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MEDICARE REFORM

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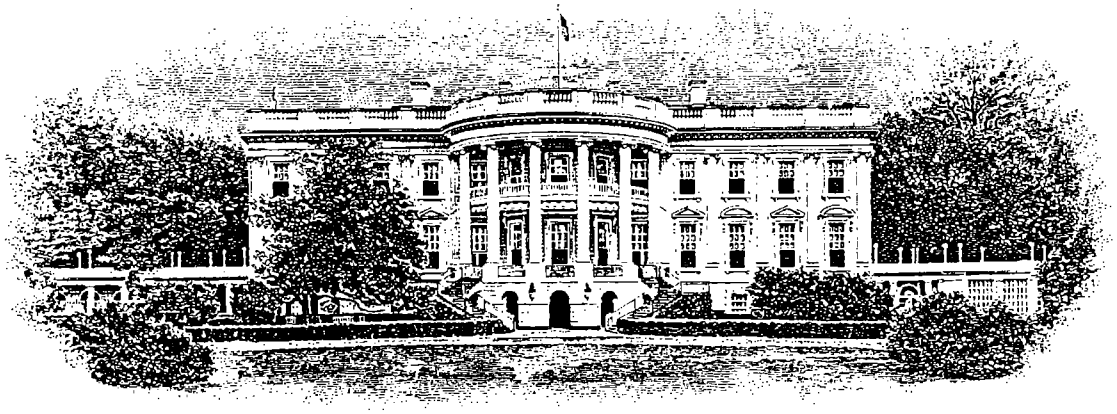
The White House



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

February 3, 1999

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

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

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

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

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

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

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

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Medicare Analysis

The Medicare Reform Debate: What Is the Next Step?

by Henry J. Aaron and Robert D. Reischauer

Abstract: Medicare costs are rising faster than projected revenues. Action to close the emerging deficit is inescapable. We propose converting Medicare from a "service reimbursement" system to a "premium support" system. These changes would resemble many that are now reshaping private employer-based insurance. Our reform would encompass not just the "public" Medicare program but also the "real" Medicare, which includes the supplemental plans to which most Medicare beneficiaries have access. Approved plans would have to offer stipulated services. We review numerous technical issues in moving to a new system that cannot be solved quickly and that preclude quick budget savings.

Medicare is at the core of two current policy debates. One centers on the steps needed to balance the federal budget over the next seven to ten years. The other focuses on how existing entitlement programs might best be modified to cope with the retirement of the baby-boom generation, which will begin at the end of the first decade of the twenty-first century. Cuts in Medicare undertaken to balance the budget now will probably contribute only modestly to meeting the second, more serious challenge; realistically, measures designed to deal with the consequences of the baby-boom generation's retirement will contribute little to short-run deficit reduction. This paper describes a reform proposal designed to address the second of these issues: the long-range future of Medicare.

Five central facts will shape the debate on the future of Medicare. First, Medicare enjoys overwhelming support among the American electorate, a popularity that is well deserved because the program has achieved all of its designers' major objectives. Second, the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts. Third, legislative reform of the entire health care system is now off the political agenda and likely will remain so for years to come. Fourth, there exists a strong and broad consensus against raising taxes. Fifth, dramatic changes are taking place in the way health care is financed and delivered for the non-Medicare population.

The implications of these facts are straightforward. First, before changes are made in Medicare, policymakers will have to assure the general population and beneficiaries alike that the reforms will not compromise the attributes of the program that the public values so much. Second, Congress will have to act soon to restore Medicare's financial viability. Third, the measures that Congress adopts will not be part of any major legislative effort to reform the overall health care system. Fourth, most, if not all, of the budgetary savings on Medicare will come from reducing federal payments to providers and raising costs to beneficiaries, not from raising Medicare payroll taxes. Fifth, congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.

Henry Aaron is director of the Economic Studies Program at The Brookings Institution. Robert Reischauer, formerly head of the Congressional Budget Office, is a senior fellow in that program.

