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THE VICE PRESIDENT: Well, thank you very much, Mr. President, for your commitment to America's seniors and the understanding that you just presented to us, that working to save Social Security and Medicare are more than just fiscal responsibilities and more than just policy priorities -- they are profoundly moral responsibilities. And we're determined that our country will face them directly.

You know, a lot of people thought that we'd never be able to balance the budget in our country, but we did. And for as long as we've heard about that concern we've also heard about the entitlement problem, as people call it. Well, we can deal with that, too, and that's what we're here to talk about. The President acknowledged all the members of the Congress, House and Senate, who are here. And we deeply appreciate your participation in this whole process. Thank you very much -- and the members of the administration team. I wanted to add to that Dr. Janet Yellen, the Chair of the President's Council of Economic Advisors. And I wish we could go ahead and identify all of the leaders of private groups that are here, many of whom have worked for a lifetime on these issues. And we're grateful for your presence here. I want to acknowledge Reverend Jesse Jackson, who is among these leaders present here today, and many others who ought to be singled out.

You know, last year the President set us on a path of progress with four memorable words: Save Social Security first. It was really a turning point in the long debate about what to do with our entitlement programs, because it created a new set of incentives that allowed our country to use this unprecedented budget surplus as leverage -- whatever your political party, whatever your place on the ideological spectrum, automatically there is an incentive to use the surplus or part of the surplus for whatever other purposes you're thinking about, but you can't do it until the country comes together, first of all, to save Social Security first and deal with this generational problem. And it really has changed the dynamic.

And last week in the State of the Union address, the President took that commitment one step further by asking us to save Medicare at the same time, dedicating 15 percent of the surplus as part of a broad-based effort to improve this important program. In the process, the President has transformed what used to be called a third rail into a second chance for America's senior citizens.

This commitment couldn't come at a better time because, as everybody knows, we're now going to finish this century with a surplus of more than \$76 billion; instead of the biggest deficit in history, now the biggest surplus in history -- so it's a good time to move forward with this issue.

And the predictions are that for the next quarter century, whatever the ups and downs of the business cycle, the general trend is going to be for surpluses every year for the next 25 years. So this is the moment for us to meet our responsibilities to the 21st century. And with 75 million baby boomers retiring over the next 15 to 20 years and with that ratio of the folks who are in the work force, compared to the folks who are retired, changing dramatically -- of course, it's more than three people working for each person drawing Social Security now and it's going to decrease to two people working for each person retired.

I guess everybody in this room surely has internalized the implications of that mathematical shift -- that's really the real reason why we're here. And that's why our responsibility is so clear.

And we must also focus on the important task of saving and strengthening Medicare, because the coming senior boom will exact a similar toll on Medicare. By 2030, the ratio of workers to Medicare beneficiaries is also expected to decline, in this case by over 40 percent. If we dedicate 60 percent of the surplus to Social Security, and 15 percent of the surplus as part of a broad-based effort to strengthen and improve Medicare, we can meet this challenge in a way that preserves the dignity of our seniors in retirement.

And of course, we've talked about all the numbers involved here, but it's always essential to remember that this, ultimately, is not really about numbers, it's about people. And our generation is the first generation to have more parents than children. And our medical care expenses, as a generation, for our parents, greatly exceeds that for our children. And all of the individuals that we are talking about have faces, and hearts, and connections to their families and their loved ones. And that's really what we're talking about here: how do we help families deal with this time of stress and transition?

It's about Medicare beneficiaries, also, who cannot now afford crucial medications without some help -- and they don't have that help today in many, many cases. And you talk to anybody in our generation helping their parents, or you talk to seniors who have retired who have health care problems -- right away the conversation will turn to, how are we going to get a little bit of help to pay for these medicines that the doctors are prescribing and that are greatly needed. And so the President has addressed that issue, as well.

It's about rural retirees who face more limited choices. And it's about assuring quality health care for women who, after all, make up 60 percent of all Medicare beneficiaries. That's why we're working on this and that's why our country has to solve this.

So Mr. President, we have a great panel here. It's my honor to just briefly introduce all of them and then I'll turn it back to you to start the dialogue here.

First, we're delighted to welcome back Laura Tyson, who was such a prominent part of this administration in its early years as Chairperson of the White House Council of Economic Advisors, and Director of our National Economic Council after that; and now a Dean of the Haas School of Business at Berkley. She's also, of course, a member of the National Bipartisan Commission on the Future of Medicare.

Second, Uwe Reinhart. Professor Reinhart is, of course, a nationally renowned health care expert from Princeton and has served on several government commissions on health care -- I could say quite a few government commissions on health care -- and is the Commissioner of the Kaiser Commission on Medicaid and the Uninsured. We're honored that you are joining us.

Third, Stuart Altman, who is a professor of National Health Policy at the Heller School for Social Policy at Brandeis University. Dr. Altman has been a nonpartisan advisor to the Congress, and also currently serves on our Medicare commission.

Fourth, Martha McSteen, President of the National Committee to Preserve Social Security and Medicare, the nation's second-largest seniors organization. And as someone who served for 39 years with the Social Security Administration, she knows a thing or two about this program.

And last, but least only in age, Hans Riemer, who is, at 26, the founder and director of the 2030 Center, a public policy organization for young adults focused on economic issues affecting all Americans. We'd like to thank each of our panel members for being a part of this discussion. And now I'll turn it back to you, Mr. President.

THE PRESIDENT: Well, I would like to begin by asking a question of Laura Tyson, who is, as has been said, on this bipartisan Medicare Commission. One of the things that I have seen -- and I alluded to this in my remarks -- one of the things that I've seen said in the press in the aftermath of the State of the Union is that by proposing to allocate 15 percent of the surplus for 15 years to the Medicare trust fund, I basically was killing any chance to reform the program because we can keep it just like it is until 2020.

I didn't see it that way, for the reasons I said. First of all, I think there are some substantive changes that ought to be made that would enrich the program, like the prescription drug program; and secondly, because I think the demographics and the costs are going to require reform anyway. I mean, if my numbers are right, I think that the Medicare spending would have to grow at half the rate of economic growth for the next decade just to extend it for another five or six years.

So what I'd like for you to talk about is whether you think it's a good thing to dedicate some of the surplus to Medicare, and whether you think it can be used as an excuse not to make any further changes in the program, or whether it would actually facilitate changes?

I think we need to get this out. And I really don't know what she's going to say, but I've been very concerned about that because when I made this suggestion, I did not intend to say that, whoop-de-do, now we don't have to make any changes in the program. What I was trying to do was to make it possible for us to change the program without pricing it out of the reach of Americans, millions of Americans.

So, Laura, you want to talk about that?

DR. TYSON: Well, frankly, I was very surprised when I heard that reaction to your speech. When I heard the speech, as a member of the bipartisan Commission on Medicare, I was in a hotel room and I started cheering -- because I know the numbers, we've all looked at the numbers on Medicare, and there is a serious financing problem.

It's a very complicated problem; it's not just a demographic problem. It has to do with health care costs, with technology, with the delivery system. And even the most conservative projections about the growth of health care costs, combined with the change in the demographics, show clearly that additional financing for Medicare will be required. And that is even with an ambitious reform program.

I think that we must all face the reality. There are things we need to do to make Medicare a better program, to modernize it, to include adequate benefits, to make it more efficient, to make it more equitable. After you do all of those things -- and we've looked carefully at the range of things you can do -- you still need additional money.

And I feel that a dedication of the surplus, the hard-won surplus of the American people, to this very important program will secure the program. It will allow the commission to come forward with reforms. I don't think we could have come forward with reforms without some agreement on some source of funds to get us through the next several years.

Now, let me also just end by saying Medicare is a problem we're going to have to revisit time and time again because there is a huge amount of uncertainty in terms of how people get care, in terms of shift to prescription drugs, in terms of the possibility of having drugs that are individualized to the genetic background of each individual. We're engaged in a huge technological revolution in health. So what I think we're going to try to do in the commission is put in place some reforms that we believe will allow Medicare to remain modern and to be flexible as health care changes. But we can't do any of that without some additional money.

So all I have to say is I cheered the proposal and I'm optimistic now that we can get something done.

THE VICE PRESIDENT: I'd like to ask Dr. Reinhart a question, following up on that one. One of the reasons why after all the deliberations here the President made the decision to dedicate -- recommend dedicating some of the surplus to Medicare, is that we've learned from our studies here that you really cannot extend the life of the trust fund for any substantial period of time without really significant reductions in Medicare.

I know you've spent so many years studying the details of this issue. Tell us why you think resources are part of the answer -- and significant resources are part of the answer, from a health, economic, budgetary perspective.

DR. REINHART: Well, Mr. Vice President, every projection I have seen that seems plausible suggests that even the present benefit package, which people say is inadequate, will be eroded unless additional money is brought into this program. I think any expert will tell you that.

And we now have the opportunity, the unique historic opportunity to provide those monies. And I think it would be sinful not to do so. I support this initiative because it is prudent, it is fair and it is civilized. What do I mean by "prudent"?

By prudent is exactly the point that every projection shows we will fall short.

Now, our method in the '80s was to create a huge deficit, then look at each other and look at each other and look at God and say we cannot be our brother's keeper because we have a deficit -- and we thought God bought the argument. Fair enough. What are we going to do in the '90s or in 2010? We have the surplus and we look at God and we say, we cannot help the elderly who now trade food for medicine -- that was on the front page of the Wall Street Journal.

So, therefore, I consider this civilized. And, finally, I consider it fair, because the baby boom created -- helped work to create the surplus. And the President proposes to put that surplus aside to help finance health care for the baby boom when they are retired. That strikes me as socially fair. So on these three counts I have in the press, as you may have read, wholeheartedly supported this, and I hope the American people will, too.

THE VICE PRESIDENT: Well, as I understand the response, those who disagree with us are uncivilized sinners. That's it basically.

DR. REINHART: As an economist I can certify-- that to stay in the club of civilized nations will require a little bit more money for Medicare and I'm willing to sign on that.

THE PRESIDENT: Let me just say for the record as someone who knows a little about such characterizations, I wouldn't do that, myself.

I'd like to ask Stuart Altman a question. Stuart has worked for Republican and for Democratic administrations. He's been through all the various generations of reforms we've had, trying to manage these health programs that we fund. And he's now on the Medicare Commission. I'd like to just ask him to give us some idea from his point of view about -- maybe be a little more specific, and I'm sure the members of Congress here would like this -- what are the type of structural reforms you think we should adopt to improve and modernize Medicare, even as we extend the life of the trust fund?

MR. ALTMAN: Well, I've been a long-term supporter of Medicare, and I have both worked with and have watched how HCFA has tried to grapple with incredibly complex problems. And what we ask of HCFA today -- and I think back to when I was in the administration -- in one day they have to solve 50 problems that used to take us five years to deal with. No private agency is ever asked to deal with the complexity.

And often we make their life so much more difficult by the rules that the Congress puts in their place. They can't operate an efficient system, an efficient health care system, with the rules. So these rules need to be changed. We need to make the Medicare program, HCFA, a much more efficient -- I know they want to do it, and I hope that the Congress will give them the tools to do that. They need to be able to contract with providers in a more efficient way; they need to be able to bill out in a more efficient way. And they need to be able to compete with the private sector.

I believe strongly in competition, and I think that as we move forward -- and I am in support of restructuring the system towards a premium support to allow HCFA to compete. I think when they have these tools they will compete very effectively.

But we also need to change the benefit package. The benefit package that was designed for Medicare was the right benefit package in 1965. There were really two legs of our chair in health care. There was physicians and it was institutional care. And Medicare did a good job in both of them.

We now have a three-legged stool. And that third leg-- prescription drugs and what goes with it -- is becoming every bit as important as the other two. The idea that Medicare does not cover prescription drugs for our seniors on an outpatient basis is a crime. And it's going to become more and more of a crime. As Uwe pointed out, the idea that seniors have to trade food for drugs; the idea that every time a physician writes a prescription, they have to think whether that thing is going to be filled -- and how many have we heard, about our seniors sort of taking one out of three, and one out of four, so that the whole prescription is useless?

Prescription drugs has to be added. It has to be added in a fiscally appropriate way. It needs to be added to the new Medicare. And I share Laura's and Uwe's comments. We could not have supported the premium support system, what we were thinking about, without more revenues, because it would have been a sham. So I, too, have applauded -- I was in another hotel room.

DR. TYSON: We lead exciting lives. The life of an ex-government official.

DR. REINHART: That's our home. So, please -- and I hope -- and I've talked to many members of Congress on both sides, as well as other commissioners -- I view this as such a positive statement. I think we've got a shot now. Thank you very much.

THE PRESIDENT: I don't want to interrupt the flow of the program; I think they're doing so well. But I just want to comment on one thing that Stuart said, because I think we want to drive it home. Many of us have actually met people who choose between food and medicine. Nobody made a deeper impression on me when, in 1992, than this elderly couple I met in the Arel Senior Center in Nashua, New Hampshire, when they described this choice they made on a weekly basis.

But the point I want to make is, when we have partisan fights in Washington, they always get a lot of publicity. And when we do something together, almost nobody notices. But one of the things that I'd like to compliment all the members of Congress here for is that there has been an enormous amount of bipartisan consensus to dramatically increase investment in medical research. And the NIH budget, for example, has grown exponentially as a result of that.

Now, what are we trying to do? Among other things, we're trying to find cures for everything from cancer to arthritis to Parkinson's to you name it. And we're also trying to develop preventions. A lot of those cures and preventions will be in the form of medicine.

And a lot of what lengthens people's lives is in the form of medicine. We will be spending more and more and more money every year that we don't have to spend, on hospital care and doctor care, if we don't provide a prescription drug benefit.

And from the point of view of the Congress, I would ask you to think, if we were all serious about all this money we have put into the NIH, then we have to be equally serious about getting the benefits of that investment to all the American people, to the health care system in general and to the economy in general. And I think it's very important because the problem Stuart mentioned is going to accelerate because of the breakthroughs that will occur as a result of the medical research that all of you have funded.

THE VICE PRESIDENT: And with the completion of the human genome within the next two to three years, we're likely to see an even further acceleration of that -- with medications for pain, medications for mental illness, all kinds of suffering can be alleviated.

Martha McSteen, I'd like to ask you about why, in your opinion, as you've said, we need to deal with Social Security and Medicare together and how this challenge is shaped by the fact that there are going to be, as the President mentioned, double the number of seniors in the year 2030, compared to now.

MS. MCSTEEN: Well, Mr. Vice President, it really is a challenge for us to be able to address both of these programs at the same time. But they are really viewed by most people as one program. When I speak to a group of seniors I find that -- about Social Security -- the first question asked is, and what about my Medicare? So Social Security and Medicare are entwined and it is very appropriate, Mr. President, Mr. Vice President, that you're addressing both of those programs at this time.

Social Security does keep millions of people out of poverty. And Social Security is, indeed, an intergenerational program. It is a program that touches the lives of all Americans. And we must make sure that as we move into the next century that these baby boomers have what they need in order to continue. Their lives are going on for many, many years and we must be thinking about how they are going to be productive in the future, because they will be moving from a marketplace probably early in life, but have to be thinking about, what am I going to do next.

There are many opportunities for volunteering. The marketplace has to make some readiness for you younger people coming back into the market -- maybe not in the same positions, but very much contributing to this society. And in line with that, how can you expect to be able to continue to age 90 and 95 if we do not have good health care. And, of course, this country has the very best health care in the world right at our fingertips.

The research grants that you are providing are tremendous. That will allow us to move into the 21st century with all of you being healthy and productive and have a goal for what you can do to help this country continue to be the greatest country in the world with productivity and enterprise and volunteering and opportunities that are unlimited.

We salute you, the National Committee to Preserve Social Security and Medicare, for taking these initiatives.

THE VICE PRESIDENT: Thanks for your leadership.

THE PRESIDENT: I'd like to close this section of the panel with Hans Riemer and ask him sort of what this looks like from his perspective. Let me remind you that the people that are now on Social Security don't have to worry about what we're talking about. The people that are now on Medicare, by and large, don't have to worry about what we're talking about -- although, there's a more immediate time problem there. What we're trying to do for Social Security is to take it out to the time when it would even cover Hans's retirement -- which it ought to as a retirement system that big -- and also to try to at least have a framework which will enable us to not only secure Medicare for 2020, but make some changes that will enable us to manage the program far beyond that.

So I'd like for Hans to talk a little about his work and how he sees this and what advice he has.

MR. RIEMER: Thank you, Mr. President. I think it's important that we should keep in mind the kinds of responsible choices that you've been making over the past six years have really brought about a certain measure of prosperity of an economy, has jobs for everyone -- and that's good for the budget. So I think we now have to use our strong position to think about that future and about tomorrow. So I would look to maintain this kind of fiscal discipline by using our surplus for the Medicare trust fund and for the Social Security trust fund, as you have proposed.

And I would also think that we should begin to take a hard look at the jobs of the future and to think about -- since my generation will be living longer than any other generation that has come before us, we need some budget flexibility, which you will be bringing to us with paying down the debt. But we also need to investigate the pension kinds of problems and health care problems, which I think your USA accounts and some of these Medicare proposals really begin to do. So I think a holistic look at fiscal responsibility and jobs will really go a long way towards putting my generation in a much better situation down the road.

THE PRESIDENT: You know, I doubt, given the global economy, at least in the foreseeable -- and I mean probably the next 10 to 20 years -- it will ever be possible for a country that wants to have a great economy to run permanent deficits again. Now, we all know, if a recession happens and you've got fewer taxpayers paying in and more money going out for unemployed people -- and we know there will be good times and bad times -- that's part of human nature -- but the elimination of the structural deficit, I think, is pretty much going to be a requirement for every country that wants to run an advanced economy and have long-term, stable conditions. Because the control of the -- the people that can decide where the money goes and why are going to pretty much demand it. And I think that that's something that we have to be quite careful about and we need to be very prudent in projecting this.

And everybody understands when we say we're going to have surpluses over 25 years that they will vary in size, depending on the condition of the economy. What we mean by that is that we have a structural surplus and that the projections are pretty good. And I think that we have to -- my sense is that that's where Congress is in both parties. There will be people who think that we ought to have a tax cut now instead of a retirement tax cut, so that it ought to be fungible now.

There will be arguments about that. But my sense is, there's almost no one willing to do anything that would in any way run the risk of returning to a structural deficit. And I think that's a big step forward for our country.

Well, I thank all of you. We have here, in addition to members of Congress, we've got a lot of health care providers and people who represent other folks. We've got a little time -- I wonder if any member of Congress who is here would like to ask a question of any member of our panel. This is not prepared. This is all.

Mr. Nadler? Mr. Pomeroy?

REPRESENTATIVE NADLER: The question I want to ask is, former Secretary Riley and others have pointed out that the projections of the Social Security actuaries, which everybody always quotes to say that the Social Security trust fund is going to go bankrupt in 2032, are based on extraordinarily conservative economic assumptions, not borne out by recent history or recent actuarial experience; and that they, in fact -- a central assumption to those economic projections is an average economic growth rate of 1.5 percent in the next 75 years, which is -- we've had 3.8 percent average for the last 35 years. Why are we -- why is the Social Security Administration using that kind of background assumption?

THE PRESIDENT: Ken, you want to answer that? He just greedily wants all the money he can get, that's all.

MR. APFEL: We think that the OMB assumptions are very prudent assumptions for the future. They're based on a lowering of the number of people joining the work force. We're going to have a very significant shift in the future. That's going to mean a lowering of overall economic growth, because we're seeing a lowering of the number of people entering the work force. If we were in a situation to rely on a much more optimistic economic forecast, and we find out 20 or 30 years from now that we're wrong we would have dug ourselves a much deeper hole, a much deeper hole to deal with this issue. Instead, if we find that the economy grows much more rapidly, we'll find ourselves in a situation 20 or 30 years from now with a very significant windfall. And I'm sure we'll be able to think of many ways to use that.

We believe that the way you deal with this issue is to use prudent economic assumptions and demographic assumptions, which we use. We think it's the right course.

THE PRESIDENT: Let me say -- I'm with you. I think they're wrong, but I don't think we can take the risk. But let me tell you why it looks like they're right.

The reason it looks like they're right is that the number of people taking early retirement, for example -- taking the early Social Security option -- is going up, still -- people checking out at 62. And then they -- if they're living to 82, then that's -- and by the way, even today people who live to be 62 have a life expectancy of nearly 80. A 76 average life expectancy is from birth. So somebody who lives to be 62 years old, unless they have some critical condition, their chances of living to be 80 or more are pretty good. So the assumptions are based on two things. Number one is a slowing of the growth of the work force, and number two is people drawing for a lot longer time.

Now, I'll make you a prediction -- that's one of the reasons that I think it's imperative that we make this bipartisan agreement this year -- we can make it wrong -- because I think you have to consider one thing. Number one, there's a record number of kids in school today. Now, they say they've factored that in, but that means you're going to have more workers in a few years. Number two, we've still got a fairly generous immigration policy, which I think, on balance, has served us well.

But the third and the most important thing is, after you get a certain percentage of people who retire at 62, and they're going to live until 82 or 85 or whatever -- if we take the earnings limit off, you will have more and more people working. The computer and the Internet are changing the nature of work. When I became President, there were only 3 million people making a living out of their homes. When I ran for reelection, the number was 12 million. I think, today, the number's almost 20 million.

So I think what you are going to have is a dramatic change in the nature of work in the next 20 years, and more people doing work in different places and different ways, especially older people. So my guess is, they are low, but if you look at people drawing Social Security for a longer period of time, and the sheer demographics, and you were in charge of keeping the thing stable, you'd probably make the same call they did.

DR. TYSON: I want to make an observation, which is that I think for the entire time I was with the economic team here we were very cautious. And the President and the Vice President correctly thought that the economy could do better -- and, in fact, they were better forecasters than his economic forecasters.

Having said that, the good news here is when you are projecting forward over very long periods of time, I really think caution is the right position, because we're talking about dedicating surpluses to two major programs. I think the American people can really have faith in this President and his economic team that the assumptions on which these surpluses are projected are very realistic and cautious assumptions.

The greatest likelihood, therefore, is positive surprises, which are the kind of surprises that we've had in the last six years. We've made cautious forecasts; the economy has done better than that. It's very important, I think, to assure people these surpluses we're predicting are realistic and we can use them.

THE VICE PRESIDENT: I just want to add briefly that in late '92, during the transition period in Little Rock, we made a conscious decision to choose the most conservative economic assumptions so that we would not have surprises on the wrong side. And we anticipated that we would have surprises on the other side. And I think that's probably the right philosophical approach here.

But beyond that, it's interesting that world economic growth right now is lower than the number used in this actuarial projection. And if you look at the unfunded pension liabilities in the countries that are some of our largest trading partners, it's a pretty sobering thought.

Final point: From the beginning of the Social Security program, its interaction with the economy was a key factor in the assumptions that we made about how Social Security's investments might strengthen economic growth above what it would otherwise be were clearly part of the projection. We ought to have a national debate, after this one about how to save Social Security, about how for the long-term we can make your prediction and Bob Reich's prediction come true by -- and I think the President's investments in next generation Internet, the IT-squared program -- there are a lot of investments that I think have the potential for really raising that economic growth number.

THE PRESIDENT: Mr. Pomeroy, Mr. Smith, and Mr. Cardin. Go ahead.

REPRESENTATIVE POMEROY: Mr. President, I think your framework has significantly advanced prospects for achieving Social Security reform. It represents in particular a conceptual breakthrough that I think is going to make this agreement possible by continuing absolutely the guarantees of Social Security; and dealing with individual accounts, the Universal Savings Account, as a new initiative to aid the retirement savings initiative and as an initiative that doesn't undermine in any way the guaranteed nature of Social Security. That was a real conceptual breakthrough and very important.

Secondly, and this is what I'd like some comment on, it seems to me in substance the critical piece of this program that maybe hasn't received enough attention since its announcement in the State of the Union is the effect of paying down the debt held by the public and positioning our country to take a greater demand on the Social Security program, on the Medicare program, as the country ages and the demographics change. Pay down the debt now, because we know we've got a bigger problem later is really the substance, heart of this as I see it. I'd like some further comment on it.

