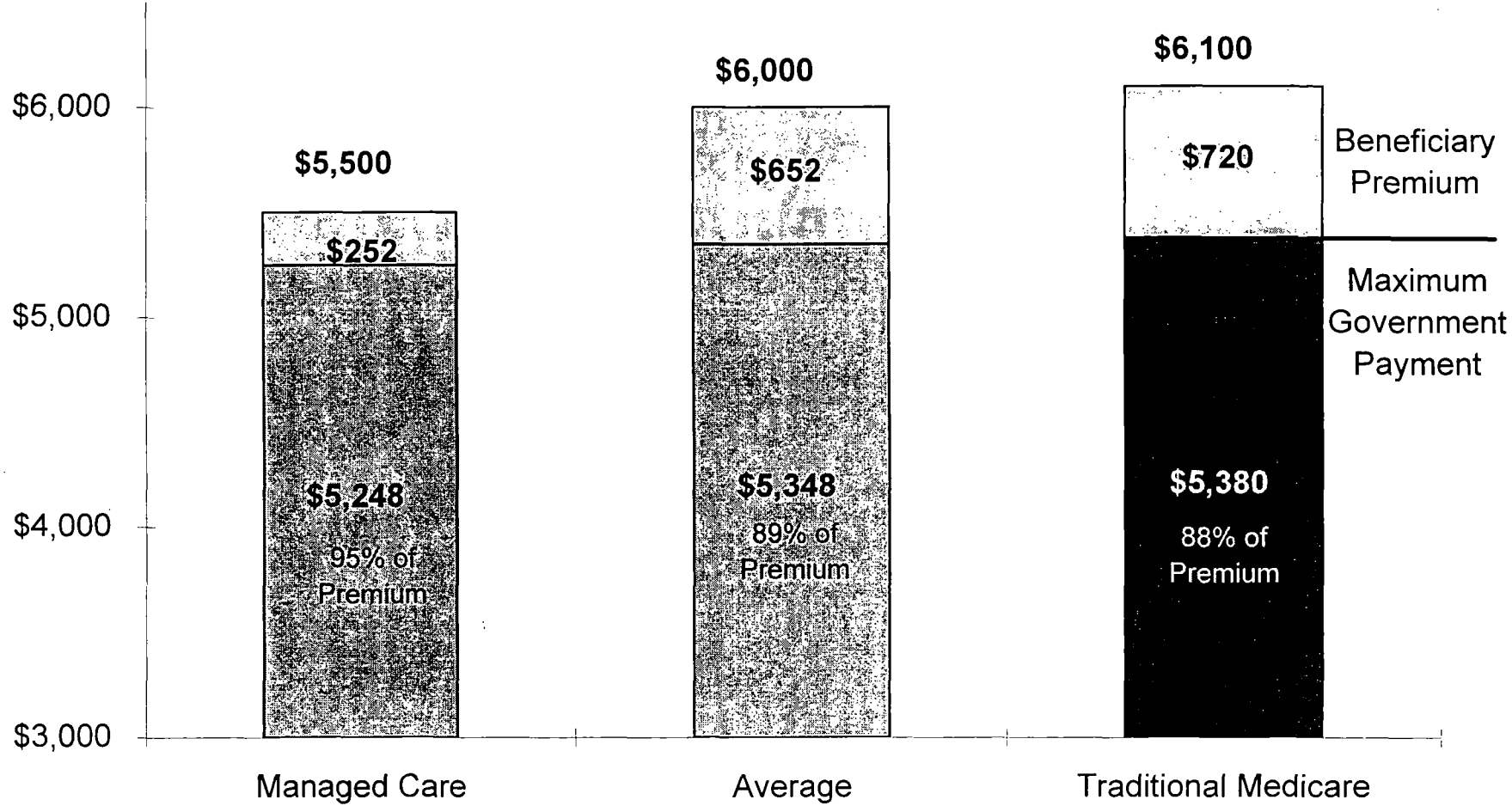


Note: $720 is approximately current law

Chart 4.

Option 3: Base Payments on Traditional Medicare

Traditional Medicare Premium Automatically Protected



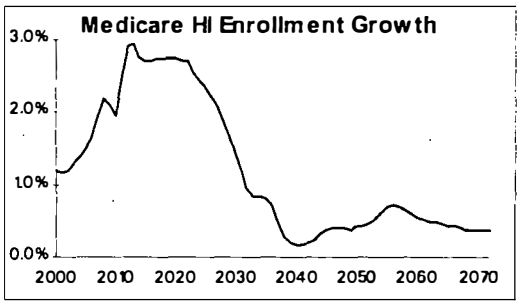
Note: $720 is approximately current law

NEW FROM CJ

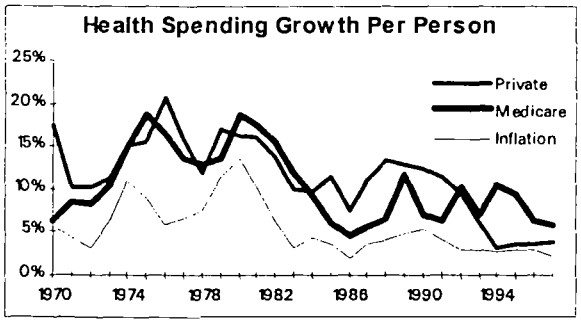
DRAFT: BACKGROUND: STRENGTHENING THE MEDICARE TRUST FUND
February 17, 1998

CHALLENGES FACING MEDICARE

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



- **Additional challenges of changing health and medicine.** Compounding the demographic challenges are the unique factors that influence health spending -- changing disease patterns, technological advances, and a high value placed on health. As a result, spending growth in health care has almost always exceeded that of general inflation.