Health Affairs, Volume 14, Number 4

Popularity And Success: A Brief History Of Medicare

Two views on how to provide assistance. Before the enactment of Medicare, few retired elderly or nonworking disabled persons had reliable health insurance coverage. The private insurance that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. The elderly and disabled feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it. To address these problems, President Lyndon Johnson proposed the Medicare program in February 1964.

The debate around this initiative displayed two conflicting principles about how government should act when private-sector services are inadequate. One view is that government should assist only those persons who are too poor to buy the service. The principle behind this approach is that, with few exceptions, markets should be permitted to allocate all goods and services. A compassionate society should provide aid to the destitute. But this assistance should disturb the operation of markets as little as possible, it is argued, because markets have intrinsic virtues, such as efficiency and consistency with the principles of personal autonomy and freedom.[1]

The other view holds that the best way, on balance, to provide some types of assistance is through a universal entitlement—aid available without regard to personal income or means but based on some more or less objective indicator of need. Advocates of this approach invoke arguments based on social solidarity or efficiency; they simply assert that, despite the value of markets in other contexts, certain goods and services should be provided to everyone at some basic level.

When Congress approved Medicare, it embraced the second philosophy by establishing a universal entitlement to stipulated benefits for everyone age sixty-five and older who has worked in a job subject to payroll taxation or who is a spouse of an entitled worker.[2] At the time, some Republicans and southern Democrats opposed this view and agreed to support Medicare

only if other Democrats would embrace a companion program of health care benefits available only to those with incomes and assets below quite modest levels. The Republican program, Medicaid, replaced various state programs of health care assistance for the poor with an open-ended federal matching grant that imposed various federal mandates and restrictions. The compromise legislation, which incorporated both programs, passed in the House of Representatives by a vote of 307 to 116 on 27 July 1965 and in the Senate by a vote of 70 to 24 the next day. President Johnson signed the Social Security Amendments of 1965, as this momentous legislation was so ingloriously called, on 30 July 1965.

Political alignments have changed over time. A new cadre of conservative representatives and senators now sees Medicaid not as the preferred method of financing health care for the indigent but as federal meddling in a domain in which states should not be hindered and as an element of a welfare system that works to the long-term disadvantage of those whom it is intended to help. They would like to see Medicaid transformed into a block grant under which each state would be given a fixed sum that it could use with few federal restrictions to provide health care services to the indigent. Some also would convert Medicare from a universal entitlement into means-tested assistance. Several proposals along these lines would impose higher costs on participants with high incomes; others would provide a voucher to assist participants who wanted to leave the program to buy private coverage in the marketplace.[3]

Growth in popularity and costs. Together with supplemental (Medigap) policies, Medicare has provided elderly and disabled persons with access on a nondiscriminatory basis, and with an unrestricted choice of providers, to the same health services that workers and their families enjoy. Moreover, beneficiaries are heavily subsidized.[4] Thus, the program's extreme popularity is understandable. The public's support for Medicare is reflected in the positions taken by politicians, few of whom seem prepared to acknowledge that Medicare benefits may need to be cut. However, it is clear that something fundamental will have to be done to modify the program because of the unsustainable growth of its projected costs.

The explosive growth of Medicare costs is neither new nor mysterious. Almost from its inception, Medicare has proved to be more costly than anticipated. The projection that the Health, Education, and Welfare actuaries made in 1965 that in 1990 the Hospital Insurance part of Medicare (Part A) would cost $9.061 billion, less than one-seventh of its actual level, has often been used to underscore this point.[5] Over the 1970s Medicare expenditures grew at an annual rate of 17.5 percent and in the 1980s at 12.1 percent; costs are projected to grow at a rate of 10.3 percent in the 1990s. While growth per enrollee has been rapid, Medicare grew less rapidly than national or private health care spending over 1984–1993.[6]

Some of the program's overall growth is attributable to increases in the number of beneficiaries, which has expanded by about 2.5 percent per year since 1968. Not all of the increase in beneficiaries reflects increased numbers of aged persons—the original focus of the program; legislation passed during the 1970s added disabled persons and persons suffering from end-stage renal disease (ESRD) to the program.