DR. TYSON: Well, I agree with that completely. I would say that in a way, economists who thought about the problems confronting the country have thought about the financing problems of Social Security and Medicare. They've also thought about the problem that for at least 30 years the savings rate in the United States has been going down.

And you need to, when you know there's going to be a demographic bulge and you know that costs of health care are going to continue to rise, you need to be saving more. And we were saving less.

The government was dis-saving when we had a huge deficit, and meanwhile, personal savings rates have continued to go down. So one of the things that this plan does-- we can say it reduces the debt. Another way I would say it is that it is going to increase the savings rate. I think the Council of Economic Advisors estimates that this might put an additional 2 percentage points on our national savings rate.

This is something which we have been trying to achieve for at least 30 years. The rest of the world has correctly been lecturing us that as a great nation we should become a creditor nation, we should not be borrowing from the rest of the world and dis-saving.

So I agree with you completely, it hasn't been remarked enough that this is a savings program, as well as the use of a savings to secure these two entitlement programs.

THE PRESIDENT: Janet Yellen, our Chair of the Council of Economic Advisors, nodded yes when she said it will add 2 points to the savings rates. That's good.

REPRESENTATIVE SMITH: Mr. President, maybe a question for Dr. Tyson. Following up on what the Vice President said, it seems to me what is going to happen in 30 years is two workers have to have a kind of productivity to produce enough goods to satisfy the Social Security and Medicare needs of themselves and one retiree. So part of the mix has got to be what are we going to do to ensure we're on the cutting edge of productivity and competitiveness.

DR. TYSON: Well, the President and the Vice President have led the way really on thinking about the right investment strategy for our future -- in education, in technology, in liberalizing trade. So I think -- I would say, we know what the ingredients are, the basic ingredients, and the policies I think they should speak to.

THE VICE PRESIDENT: Well, the new Governor of California, Gray Davis, points out that if every retiree 30 years from now is going to have two workers financing his retirement, he says, I don't want my two to have a C average and inadequate schools today. A pretty good way to put it.

THE PRESIDENT: You talk about our long-term productivity. Let me just mention one thing that was a part of my State of the Union address that didn't get a lot of attention, but I hope that it will get more and I hope that there will be a real bipartisan effort here. And that is that I think we still have a lot of capacity for growth and productivity within the borders of the United States.

When you've got hundreds of thousands of high-tech computer jobs going begging, and when you've got neighborhoods in this country where the unemployment rate is still in double digits, mostly in inner cities and rural areas -- our trick in the next 10 years, if you want to think about how we can continue to grow this economy with no inflation, will be to try to find the right mix of incentives for private sector investment and then removing the barriers to employment investment in a lot of places, whether it's education and training or whatever else.

We've had some success with the empowerment zones. I proposed some new initiatives in my State of the Union. But for the last two years -- Reverend Jackson is here -- I've gone to this unusual meeting with Jesse Jackson, Jack Kemp and Wall Street to talk about how we can get Wall Street to try to invest more in our inner cities and our isolated rural areas. And I think that's something we should not dismiss the potential of.

If you think about it, if you go into a place where there is complete under-investment and, therefore, under-purchasing of American goods and services, if it works when we invest in Central America or whatever, it would certainly work here. And I'd like to see some more careful attention given to that.

Mr. Cardin and Mr. Markey?

REPRESENTATIVE CARDIN: I think there is a general theme that has been carried here today of the economic security for our older Americans. And I'm glad Mr. Riemer is here because I think you have to -- this generation in order to really deal with the problems of our future seniors. We are talking about programs that will be for 20, 30, 40 years from now.

The Social Security program is so important as far as economic security for future generations. And I'm glad to hear that paying down our deficit -- Dr. Tyson's analysis that that could add 2 percentage points to the personal savings -- because one of the statistics we're not proud about in below savings ratios of Americans -- Social Security is part of a three-legged commitment to economic security -- private savings and private retirement being the other.

I guess my question is to Mr. Riemer. I'm very intrigued by the USA accounts, in which you provide incentives for young people and for low-wage workers to start retirement accounts, by offering economic incentives from the government to match their savings so that you put money away, in addition to Social Security, for your future. How do we get that message across to young people about the economics of saving and the economics of involving themselves in retirement accounts?

MR. RIEMER: That's a great question. I think a lot of young people are thinking about that issue, and they're thinking about it in very concrete ways. Benefits are one of the most important issues for new job applicants, as surveys have shown.

But I think all this talk about Social Security and the insecurity that many people feel about the future of the program have made young workers turn to saving and investments. And they've really increased the focus on pensions. So I think there is a receptivity to the message, but we have to get out with a campaign to put out an idea like USA accounts, which I think truly is a great policy for the next generation, and really stir up some excitement about it.

But I think that young people are waiting to hear for this kind of long-term thinking. I think when you combine an approach that strengthens Social Security, but supplements Social Security with a new kind of saving program, it really begins to broaden the opportunity to save. I think that's exactly what young people are waiting to hear.

So I would say that young people have been waiting for this kind of a policy for a long time, and it's just now a matter of speaking.

THE PRESIDENT: Mr. Markey?

REPRESENTATIVE MARKEY: I think it's a really brilliant package of recommendations which you've made. One of the questions that has been raised is that, although -- as you point out, Mr. President -- only four percent of the market at any time would have government investment in it, that that's still too much, and that you have to have safeguards against government interference with the market. And what I was wondering is if Laura could take that question, and perhaps construct a set of safeguards that we could use as a touchstone to answer that question of how to protect the market from government interference.

DR. TYSON: Well, first of all, I want to say that we do have models that show we can do this. We have models of state and local governments that do it. We have the Federal Retirement Investment Board. When I was a member of the government, I was part of the Thrift Savings Plan, and we had a board, and we had a set of funds, and the funds included equity funds and bond equity funds -- every sort of set of funds you would normally get in a private retirement system like UC-Berkeley, where I am. And they were managed efficiently and independently.

I think that the issues here -- and I really would refer to a proposal that has been suggested by Henry Aaron and Bob Reischauer. They've actually laid out a very nice proposal. The ingredients are how the board of managers was chosen; the fact that they would accept bids from private institutions to handle the money for them; the fact that if the government had ownership rights, through holding equity, that those rights would be proxy-voted by members of the board, independently of government considerations.

The key thing is that these decisions on how to invest and how to vote as an equity owner need to be based on fiduciary responsibility, not on political influence, not on political concerns. But we have examples of institutions already doing that at the Federal level, and furthermore, we know what the ingredients are. So I think this is a brilliant -- I agree with your word entirely -- I think it's a brilliant proposal.

Look, any portfolio manager would tell any entity that was holding a lot of reserves, you should diversify your portfolio. The government has a huge portfolio. It is not diversified right now. It is an elementary economic logic that we should have some diversification. We can solve the problem, administratively, of how to do it.

THE VICE PRESIDENT: If I could add briefly to that -- on the side of the investments chosen, there are also some options there. Index funds -- there are all kinds of investment opportunities that add a whole new layer of insulation from the political problems that some people have raised, which we looked at so carefully.

And, you know, during this whole national discussion, one of the single most important, salient facts that jumped out at everybody is that, over any 10-year period in American history, returns on equities are just significantly higher than these other returns. And in order to capture some part of that economic advantage, surely there is a way to solve these problems. And the people who have spent time on it are just totally convinced that it can be solved pretty easily.

THE PRESIDENT: I want to call on Mr. Portman, but Gene Sperling, did you want to say anything about the question here?

MR. SPERLING: I think Laura hit the issues well. But I think that a couple of principles that we are working with the President and Vice President on that I think we want to articulate is the one that whatever the trustees do, their role -- essentially they should be dealing with competitive bidding so that private sector managers are investors. So the actual investment will be taking place by private sector managers.

To the extent that you had several doing that, then you have even more -- of power. So let's say that the President said that the Social Security trust fund would have 4 percent of the market when it was fully implemented. If there is competitive bidding -- then no one would have more than 1 percent -- it would be a very small amount of market power -- if all of the investment is by private sector managers, then you have an -- index which are passive. We don't allow any picking of stocks. And that means discipline by all sides politically. No political interference at all.

So if you have an independent structure like -- where they cannot be removed, protected for political reasons, we have independence; you have private sector managers, competitive bidding; you have broad-based index without any kind of picking, then you're creating the kind of system that is insulated and should get the highest return.

We should note that when you have this kind of investment, the administrative costs are very, very low, and that means more dollars are going to the recipient and less are being diverted to brokerage fees and other things that would happen where you have millions and millions in individual accounts.

THE PRESIDENT: Mr. Portman.

REPRESENTATIVE PORTMAN: Mr. President, I commend you for raising the profile of this issue and again addressing it in the State of the Union. I think you've made some very -- in just the last couple of weeks -- being able to.

I was impressed at the retirement summit in December when you made the point that there really are three major options here to deal with -- talked about earlier. One is increasing payroll taxes. I don't think anybody is particularly -- Another is reducing benefits, which I don't think, again.

And the third really is, as you said, taking advantage of the dynamics of the marketplace to get -- historically from the market. And I would just encourage you and your administration to keep the notion of private savings accounts on the table as we enter into these more intense discussions between the Congress.

As a Republican I have worked very hard on the issue of private savings with Representative Pomeroy and others, and I think USA accounts are a step in the right direction. But ultimately, they don't tie into Social Security, of course. And if we are going to solve this problem long-term, I think we need to deal with Chairman Greenspan's and others about political interference in the marketplace, notwithstanding Gene Sperling's comments to Congress -- I'm not sure that is something that most of us could be helpful with.

And the second is his concern -- and, perhaps, Dr. Tyson, I misunderstood you, -- you talked about the need to increase net personal savings, that ultimately it's about creating new savings and that that is so important in terms of our economic growth and creating new jobs for the future.

And then -- the government borrowing money and then investing it, you're not telling us what we need to do, which is to increase net savings -- and then rather than having individuals invest that money in the private market -- have a better impact -- on the economy in the long run. Thank you.

DR. TYSON: Can I just clarify something? This proposal does increase national savings. It increases government savings, because the government is actually for -- surplus projection means the government is bringing in more revenue than it's spending. It is holding those revenues in reserves to pay off Social Security and Medicare claims going forward.

So there is an increase in savings. I believe Chairman Greenspan was saying, and others would say, that if you look at the personal savings rate, what households are doing in the United States, that we've had a disturbing tendency for that rate to continue to go down. In fact, in the last quarter of last year the observed measured savings rate was negative -- people were actually spending more than they were bringing in.

Now, I think in thinking about the role of private saving accounts in this, I will tell you my position, and I think it would be that, if one wants to have private saving accounts, having them as a complement to Social Security is one thing. Having them as a substitute for Social Security is quite something else, because a substitute for Social Security undermines the social insurance value of Social Security.

We have a system in which individuals' retirement through Social Security depends upon their earnings during lifetime. It does not depend upon the riskiness of their investment strategy. It does not depend upon them paying administrative fees to get a high rate of return on a private account. It does not depend upon the date they retire and what the stock market looks like that day. I think we want to maintain those great benefits of social insurance. So that's what the USA accounts seem to me to do. They complement -- they add to Social Security.

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Medicare Chronic Disease Prescription Drug Benefit Act of 1999 Bill Summary

Introduced on May 13, 1999 by
Rep. Benjamin L. Cardin (MD), Rep. William Coyne (PA),
Rep. Sander Levin (MI), and Rep. Pete Stark (CA)

Provides Medicare beneficiaries a prescription drug benefit for the treatment of certain chronic conditions: hypertension, diabetes, congestive or ischemic heart disease, major depression, and rheumatoid arthritis.

Establishes a process through which the Agency of Health Care Policy and Research (AHCPR) reviews available data on prevalence of chronic diseases and demonstrated drug therapies. The Secretary of Health and Human Services identifies prescription drugs that offer demonstrated benefits to individuals with these chronic conditions, subject to a \$250 annual deductible, and co-payments. Co-payments will be \$0 for generic drugs and not more than 20% of the cost of non-generic drugs. SLMBs will be excluded from deductible and co-payments.

Institutes a procedure whereby providers, advocacy groups and other interested parties may present evidence to the Institute of Medicine for review to determine whether additional chronic conditions and prescription drugs should be covered.

Establishes a competitive bidding process for a regional pharmacy benefit manager (PBM) system.

Entities acting as pharmacy benefit managers must:

- Enroll all Medicare beneficiaries not in Medicare+Choice plans
- Provide Medicare beneficiaries with access to all classes of prescription drugs approved by the Secretary for the treatment of certain chronic conditions
- Institute procedures to provide Medicare beneficiaries with alternative drugs for the treatment of certain chronic conditions when a physician certifies that, because of drug allergy or other documented medical condition, that none of the drugs approved by the Secretary for treatment of these conditions can adequately treat the patient and that these drugs are medically necessary
- Institute procedures to inform patients and providers about benefits and procedures for coverage of non-formulary and alternative medications
- Institute procedures to ensure proper utilization and avoid adverse drug reactions, including on-line review and educational programs for beneficiaries, providers, and pharmacists
- Provide service 24 hours a day, 7 days a week
- Institute procedures to ensure patient confidentiality
- If using formularies, provide for timely review of denials and appeals

Establishes an annual review process by the Institute of Medicine to determine the effectiveness of the covered drug benefit in reducing demand for acute medical services, the annual costs of the drug benefit and the annual savings in acute medical services paid by Medicare, and additional diagnoses and prescription drugs that should be considered for coverage.



Congressman

Ben Cardin

Third District — Maryland



For Immediate Release
May 13, 1999

Contact: Susan Sullam
Phone: 410-433-8886

REP. CARDIN INTRODUCES MEDICARE PRESCRIPTION DRUG BENEFIT LEGISLATION

WASHINGTON – Rep. Benjamin L. Cardin, with fellow members of the Ways and Means Committee, today introduced the Medicare Chronic Disease Drug Benefit Act to provide Medicare fee-for-service beneficiaries with a prescription drug benefit for treatment of specific, chronic conditions that have been shown to be highly responsive to medications. The legislation builds on Rep. Cardin's Medicare Preventive Benefits Act, which was incorporated into the Balanced Budget Act of 1997.

Rep. Cardin's legislation provides outpatient drug coverage for the treatment of five chronic conditions – hypertension, major depression, diabetes, rheumatoid arthritis, and congestive and ischemic heart disease. Benefits are subject to a \$250 annual deductible and co-payment of \$0 for generics and 20% for non-generics. HCFA will coordinate the claims process through Pharmacy Benefit Managers.

Here are some of the facts about the chronic conditions that would be covered by the legislation:

- * **Hypertension** is a major risk factor for heart disease, stroke and kidney failure, affecting nearly 40% of all Medicare beneficiaries. It is responsible for 32,000 inpatient admissions each year.
- * **Major depression** affects more than one million beneficiaries, more than any diagnosis except heart disease. Medicare spends \$1.8 billion each year for 320,000 admissions to treat major depression. Treatment has been found to reduce overall health costs by 29%.
- * **Diabetes** affects six million Americans over age 65. Diabetes is the leading cause of end-stage renal disease, and it costs Medicare \$237 million each year to treat on an inpatient basis.
- * **Rheumatoid arthritis** affects more than 1.75 million beneficiaries. The annual rate of hospitalization (34%) is nearly twice the rate for all Medicare beneficiaries (18.7%).
- * **Heart disease** is the largest single cause of death for the elderly. Drug therapy can reduce death rates for heart patients by 40%, but only half the people who could benefit from these drugs receive them. Medicare spends \$7 billion annually for inpatient treatment of heart disease.

Studies show that seniors who have prescription drug coverage lead healthier lives. In a recent Medicare Beneficiary Survey, 40% of Medicare enrollees without drug coverage reported that their health is only fair or poor, compared to 23 percent of those who have drug coverage. But 35% of beneficiaries have no drug coverage to help pay for the 18 prescriptions each year they use on average.

"Seniors are highly dependent on drug therapy to maintain their health. By adding this benefit to basic Medicare, we can save lives, reduce hospitalizations, and decrease future Medicare expenditures," said Rep. Cardin. Since the inception of Medicare HMOs, many plans have scaled back their drug coverage, and others have eliminated the benefit entirely. In addition, review of enrollment data shows that seniors suffering from chronic, debilitating diseases are less likely to enroll in Medicare+Choice HMOs.

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TABLE 1. ESTIMATED COSTS FOR SELECTED PRESCRIPTION DRUG OPTIONS WITHOUT STOPLOSS PROVISION

Outlays in Billions for Fiscal Years	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	5-Year	10-Year
Option: cyb0c Rx benefit added to SMI program; \$100 deductible, 20% coinsurance, maximum benefit paid=\$1200												
Medicare Gross Outlays	16,044	25,424	29,284	27,740	25,287	31,113	31,913	33,497	33,493	37,274	124,728	284,188
SMI Premiums	-5,580	-8,378	-8,682	-8,852	-7,325	-7,785	-7,894	-8,426	-8,882	-9,888	-51,008	-74,253
Net Medicare Outlays	11,464	17,046	20,602	20,788	21,911	23,318	23,918	25,071	24,611	27,386	73,720	210,935
Medicaid Outlays	-0,398	-0,508	-0,484	-0,457	-0,411	-0,350	-0,307	-0,238	-0,182	-0,084	-2,286	-3,407
Net Effect on Federal Spending	11,066	16,538	20,118	20,331	21,501	22,968	23,611	24,833	24,429	27,302	71,434	207,528
Change in monthly SMI premium	18.58	14.35	14.55	16.32	15.80	18.77	18.74	17.58	18.12	18.85		
Option: cyb0 Rx benefit added to SMI program; \$100 deductible, 20% coinsurance, maximum benefit paid=\$1500												
Medicare Gross Outlays	17,534	28,332	29,409	31,171	32,992	35,249	35,275	35,344	40,565	42,885	139,797	302,868
SMI Premiums	-5,068	-7,111	-7,378	-7,815	-8,288	-8,833	-9,088	-8,802	-10,164	-10,888	-55,842	-84,034
Net Medicare Outlays	12,466	21,221	22,031	23,356	24,704	26,416	26,187	26,542	30,401	31,997	83,955	218,834
Medicaid Outlays	-0,501	-0,654	-0,646	-0,618	-0,675	-0,518	-0,482	-0,417	-0,344	-0,266	-2,853	-5,019
Net Effect on Federal Spending	11,965	20,567	21,385	22,740	24,029	25,898	25,705	26,125	29,957	31,731	81,102	213,815
Change in monthly SMI premium	15.11	18.01	18.50	17.84	17.88	19.02	18.05	20.05	20.73	21.88		
Option: cyb0a Rx benefit added to SMI program; \$100 deductible, 20% coinsurance, maximum benefit paid=\$1750												
Medicare Gross Outlays	19,028	30,816	31,570	33,550	35,607	38,157	39,383	41,752	44,277	46,897	150,070	350,338
SMI Premiums	-5,408	-7,811	-7,823	-8,413	-8,827	-9,584	-9,871	-10,453	-11,087	-11,792	-58,281	-90,878
Net Medicare Outlays	13,620	23,005	23,747	25,137	26,780	28,573	29,512	31,299	33,190	35,105	91,789	259,460
Medicaid Outlays	-0,573	-0,758	-0,757	-0,731	-0,684	-0,640	-0,610	-0,548	-0,479	-0,408	-3,510	-6,183
Net Effect on Federal Spending	13,047	22,247	22,990	24,406	26,096	27,933	28,902	30,751	32,711	34,697	88,279	253,277
Change in monthly SMI premium	16.12	17.18	17.52	18.57	18.41	20.81	20.70	21.88	22.54	23.40		
Option: cyb0b Rx benefit added to SMI program; \$100 deductible, 20% coinsurance, maximum benefit paid=\$2000												
Medicare Gross Outlays	18,881	31,816	33,370	35,594	37,875	40,677	42,008	44,738	47,561	50,285	160,737	364,081
SMI Premiums	-5,678	-8,015	-8,377	-8,829	-9,497	-10,180	-10,550	-11,218	-11,822	-12,604	-60,480	-95,285
Net Medicare Outlays	13,203	23,801	25,003	26,765	28,378	30,497	31,458	33,520	35,739	37,681	100,257	268,796
Medicaid Outlays	-0,831	-0,840	-0,851	-0,831	-0,800	-0,751	-0,725	-0,687	-0,601	-0,532	-3,854	-7,230
Net Effect on Federal Spending	12,372	22,961	24,152	25,934	27,578	29,746	30,733	32,833	35,138	37,149	96,403	261,566
Change in monthly SMI premium	16.83	18.08	18.54	18.73	20.55	21.90	22.14	23.44	24.84	25.23		

SOURCE:

Congressional Budget Office (March 1999 baseline).
Estimates have not been reviewed and are preliminary.
Does not include estimate of administrative costs.

TABLE 2. ESTIMATED COSTS FOR SELECTED PRESCRIPTION DRUG OPTIONS WITH STOPLOSS PROVISION

Outlays in Billions for Fiscal Years	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	5-Year	10-Year
Option: Cyb6d Rx benefit added to SMI program; \$100 deductible, 20% coinsurance, maximum benefit paid=\$1200 but with \$4000 stop loss												
Medicare Gross Outlays	17,869	28,785	30,618	38,198	35,197	40,045	42,887	47,411	52,983	58,502	148,545	388,053
SMI Premiums	-8,078	-7,282	-7,672	-8,341	-8,087	-10,084	-10,777	-11,822	-13,251	-14,719	-37,420	-88,158
Net Medicare Outlays	12,791	21,503	22,946	29,857	27,110	29,961	32,080	35,589	39,732	43,783	109,124	299,895
Medicaid Outlays	-0.576	-0.784	-0.848	-0.893	-0.922	-0.952	-1.018	-1.058	-1.106	-1.168	-4.025	-8.325
Net Effect on Federal Spending	12,215	20,719	21,998	28,964	26,188	29,009	31,074	34,432	38,625	42,615	105,099	291,570
Change in monthly SMI premium	15.14	16.36	17.08	18.52	19.01	21.68	22.81	25.16	27.34	29.00		
Option: Cyb8e Rx benefit added to SMI program; \$200 deductible, 20% coinsurance, maximum benefit paid=\$1200 but with \$4000 stop loss												
Medicare Gross Outlays	15,912	25,781	27,615	30,328	33,372	37,244	40,185	44,775	50,081	56,970	183,007	351,272
SMI Premiums	-4,522	-5,457	-6,048	-7,687	-8,593	-9,387	-10,103	-11,255	-12,808	-14,087	-33,977	-81,410
Medicare Outlays	11,390	19,324	20,567	22,641	24,779	27,857	30,077	33,510	37,273	41,883	99,030	269,862
Medicaid Outlays	-0.511	-0.710	-0.758	-0.808	-0.851	-0.909	-0.959	-1.008	-1.059	-1.124	-3.549	-8.801
Net Effect on Federal Spending	10,879	18,614	19,809	21,833	24,128	26,888	29,118	32,502	36,214	40,759	95,481	261,051
Change in monthly SMI premium	13.46	14.71	15.47	16.87	18.41	20.98	21.44	23.81	26.05	28.59		
Option: cyb6f Rx benefit added to SMI program; \$200 deductible, 20% coinsurance, maximum benefit paid=\$1200 but with \$4000 stop loss												
Medicare Gross Outlays	16,751	27,074	28,891	31,590	34,834	38,501	41,982	46,868	51,289	57,124	158,048	373,203
SMI Premiums	-4,781	-5,810	-7,287	-7,844	-8,758	-9,880	-10,419	-11,583	-12,888	-14,374	-35,488	-84,414
Net Medicare Outlays	11,970	20,264	21,604	23,746	26,076	28,621	30,563	34,005	38,401	42,750	103,400	278,789
Medicaid Outlays	-0.541	-0.740	-0.804	-0.843	-0.885	-0.920	-0.967	-1.031	-1.082	-1.148	-3.523	-8.900
Net Effect on Federal Spending	11,429	19,524	20,800	22,903	25,042	27,601	29,596	33,374	37,319	41,602	99,877	269,789
Change in monthly SMI premium	14.19	15.43	16.17	17.86	19.09	21.04	22.08	24.42	26.84	29.19		
Option: cyb8g Rx benefit added to SMI program; \$250 deductible, 20% coinsurance, maximum benefit paid=\$1500 but with \$3000 stop loss												
Medicare Gross Outlays	17,848	28,908	31,172	34,381	37,953	42,488	45,983	51,394	57,819	64,362	180,320	411,083
SMI Premiums	-8,072	-7,288	-7,648	-8,844	-9,547	-10,586	-11,586	-12,816	-14,477	-16,201	-38,407	-104,252
Net Medicare Outlays	12,774	21,620	23,524	25,537	28,406	31,902	34,398	38,578	43,342	48,161	111,921	287,731
Medicaid Outlays	-0.526	-0.775	-0.850	-1.005	-1.058	-1.088	-1.179	-1.237	-1.309	-1.396	-4,512	-10,792
Net Effect on Federal Spending	12,148	20,845	22,674	24,712	27,348	30,702	33,219	37,172	41,732	46,765	107,409	286,939
Change in monthly SMI premium	15.12	16.58	17.49	18.25	20.08	22.37	24.54	27.31	29.83	32.88		
Option: cyb8h Rx benefit added to SMI program; \$250 deductible, 20% coinsurance, maximum benefit paid=\$1500 but with \$4000 stop loss												
Medicare Gross Outlays	17,859	28,670	30,539	33,447	36,689	40,784	43,810	48,578	54,052	60,052	148,812	384,185
SMI Premiums	-5,019	-7,182	-7,682	-8,440	-9,224	-10,253	-11,012	-12,218	-13,887	-15,109	-37,824	-89,718
Net Medicare Outlays	12,640	21,488	22,857	25,007	27,465	30,531	32,793	36,360	40,165	44,943	109,388	294,467
Medicaid Outlays	-0.539	-0.829	-0.955	-0.929	-0.971	-1.097	-1.080	-1.128	-1.177	-1,280	-4,216	-8,843
Net Effect on Federal Spending	12,041	20,659	21,902	24,108	26,494	29,523	31,714	35,232	39,278	43,700	105,172	285,624
Change in monthly SMI premium	14.98	16.50	17.10	18.70	20.21	22.28	23.34	25.76	28.08	30.59		

SOURCE:

Congressional Budget Office (March 1998 base line).
Estimates have not been reviewed and are preliminary.
Does not include estimate of administrative costs.