In the last 35 years, neither private health nor Medicare spending growth per person has been below general inflation. Recent low growth, in part due to unique trends such as the shift to managed care, is expected to end. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.

- **Improved but still large Trust Fund problem.** In 1993 when President Clinton took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent through 2008, in large part because of the historic changes in the Balanced Budget Act of 1997. Medicare contributed a major share of the savings that went to balancing the budget and leading to the surplus that we have today.

  - If Medicare growth in 1999 remains low, Medicare will have had four consecutive years of single-digit spending growth for the first time in history.

  - Medicare spending growth per beneficiary (HI and supplemental medical insurance, Parts A and B) is projected to grow at 5.8 percent between 2000 and 2020. This compares to an average per beneficiary growth rate of 10.8 percent between 1970 and 1996.

Despite this improvement, the Medicare Trustees' report currently projects the Trust Fund to become insolvent in 2008, just as the baby boom generation begins to retire.

ACTIONS NEEDED WITHOUT NEW REVENUE

- **Unsustainable, low growth rates.** Competition, efficiency and traditional savings alone cannot secure Medicare. If reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be constrained to 2.8 percent per year -- in every year -- to get to 2020. To put this rate into perspective:

  - Medicare growth would have to be over 60 percent below projected private health insurance spending per person (7.3 percent).

  - By 2020, a growth rate of 2.8 percent per beneficiary would result in Medicare spending that is over 40 percent below what is projected to be under current law.

  - Since this growth rate is below inflation, the value of Medicare spending per beneficiary would erode. By 2020, Medicare's spending would be 10 percent below today's level.

- **Removing critical services**. To give a sense of the size of the problem, even removing the following services from Medicare Trust Fund financing alone would not be sufficient to extend the life of the Trust Fund through 2020:

  - All skilled nursing facility plus hospice spending, or
  - Part A home health spending, or
  - All graduate medical education and disproportionate share hospital spending.

NEW REVENUE OPTIONS

- **Dedicating 15 percent of the surplus to Medicare.** The President has proposed to dedicate an amount equal to 15 percent of the surplus over the next 15 years to Medicare. This amount is $689 billion over 15 years, $120 billion between 2000 and 2004 alone. This will have the effect of extending the life of the Trust Fund until 2020 with no other changes.

  The surplus is probably the most fair and appropriate source of new revenue for Medicare. It was created largely by the people who will soon become Medicare beneficiaries -- the baby boom generation and those nearing retirement -- whose contributions to the economy have increased revenues.

- **Alternatives would hurt lower wage workers and vulnerable beneficiaries.** The two major alternative sources of new revenue are an increase in the payroll tax and a new beneficiary premium targeted for the Medicare Trust Fund. To get to 2020:

  Nearly a 20 percent increase in the payroll tax for both employees or employers would be needed (from 2.9 to 3.4 percent combined).

  A new beneficiary premium of $38 per month on top of the current premium would be needed to equal the amount transferred from the surplus in 2000 under the President's proposal. This would increase Medicare beneficiaries' premium costs to about $90 per month -- over 75 percent of the level under current law.

THE PRESIDENT'S FRAMEWORK FOR MEDICARE: HOW IT WORKS IN THE BUDGET, DRAFT: April 14, 1999

The President's framework ensures that we protect and extend the solvency of Social Security and Medicare before taking on new obligations. The framework would lock in our commitment to debt reduction and guarantee the benefits of debt reduction for Social Security and Medicare.

- **President's Commitment to Addressing Medicare's Long-Term Solvency**: The President has an unparalleled record of strengthening and improving Medicare. When he took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be bankrupt this year -- 1999. Today, the Trust Fund is projected to be solvent through 2015 and its growth rate per beneficiary is below that of private health spending. However, Medicare's Trust Fund will become insolvent 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. As such, the President has proposed a framework for dedicating part of the surplus to Medicare. This will be combined with a plan to modernize the program, make it more efficient and competitive, and add a long-overdue prescription drug benefit.

- **A Time-Tested Use of Funds:** The President's framework would extend the solvency of the Medicare Trust Fund by another decade by adding new financial resources -- about $690 billion over the next 15 years. These bonds will guarantee that Medicare will get the benefits from the fiscal improvement that debt reduction and lower net interest costs will bring about.

- **Lower Interest Costs:** By reducing debt held by the public, the framework would dramatically 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 allow the government to meet its existing Social Security and Medicare commitments.

- **A Stable Share of the Economy:** Social Security and Medicare costs are projected to rise in the future, 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:

The Sum of Social Security, Medicare, and Net Interest Payments as a Share of GDP

Year	Share of GDP
1999	9.4 %
2010	8.2 %
2020	9.1 %

- **Additional Benefits to the Economy:** 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 credit), interest rates (the price of credit) should come down, making private sector investment more economical, and increasing economic growth, yielding a fiscal dividend of increased budget surpluses in addition to the effects of declining net interest costs.

HOW THE PRESIDENT'S FRAMEWORK FOR MEDICARE WOULD WORK

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 over the next 15 years, reducing the government's demands on the credit market.

- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), 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.

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 its children get ready for college, the family 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.

WHAT WOULD HAPPEN IF THE SURPLUS IS USED FOR A TAX CUT RATHER THAN FOR MEDICARE

- **Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases and/or tax increases to extend the life of the Trust Fund.**

- **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 also 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.

- **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 at high levels.

  - **Effect # 3:** It would yield no extension of the life of the Medicare Trust Fund.

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 better 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 commitment 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 for debt reduction that, 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 guarantees Social Security and Medicare 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: The money devoted to Medicare is in addition to the funds devoted to Social Security. 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 Social Security 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: We propose changes in the budget rules to lock in the transfer of 15 percent of the surplus to Medicare. 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. 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.