Benefit expansion also has contributed some to the growth in costs. For example, to the list of covered services Congress has added hospice care; mammography; Pap smears; hepatitis, influenza, and pneumococcal pneumonia vaccines; and kidney dialysis and transplants. Administrative actions also have expanded services; the redefinition of allowable home health and skilled nursing facility services has contributed significantly to cost increases in recent years.

Although benefits have increased somewhat over the program's thirty years, the Medicare benefit package remains comparatively parsimonious. In contrast to typical employer-sponsored insurance, Medicare provides no benefits for outpatient drugs and provides poor catastrophic coverage. In addition, Medicare deductibles and copayments for inpatient hospital services—currently $716 for the first day of hospitalization and $179 per day for hospitalization of more than sixty but fewer than ninety-one days per year—are far higher than those of typical private insurance plans.[7] Like most private health plans, Medicare does not cover long-term nursing home services and does not provide dental or vision coverage. It does, however, pay for home health services and short-term skilled nursing facility services. Medicare's benefit package is less generous than about 85 percent of private health plans. The program covers only about 45 percent of the total annual health care bill of the elderly, who, on average, spend considerably more out of pocket on health care than the nonelderly spend.[8] Medicare benefit cuts would only increase these disparities.

The major contributor to the explosive growth of both Medicare and other health care costs has been the increased capabilities of medicine. The proliferation of medical technology has produced many new diagnostic tools, procedures, treatments, and drugs. Few people advocate policies that might dampen this source of cost growth, nor would it be reasonable to deny Medicare participants the fruits of medical advances available to those with employer-sponsored or private health insurance.

Some Considerations Relevant For Reform

Successful and sensible Medicare reform must build on an appreciation of the way in which the current program operates, of its central charac-

teristics, and of the larger health care environment of which it is a part. Reformers must be aware of the limited contribution Medicare now makes to covering the health care expenditures of the aged and disabled, the program's bifurcated structure, the limited role of managed care, the potential under the existing payment structure for pernicious competition on risk selection, the uncertainty of cost projections, and the interaction between Medicare and Medicaid.

Public Medicare and "real Medicare." The federally financed Medicare benefit package is not the health insurance plan that most Medicare participants actually live with. Approximately 65 percent of elderly and disabled Medicare participants also are covered by employer-sponsored retiree plans or private Medigap plans, or both.[9] These plans supplement Medicare, usually by covering deductibles, copayments, some prescription drugs, and hospitalization beyond ninety days.[10] In addition, approximately 16 percent of Medicare participants also have some sort of Medicaid coverage. About 12 percent are categorically eligible (Supplemental Security Income recipients) or meet state Medicaid eligibility standards.[11] For these "dual eligibles," Medicaid pays Medicare Part B premiums, deductibles, and copayments and covers services—primarily prescription drugs and long-term care—that are covered by Medicaid but not Medicare. For those with incomes below the poverty line who are not dually eligible (qualified Medicare beneficiaries, or QMBs), Medicaid pays Part B premiums, deductibles, and coinsurance. The key point is that persons who are covered one way or another by Medicaid, like those with Medigap and retiree policies, face low or no deductibles and little or no cost sharing.

The public Medicare system, therefore, does not define the health care system in which most Medicare-eligible persons participate. Instead, most live with a hybrid system that comes in two forms, both of which have the public Medicare program as their base. For most, the hybrid is a blend of Medicare, which is available to most elderly and disabled persons for very modest premiums (now $46.10 per month), and employer-sponsored retiree coverage or private Medigap insurance. This version has a benefit package that is much more generous than that of Medicare alone. However, if a former employer is not paying at least part of the cost of the supplemental coverage, the cost of this version of the hybrid is considerably more than the cost of Medicare alone. Monthly Medigap premiums average about $70.[12] The second form of the hybrid, a blend of Medicare and Medicaid, offers even more generous benefits and costs the beneficiary less than Medicare alone or the other form of the hybrid.