14-Apr-99

TABLE 3. PERCENTAGE DISTRIBUTION OF MEDICARE ENROLLEES BY COST OF PRESCRIPTION DRUGS USED, CY 2006 PROJECTIONS

Spending Category (\$ per year)	0	1-200	201-400	401-600	601-800	801-1000	1001-2000	2001-5000	5000+
All Enrollees	19.9%	12.9%	8.5%	7.4%	6.1%	4.9%	18.4%	9.4%	11.5%
Enrollees by Poverty Class (a)									
Less than 1	28.1%	11.4%	7.5%	8.0%	4.7%	3.3%	17.8%	9.7%	13.2%
Between 1 and 2	20.8%	11.8%	9.1%	8.1%	6.4%	6.0%	18.0%	8.7%	11.2%
Between 2 and 3	18.5%	13.3%	9.8%	8.1%	6.8%	4.8%	20.2%	9.3%	11.8%
Between 3 and 4	19.0%	14.5%	10.9%	8.1%	6.4%	4.8%	17.9%	8.7%	10.7%
Greater than 4	17.2%	13.8%	10.4%	8.1%	6.5%	4.9%	18.2%	10.8%	10.5%

SOURCE: Congressional Budget Office (March 1998 baseline).

14-Apr-99

a. Poverty classes are defined by the ratio of family income to the poverty line for the family.

Mount
Sinai

The Mount Sinai Medical Center

The Mount Sinai Hospital
Mount Sinai School of MedicineOne Gustave L. Levy Place
New York, NY 10029-6574**Institute for Medicare Practice**
Tel. (212) 241-3845 Fax (212) 423-2998

Fax

To: *Chris Jennings* From: Bruce Vladeck, Ph.D.
Fax: *(202) 456-5557* Pages: *8*
Phone: Date: *4/5/12/99*
Re: *"Plenty of Nothing" As promised.*

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

● Comments:

See attached 1

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Page 1 of 7

Sounding Board**PLENTY OF NOTHING — A REPORT
FROM THE MEDICARE COMMISSION**

THE National Bipartisan Commission on the Future of Medicare, which began its work to great fanfare just over a year ago, held its last meeting on March 16. The commission, established by the Balanced Budget Act of 1997, had 17 members. The act required 11 affirmative votes for the adoption of any recommendations, a provision interpreted by the commission's cochairs, Senator John Breaux (D-La.) and Representative Bill Thomas (R-Calif.), as requiring 11 votes for any action, even issuing a report. Thus, when on March 16 a package of proposals assembled by the chairs commanded only 10 "yeas," the commission concluded its existence having produced literally nothing. (I, for reasons that will become apparent, was one of the seven "nos.")

In keeping with the Hippocratic principle of first doing no harm, the absence of a product of the commission's work should not be assumed to be a bad outcome, but the lack of consensus revealed by that process has some broader, and more distressing, implications. Medicare, this nation's largest and most important health insurance program, does indeed have a number of important problems, which are likely to worsen over time if not addressed. Yet members of the commission could not even reach consensus among themselves as to what those problems are, or in what priority they should be addressed. A number of analysts of the U.S. political system have recently observed, in the context of the extraordinary events surrounding the impeachment and trial of the President for sexual indiscretions and their sequelae, that this nation's political institutions are more polarized, more partisan, and more ~~subject~~ ideological ~~conflict~~ than at any time in the past century; that "sound bites" and rhetoric have largely driven substantive conversation out of political discourse; that the Washington, D.C., representatives of the mass media are at least as out of touch with the public outside the Beltway as the politicians are; and that the American people, as a result, are more alienated from and dissatisfied with the political system than they have been in many years. The experience

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of the Medicare commission is entirely consistent with that picture.

The apparent cause of the commission's failure to reach consensus was a fight about money. Medicare costs, like most health care costs, have historically grown faster than the economy as a whole — a pattern that is expected to continue into the future. In the case of Medicare, however, the economic and fiscal effects of that growth will be substantially heightened by the extraordinary increase in the number of beneficiaries that will be result from the aging of the baby boomers born between 1945 and 1965. Today, there are roughly 38 million Medicare beneficiaries; by 2030, when the last of the baby boomers will turn 65, that number will have doubled. The costs of benefits for that many people will almost certainly exceed the capacity of Medicare's current sources of financing — primarily payroll taxes, income taxes, and premiums paid by beneficiaries. All other things being equal (which of course they never are, but which is an inevitable and perhaps unavoidable assumption in government budgeting), Medicare will also consume an ever-larger share of the federal budget, thus diminishing the funds available for other purposes. So the primary task given the commission in the Balanced Budget Act of 1997 was to address long-term financing.

For a majority of commission members, however, the injection of additional revenues into Medicare was, if not literally inconceivable, then certainly something one should not talk about in public. How much additional revenue Medicare will require in the future depends, of course, on what happens to the growth of medical costs as well as on demographic change, and no one on the commission disagreed with the proposition that everyone's interests are best served by having Medicare work as efficiently and cost effectively as possible. So ~~a majority of~~ *while most of the* commissioners supported the position that Congress should adopt a number of Medicare "reforms" *the majority* in order to save money; ~~the members~~ then sought to defer any further discussion of revenues, although the commission's own, wildly optimistic staff analyses demonstrated that even those largely hypothetical savings would not be enough. Most of the Democrats on the commission, however, encouraged by the President's proposal to allocate 15 percent of the current and anticipated federal surplus to Medicare, refused to support a package that did not include at least that much new money.

The discussion of Medicare financing in the commission was further complicated by the increasing unreality that characterizes most federal budget debates. The unprecedented magnitude and duration of the current economic boom was not anticipated by most economic forecasters, and certainly not by those who make the official government projections. For at least the past 15 years, domestic politics had

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revolved primarily around issues related to the federal budget deficit — issues sufficiently compelling that politicians of all stripes were able to compromise on the Balanced Budget Act of 1997, including its substantial Medicare provisions. No sooner was the budget enacted, however, than the economic forecasts on which it was based turned out to have been far too pessimistic. Just 18 months later, the federal treasury is awash in revenues. Political leaders are having a hard time adjusting to this new reality; their instinctive response is to deny that it exists.

Thus, just two weeks after the commission went out of business, the trustees of the Medicare program reported that, thanks to the strength of the economy and the effects of the Balanced Budget Act of 1997, Medicare was in fact in far better financial shape than anyone had previously thought — although the trustees then gave the inevitable lip service to the continuing need for "reform." But this recent experience raises questions not only about the urgency of doing anything about Medicare, but also about the extent to which policy changes that might have far-reaching consequences for millions of beneficiaries and thousands of providers ought to be made on the basis of long-term forecasting models that have been so wildly inaccurate in the recent past.

Disagreements about money split the commission in other ways as well. How to pay, over time, for Medicare benefits is not the only problem facing the program; at least as important is the fact that the current benefit structure is so inadequate. On average, Medicare now pays barely half the total costs of health care for an average beneficiary, and out-of-pocket costs for premiums, supplemental insurance, and noncovered services are growing faster than overall health care costs, and much faster than beneficiaries' incomes. The most glaring deficiency in the benefit package, in the current environment, is the absence of coverage for outpatient prescription drugs, which are continuously becoming both more expensive and more necessary for the optimal treatment of the most common illnesses of the elderly. Most of the Democrats on the commission decided, early in the process, that they would not support any package of recommendations that did not provide some realistic method of coverage for at least some part of prescription-drug expenses; most of the Republicans on the commission refused to support any proposal to add new government spending for that purpose.

In order to resolve the contradictions between the need to improve Medicare's long-term financial outlook and opposition to new revenues, and between the demands for a prescription-drug benefit and opposition to new government financing, the commission's coauthors concentrated, from an early stage in the proceedings, on a proposal to redesign the entire

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Medicare managed care
and the largest reductions in
provider payments in the
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Medicare program around the theory of "premium support." Initially proposed by Henry Aaron and Robert Reischauer,¹ and ostensibly modeled on the Federal Employees Health Benefits Program, premium support would require private plans, and the existing Medicare fee-for-service program, to submit annual bids to supply the existing Medicare benefit package and possibly additional benefits as well. An average bid, weighted for the plan's enrollment and adjusted to reflect a part of regional cost variations, would then be calculated, and the government "contribution" would then be fixed at some proportion of the weighted average bid, with beneficiaries required to contribute the balance. In theory, such a process would encourage beneficiaries to select lower-cost plans and, over time, would drive down the aggregate rate of growth in Medicare costs. It would thus at least partially address the financing problem without any new tax dollars and possibly even create the opportunity for efficient plans to offer expanded benefits, such as prescription-drug coverage.

As applied to Medicare, of course, premium support is still purely a theory, and a pretty elastic one at that. Many of the details of what became the proposal voted on by the commission were in flux until the night before the commission meeting. It is also a theory with many substantial holes in it, some of which may not be able to be repaired. Briefly, some of the issues to be resolved are the problems of managing risk selection and risk adjustment; accounting for cost variations among geographic regions; methods of preventing various forms of "gaming" and cheating in the bidding process; ensuring adequate levels of performance by participating plans; and protecting rural, low-income, and severely ill beneficiaries and the communities in which they reside. But a proposal for premium support might still have commanded 11 — or even 12 or 13 — votes, had the commission been able to solve either the financing or the prescription-drug problem.

Since no one has ever seen a premium-support system operated along the lines proposed to the commission, no one really knows whether it would save any money at all. The commission staff produced estimates of enormous savings, but those were based on assumptions so questionable that they were not taken seriously by any other experts; indeed, economists on the commission expressed some skepticism about whether premium support might ever produce any savings. Probably the most objective estimates were those of the ^{actuary} of the Health Care Financing Administration (HCFA), who estimated that, over 30 years, premium support might reduce total Medicare spending by perhaps 0.5 percent — a substantial sum of money, to be sure, but far short of what is needed to solve the long-term financing problem, and only a fraction of

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the savings attained by such crude, "traditional" policies as those contained by the Balanced Budget Act of 1997. Perhaps more tellingly, at least from the perspective of this commissioner, the HCFA actuary attributed most of the savings premium support would accomplish in its first 10 years to increasing costs to beneficiaries — savings, in other words, attained not by increasing efficiency but by shifting costs to people with relatively low incomes.

As a means of providing a cost-free way to provide a prescription-drug benefit, premium support does even worse. Much of the rhetoric in favor of premium support during the commission's discussions involved the notion that encouraging the participation of many private insurance plans would create the opportunity for innovation and expansion of the Medicare benefit package. After the actuaries and economists began to analyze the potential effects of adverse risk selection on a premium-support program, however, and to look more closely at the actual experience in the Federal Employees Health Benefits Program, it became apparent that premium support would probably actually *increase* total Medicare expenditures, unless the ability of plans to provide any variation from the basic benefit package was severely constrained, or even eliminated. In fact, the proposal voted on in March would probably have had the effect of forcing many health maintenance organizations that now offer limited prescription-drug coverage to their Medicare beneficiaries to discontinue it. In other words, premium support could not provide a free lunch; if beneficiaries were to get a prescription-drug benefit, someone would have to pay for it.

But premium support still got 10 votes on the commission, remains the heart of the legislation that the commission's cochairs intend to introduce in Congress, and lies implicitly at the heart of the Budget Resolutions adopted by both houses of Congress along largely partisan lines. In Washington, D.C., no bad idea ever truly dies. Since the economic rationale for premium support is so shaky, it is important to understand why the concept has so much political staying power.

To begin with, many Republican members of Congress, including some in key leadership positions, simply cannot abide the notion of a large, government-operated, redistributive health insurance program. In 1995, they voted overwhelmingly to transform Medicare into a voucher program with defined contributions, but the perceived electoral consequences of that decision were so fearsome that it is no longer politic to take such a position openly. Medicare, as it is now constituted, remains enormously popular with the American people, beneficiaries and younger citizens alike. Proponents of premium support will vehemently deny that theirs is a defined-contribution program and insist that they

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seek to preserve Medicare's existing benefits, but the ~~generic markers~~ in premium support are unmistakable, and one does not have to be paranoid to imagine how easily some future Congress could convert a system of premium support into a purely arbitrary defined government contribution.

In the current political and intellectual climate, even many people who are not hostile to the basic principle of Medicare share the prevailing conventional wisdom that, because it is a government program, Medicare must by definition be less efficient and more costly than the same benefits provided by private insurers. The evidence to the contrary is overwhelming, but largely irrelevant to the political process. Thus, both moderate Republicans and many "new Democrats," such as Senator Breaux and many senior Clinton Administration officials, are attracted to premium support because they like the ideas of privatization, increased competition within government programs, and other efforts to recast New Deal and Great Society programs into what appear to be more contemporary forms. In these preferences, they are supported by the hegemony of classical microeconomic analysis in think tanks and policy-analysis centers; despite the clear, and repeatedly demonstrated, inapplicability of neoclassical economic models to health services and health insurance, theirs continues to be the only intellectually respectable game in town.

In fact, the more closely one looks, the more premium support appears to resemble not so much the defined-contribution approach of the Republican Congress's Contract with America, but the "managed competition" theory of the Clinton administration's 1993-1994 health reform proposals. It is ironic, but hardly surprising, that many of the same political leaders who so aggressively attacked the Health Security Act as excessively bureaucratic and unworkable when it was proposed as a means to ensure universal coverage are now willing to apply a very similar approach to Medicare benefits.

Any wise physician knows that the most prudent, and probably most effective, response to some medical problems is to do nothing, but for elected politicians, professional pundits, or academic policy analysts, acknowledging the wisdom of such an approach creates the danger of unemployment. At the moment, the Medicare program is in its best financial shape in decades; the U.S. health care system in which Medicare plays such a central role is experiencing an unprecedented level of disequilibrium, and only the most foolhardy have any certainty as to what the future may hold. The consensus of leading economic forecasters has, as the old Wall Street cliché puts it, predicted five of the last two recessions. Our political system is increasingly conflict-ridden and dysfunctional, and most of the so-called experts, including most of the members of the Medicare

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commission and its staff, have only the foggiest idea of how Medicare actually works. It may turn out that, in doing nothing, the Medicare commission produced the best currently attainable outcome.

BRUCE C. VLADECK, Ph.D.
Mount Sinai School of Medicine
New York, NY 10029

Supported in part by the Commonwealth Fund. The views presented here are those of the author and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

REFERENCES

1. Aaron H, Reischauer R. ~~xxxx~~

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**Health Care Financing Administration
Office of Legislation**

FAX COVER SHEET

May 25, 1999



FAX TO: **Chris Jennings**

FAX #: **(202) 456-5557**

PHONE #:

ORGANIZATION: **White House**

FROM: **Bonnie Washington**

FAX #: **(202) 690-8168**

PHONE#: **(202) 690-5960**

RE: **Letters from Bill Thomas regarding Medicare Handbook**

PAGES (INCLUDING COVER): **8**

COMMENTS:

Three letters are attached:

- (1) Letter from Nancy-Ann Min DeParle to Bill Thomas (dated March 30) asking for his support for moving the ACR deadline from May 1 to July 1 and changing the statutory requirements regarding the types of plan comparison information the handbook must include.
- (2) Letter from Bill Thomas to Nancy-Ann Min DeParle (dated April 1) supporting the decision to move the ACR deadline to July 1 but asking for more information about changing the statutory requirements regarding the handbook.
- (3) Letter from Bill Thomas to Nancy-Ann Min DeParle (dated May 21) outlining his concerns with the handbook draft.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 30 7

The Honorable William Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

As you know, the Balanced Budget Act of 1997 (BBA) made significant changes to the Medicare program, including the introduction of Medicare+Choice. As part of the Medicare+Choice program, the BBA moved the date when health plans are required to submit their Adjusted Community Rate (ACR) proposals, from mid-November to May 1. As I understand it, this deadline was changed to accommodate the production of education materials and the implementation of other activities for each fall's coordinated open enrollment period.

As you and I have discussed, the May 1 ACR deadline presented difficulties for health plans last year because they had less time than they felt was needed to evaluate market trends and costs. I believe that this early deadline also increases the likelihood that the data we provide beneficiaries in October 1999 as a part of the beneficiary education campaign mandated by the BBA will be inaccurate. For these reasons, I believe that it would be in the best interest of both beneficiaries and health plans that we move the ACR deadline to July 1. We have proposed to move this date as part of the President's FY 2000 budget. Based on the support for this proposal in the Congress, we assume that legislation to effect this change can be enacted later this year. However, we have to inform plans within a week about the deadline that will be used this year for the 2000 ACR filing. Therefore, we are planning to notify plans that the deadline for the calendar year 2000 ACR submissions will be July 1, 1999. It would be helpful, however, to have a letter from you and the Ranking Member of the Subcommittee indicating your support for this action. We have received such a letter from the Chair and Ranking Member of the Finance Committee and from the Chair and Ranking Member of the Commerce Health Subcommittee.

Page 2 - The Honorable William Thomas

The BBA also includes detailed requirements regarding the information to be included in the beneficiary mailings. In 1998, we provided this information on a pilot basis through the 1999 *Medicare & You* handbook. In some of the pilot sites, the late decision of some managed care plans to leave the market after the handbook had been sent to the printer caused some of the detailed benefit information in the handbooks to be inaccurate. We hope that moving the ACR deadline to July will mitigate this problem for 1999. But I am concerned that even a July deadline will not eliminate accuracy problems with regard to detailed benefit information. Given the complex production schedule for getting *Medicare & You* into the mail to beneficiaries by October 15, there would not be time to validate benefit information submitted directly by plans. As a result, some portion of this information could be inaccurate compared to final, approved benefits. Based on last year's experience and our preliminary evaluation of the 1999 handbook, including focus groups with beneficiaries in the pilot states, and taking into account the compressed production schedule resulting from the later ACR deadline, I believe it would be better to provide less detailed, but more accurate information to beneficiaries in the handbook and supplement it with information through other sources.

While detailed benefit information would not be available in *Medicare & You*, it would still be available to beneficiaries by: calling 1-800-MEDICAR(E) and requesting a printed copy of information; accessing the Medicare Compare database on the Internet; or participating in regional special information sessions. As with the change in the ACR deadline, we have proposed legislation to modify the BBA information requirement, but such legislation will probably not be enacted before the time when we need to finalize the content of the 2000 handbook. An indication of support for paring back the amount of detailed benefit information in the handbook would also be helpful.

I look forward to working with you to enact legislation to make these changes possible.

Sincerely,

A handwritten signature in black ink, reading "Nancy-Ann DeParle". The signature is fluid and cursive, with the first name "Nancy" and last name "DeParle" clearly distinguishable.

Nancy-Ann DeParle
Administrator

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BILL VAUGHAN, SUBCOMMITTEE MINORITY

April 1, 1999

The Honorable Nancy-Ann DeParle
Administrator
Health Care Financing Administration
Room 314-G
200 Independence Ave, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

As you know, the Balanced Budget Act of 1997(BBA) moved the deadline for Medicare+Choice plans to submit their annual Adjusted Community Rate (ACR) proposals to the Health Care Financing Administration from November 1 to May 1. During the BBA negotiations, the Administration argued that the Health Care Financing Administration needed a full seven months to process the ACR filings and to produce the detailed comparative information booklets that Congress then envisioned for the new Medicare+Choice program.

During the first year of implementation of the Medicare+Choice program, many plans found that it was extremely difficult to predict their Medicare costs seven months in advance of the payment. When plans received additional data later in the year, some decided to limit their participation to fewer counties or to withdraw from the program. In your letter dated March 30, 1999, you note that the Administration was unable to include information reflecting these changes in the Medicare&You booklets, resulting in seniors receiving inaccurate information. You also ask for Congress to enact legislation to move the filing date to July 1, and to support reducing the amount of detailed information provided to seniors.

I support moving the ACR filing date from May 1 to July 1 and intend to enact legislation to make this change. However, providing seniors with accurate and comparative information about all of their Medicare options is of utmost importance and is one of the fundamental pieces of the Medicare+Choice legislation. Unfortunately, at a

March 18 Health Subcommittee hearing we heard testimony questioning the effectiveness of HCFA's inaugural information campaign. In particular, concerns were raised about the timing of the information mailings, the complexity and structure of the booklet, and the difficulty in accessing and using the HCFA website. Before considering changing the BBA information requirements, a comprehensive review of last year's information campaign and a detailed analysis of the impact of moving the filing date from May 1st to July 1st is warranted. As a first step, I would like your response to the concerns raised at the hearing.

Thank you for your attention to this matter.

Sincerely

A handwritten signature in black ink, appearing to read "Bill Thomas", with a stylized flourish at the end.

Bill Thomas
Chairman

BILL THOMAS, CALIFORNIA, CHAIRMAN
SUBCOMMITTEE ON HEALTH

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

May 21, 1999

The Honorable Nancy Ann DeParle
Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

We have reviewed your agency's recent draft of the proposed *Medicare and You* handbook for the year 2000. As currently drafted, we find the handbook to be legally insufficient, delusive, wasteful and confusing. It ignores the statutory requirements spelled out for the publication as part of Medicare+Choice ("M+C") program. As disturbing, rather than "promoting informed choice" as envisioned by the Medicare+Choice law, it seems designed to frustrate a beneficiary's ability to evaluate the comparative benefits of different health plan options available to them through Medicare.

The specific problems described below underlie, in part, my sentiments:

VIOLATIONS OF THE STATUTE

As part of its broader effort to ensure that seniors could comparatively evaluate all of their options under the Medicare program, Congress mandated that the Health Care Financing Administration ("HCFA") specifically include in the material mailed to each beneficiary prior to the new open enrollment period *more than a dozen specific facts about each specific Medicare+Choice plan* available in the beneficiary's area. In spite of this mandate, the draft handbook contains absolutely no detailed benefit information about any specific plan. It doesn't even contain basic elements such as how much a given plan costs, or what, if any, additional benefits it covers. In fact, nowhere does it contain a decent summary of the benefits a typical Medicare+Choice plan offers.

Instead, the handbook contains only aggregated, cryptic, poorly organized, and relatively meaningless information organized by Medicare+Choice contractor. Even then, comparative information is limited to the name of the contractor, the total number of plans they offer in each state, the range of premiums they charge for these plans, the number of plans they offer that cover prescription drugs (not which ones), and a phone number.

This format makes it impossible to learn even the most basic plan information. The reader

cannot tell if a specific plan is available to them, what the premium is for a given plan, what the applicable co-payments or deductibles are, or what, if any, extra benefits are covered. This is not what the statute requires, and clearly not what Congress envisioned when it enacted the mailing requirement.

CONTENT BIASED AGAINST MEDICARE+CHOICE

In some ways we find it even more troubling that the content of the handbook seems designed to frustrate the very purpose for which it was clearly created -- to help educate seniors and enable them to make informed choices under the new Medicare+Choice program. Sadly, the draft contains no significant discussion of the options available because of Medicare+Choice until page 17 (after an extensive description of the traditional Medicare program, and its benefits and a description of the low-income assistance programs).

Where the handbook does discuss the M+C program, it fails to make clear even the most basic distinctions and relationships between "The Original Medicare Plan" and Medicare+Choice plans. For example, nowhere is it clearly stated that all Medicare+Choice plans must cover all of the benefits covered in both Medicare Parts A and B.

WOEFULLY INADEQUATE QUALITY AND PERFORMANCE INFORMATION

The paucity of comparative quality data that is included in the draft is poorly presented and "oversold." More importantly, it fails to adequately include and present comparisons to the traditional Medicare plan.

Only one quality indicator comparing Medicare+Choice plans to traditional Medicare is included. It reports plan mammography rates. Even then, the traditional Medicare program data is not presented in the bar graphs comparing individual M+C plans, but is compared to aggregate M+C data for each state. It is as if HCFA does not want the traditional program to be judged on its own relative merits.

The only additional comparative "quality" measure for Medicare+Choice plans is derived from the results of an enrollee survey, and reflects the perceived communication skills of a plan's participating doctors. Representing this information as a major quality indicator is dubious at best. Yet, the draft devotes 7 full pages to reporting this one fact -- via a nearly indecipherable multi-variable bar graph. By comparison, the Office of Personnel Management's ("OPM") standard beneficiary booklet for the Federal Employee Health Benefit Plan presents on one page the results of 11 different consumer satisfaction measures. I ask you -- can't HCFA do a better job of giving seniors some truly valuable information?

OVERALL CONTENT CONFUSING AND WASTEFUL

Finally, the overall structure and layout of the booklet is long, duplicative and poorly organized. As a result, it only further frustrates the purpose for which it was mandated and is a poor reflection on the program. A few examples:

- It devotes nearly a dozen pages to describing in detail the benefits structure of the traditional fee-for-service program -- before adequately explaining the general advantages and disadvantages of fee-for-service Medicare as compared to Medicare+Choice.

- The vast majority of the text contains general explanatory text -- much of which is redundant and not clearly written. Only 11 pages are devoted to providing comparative information. And then a grand total of 7 facts per *contractor* are provided -- this includes the contractor's name and phone number. By comparison, the most recent OPM booklet devotes 41 of 55 pages to comparative, plan specific information. It provides roughly 35 facts concerning every plan in the country (approximately 300 plans).
- One final example of wasted space is the listing of phone numbers one can call to get additional information. In addition to numerous references to phone numbers spread throughout the text, a full 7 pages are devoted to nothing but describing government phone numbers where seniors can get more information -- yet, approximately 75% of this material refers seniors to the same 1-800-MEDICARE number. This could easily be condensed into two pages at most and either save money or free up space for more detailed, comparative plan information that seniors could actually use.

At a time when many seniors are struggling to determine how to pay for medical needs such as prescription drugs, the government does not serve them well by providing only incomplete and misleading information about their options under the Medicare+Choice program.

Given the potential of the Medicare+Choice program to help millions of seniors and disabled citizens, I ask that you take the necessary steps to ensure that these inadequacies are addressed before authorizing the expenditure of any printing funds for this project.

Sincerely,



Bill Thomas
Chairman

cc: The Honorable Donna Shalala

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. fax	Mark Felsenthal to Chris Jennings re: phone number (partial) (1 page)	05/27/1999	P6/b(6)

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- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FAX

To: Chris Jennings

Voice Phone Number:

From: Mark Felsenthal

Company: BNA

Fax Number: (202) 628-9129

Voice Number: (202) 347-2710

MESSAGE

Chris -- attached is BNA's coverage of Breaux's testimony yesterday. Our reporter seems to have clearly understood Breaux to suggest a softening on prescription drug coverage and maintaining eligibility at 65, as well as on provider spending and graduate education. I'd love to be able to use your comments on background -- or even better, on the record -- on this if I could. Please call if you get a second: 347-2710 or P6(b)(6) [001]

Thanks.

Best regards,

Mark Felsenthal

Date: 5/27/99

Pages: 1 of 1

Previous Doc Next Doc Search Contents

BNA, Inc.

Daily Report for Executives

No. 102

Page A-20

Thursday May 27, 1999

ISSN 1523-567X

Regulation, Law & Economics

Medicare

Breaux, Thomas Resurrect Reform Plan; Lott Attends Hearing to Support Initiative

The co-chairmen of the National Bipartisan Commission on the Future of Medicare May 26 resurrected their Medicare reform plan before the Senate Finance Committee, telling lawmakers that the proposal still offers the best chance to modernize the program and give beneficiaries more health care choices.

While the proposal they described was nearly identical to the one the commission in March failed to recommend to the White House and Congress, Sen. John B. Breaux (D-La.) and Rep. William M. Thomas (R-Calif.) at a committee hearing signaled their willingness to negotiate several controversial provisions.

Those included adding a more comprehensive prescription drug benefit; maintaining graduate medical education funding in Medicare rather than possibly moving it to the congressional appropriations process; scaling back or eliminating a provision to extend provider spending reductions in the Balanced Budget Act of 1997 past their 2002 expiration date; and leaving the eligibility age at 65 rather than moving it to 67.

Both lawmakers said they plan to introduce legislation in June that would include a Federal Employee Health Benefits Program option in Medicare as well as make numerous other changes.

Under their proposal, beneficiaries would be able to choose to enroll in a new plan, most likely a managed care plan, and the government would pay most of the premium. The current fee-for-service option would remain available.

"We didn't reinvent the wheel here," Breaux said of the premium support model. "This is a proven type of concept that works very well."

Lott Urges Passage

While most observers believe it unlikely that the legislation would become law this year, the pair received a boost when Senate Majority Leader Trent Lott (R-Miss.) appeared at the hearing to urge the committee to pass the plan, saying it would "be a marker for everyone else to consider," including the White House, the House, and the Senate.

The Clinton administration is expected to put forth its reform plan next month as well. While few details of Clinton's plan have surfaced, Thomas told reporters there are few available options for reforming Medicare.

Clinton's plan is likely to be "remarkably more similar than dissimilar" to the bipartisan commission's proposal, Thomas said.

Thomas told reporters after the hearing that he would introduce legislation encompassing the bipartisan commission's plan within a week or so, while an aide to Breaux told BNA the senator would introduce his bill within several weeks.

Thomas, who has pledged to bring a Medicare reform bill to the House floor this year, said the House would hold hearings on his bill, although none has been scheduled.

Approval Predicted

The fifth of five Finance Committee hearings on Medicare reform is scheduled for May 27, and Committee Chairman William V. Roth Jr. (R-Del.) has pledged to pass a bill. Even harsh critics of the plan, such as Sen. John D. Rockefeller IV (D-W.Va.), have said legislation establishing a premium support option for Medicare is likely to be approved by the committee.

The appearance of Breaux and Thomas before the committee to discuss their plan in many ways mirrored the debate that resulted in the bipartisan commission failing by one vote to produce a recommendation.

Both lawmakers said a premium support model would modernize Medicare and introduce much-needed competition into the system, while some Democrats on the panel, including Rockefeller, claimed the proposal still lacks specifics and does not guarantee a standard benefits package for beneficiaries.

Rockefeller agreed that Medicare should be reformed, but said the Breaux-Thomas plan remains vague. He charged that those opposing the plan are being labeled resistant to change.

Both sides of the debate produced witnesses for a second panel who testified that premium support would either enhance or harm health care for the elderly.

For example, former commission member Deborah Steelman of the consulting firm Steelman Health Strategies, Washington, D.C., said a premium support plan would enable beneficiaries to take advantage of the latest medical technologies, modernize service delivery, and introduce competition into the system.

Destabilizing Medicare

However, Bruce C. Vladeck, former administrator of the Health Care Financing Administration and a member of the bipartisan commission, said adopting a premium support option would destabilize Medicare at a time when the private health insurance market is in crisis.

As in the commission's proposal, Breaux said, under his legislation the federal government would pay 88 percent of the premium for beneficiaries choosing the premium support option and a Medicare board would be established to oversee new plans entering the system.

The standard benefits package offered would consist of all services mandated under current law, and the proposal would combine Parts A and B that would draw on three revenue sources: payroll taxes, premiums, and general revenues.

The plan would provide prescription drug coverage and full payment of the premium for beneficiaries with incomes of up to 135 percent of poverty, but Breaux and Thomas said they were willing to discuss broadening the coverage by making it available to more beneficiaries.

Thomas told reporters that language in his bill could reflect discussions with some House Democrats to offer drug coverage to those with low-moderate or moderate incomes.

Appeal for Action

In a May 21 letter to House Speaker J. Dennis Hastert (R-Ill.) and House Minority Leader Richard A. Gephardt (D-Mo.), a group of eight moderate and conservative Democrats urged that Medicare reform be passed this Congress. However, the group urged that prescription drug coverage be offered to more beneficiaries and that the eligibility age remain age 65.

The drug premium subsidy provision as currently configured would cost \$61 billion over 10 years, and neither Breaux nor Thomas said how they were going to pay for it. Democrats on the commission urged the body to recommend setting aside 15 percent of the expected federal budget surplus to pay for the new benefit as has been suggested by President Clinton. Rockefeller told the pair that an infusion of new funds would be needed to pay for the benefit.

In addition, the proposal would require all 10 Medigap plans to offer prescription drug coverage. Only three plans offer drug coverage now. ☞



FAX COVER SHEET
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To: Chris Jennings
Jeanne Lambrew

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Phone: _____

REMARKS: We cant quite find another
piece which is more articulate than
this one. - We'll get you the other one
tomorrow morning

HEALTH CARE FINANCING ADMINISTRATION

200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Disadvantages of a New Board Administering Premium Support

◆ Diffuses accountability for the program, and may diminish accountability

To whom would this board be accountable?

Does this mean that the Congress and the States would have two bureaucracies to deal with?

Allowing the Board to "be more nimble" and **not** comply with certain requirements for due process and Governmental decision that apply to HCFA, such as notice and comment rule making, may lessen accountability and serve to undermine the rights currently enjoyed by beneficiaries and providers

◆ Duplicates functions, increasing overhead costs for taxpayers and beneficiaries

The Board will have to undertake many of the **same** functions HCFA currently performs, such as ensuring that there is appropriate certification and monitoring of health plans, fighting fraud and abuse, ensuring that beneficiaries and providers have appropriate appeal rights and that there are mechanisms for granting appeal rights, providing for appropriate enrollment of beneficiaries and changes in status, along with ensuring appropriate payment to plans—a role that requires highly sophisticated information technology; coordinating information systems with Social Security and the States (for Medicaid eligibles); undertaking quality monitoring and improvement initiatives; etc.

◆ Abrogates our responsibility to our beneficiaries

- Unlike FEHBP, which some view as the model for a board structure, Medicare is not a program whose main purpose is to provide health care coverage to workers and retirees. FEHBP is not a government entitlement program providing health care security for a population of aged and disabled individuals, most of whom have limited income.

◆ Does not insulate policy makers from political pressure applied by affected constituents

- The vast majority of beneficiaries will remain in FFS Medicare, and policy makers (i.e., the Congress) will still be faced by constituent pressures related to the traditional Medicare FFS program, such as provider payments, provider participation, rural/urban issues, benefit package issues.

♦ **Creates confusion among beneficiaries and providers**

Beneficiaries and providers will, in many cases, have two separate entities to deal with, and the lines between the two entities and their roles may be confusing, particularly for beneficiaries

♦ **Creates an unhealthy tension between the staffs of the two entities, and potential bias on the part of each entity that does not exist today**

Creating two entities (i.e., the Medicare Board and HCFA) is likely to result in a bias against each other

Managed care is today an integral part of the Medicare program. From the first day of the existence of the Medicare program, the statute has always provided the opportunity for managed care plans to participate in the Medicare program. The Medicare amendments of 1972, for example, defined the term "health maintenance organization" even before the passage of the Federal HMO Act the following year.

After HCFA's reorganization, the leadership of the HCFA center that deals with both fee-for-service and managed care issues has always been a person coming from the managed care world (Fried and Berenson)

♦ **Separates the social responsibilities of the program from a major portion of its operations**

- Special concerns of rural providers, teaching institutions, and safety net providers would rest with one segment of the program and not the other, diminishing the focus on these concerns

May 17, 1999



Health Division



Purpose: Viable alt.

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to:	The Director	<u>ACTION:</u>	<u>Needed By:</u>
		Decision _____	Date: ____ / ____ / ____
Through:	Dan Mendelson	Signature _____	Time: ____ : ____ am/pm
	Barry Clendenin	Comment _____	
	Mark Miller	As requested <u>X</u>	<u>Copies to:</u> HD/HFB
		Information _____	chrons.; Gina Mooers;
			HFB Medicare
Subject:	Additional offsets for Medicare reform package		Post this
		Phone: 202/395-7844	Document on HD
		Fax: 202/395-7840	Intranet? <u>NO</u>
From:	Medicare examiners	Room: NEOB #7002	

The table at Tab A displays the current set of spending and savings assumptions for the Administration's Medicare plan. As the table shows, the costs of this plan exceed the offsets by \$81-101 billion over 2000-2009. If we move to mitigate present BBA savings (e.g., for hospitals or SNFs), this gap will grow depending on the size of the BBA modifications. This memorandum discusses additional ways to offset these costs.

→ Could Be Cast as "Structural Reform" [HCFA offer a plan] INDUSTRY & Rules

1. Prohibit Medigap Coverage of Medicare Deductibles. Earlier versions of the Breaux commission plan included a proposal that would have prohibited individual Medigap plans from covering Medicare deductibles. We understand that this proposal is no longer being considered for inclusion in the Administration's upcoming Medicare reform package. Given the savings (\$10 billion over FY2000-09) and potential policy benefits from this proposal (see below), policy officials may want to reconsider it for inclusion in the plan. *FY 2000-2009 savings: \$10 billion (assuming FY 2001 effective date).*

• Could deal it up by putting in Co-insurance - First \$100.

Background: Approximately one-third of all Medicare's fee-for-service enrollees purchase individual Medigap policies that cover all or most cost-sharing that Medicare requires.¹ (Note that nine of the ten standardized plans cover the Part A deductible, while three cover both the Part A and Part B deductibles.) Such "first-dollar" coverage, which insulates beneficiaries from cost-sharing, tends to encourage unnecessary utilization and increased Medicare program costs. According to CBO, Medigap policyholders use at least 25 percent more services than they would if they did not have first-dollar coverage.

*• "not a Beneficiary hit" - currently paying it anyway
• Industry...*

Pros: A policy that prohibits Medigap coverage of the Medicare deductibles could lead to significant program savings by providing a financial incentive for beneficiaries to use services more prudently. As a

¹ Approximately 87 percent of FFS beneficiaries have some form of supplementary coverage through Medigap, employer-sponsored plans and Medicaid.

result, this behavioral change would also likely reduce unnecessary utilization of health services. In addition, this policy represents a middle ground in that beneficiaries would still be able to purchase Medigap policies to cover Part A and Part B coinsurance. CBO and others have recommended a more extensive prohibition on first-dollar coverage (including both deductibles and coinsurance). The Administration also could receive credit for proposing a substantive reform.

→ Resistance from the industry

Cons: The policy would have a financial impact on almost a third of all Medicare beneficiaries and could be seen as "heavy-handed" because it would prohibit the Medigap industry from offering a popular benefit. Medigap insurers also might not pass on their full savings from this policy to beneficiaries in lower premiums.² Our scoring of the proposal assumes a behavioral change among beneficiaries that would lead to more prudent utilization of services. If this behavioral change does not occur as anticipated, the policy may not lead to significant program savings.

*→ B-Thomas assumed MB - 1.7
• MB - 1.5 gets \$12 B.*

2. Use a "true" extender package with no BBA modifications. The current consensus BBA extender package appears to be a combination of a less-aggressive extender package (which includes generally lower hospital cuts and especially low cuts for rural hospitals) and some set of provider-specific reductions in BBA savings. Alternatively, the Administration could propose a package of extenders that more closely matches the cuts in the final years of the BBA (i.e., does not soften the blow for the hospitals), with no modifications to the BBA savings provisions (see Tab B).

*— Hospital - 50%
— I Postages & diff savings levels. ← — Other - "*

Aside from providing savings to offset the costs of the drug benefit, this option is easier to explain as a true "extender" package than the policy currently assumed, because it simply extends most of the cuts from the final years of the BBA rather than providing different updates for urban and rural hospitals. On the other hand, the current interest in reducing the savings from the BBA may make deeper extender savings difficult to achieve. *FY 2000-2009 savings: \$27 billion (above the currently-assumed level).*

3. Require all State and Local Government Employees to Pay Part A Tax. For employees hired before March 31, 1986, state and local governments have the option of paying the Hospital Insurance (HI) payroll tax. Because these employees gain eligibility for Medicare in other ways (i.e., through their covered spouse, or through their work for other employers), they receive Medicare benefits for a smaller amount of lifetime payroll taxes than those paid by people who work continuously in covered employment. This proposal would require that all state and local government employees and employers contribute to the HI Trust Fund by paying the Part A payroll tax. *FY 2000-2009 savings: \$11.3 billion (CBO scoring).*

In light of Tobacco tax.

→ Option: transition to Buy-in

Pros/Cons. This proposal would place all state and local government employees on the same footing as almost all other employees in the country. This provision also would eliminate the inequity between employees hired before April 1986 and those hired subsequently. However, state and local governments may view this proposal as an unfunded mandate. Because state and local governments had the option (before 1986) of participating in Medicare, the effect of this proposal will vary depending on

² Insurers ability to engage in such uncompetitive practices would be minimized by Federal rules that require Medigap insurers to maintain minimum loss ratios – the percentage of premiums returned to policyholders as benefits. When loss ratios fall below these Federal standards (65 percent for policies sold to individuals and 75 percent for policies sold to groups), insurers are required to provide refunds or credits to beneficiaries.

how many employees hired before April, 1986 have contributed to Medicare. The following states have the most employees who do not currently contribute to Part A: California; Ohio; Texas; Illinois; and Massachusetts.

→ other options: require States to pay Drugs For Dual Eligibles.

4. Increase the Tobacco Tax By An Additional \$0.45 Above the \$0.55 Increase in the FY 2000

Budget. This policy would provide an additional \$41 billion in revenue over FY 2000-09 to help offset a Medicare drug benefit. Note, however, the FY 2000 Budget policies, plus the estimated increase in cigarette prices as a result of the comprehensive state tobacco settlement, are comparable in FY 2000-02 to the tobacco tax increase proposed in the FY 1999 Budget. An additional \$0.45 increase, coupled with the FY 2000 Budget policies and the expected price increase from the State settlement, would result in a price increase well above the amount originally proposed in the FY 1999 Budget. (For example, the real per pack price increase, in 1999 dollars, proposed in the FY 1999 Budget for FY 2001 was \$0.90. A policy that adds \$0.45 to the amount proposed in the FY 2000 Budget would equate to a \$1.33 increase in FY 2001.) As a result, the Administration could be criticized for proposing a price increase above the level that Congress rejected in 1998 and, thus, reduce the credibility of the Administration's plan. *FY 2000-2009 savings: \$41 billion.*

5. FY 2000 Budget offsets for Jeffords-Kennedy. The FY 2000 President's Budget includes \$3.4 billion in Medicare/Medicaid/Disability Insurance costs from Jeffords-Kennedy over FY 2000-2009. These costs were fully offset in the Budget; however, if the Hill chooses not to use the Budget offsets to pay for Jeffords-Kennedy, these savings could be used to help offset the costs of the Medicare reform package. We would note that the Budget does not specify which health offsets would pay for Jeffords-Kennedy, so implementing this option may not be possible unless the reform plan is tied to the Budget's policies. *FY 2000-2009 savings: \$3.4 billion.*

6. Cost-sharing modifications. As you know, one possible source of funding for a Medicare drug benefit would be a revised cost-sharing package that would produce savings (rather than a budget-neutral package). The option that is most often discussed would drop the proposals to (1) combine the Part A and Part B deductibles and (2) eliminate inpatient hospital coinsurance and day limits. *FY 2000-2009 savings: As much as \$25 billion over 10 years.*

We also note that the current cost-sharing package would impose a \$5 copayment on a beneficiary's first 60 home health visits. To produce additional savings, the 60-visit cap could be increased or eliminated.

Conclusion

If we want to propose a reasonably generous drug benefit without spending the surplus, we will need to use offsets that are politically difficult or may be seen as unrealistic. Of the offsets above, the increased tobacco tax is clearly the most attractive. The remaining choices target beneficiaries, providers, or insurers. We will continue to work with Treasury to identify further revenue sources, as our ability to keep surplus revenues off the table appears contingent on adopting such measures.

- Tobacco - \$40B

- State HTS - \$

- Reducibility of Insurance for high income.

Tab A

Current Medicare Plan State of Play (\$ in billions)

	<u>FY 2000-2009 Costs (Savings)¹</u>
<u>New spending</u>	
Prescription drug benefit	\$160-180
<u>Offsets</u>	
BBA Extenders	(\$30)
HCFA modernization	(\$14)
Income-related premium	(\$25)
Competition/premium support	(\$10)
Cost-sharing changes	(\$0)
<i>Subtotal, Current Offsets</i>	<i>(\$79)</i>
Total shortfall	\$81-101
<i>New Offsets in this Memo</i>	
Medigap	(\$10)
Deeper extenders	(\$27)
HI tax for State/local workers	(\$11.3)
Increase tobacco tax by additional 45	(\$41) ←
Jeffords/Kennedy offsets	(\$3.4)
Cost-sharing modifications	(\$25)
<i>Total offsets in this memo</i>	<i>(\$117.7)</i>

¹Note that in some cases (e.g., a drug benefit for \$160-180 billion) the scoring reflects a target amount of spending or savings, rather than a defined policy or set of policies.

Tab B

Policies Assumed in "True" Extender Package

- PPS hospital update: MB-1.1 each year
- PPS exempt hospitals: cut using the BBA relationship between costs and target amounts
- PPS hospital capital: extend 2.1% cut
- PPS exempt hospital capital: extend 15% cut
- Skilled nursing facilities: reduce update by 1 percentage point each year
- Hospice: reduce update by 1 percentage point each year
- Hospital outpatient departments: reduce update by 1 percentage point each year
- Labs/durable medical equipment /parenteral and enteral nutrition: freeze
- Ambulance/prosthetics and orthotics: update by CPI-1 percentage point each year
- Ambulatory surgical centers: update by CPI-2 percentage points each year

Hospital Concept (1) about half from Hospitals.

(2) Need to do something for
Rural + Urban teaching.

- 1/2 rural - 1/2 of Hospitals
15% of \$.

- Teaching - 1,700 or if you
go just to 60% - less burden.

(3) doing option on this - open?