Most discussion of Medicare reform focuses on the public program alone, not the hybrid system. But because the large majority of beneficiaries live with the coverage and incentives of the hybrid system, sensible policy

change can be formulated only by considering how best to transform the entire system. Not doing so risks adopting ineffectual reforms or reforms that have unintended consequences, which can be illustrated by examining a commonly advocated policy for reducing Medicare costs: increasing the Part B deductible and raising coinsurance.

In most private insurance plans, deductibles and coinsurance serve to discourage the use of low-benefit care. Deductibles also spare insurers the administrative cost and spare the insured person the added premiums to cover the cost of processing many small claims. Because the Medicare Part B deductible is relatively low, its effect in these respects is limited. At $100 a year, it is well below the typical deductible for private insurance and only one-eighth what it was in 1967 relative to annual average per capita charges. The coinsurance for most Part B services, 20 percent, is similar to that of private plans. However, some services, such as clinical laboratory, home health, and skilled nursing facility services for the first twenty days, require no coinsurance. Some critics of the current system have suggested that increasing the Part B deductible, extending coinsurance to all services, and raising it to 25 percent would curtail the use of low-benefit services and reduce administrative costs. Federal spending thereby would be held down and concentrated on more costly episodes of illness.

Under current arrangements, however, Medicare deductibles and coinsurance do not serve their intended purposes, and increasing them would not have the intended effects. Except for the 18 percent who lack supplemental coverage, Medicare beneficiaries do not face coinsurance because retiree supplements, Medigap, or Medicaid typically pays it.[13] Many supplementary policies also pick up the Part B deductible. Increases in coinsurance or deductibles, therefore, would not materially reduce use of low-benefit care or deter nuisance claims. Instead, retiree policies and Medigap vendors would liberalize their coverage of coinsurance and deductibles and would boost premiums. A few people might drop Medigap coverage or buy less-generous coverage, and they might demand somewhat fewer medical services. But most Medicare beneficiaries would either keep their supplemental coverage and pay the higher premium or let Medicaid pay the higher coinsurance and deductible.

While doing little to reduce low-benefit services and nuisance claims, increases in coinsurance and deductibles would transfer costs from the Medicare trust fund to Medicare eligibles (for those with Medigap insurance), their former employers, or other accounts in the federal budget and the states. While such transfers may or may not be desirable, there may well be better ways to accomplish them.

One implication of the foregoing discussion is that retiree, Medigap, and Medicaid coverage actually increase the budget cost of Medicare, by short-

circuiting the economizing effects of deductibles and cost sharing on demand and administrative costs. Supplemental insurance increases Medicare costs by raising the use of Medicare-covered services, but these added costs do not show up in the premiums for these policies.

To reform the hybrid, public/private Medicare system that people actually use and pay for, it will be necessary to consider the systemic effects of changes in the public program. Reform of Medicare should not be confined to the public program but should encompass rules affecting the sale and pricing of supplemental policies.

The A and B of Medicare reform. Part A of Medicare pays for inpatient hospital care, home health care, hospice care, and limited skilled nursing services; Part B pays for physician services, outpatient hospital and clinic care, laboratory and other diagnostic tests, and other services. Persons age sixty-five and older who are eligible for Social Security or Railroad Retirement benefits, those who have received disability benefits for two or more years, and those with ESRD are automatically entitled to Part A benefits.[14] Whether or not they are eligible for Part A, all persons age sixty-five and older may join Part B by paying a monthly premium; so too may disabled and ESRD participants in Part A.

Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete. Services once provided only in hospitals on an inpatient basis are now provided routinely on an outpatient basis, in physicians' offices, or even at home. The line between care provided during a hospital stay and that provided after discharge is increasingly blurred. Yet reimbursement for inpatient hospital care under the diagnosis-related group (DRG) system and that for outpatient hospital and physician services under the resource-based relative value scale (RBRVS) system and other fee schedules remain distinct and serve to reinforce a structure for the delivery of care that is becoming anachronistic. This payment system is not easily integrated with managed care arrangements and capitated payment systems.