Managed Care: (4) "giveback" currently on table

HEALTH CARE FINANCING ADMINISTRATION

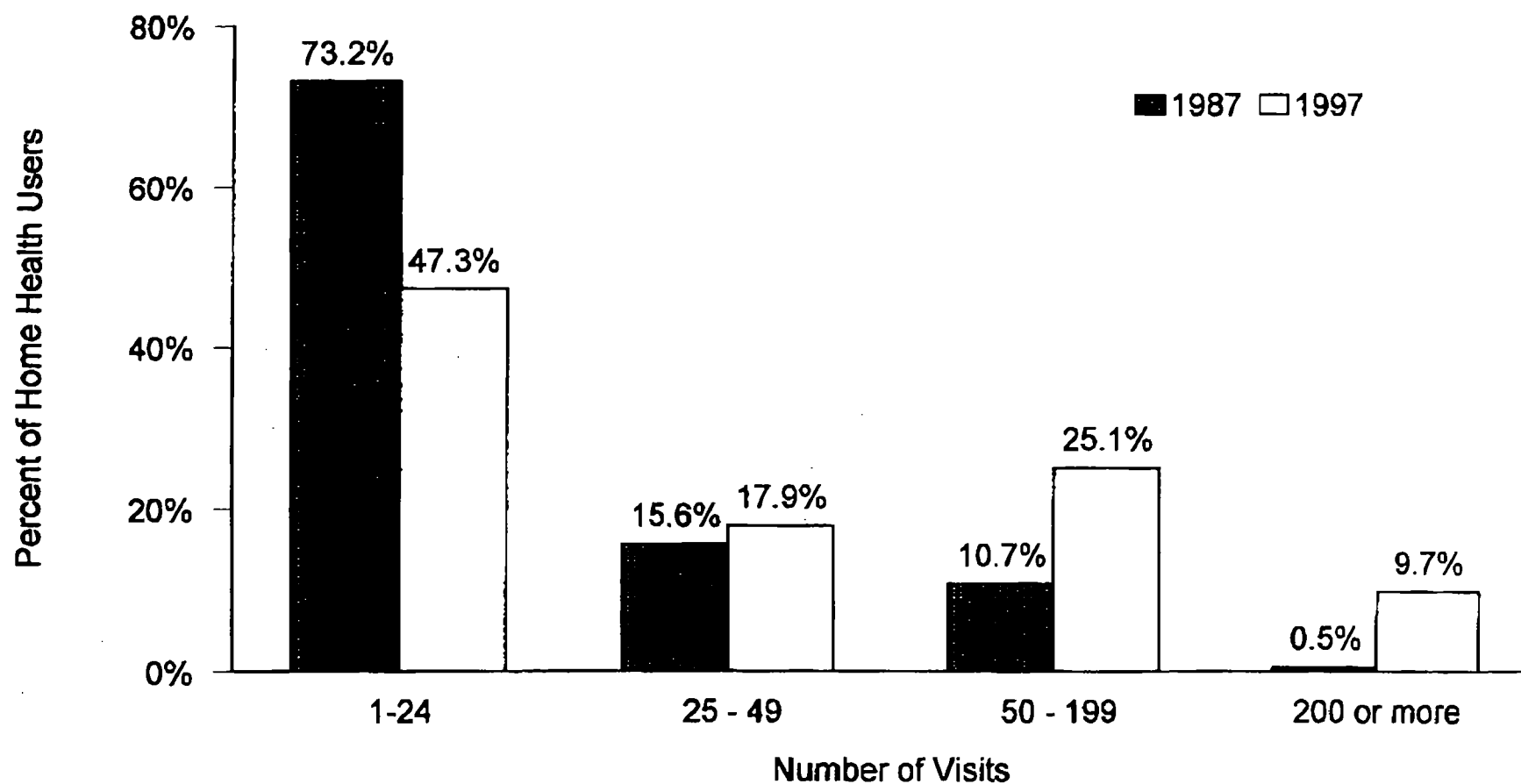
**ADDRESSEE:***Christ Leanne***PHONE:** _____**FROM:** *Bonnie*

**OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201**

PHONE: 202-690-6726**FAX :** 202-690-6262**TOTAL PAGES:****ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:***HH Charts*

Distribution of Home Health Users by Number of Visits, 1987 and 1997

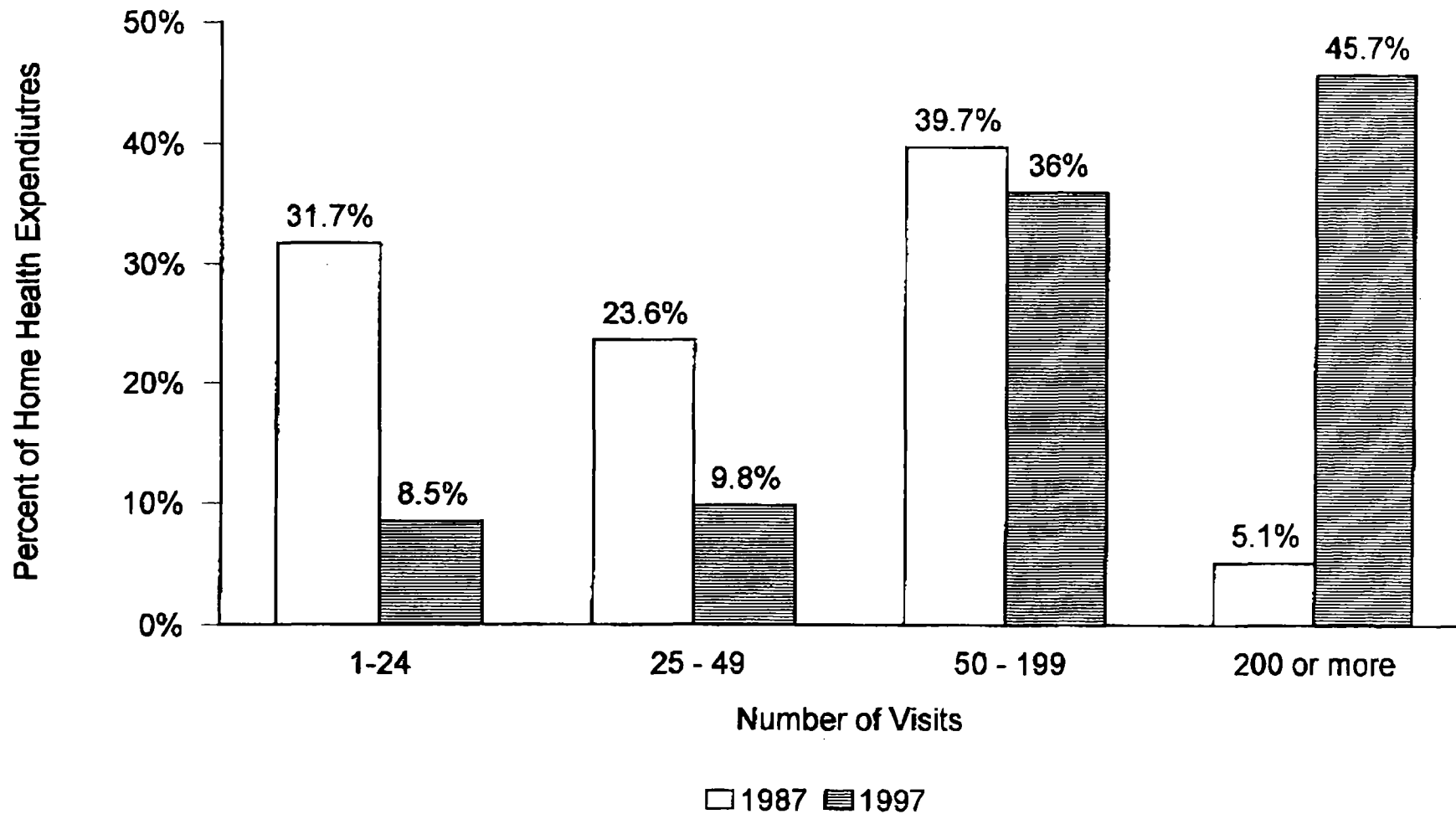
The proportion of users receiving 200 or more visits has grown substantially.



Source: HCFA unpublished data.

Distribution of Home Health Expenditures by Number of Visits, 1987 and 1997

Users with 200 or more visits now account for nearly half of home health spending; in 1987 they accounted for only one-twentieth.

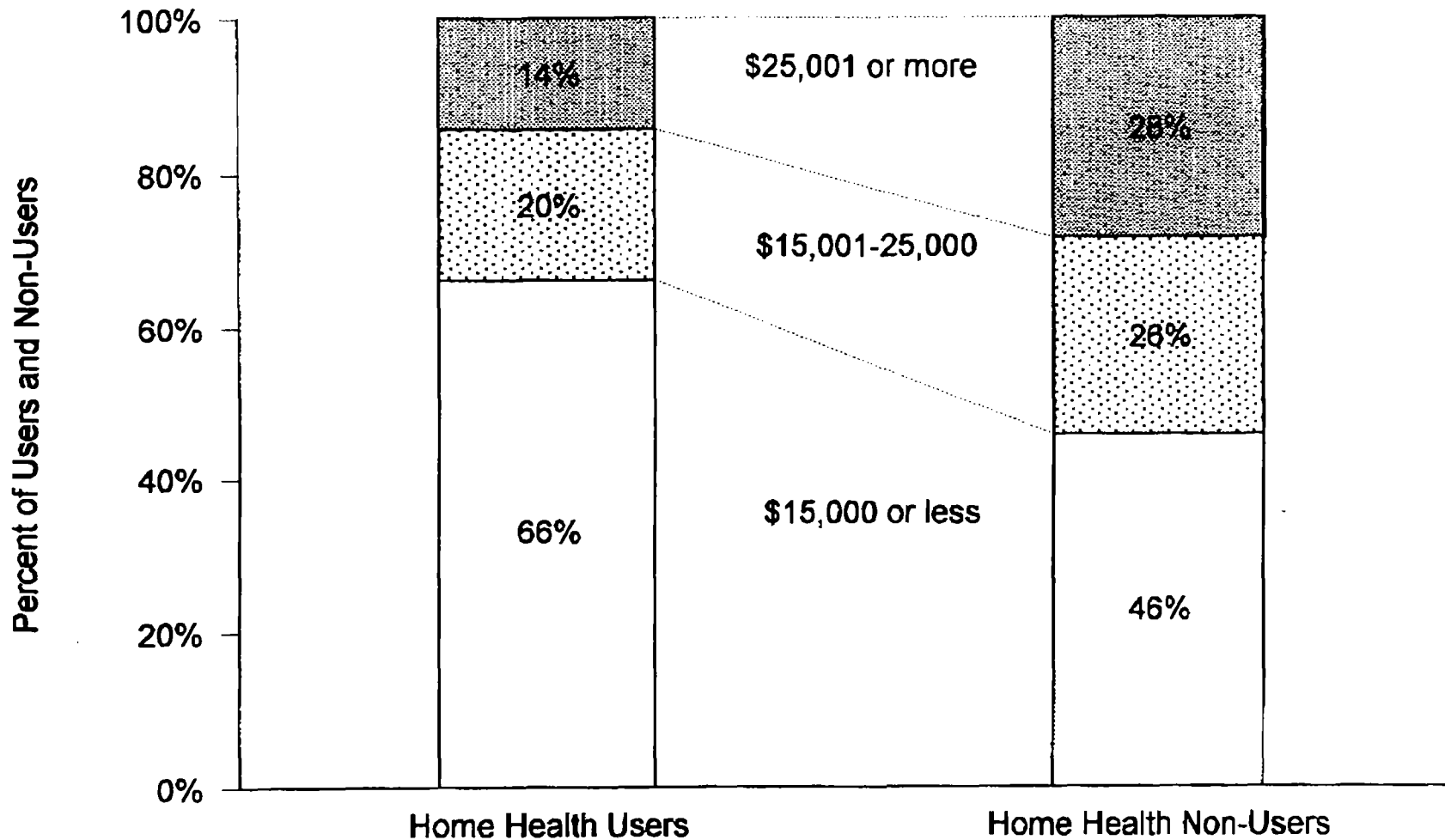


Note: The percentages cited for 1987 data do not sum to 100% due to rounding.

Source: HCFA unpublished data.

Home Health Users and Non-Users By Income

Two-thirds of home health users have incomes of \$15,000 or less.

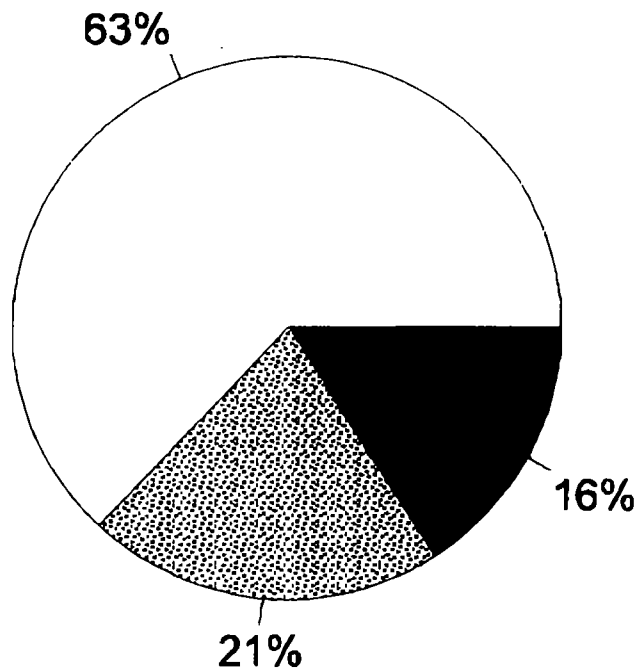


Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

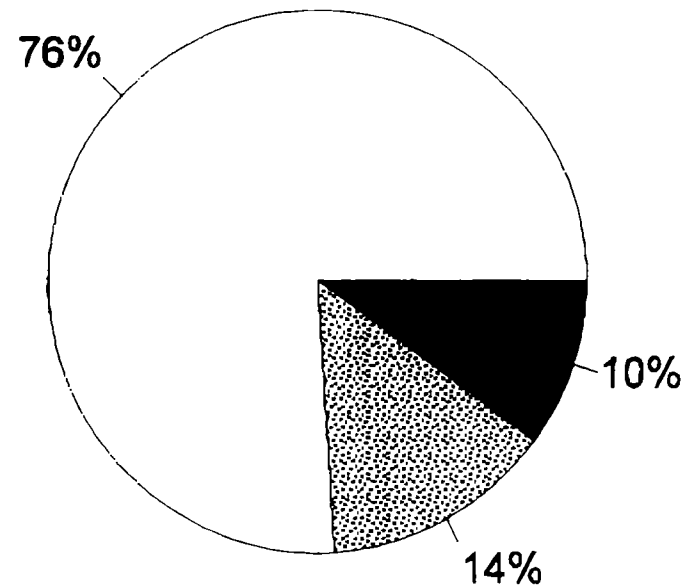
Distribution of Home Health Users by level of Visits and Income

Home health users who receive over 100 visits tend to have lower incomes than those who receive under 100 visits.

Users with 1-100 Visits



Users with Over 100 Visits



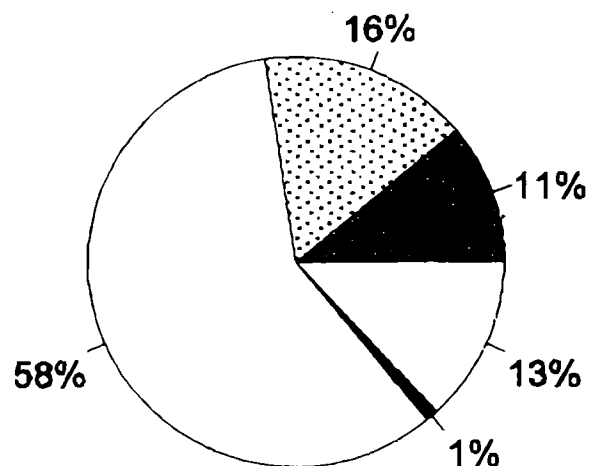
□ Less than \$15,000 ▨ \$15,000 - \$25,000 ■ Over \$25,000

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

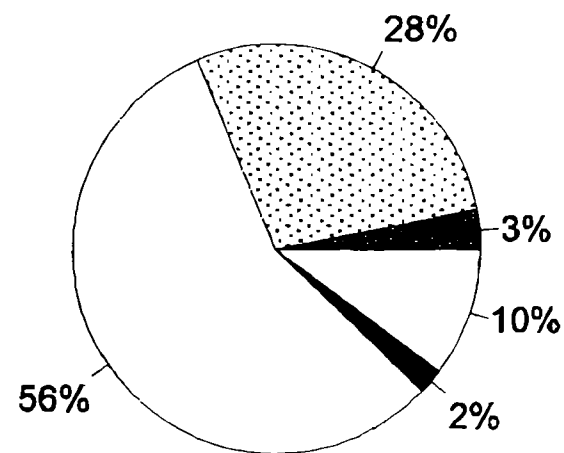
Insurance Coverage for Home Health Users and Non-Users

A greater percentage of home health users have some Medicaid coverage than non-users.

Non-Home Health Users



Home Health Users



■ Medicare HMO ■ Medicaid □ Private Health Insurance ■ Other □ Medicare Only

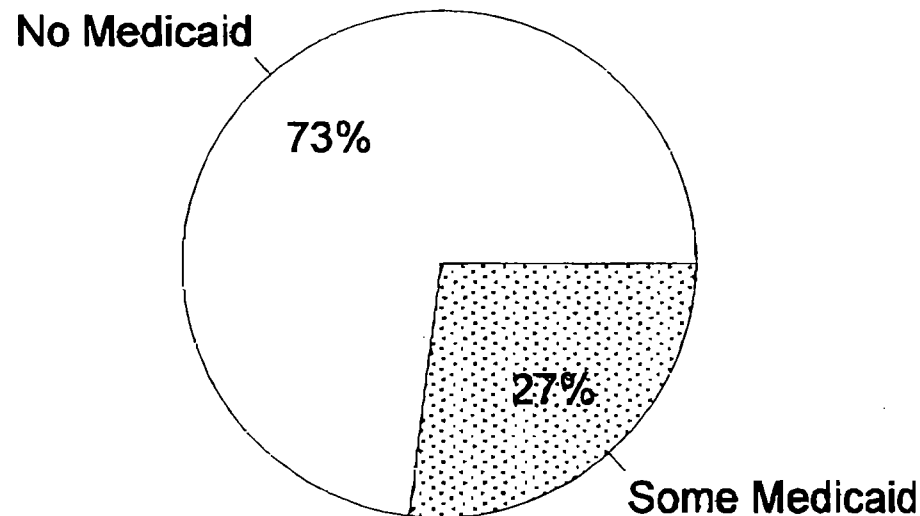
Note: Individuals in Medicare HMOs may have had additional or different insurance coverage sometime during the year. The percentages do not sum to 100 percent due to rounding.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

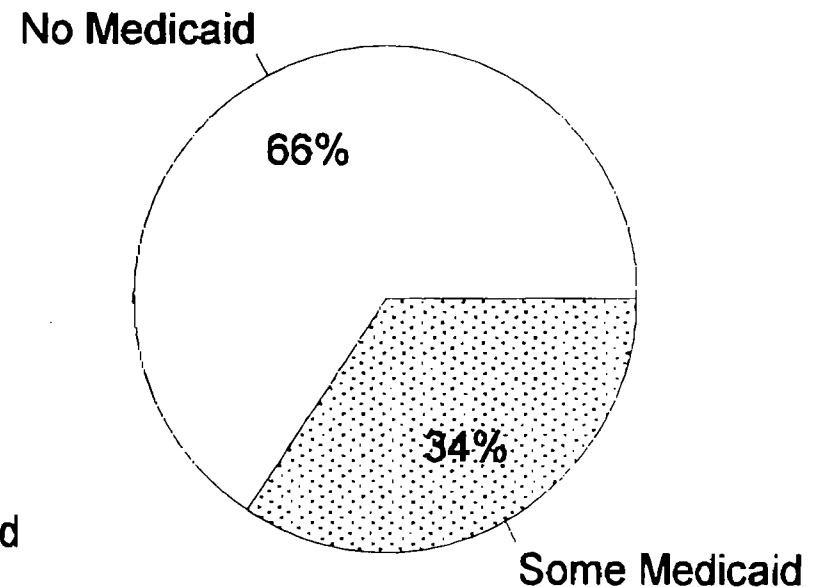
Medicaid Status of Medicare Home Health Users by Level of Visits

Home health users with over 100 visits are more likely to receive some Medicaid assistance.

Users with 1-100 Visits



Users with Over 100 Visits

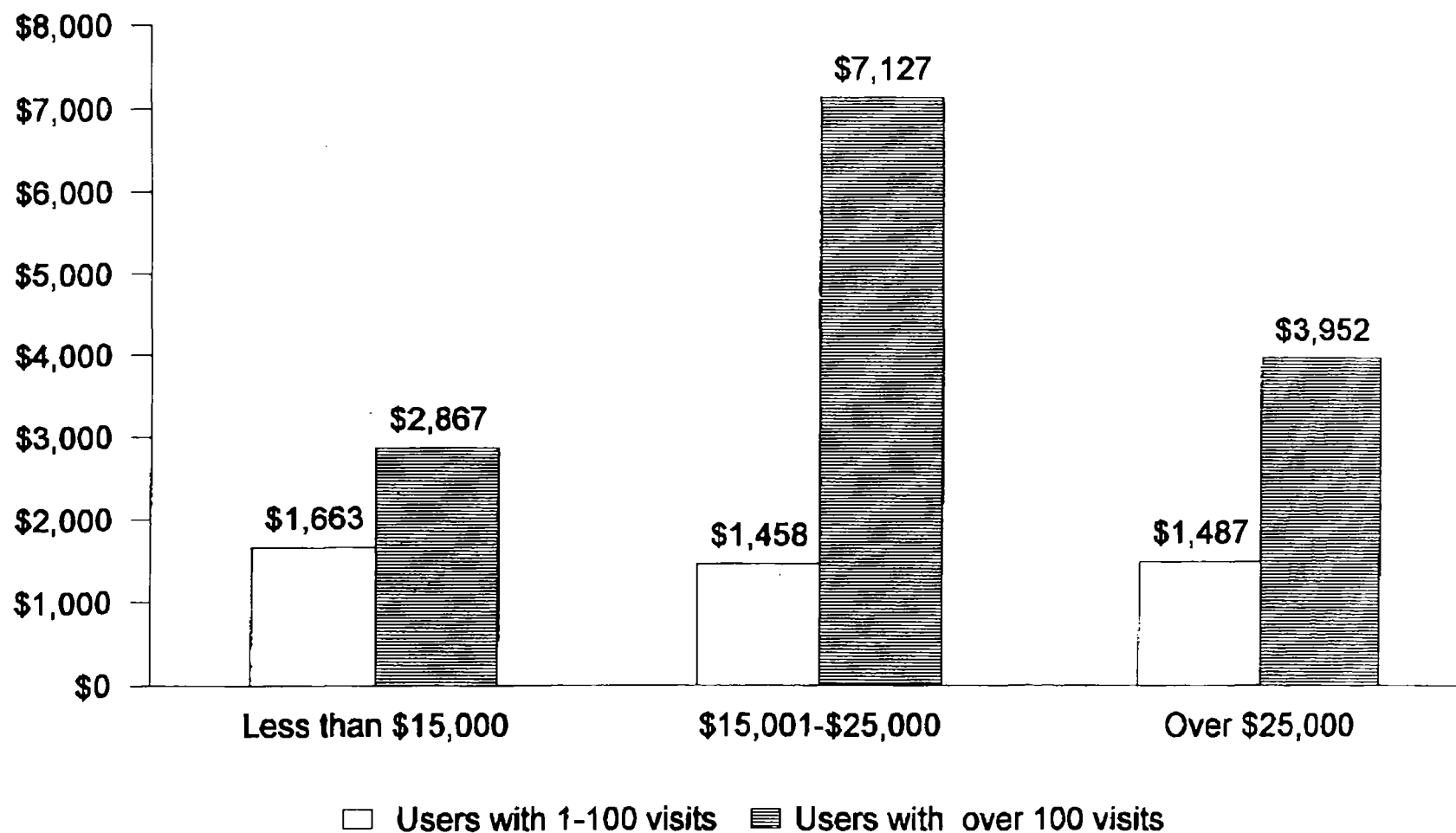


Note: "Some Medicaid" means the beneficiary either qualifies for full Medicaid benefits, or is receiving Medicaid assistance in paying certain Medicare cost sharing requirements as a qualified Medicare beneficiary (QMB) or as a specified low-income beneficiary (SLMB).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Out-of-Pocket Total Health Care Costs for Home Health Users, by Visit Level

Because they are less likely to qualify for Medicaid but cannot afford supplemental coverage, individuals with over 100 visits and incomes from \$15,001-\$25,000 have the highest total out-of-pocket health care costs.

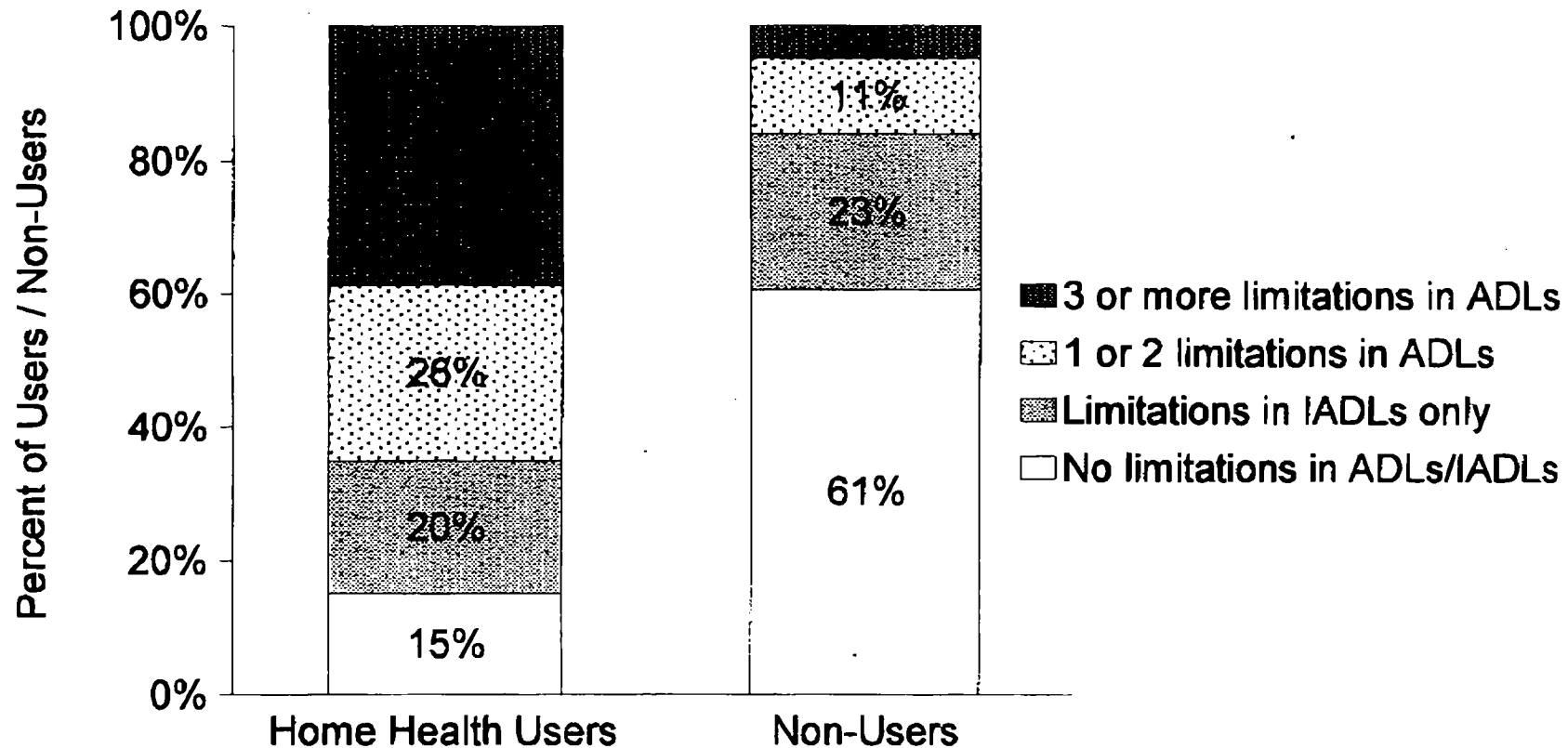


Note: Total out-of-pocket costs includes coinsurance, copayments and deductibles. Medicare Part B premiums and private premiums are not included.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Activities of Daily Living (ADL) Impairments for Home Health Users and Non-Users

Home health users have higher impairment rates compared to non-users.



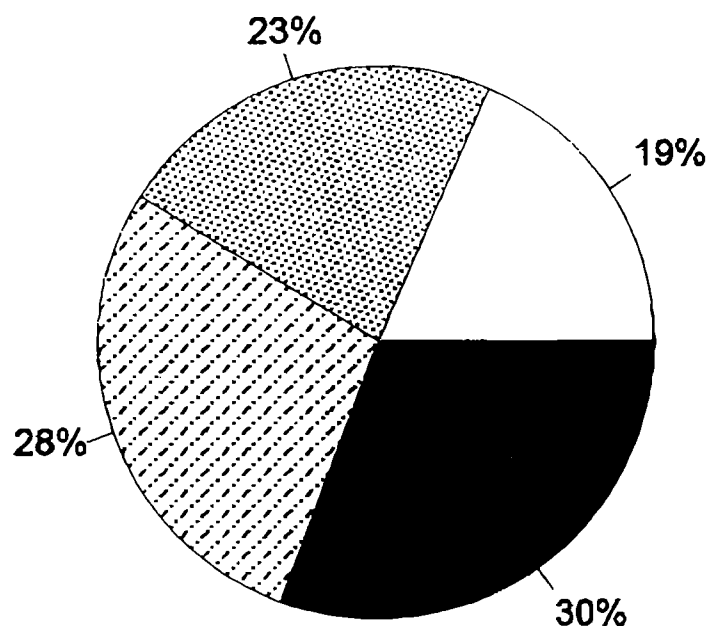
Note: ADL= Activities of Daily Living (e.g., bathing, eating). IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

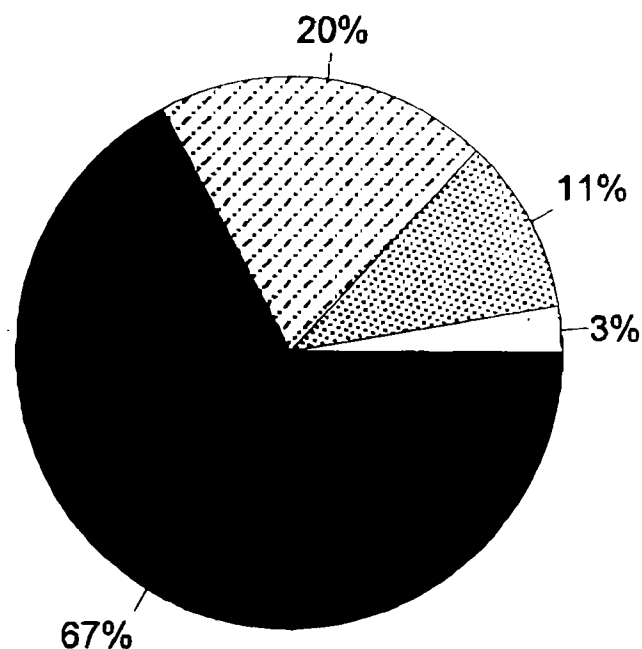
Distribution of Home Health Users by Impairments in Activities of Daily (ADL) and by Level of Visits

Home Health Users with over 100 visits have more functional limitations.

Users with 1-100 Visits



Users with Over 100 Visits



- | | |
|---|--|
| ☐ No limitations in ADLs/IADLs | ☐ Limitations in IADLs only |
| ☐ 1-2 limitations in ADLs | ☐ 3 or more limitations in ADLs |

Note: ADL= Activities of Daily Living (e.g., bathing, eating). IADL = Instrumental Activities of Daily Living (e.g., shopping, use of phone, cleaning). Totals may not sum to 100 due to rounding.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

HEALTH CARE FINANCING ADMINISTRATION

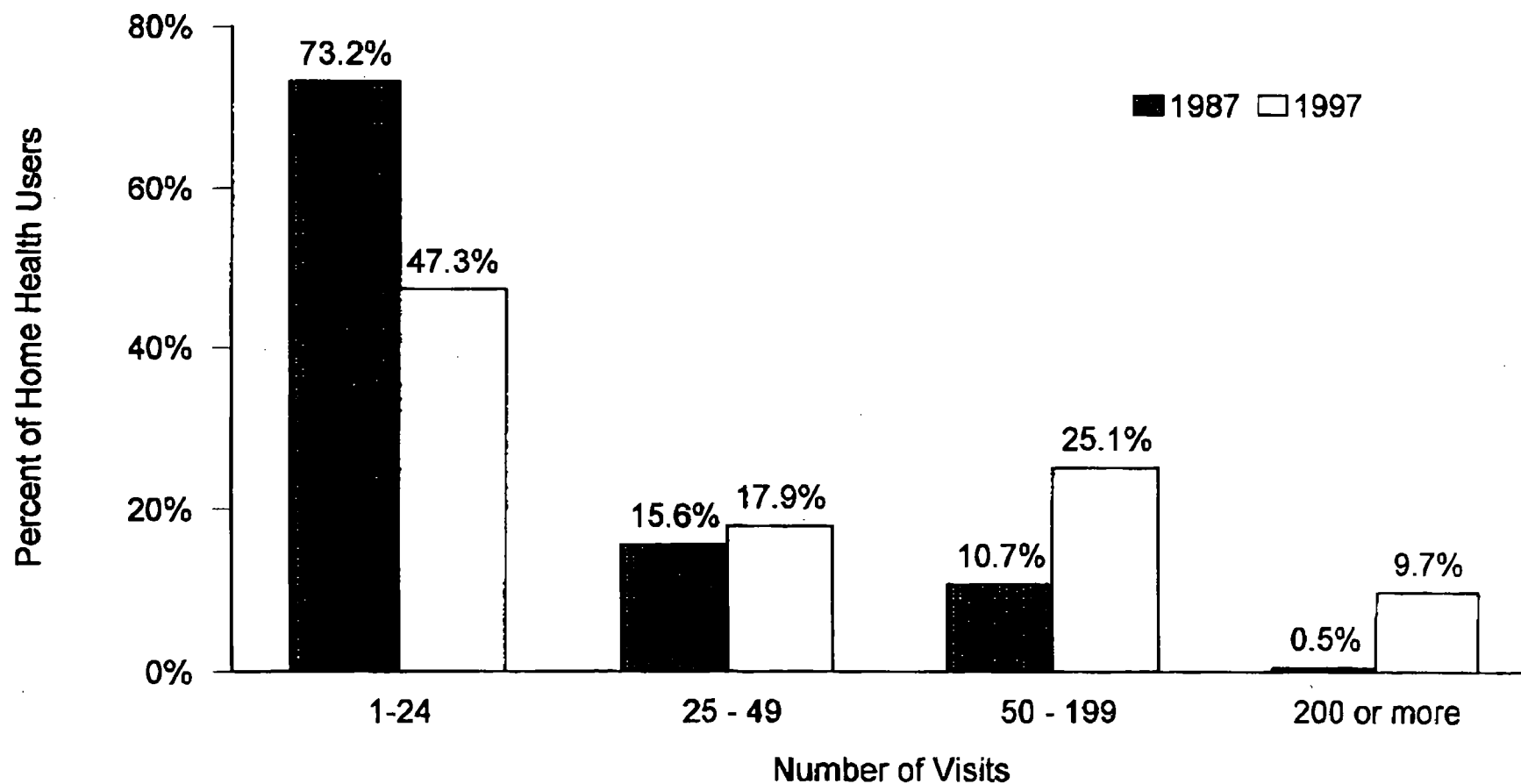
**ADDRESSEE:***Christ Leamy***PHONE:** _____**FROM:** *Bonnie*

**OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201**

PHONE: 202-690-6726**FAX :** 202-690-6262**TOTAL PAGES:****ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:***HH charts*

Distribution of Home Health Users by Number of Visits, 1987 and 1997

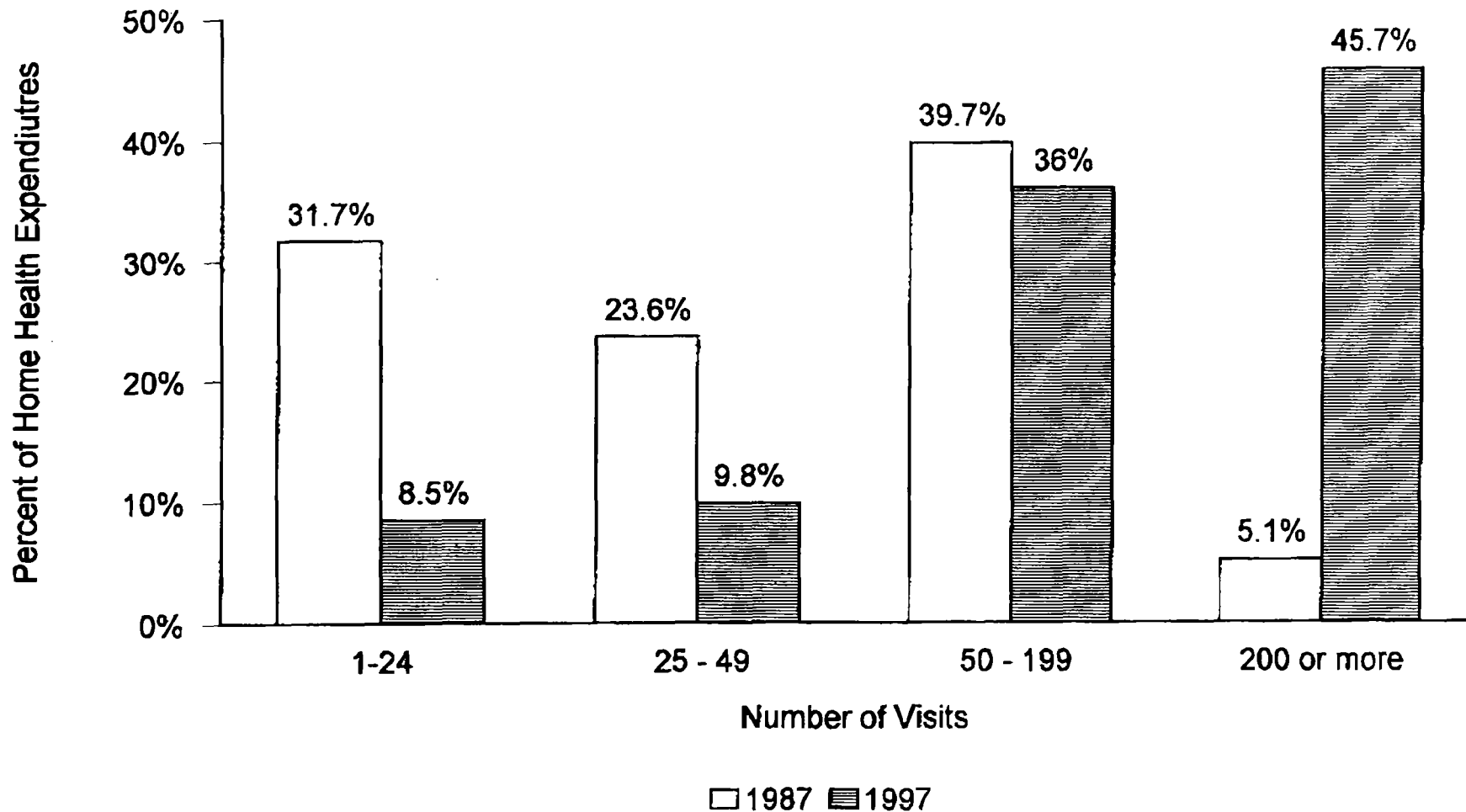
The proportion of users receiving 200 or more visits has grown substantially.



Source: HCFA unpublished data.

Distribution of Home Health Expenditures by Number of Visits, 1987 and 1997

Users with 200 or more visits now account for nearly half of home health spending; in 1987 they accounted for only one-twentieth.

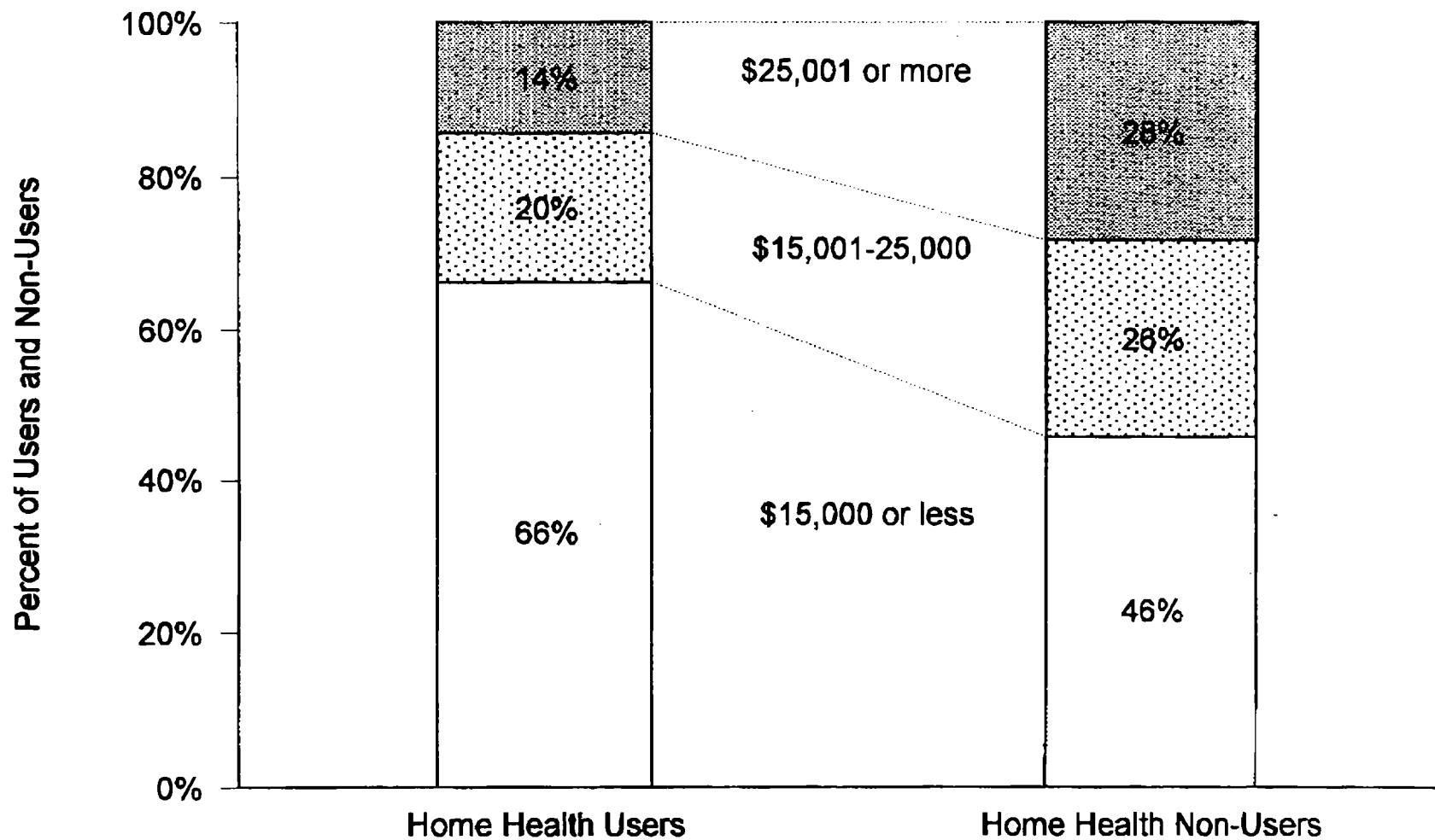


Note: The percentages cited for 1987 data do not sum to 100% due to rounding.

Source: HCFA unpublished data.

Home Health Users and Non-Users By Income

Two-thirds of home health users have incomes of \$15,000 or less.

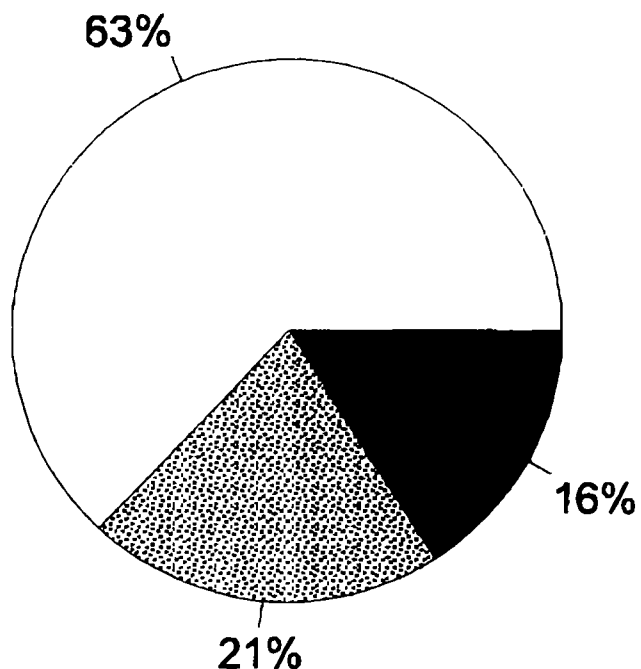


Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

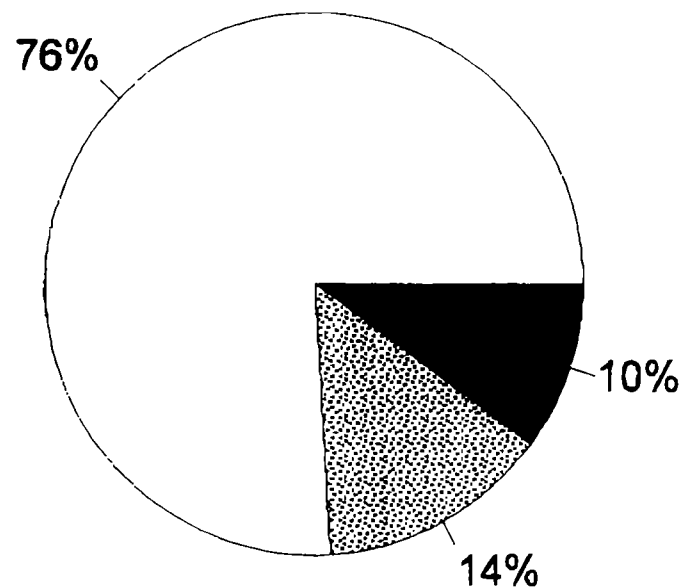
Distribution of Home Health Users by level of Visits and Income

Home health users who receive over 100 visits tend to have lower incomes than those who receive under 100 visits.

Users with 1-100 Visits



Users with Over 100 Visits



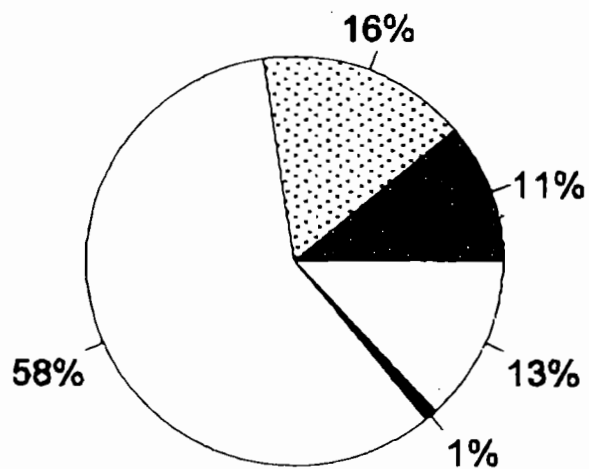
□ Less than \$15,000 ▨ \$15,000 - \$25,000 ■ Over \$25,000

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

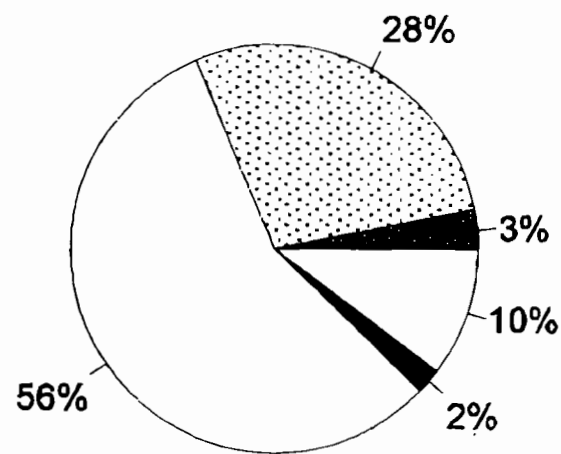
Insurance Coverage for Home Health Users and Non-Users

A greater percentage of home health users have some Medicaid coverage than non-users.