No good case can be made, in our judgment, for perpetuating Parts A and B of Medicare. To the extent that the public sector has a legitimate role to play in the financing of health care for the elderly and disabled, that interest is common across the range of covered medical services. The distinction that Part B is "voluntary" is close to meaningless, because 97 percent of the participants in Part A elect to participate in Part B.[15]

The distinct methods of financing Parts A and B—the former with a payroll tax and the latter through premiums and regular appropriations—have created different political and economic dynamics for the two parts. Part A enjoys the advantage of an earmarked tax and is subject to the

discipline that stems from the fact that outlays cannot, in practice, exceed revenues from that tax plus accumulated reserves and the interest earnings of those reserves. Congress originally declared that it intended to charge eligible households half of the cost of Part B. However, Congress lacked the political will to deliver on that promise, thereby freeing Part B from the budgetary discipline that has driven the debate about Part A. Any major reform of Medicare should unify Parts A and B. The consolidation should not, however, be used as an opportunity to relax the limited fiscal constraints under which the program now operates and tap into general revenues to support Part A.

Fee-for-service and risk contracts. Medicare is rapidly becoming the last remnant of relatively unmanaged fee-for-service care in the United States. As of 1995 a majority of nonelderly Americans with private health insurance were covered under one form or another of managed care.[16] This extremely elastic term includes health maintenance organizations (HMOs) in their various forms and preferred provider organizations (PPOs). Health care delivery, financing, and risk-sharing arrangements are blooming in huge numbers and riotous diversity.

Except in Medicare. Medicare participants can enroll in one of three delivery and financing arrangements. More than 90 percent "choose" the traditional fee-for-service arrangement.[17] Managed care plans that are reimbursed on the basis of reasonable costs serve another 2 percent, and managed care plans that are paid on a capitated basis (risk contracts) serve 7 percent. Under these risk contracts, plans provide the Medicare benefit package for 95 percent of the average cost of fee-for-service Medicare benefits in their county (adjusted average per capita cost, or AAPCC).[18] The number of Medicare beneficiaries covered by such plans is increasing, but their penetration is projected to lag far behind the penetration of this form of payment for the nonaged population.

The use of Medicare risk contracts varies widely across the United States, reflecting the huge geographical variation in the availability of managed care plans, the limited information that is provided to participants about their options, and the lack of familiarity among the elderly population with managed care delivery systems. Overall, about three-quarters of the Medicare population live in an area in which a managed care option is available.[19] Nevertheless, there is no significant Medicare enrollment by risk contractors in twenty-eight states.[20] These plans have no incentive to market aggressively in counties in which the AAPCC is low. The AAPCC's year-to-year volatility also represents a deterrent. The highest penetration of risk contracts is found in California and Arizona, where close to 30 percent of all Medicare participants get their care from such plans.[21] All of this implies that reforms that propose to move Medicare

beneficiaries into managed care plans will take time. Institutional capabilities will have to be developed, and participants will have to learn more about and become more comfortable with managed care delivery systems.

The "cherry-picking" potential in Medicare. Insurance carriers or managed care plans can increase their profits either by providing services more efficiently or by seeking to insure persons with lower-than-average health care costs. In the case of employer-sponsored plans, the potential of the latter approach is limited because the sponsor is generally seeking coverage for an entire employee group and its dependents. The opportunity to "cherry pick" is greater under Medicare because beneficiaries enroll as individuals, and the stakes are higher because variability of the costs of care among Medicare enrollees—the disabled and the elderly—is far greater than that among the general population.

Medicare risk contractors must accept any Medicare participant who wants to join their plan. Nevertheless, disproportionate numbers of participants who have lower-than-average costs have signed up for these plans under the current Medicare program. Estimates suggest that Medicare's current payments to risk contractors, which are set at 95 percent of the AAPCC, are roughly 6 percent more than the costs that these lower-than-average-risk participants would incur in the standard Medicare program.[22] In other words, risk contracting raises costs to the government, although the risk contractors may produce health care more efficiently than other providers do and therefore may save money for the nation.