Non-Home Health Users



Home Health Users



■ Medicare HMO ■ Medicaid □ Private Health Insurance ■ Other □ Medicare Only

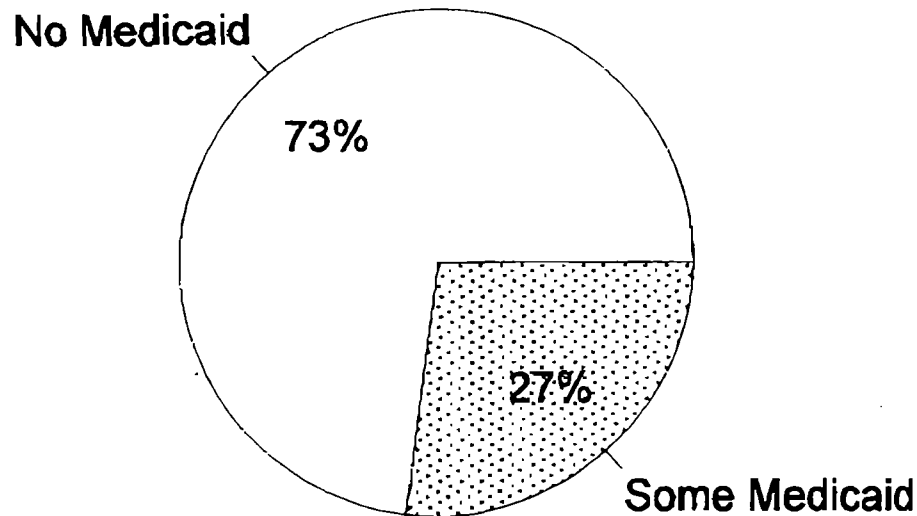
Note: Individuals in Medicare HMOs may have had additional or different insurance coverage sometime during the year. The percentages do not sum to 100 percent due to rounding.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

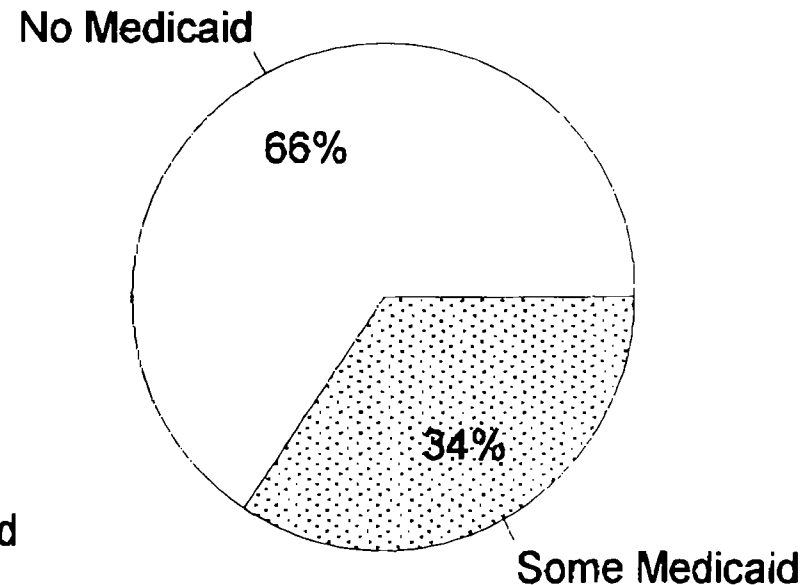
Medicaid Status of Medicare Home Health Users by Level of Visits

Home health users with over 100 visits are more likely to receive some Medicaid assistance.

Users with 1-100 Visits



Users with Over 100 Visits

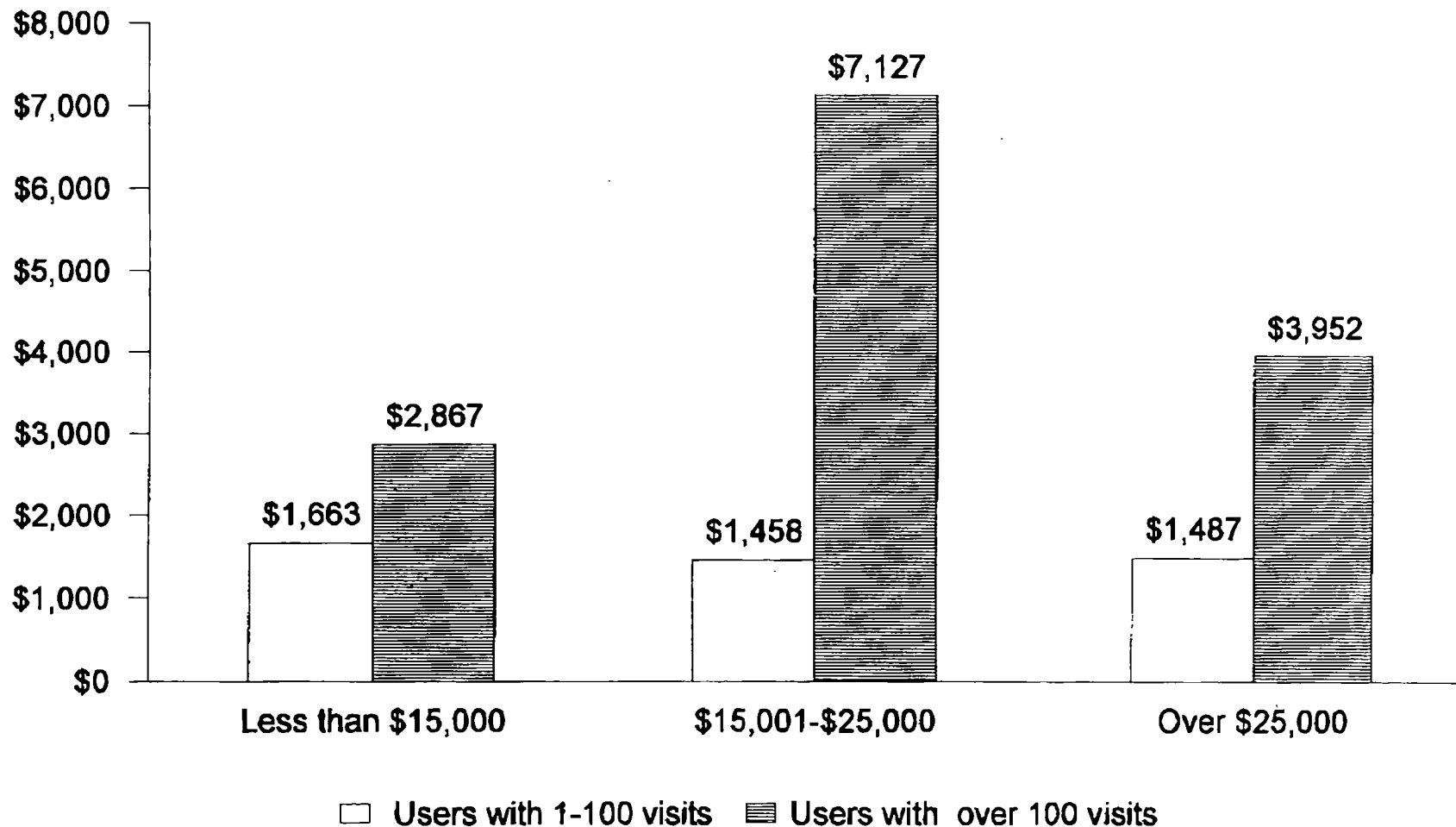


Note: "Some Medicaid" means the beneficiary either qualifies for full Medicaid benefits, or is receiving Medicaid assistance in paying certain Medicare cost sharing requirements as a qualified Medicare beneficiary (QMB) or as a specified low-income beneficiary (SLMB).

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Out-of-Pocket Total Health Care Costs for Home Health Users, by Visit Level

Because they are less likely to qualify for Medicaid but cannot afford supplemental coverage, individuals with over 100 visits and incomes from \$15,001-\$25,000 have the highest total out-of-pocket health care costs.

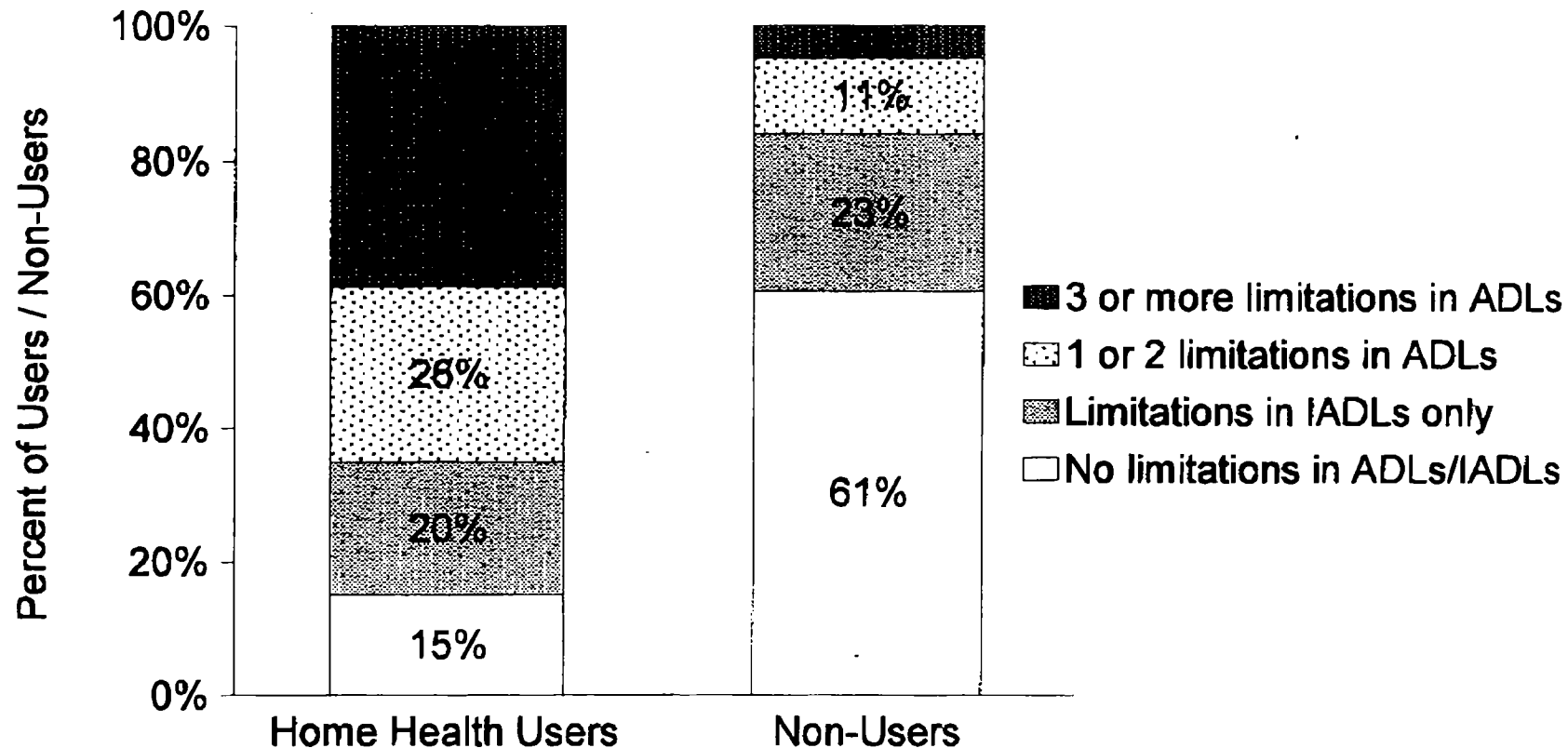


Note: Total out-of-pocket costs includes coinsurance, copayments and deductibles. Medicare Part B premiums and private premiums are not included.

Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

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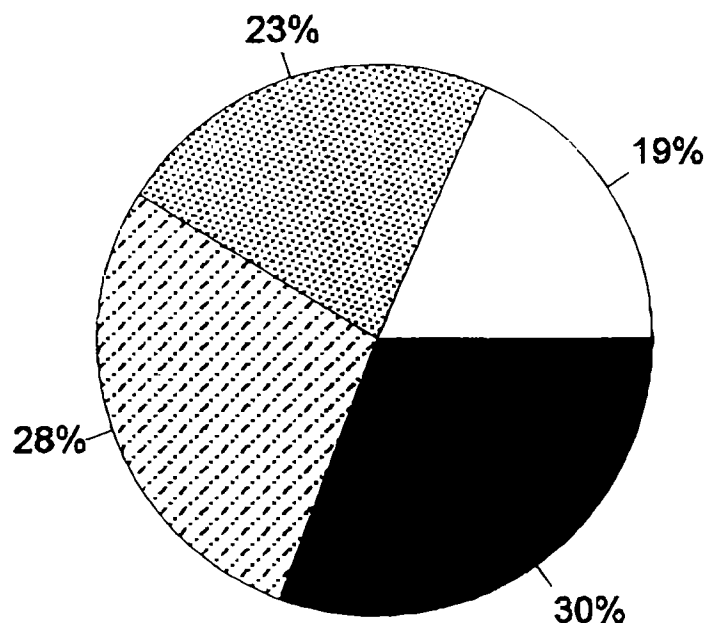
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Source: HCFA/Office of Strategic Planning; data from the Medicare Current Beneficiary Survey, 1995.

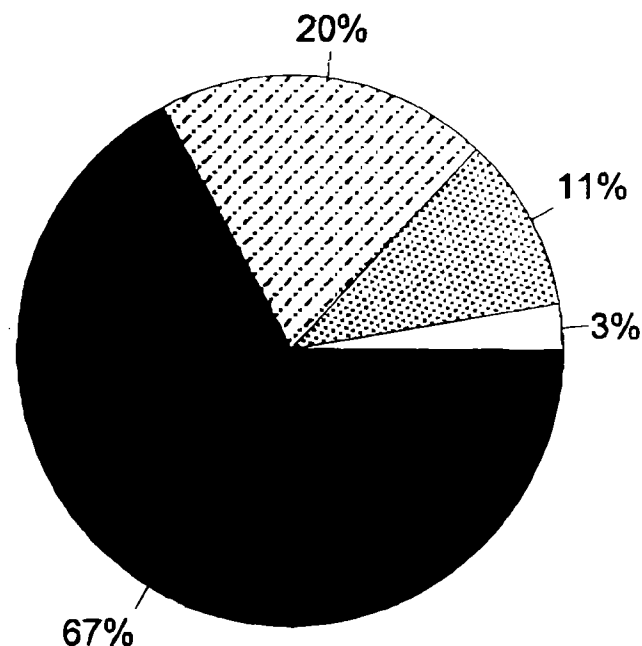
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Source: HCFA/Office of Strategic Planning: data from the Medicare Current Beneficiary Survey, 1995.

Record Type: Record

To: Jeanne Lambrew/OPD/EOP@EOP

cc: douglas_w._elmendorf@cea.eop.gov, William G. Dauster/OPD/EOP@EOP

Subject: Re: Medicare Stream 

Phil Ellis and Mark McClellan at Treasury.

(see Attached stream)

Gene Sperling asked the Social Security team to assume that the net cost of prescription drugs would be about \$30-40 billion over 10 years. This information falls short of what we need in two ways, however: first, we need to know the pattern within the 10 years, and second, we need a series of numbers for 75 years. So David Wilcox and I asked Phil to pick some set of policies that would meet Gene's constraint and then extend that series into the vast future in a sensible way. (Phil grows each of the components of the net drug cost at its own rate and then nets these series, which seems more sensible than taking the net number for year 10 and growing that net number at some arbitrary rate, as we had previously been doing.) Phil and Mark emphasized that they were only guessing, but we insisted that we needed something to get started with.

Refinements would, of course, be welcome.

P.S. I think we
need to revise ~~ass~~.
Please advise

~~Therapy~~ caps

Also, Principals'
Meeting looks like
it is postponed
to Friday. I'll fax
Paper to you as
home.

*B.11 later**(CL2-0563)*

Net Drug Costs: VERY Rough Estimate

2000	0.0	
2001	-1.0	
2002	1.0	
2003	5.8	
2004	6.3	
2005	6.2	
2006	6.1	
2007	4.9	
2008	3.6	sum 2000-09:
2009	2.1	35.00
2010	3.1	
2011	4.1	
2012	5.3	
2013	6.6	
2014	8.1	
2015	8.7	
2016	9.2	
2017	9.8	
2018	10.4	
2019	11.1	
2020	11.8	
2021	12.5	
2022	13.3	
2023	14.1	
2024	15.0	
2025	15.9	
2026	16.8	
2027	17.7	
2028	18.7	
2029	19.7	
2030	20.8	
2031	21.8	
2032	22.9	
2033	24.0	
2034	25.2	
2035	26.4	
2036	27.5	
2037	28.7	
2038	29.8	
2039	31.0	
2040	32.3	
2041	33.5	
2042	34.8	
2043	36.0	
2044	37.3	
2045	38.7	
2046	40.1	
2047	41.5	
2048	43.0	
2049	44.5	
2050	46.0	
2051	47.7	
2052	49.4	
2053	51.2	
2054	53.1	
2055	55.0	
2056	57.1	
2057	59.4	
2058	61.7	
2059	64.1	
2060	66.6	
2061	69.3	
2062	72.1	
2063	74.9	
2064	77.9	
2065	81.1	
2066	84.2	
2067	87.4	
2068	90.7	
2069	94.2	
2070	97.8	
2071	101.5	
2072	105.3	
2073	109.2	
2074	113.3	
2075	117.6	

BASE PACKAGE

(Trustees' 1999 Baseline, Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-04	00-09
PRESCRIPTION DRUG BENEFIT												
\$0 ded., 50% to \$5000 (no catastrophic)	0.0	0.0	6.7	12.9	15.0	17.9	20.7	22.9	24.7	26.7	34.6	147.5
State MOE (Rough)	0.0	0.0	-0.6	-0.6	-0.6	-0.6	-0.6	-0.7	-0.7	-0.7	-1.7	-5.0
NET DRUG COST	0.0	0.0	6.1	12.3	14.4	17.3	20.1	22.2	24.0	26.0	32.9	142.5
<i>Premiums (60% subsidy)</i>	0.0	\$0	\$19	\$20	\$25	\$29	\$33	\$34	\$36	\$38		
COMPETITION												
Managed Care	0.0	0.0	0.0	0.0	0.0	-0.7	-1.5	-2.0	-2.5	-2.8	0.0	-9.5
Modernizing Traditional Program	0.0	-0.6	-0.9	-1.1	-1.3	-1.5	-1.7	-2.0	-2.3	-2.6	-3.9	-14.0
Modified BBA Extenders	0.0	0.0	0.0	-1.1	-2.4	-3.8	-5.5	-7.1	-9.3	-11.5	-3.5	-40.9
INCOME-RELATED PREMIUM												
\$80/100,000	0.0	-0.4	-2.9	-2.6	-2.5	-2.7	-2.9	-3.2	-3.5	-3.8	-8.4	-24.5
COST SHARING												
Eliminating Preventive Copays	0.0	0.0	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.9	2.9
Adding 20% Lab Copay	0.0	0.0	-0.7	-1.0	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-2.7	-9.2
Rationalizing Nursing Home Copays	0.0	0.0	-0.3	-0.4	-0.5	-0.5	-0.6	-0.7	-0.7	-0.8	-1.2	-4.5
Indexing Part B Deductible	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.2	-1.4
MEDICARE SAVINGS	0.0	-1.0	-4.6	-6.0	-7.4	-10.0	-13.2	-16.1	-19.6	-23.0	-19.0	-101.1
TOTAL	0.0	-1.0	1.5	-6.3	7.0	7.2	6.8	6.1	4.4	3.0	13.8	41.4
SURPLUS FOR TRUST FUND SOLVENCY												
	18.3	20.3	28.1	26.9	30.4	33.4	40.8	45.9	50.3	55.6	124.0	349.9

NOTES: Cost sharing estimates, MOE estimates rough estimates/ not done by actuaries BBA extenders reduced pro-rata; cost sharing postponed to 2002 to correspond to drug benefit start.

Record Type: Record

To: Jeanne Lambrew/OPD/EOP@EOP

cc:

Subject: BNA story-you've probably already seen...

Medicare

Clinton Huddles With Advisers to Develop
Medicare Reform Proposal Due Out in June

President Clinton met with senior advisors June 1 to discuss a Medicare reform proposal he plans to announce this month, White House spokesman Joseph P. Lockhart said.

Clinton will announce a proposal either just before he leaves for Europe June 15 or shortly after he returns June 22, Lockhart told reporters. The president pledged in March to offer his own plan when a bipartisan commission failed to endorse a proposal by the commission's chairman, Sen. John Breaux (D-La.).

During a recent holiday in Florida, the president studied a Medicare reform briefing book prepared for him by National Economic Council chair Gene Sperling, Lockhart told reporters. Clinton discussed his options June 1 with outgoing Treasury Secretary Robert Rubin, Treasury Secretary nominee Lawrence Summers, White House Chief of Staff John Podesta, Secretary of Health and Human Services Donna Shalala, Director of the Office of Management and Budget Jacob J. Lew, chief health policy advisor Christopher C. Jennings, administrator of the Health Care Financing Administration Nancy-Ann DeParle, and Sperling for around an hour June 1, Lockhart said.

Jennings has told health care advocacy groups the president's plan will make Medicare more efficient and will use some of the cost-containment strategies employed successfully by private health insurers. Specific approaches include competitive pricing for services like medical supplies and selectively contracting with lower-cost but reliable providers, according to an outline of a presentation Jennings gave in April.

The administration will also examine other ways to reduce overpayments and cut costs, the health policy advisor has said.

No Bill Expected This Year

The president is further committed to guaranteeing and perhaps improving existing benefits as defined under the Medicare system, Jennings told advocates. The president's proposal will provide affordable prescription drug coverage, he said.

Clinton will continue to push for dedicating 15 percent of the estimated \$4.4 trillion 15-year budget surplus--about \$686 billion--to add another 10 years to the solvency of the Medicare Trust Fund, which is expected to be depleted in 2015.

However, a former senior administration official said June 1 reform proposals are unlikely to result in the enactment of any legislation this year.

Medicare is financially in the best shape it has been in for a while and "there is no great public clamor" for reform, the former official told BNA. The official further characterized current reform efforts as motivated by "political urgency rather than a substantive urgency."