The extent to which vendors consciously try to attract only better-than-average risks to their plans is not known. To date, these vendors have been able to maintain acceptable profit margins and even offer additional benefits because they generally can provide services more inexpensively than the fee-for-service sector can, competition among risk contractors is low, and Medicare payment is generous. But if profit margins narrow, competitive pressures to engage in marketing and other administrative practices that attract low-cost enrollees and repel high-cost enrollees could intensify.

The profit-boosting potential of such efforts could be substantial, given the skewed nature of health care costs. Roughly 5 percent of Medicare participants account for more than half of the program's total cost; one-quarter of the program's participants account for more than 90 percent of the costs.[23] Under the existing payment system, a provider can boost profits significantly by small reductions in high-risk enrollments. A plan might attract a disproportionate number of healthy or younger elderly enrollees by offering exercise classes or other services that such participants find attractive or by locating its facilities in certain geographic areas. Similarly, subtle differences in the availability of services might make a plan unattractive to people with certain chronic health problems or might encourage participants who become heavy users to leave a plan. The current policy of permitting Medicare participants to switch from managed care plans into the traditional Medicare delivery system with a month's notice facilitates such practices.

All of this suggests that if Medicare is going to move from a fee-for-service reimbursement system toward one that emphasizes capitation, payments made to the plans will have to be better calibrated to the health risks of persons covered by those plans. Care will have to be given to ensure that plans do not engage in subtle practices to ward off high-risk participants.

Cost variations. The Medicare benefit package is uniform nationwide, but its cost is not. In 1992 reimbursements nationally averaged $4,341 per person served but varied from a low of $3,048 in Nebraska to a high of $5,114 in Louisiana.[24] The variations across substate areas are even greater: Cost per enrollee in Miami, Florida, is 2.4 times that in Waco, Texas.[25] Such differences reflect interstate variations in DRG prices and RBRVS fees, salary levels, and medical practice patterns and the propensity to use services. Such variations survive without serious scrutiny in a system that simply pays for services rendered or that pays fixed fees to providers based on local costs. But such variations would be hard to justify or sustain if Medicare shifts from paying for services to paying for insurance. Pressure would arise to justify variations in payments per person. While variations associated with differences in input prices could be rationalized, it is doubtful that a persuasive case could be made for per person reimbursements that are 68 percent higher in Louisiana than in Nebraska.

Uncertainty about costs. Actuarial projections that Part A of Medicare will be insolvent in a few years add a sense of urgency to the need to "do something" to fix Medicare. The impossibility of balancing the budget in seven (or even ten) years without large reductions in Medicare raises this sense of urgency to almost frantic levels.

Two aspects of the actuarial projections are relevant to the process of reform. The first is that the actuarial projections are extremely volatile. The period until projected insolvency has changed by many years from one trustees' report to another (Exhibit 1). Some of these changes are attributable to legislation, but many are not, such as the change from 1992 to 1993. The estimated cost of Part A benefits, measured as a percentage of taxable payroll, also has oscillated widely. To illustrate, the trustees' reports of 1982, 1987, 1994, and 1995 placed the cost of Part A, as a share of taxable payroll, at 6.7 percent, 3.65 percent, 4.52 percent, and 4.17 percent, respectively. The change from 1994 to 1995 is particularly noteworthy, because no relevant legislation was enacted between the two projections. We know of no methodological breakthroughs to suggest that similar variations will not occur in the future. Thus, the magnitude of reductions in Medicare

Exhibit 1
Number Of Years From Medicare Hospital Insurance (Part A) Trustees' Projection Until Insolvency

Year of trustees' report	Years until insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20[a]
1976	About 15[a]
1977	About 10[a]
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966–1995.
[a] Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

costs or of increases in payroll taxes necessary to close projected deficits is not known with any certainty.