By Mark Felsenthal

MEDICARE PRINCIPALS' MEETING

DRAFT: MAY 20, 1999

I. Elements of Reform Package

II. Draft Reform Packages

- Senate Finance Democrats-Like Option
- Base Democrats-Like Option
- Moderate Option

III. Updated Drug Estimates

IV. Budget-Neutral Options

- Medicare "Medigap" Option
- Medicare Board
- Dual Eligible Coordinated Care
- Other

680-7380

To: Rich

I. ELEMENTS OF REFORM PACKAGE COMPETITION

(10-year costs / savings in billions of dollars, fiscal years)

- **Traditional Medicare: Adding Private Sector Tools** **-\$14 b**
 - Series of ideas that are agreed to by all

- **Managed Care: Allowing Price Competition** **-\$10 b**
 - Controversial since some argue that it resembles premium support
 - Options:
 - Do nothing
 - Link maximum government payment to fee-for-service costs
 - Link maximum government payment to national average costs

SAVINGS

- **Providers: Modifications and/or Extension of BBA Policies** **-\$40-50 b**
 - Commission extenders through 2009 (\$57 billion over 10)
 - Options:
 - Administrative actions: Can help hospitals, home health, therapy caps
 - Legislative changes
- **Beneficiaries: Cost Sharing** **-\$5-10 b**
 - Help offsets drug benefit, but controversial
 - Options:
 - Lab, nursing facility, and home health / eliminate preventive cost sharing (-\$10 b)
 - Combine A & B deductible (\$400); prohibit Medigap deductible coverage (-\$10 b)
- **Beneficiaries: Income-Related Premium** **-\$25 b**
 - Recommended since previously supported, progressive financing source

PRESCRIPTION DRUG BENEFIT

- **Base Option:** **-\$160-180**
 - \$0 deductible
 - 50 percent coinsurance up to \$5,000 in spending
 - Beginning in 2002, phased in by 2006
 - 50 percent premium subsidy
- **Additions:**
 - 67 percent premium subsidy
 - Catastrophic: 20 percent coinsurance beyond cap
 - Income-related premium
 - Employer maintenance of effort: If 67% premium subsidy, have employers pay 50% (savings the government 17%)

II. DRAFT REFORM PACKAGES

1: SENATE FINANCE DEMOCRATS-LIKE OPTION

Competition:

Modernizing Traditional Medicare -\$15

Managed Care Competition: *Lower premiums for low-cost private plans* -\$10

Savings:

Providers: Reformed Balanced Budget Act Extenders -\$50

Legislative Balanced Budget Act Fixes --

Beneficiaries: Income-Related Premium: *(\$50,000 single, \$75,000 couple)* -\$35

Cost Sharing Changes: *Home health, nursing home & lab copay* -\$20

No preventive copays, single deductible (\$400), no Medigap deductible coverage

Prescription Drug Option:

67% premium (\$25-30): *\$0 deductible, 50% copay to \$5,000, 20% thereafter* +\$180

New Financing:

Tobacco tax: *Additional \$0.45 on top of budget* -\$40

Budget-Neutral Proposals:

Medicare Medigap Option: *Unsubsidized option to buy catastrophic cost sharing coverage*

New Medicare Board: *Private oversight board for private plans*

Dual Eligible Funding: *Gives states Medicare payments to manage care*

New Trustees' Report: *Combines Part A and B; creates new section on overall Medicare*

2: BASE DEMOCRATS-LIKE OPTION

Competition:

Modernizing Traditional Medicare	-\$15
Managed Care Competition:	na

Savings:

Providers:	Reformed Balanced Budget Act Extenders	-\$50
	Legislative Balanced Budget Act Fixes	+\$10-25

Beneficiaries: Income-Related Premium:	na
Cost Sharing Changes:	na

Prescription Drug Option:

67% premium (\$15-20): \$0 deductible, 50% copay to \$5,000, 20% thereafter	+\$180
---	--------

New Financing:

Surplus: One-third of amount dedicated to Medicare	-\$115
--	--------

Budget-Neutral Proposals:

Modernizing Medicare Management:	Series of admin, leg proposals to improve oversight
Coordinated Care for Dual Eligibles:	Develop coordination model for Medicare/Medicaid

3: MODERATE OPTION

Competition:

Modernizing Traditional Medicare	-\$15
Managed Care Competition: <i>Lower premiums for low-cost private plans</i>	-\$10

Savings:

Providers: Reformed Balanced Budget Act Extenders	-\$50
Legislative Balanced Budget Act Fixes	+\$10-25

Beneficiaries: Income-Related Premium: <i>(\$80,000 single, \$100,000 couple)</i>	-\$25
Cost Sharing Changes: <i>Home health, nursing home & lab copay</i>	-\$10
<i>No preventive copays,</i>	

Prescription Drug Option:

67% premium (\$25-30): <i>\$0 deductible, 50% copay to \$5,000, 20% thereafter</i>	+\$180
--	--------

New Financing:

Tobacco tax & additional provider or beneficiary cuts OR surplus:	-\$80-100
---	-----------

Budget-Neutral Proposals:

Medicare Medigap Option: <i>Unsubsidized option to buy catastrophic cost sharing coverage</i>	
Modernizing Medicare Management: <i>Series of admin, leg proposals to improve oversight</i>	
Coordinated Care for Dual Eligibles: <i>Develop coordination model for Medicare/Medicaid</i>	
New Trustees' Report: <i>Combines Part A and B; creates new section on overall Medicare</i>	

III. UPDATED DRUG ESTIMATES

[done tomorrow]

IV. BUDGET-NEUTRAL OPTIONS

MEDICARE “MEDIGAP” OPTION

- **Issue:** About 90 percent of Medicare beneficiaries have some form of supplemental insurance to pay for Medicare’s high cost sharing.
 - Typical Medigap premium: \$1,000 to \$3,000
 - Access problems: AARP is the only nationwide insurer [add]
- **Option:** Unsubsidized Medicare Medigap option
 - Provides stop-loss for base Medicare services (\$2,500 annual)
 - Reduces cost sharing to nominal levels and eliminates hospital cost sharing
 - Expected premium (without selection): \$50 to \$60 per month

MEDICARE MEDIGAP OPTION

- **Pros:**
 - Viewed as structural reform – one of major points for premium support advocates and economists
 - Moves towards private sector benefits package
 - Mitigates against cost sharing increases
- **Cons:**
 - Opposed by insurers and conservatives as a government take-over
 - Risks being selected against / becoming expensive
 - Complicated policy that may not be worth the political gain

MEDICARE BOARD

- Commission Proposal:
- Alternative:

DRAFT

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Hospitals	Repeal the Transfer Provision	AHA	Legislative	The transfer provision requires Medicare to reduce payments to hospitals that transfer patients to another hospital, or unit, skilled nursing facility, or home health agency after a shorter than average length of stay. The transfer policy applies to only ten DRGs. \$1.3 or 5
Hospitals	Limit Impact of Outpatient PPS <i>Academy Health Panel</i>	AHA	Legislative	While HCFA is considering various proposals to limit the impact of the OPD PPS, existing authority would have this happen on a budget neutral basis. AHA is asking for new spending which they estimate will be \$1.9 billion
Hospitals	Establishment of a Clinical Education Trust Fund that Both Private and Public Payers Contribute	AHA AAMC	Legislative	
Hospitals	Make Medicare+Choice Payment Rates More Uniform Nationwide	AHA	Legislative	Would like Congress to make additional dollars available so blend works as Congress intended. Note that in 2000, blend rates in effect in 63% of counties.
Hospitals 	Carve-Out DSH Payments from Medicare Payments to Medicare+Choice Plans	AHA AAMC	Legislative	Would like payments to go directly to hospitals that incur the cost of caring for those who cannot pay.
Hospitals	Eliminate the Volume Expenditure Cap Included in the Proposed Outpatient Prospective Payment System Regulation	AHA	Legislative	The statute currently requires us to develop a mechanism for controlling volume. HCFA could potentially delay imposition of a volume expenditure cap for a few years.

J

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Hospitals	Remove the \$510 Million Cut in Outpatient Reimbursement Included in the Proposed Outpatient Prospective Payment System Regulation.	AHA	Legislative	Copayment would be calculated according to a different formula resulting in higher beneficiary copayments.
Teaching Hospitals	Eliminate IME Cuts Included in the BBA	AAMC	Legislative	Included in the BBA, the IME adjustment rate was reduced from 7.0 percent to 5.5 percent over 4 years. <i>70 - in 66</i>
Teaching Hospitals	Eliminate DME and IME Caps Included in the BBA	AAMC	Legislative	
Home Health Agencies	Grant home health agencies overpayment forgiveness for payments in excess of their IPS limits.	NAHC	Legislative	
~~Home Health Agencies~~	Under IPS, develop outlier payments for sicker patients (or some mechanism for patient or case-mix adjustments).	NAHC	Legislative	
Home Health Agencies	Eliminate the mandatory October 1, 2000, 15% reduction in the limits. <i>ease-up</i>	NAHC	Legislative	<i>→ 2000 at 5.1% - 7% - cutting in 66</i>
Home Health Agencies	Increase home health per visit cost limits to 112% of the mean, rather than 106% of the median, lift the application of the freeze to the cost limits, and require that the data used to calculate the limits be based on all types of home health agencies, including hospital-based programs.	NAHC	Legislative	

Rural

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
~~Home Health Agencies~~	Reimburse agencies the full costs agencies will incur in implementing and continued management of OASIS.	NAHC	Legislative	
~~Home Health Agencies~~	Delay OASIS by requiring HHAs to begin implementing OASIS based on the amount of advance time and data actually needed for the development of a home health PPS.	NAHC	Legislative	
~~Home Health Agencies~~	Restore the full market basket update to home care payments.	NAHC	Legislative	\$5 billion \$900 million in \$
Home Health Agencies	Oppose coinsurance for Medicare and Medicaid home health services.	NAHC	Legislative	Currently, there is no copayment in Medicare home health. However, the Medicare Commission is proposing a 10 percent copayment.
Home Health Agencies	Repeal or significantly alter the surety bond requirements, applying them only to agencies with poor records of repayment to Medicare and/or Medicaid or to new agencies wishing to participate in the program(s). Requirements should be reasonable so that legitimate, reputable home care agencies can meet them.	NAHC	Legislative	The surety bond proposed rule is being developed for publication later this year. The rule will include a \$50,000 bond and will not be effective until PPS begins on 10/1/00.

High cost patients
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Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Home Health Agencies	Enact homebound definition that ensures access and eligibility to the home care benefit based upon the beneficiary's functional limitations and clinical condition. 	NAHC	Legislative	Currently, eligibility requirements include physician certification that the patient is under a physician's care; a plan of care developed by a physician; physician certification that the patient is confined to the home; and need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology, or continued occupational therapy. The BBA requires the Secretary to report to Congress on the study of the homebound issue and make recommendations by 10/1/98. This report is currently under clearance in the Secretary's office. We recommend retaining the current homebound policy.
Home Health Agencies	Provide HCFA with authorization to issue emergency no-interest payments to health care providers where Medicare claims processing, payment, and payment rate updates are delayed as a result of incomplete or erroneous Y2K computer changes. Reimbursement limits should be adjusted and payments for home health agencies to allow completion of Y2K compliance efforts.	NAHC	Legislative	

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Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Skilled Nursing Facilities	Legislate exceptions to the therapy caps	AHCA AOTA APTA ASHA AAHSA	Legislative	These groups had tried in the 105th Congress to eliminate the caps entirely, but have focused their efforts in the 106th on backing the Grassley bill which would allow exceptions to the caps. OACT scores the bill at about \$2.6 billion over the 5 year period, 2000-2004. \$1 \$2 SN
Skilled Nursing Facilities	Outlier policy for medically complex patients RUCS act 1 yr	AHCA NSCA AACP NSCLC	Legislative	These groups are unhappy with the way the SNF PPS rates account for non-therapy ancillary services (including drugs) and support higher PPS payments for medically complex patients. The BBA does not specify an outlier policy for SNFs.
~~Skilled Nursing Facilities~~	~~Exclude non-therapy ancillary services from the PPS rates. Drug payments~~	~~AHCA NASL AACP~~	~~Legislative~~	~~This is another proposal supported by industry groups to increase payments for non-therapy ancillary products and services. The BBA specifically requires that these types of services be bundled into the rates. A December GC memo states that HCFA can not do this administratively.~~
~~Skilled Nursing Facilities~~	~~Fight reductions in baseline spending~~	~~AHCA NASL NSCA~~	~~Legislative~~	~~This proposal reflects the belief that the amount of savings from the SNF PPS provision in the BBA has increased from about \$9 billion to about \$16 billion because CBO has adjusted their baseline. CBO has not, however, rescored the provision.~~

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Managed Care Organizations	Delay implementation of M+C risk adjustment	AAHP HIAA BCBS	Legislative	In support of this proposal, AAHP and HIAA note concerns with using an in-patient based methodology and with data collection and transmission. HIAA suggests a demonstration of the methodology and capping the impact at 1% of payments. AAHP also noted the exclusion of 1-day hospital stays.
Managed Care Organizations	Implement M+C risk adjustment on a budget neutral basis	AAHP HIAA	Administrative	AAHP characterizes this as one element of a "fairness gap", indicating that relative to Medicare FFS payments, the national average 7.6% impact of implementing risk adjustment contributes to M+C payments being only 82% of FFS in 2004. The starting point for AAHP's analysis is that pre-BBA rates were 95% of fee-for-service costs. However, taking favorable selection into account, they were actually in the range of 102-110% of fee-for-service costs.
Managed Care Organizations	Modify method for updating M+C rates -- no very specific proposals o AAHP suggests linking rates more closely to local FFS spending o HIAA suggests assuring that they cover medical inflation	AAHP HIAA	Legislative	One approach to increasing payments would be to drop the 0.5% reduction in the update in 2001 and 2002. Additionally, the reductions for 1998-2000 could also be given back in 2001.

Provider Type	Proposal	Supporting Organizations (1)	Legislative or Administrative	Comments
Managed Care Organizations	Modify M+C "user fee" provisions so M+C plans are not the source for all funding for M+C information activities	AAHP HIAA	Legislative	Administration's FY2000 budget includes a proposal to increase the authorization from \$100 million to \$150 million for FY 2000 and beyond. Alternative funding mechanisms were considered and rejected during the FY2000 process.

- (1) Organizations that have expressed support in public statements such as Congressional testimony or press releases or in meetings with HCFA. Other organizations may also support these proposals.

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MAJOR ISSUES AND POLICIES

An infinite number of policies, goals, and outcomes could be considered in designing a plan to strengthen and improve Medicare. Many of the available options have been taken off the table for policy and political reasons, but even with this screening, a large number remains.

The following is a preliminary list of the key questions that we have been using to assist us in developing options. The next page contains a list of the options being considered.

- **Savings Options**
 - What is a viable level of provider and beneficiary savings
 - What is the ideal ratio of beneficiary savings to provider savings
 - What is the ratio of total Medicare reform savings to drug costs
- **Reform Options**
 - What, if any, competitive reforms should be included in the proposal
 - Should the plan include cost sharing rationalization (e.g., applying consistent copayments across the program and using savings to reduce excessive cost sharing, improve benefits, or fund a prescription drug benefit)
- **Drug Benefit Design**
 - What is the highest beneficiary premium that could be supported
 - What is the best mix of deductibles, copayments, and benefit caps
 - Do we support a high copay, even if that potentially reduces needed utilization
 - How aggressive should the drug management be, recognizing the tradeoff between lower costs and greater industry opposition
 - How comparable is the benefit design to plans in market today
- **Use of Surplus / Impact on Trust Fund**
 - What is the minimum number of years added to the Trust Fund that is acceptable
 - How much, if any, of the surplus can be used for the drug benefit? If any, what should be the ratio of surplus to Medicare savings / beneficiary contributions

MAJOR MEDICARE POLICIES UNDER CONSIDERATION

POLICY	IN BREAU-THOMAS	STATUS
TRADITIONAL MEDICARE		
Extending / modifying BBA policies	Yes, as a placeholder	Considering modifications to address concerns of providers
Giving traditional Medicare more private sector cost containment tools	Yes	Assumed in plan
MANAGED CARE / COMPETITION		
Combining A & B deductible	Yes	Considering modifications to make Medicare more competitive while protecting traditional Medicare
COST SHARING CHANGES		
Combining A & B deductible	Yes	Under consideration
Eliminating preventive cost sharing	Yes	Under consideration
Ending hospital coverage limits	Yes	Under consideration
Replace SNF coverage limit w/20% copay	Yes	Under consideration
Adding a 20% lab coinsurance	Yes	Under consideration
Adding a 10% home health copay	Yes	Considering a 10% copay with a limit after a certain number of visits to protect high users
Adding catastrophic coverage	No	Probably too expensive
PRESCRIPTION DRUG BENEFIT		
Voluntary Medicare benefit	No (Medicaid)	Yes
OTHER REFORMS		
Income-related premium	No	Under consideration
Raising Medicare's age eligibility	Yes	No
Medicare buy-in for 55-65	No	Yes
Ending Medicare funding / liability for graduate medical education	Yes	Policy / politically problematic; could consider with significant modifications
Merging the Part A & B trust fund	Yes	No – opens up discussion of capping general revenue contribution to Medicare
Medicare board	Yes	Not in the way it is currently formulated. Examining options.
FINANCING		
Surplus for Medicare	No	Yes

AGENDA: MEDICARE PRINCIPALS' MEETING

JUNE 9, 1999

- I. DRAFT OPTION**
- II. OUTSTANDING POLICY ISSUES**
- III. CHALLENGES IN ROLL-OUT**

I. DRAFT OPTION

I. MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

Managed Care Competition:

- \$7

Begins in 2004; fully adjusts for geographic variation, with hold harmless

Modernizing Traditional Medicare

- \$14

Competitive pricing for negotiated pricing and selective contracting

Medicare PPO

Primary care case management

Stronger prior authorization and utilization review

Selected "Centers of Excellence" Global payments for services, sites or conditions

Incentive payments for qualified integrated delivery arrangements

Contracting reform

Providers: Smoothing Out BBA Extenders*

- \$44

DROPPED: Nursing home, home health, DSH extenders. Straight BBA extenders = \$62 billion.

Hospital PPS update for urban hospitals of market basket minus 1.0 for 2003-09

Hospital PPS update for rural hospitals of market basket minus 0.5 for 2003-09

Hospital PPS capital reduction of 1 percent for 2003-09

Hospital PPS exempt update of relationship between operating cost and target amount for 2003-09

Hospital PPS exempt capital reduction of 15 percent for 2003-09

Hospital outpatient department update of market basket minus 1 for 2003-09

Hospice update of market basket minus 1 for 2003-09

Lab update of CPI – 1 for 2003-09

Ambulatory surgical center, durable medical equipment, prosthetics & orthotics, parental nutrients update of CPI –1

Improving Medicare Management

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Increasing management flexibility to improve ability to hire private sector staff. Increasing accountability:

Management Advisory Committee, Medicare Coverage Advisory Committee & Citizens' Advisory Panel on

Medicare Education; Restructuring central and regional office system

II. MODERNIZING MEDICARE'S BENEFITS

Prescription Drug Benefit (placeholder: 50% up to \$5,000; 55% premium subsidy) +\$137

Improving Preventive Benefits +\$3

Eliminating all preventive services cost sharing

Conduct major information campaign to encourage beneficiaries to use services

Expanding the mission of the U.S. Preventive Services Task Force to provide periodic recommendations on services for Medicare beneficiaries

Conducting a demonstration of the cost effectiveness of smoking cessation drugs and counseling

Rationalizing Cost Sharing and Medigap Reform -\$15

Adding 20 percent laboratory coinsurance (-\$9 billion)

Indexing the Part B deductible (-\$1.5 billion)

Changing the skilled nursing facility copayment (-\$4.5 billion)

Add a new Medigap plan option that allows for nominal (rather than no) cost sharing

Allow access to Medigap for beneficiaries whose managed care plan withdraws from Medicare

Direct the Secretary of Health and Human Services and the National Association of Insurance Commissioners to update benefits in all Medigap plans

Improving Care Coordination for Dual Eligibles

Information to all new Medicare-Medicaid beneficiaries on coverage

Demonstration of financing / management options for coordinating care

Medicare Buy-In for Certain People Ages 55-56 (paid for in President's Budget)

People ages 62-64

Displaced workers ages 55-62

"Broken promise" people

III. FINANCING THAT SUPPLEMENTS PROVIDER AND BENEFICIARY SAVINGS

Dedicated Surplus for Strengthening Medicare (amount not counted toward savings)

Income-Related Premium - \$25
Begins at \$80,000 single, \$100,000 couple

Medicare Tobacco Lawsuit?

Interactions: +\$2

TOTAL SAVINGS: - \$100

DRUG BENEFIT: 50% up to \$5,000 limit, 55% premium subsidy +\$137

Handwritten calculations:
100 / 37 = 2.7
100 / 74 = 1.35
2.7 + 1.35 = 4.05
4.05 * 25 = 101.25

PRESCRIPTION DRUG BENEFIT OPTIONS (\$ BILLIONS -- Preliminary -- Excludes Maintenance of Effort)										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	00-09
\$5,000 LIMIT	<u>Cap:</u>	<u>\$2,000</u>	<u>\$2,000</u>	<u>\$3,000</u>	<u>\$4,000</u>	<u>\$5,000</u>	<u>indexed</u>			
50% Premium	0	5.4	10.5	12.3	14.8	17.2	19.0	20.6	22.3	122.2
Medicaid		0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	3.4
Total		5.9	11.0	12.8	15.3	17.6	19.4	21.0	22.7	125.6
<i>Premiums</i>		\$24	\$25	\$31	\$36	\$41	\$43	\$45	\$48	
 55% Premium	0	5.9	11.6	13.6	16.3	18.9	20.9	22.6	24.5	134.4
Medicaid		0.4	0.4	0.4	0.3	0.2	0.2	0.2	0.2	2.2
Total		6.3	12.0	13.9	16.6	19.2	21.1	22.8	24.7	136.7
<i>Premiums</i>		\$22	\$22	\$28	\$33	\$37	\$39	\$41	\$43	
 60% Premium	0	5.8	12.7	14.8	17.8	20.7	23.0	24.9	26.9	146.6
Medicaid		0.3	0.3	0.2	0.2	0.1	0.0	0.0	0.0	1.0
Total		6.1	13.0	15.0	17.9	20.7	23.0	24.9	26.9	147.6
<i>Premiums</i>		\$19	\$20	\$25	\$29	\$32	\$34	\$36	\$38	
 67% Premium	0	7.2	14.1	16.5	19.8	23.0	25.4	27.5	29.7	163.0
Medicaid		0.2	0.2	0.1	0.0	-0.2	-0.2	-0.3	-0.3	-0.6
Total		7.4	14.2	16.6	19.8	22.8	25.2	27.2	29.4	162.5
<i>Premiums</i>		\$16	\$17	\$21	\$24	\$27	\$29	\$30	\$32	
 NO LIMIT:	<u>Cap:</u>	<u>\$2,000</u>	<u>\$3,000</u>	<u>\$3,000</u>	<u>\$4,000</u>	<u>\$5,000</u>	<u>None</u>			
50% Premium	0	5.4	11.8	13.1	15.0	17.3	21.2	24.4	27.0	135.1
<i>Premiums</i>		\$24	\$30	\$31	\$36	\$41	\$51	\$54	\$58	
 67% Premium	0	7.2	15.7	17.5	20.0	23.0	28.3	32.6	36.0	180.3
<i>Premiums</i>		\$16	\$20	\$21	\$24	\$27	\$34	\$36	\$39	

II. OUTSTANDING ISSUES

- **Balanced Budget BBA fixes:** What to include, if anything
 - Pay for transition to national rates for hospital outpatient departments +0.8
 - Keep indirect medical education adjustment at 6.5% through 2002 +1.6
 - Nursing homes: address high-cost cases +0.9
 - Relieve pressure on therapy caps +1.9
- **Cost sharing:** Final sign-off
- **Size of Drug Benefit:**
 - Amount of subsidy; catastrophic coverage or not
- **Surplus:**
 - Timing, amount, ratios, stream
- **Process for POTUS sign-off:** Meeting or memo

CHALLENGES IN ROLL-OUT

- **Overall Package:**

- Impact on Trust Fund
- Impact on Beneficiaries – Ratio of beneficiary premiums and cost sharing to drug premium subsidy. Ratio of provider to beneficiary savings
- Out-year balance of cost and savings

- **Surplus for Drugs:**

- Rationale
- Ratio of financing through savings / surplus

- **Drug Benefit:**

- Examples of how it works, who it helps
- Defense against criticism of substitution; not enough (no catastrophic coverage)

- **Competition:**

- How to explain
- How to differentiate from Breaux-Thomas plan
- How to fend off industry claims of unfair competition, benefit reductions
- **Provider savings:**
 - How justified in light of BBA / why no BBA fixes (if so decided)
 - All backloaded
- **Cost Sharing:**
 - Who is helped / who is hurt
 - Is this reform without adding catastrophic coverage
- **Medicare management**
 - Does plan give HCFA too much flexibility
 - Why not adopt the Breaux-Thomas Medicare board