The second aspect of the projections that is relevant to reform is that the gap between current revenues and current benefits is so large that even the large fluctuations in projected costs shown in Exhibit 1 give no hope that the current system can be sustained. In 1995 actuaries projected that the Part A trust fund would be insolvent in 2002. The large cuts in Medicare Part A implied by the budget resolution for fiscal year 1996 would only delay insolvency by a few years. The twenty-five-year actuarial projections

indicate that Part A outlays would have to be cut 30 percent or revenues increased 43 percent to balance the program. Since any legislative changes would be small at first, the changes in the terminal years of the projection period would have to be considerably larger.

The growth of spending under Part B is considerably higher than under Part A, in large measure because many services that were once provided in hospitals can now be provided on an outpatient basis or in physicians' offices. As a share of gross domestic product (GDP), Part A is projected to increase from 1.62 percent in 1995 to 2.83 percent in 2020, a 75 percent increase. Part B is projected to increase from 0.93 percent of GDP to 3.18 percent over the same period, a 242 percent increase.

Medicaid and Medicare. State Medicaid programs, as has already been pointed out, have been called upon to supplement Medicare for low-income participants. Dually eligible participants have whatever benefits their state's Medicaid program provides and assistance to pay their Medicare Part B premiums, coinsurance, and deductibles. Medicaid programs also have been required to cover the Part B premiums, coinsurance, and deductibles of QMBs. State Medicaid programs pay the full actuarial cost of Part A for elderly and disabled persons who have incomes below the poverty line but do not have sufficient work histories to be eligible for Part A. As of January 1995 Medicaid also pays Part B premiums for those with incomes between 100 percent and 120 percent of the poverty threshold.

Congress has adopted these requirements over the past decade because Medicare's coverage, by itself, is not overly generous. Low-income participants in poor health who lack this supplemental protection could find most of their limited income absorbed by out-of-pocket spending for health care. But these requirements also have imposed a significant burden on states, which, on average, pay 43 percent of the costs of Medicaid.

As Medicare evolves or is changed, the logic of dividing the responsibility for health care for the low-income aged and disabled between these two programs will weaken. As more participants have the opportunity to join plans that offer benefit packages that include prescription drug coverage and catastrophic protection and that have low cost-sharing requirements, the need for the QMB protection will diminish. Furthermore, if premium subsidies must be provided, equity suggests that they should be uniform nationwide. Estimates suggest that fewer than half of persons eligible for QMB subsidies have received them. The take-up rate is thought to vary considerably because of differences in states' outreach efforts. The possibility that Medicaid payments per recipient might be capped or transformed into a block grant reinforces the logic of having Medicare assume full responsibility for covering the acute health care costs of low-income aged and disabled persons.

A Program For Medicare Reform

Goals and principles. Any fundamental social policy reform should be guided by clear principles and goals. The following four should direct the changes that Medicare will require. (1) Reforms should deal not just with "public" Medicare but with the full package of benefits most Medicare beneficiaries use. (2) Under a reformed Medicare program, the quality of health care provided to the elderly and disabled should not be materially different from that available to the general population. Nor should the delivery system for this population be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care). (3) Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide high-quality care at the lowest possible cost. This does not necessarily mean, as some advocates of managed care seem to suggest, that the least costly providers are the best, nor does it define the limits of care that public financing should support. (4) Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population.

Designing an entirely new program is usually easier than reforming an existing one. Program designers need to concern themselves with objectives and feasibility. Program reformers must attend not only to these concerns but also to current entitlements and people's sense of ownership in these entitlements. For Medicare, the political acceptability of proposed changes hinges not just on whether they are, in some sense, objectively fair, but also on how they affect the access of two very vulnerable groups, the elderly and the disabled, to choices and services they regard as rights. Furthermore, creating new administrative and institutional frameworks is typically easier than transforming existing ones. Established institutions and bureaucracies that feel threatened typically resist reform. The reforms described here, which we believe would have to be phased in over a considerable period of time, attempt to reflect these constraints.

A new Medicare system. We propose converting Medicare from a "service reimbursement" system into a "premium support" system. Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a PPO, or operate through an HMO. Plans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately would receive a predetermined amount to be applied to the purchase of a health plan providing defined services. Because health care costs differ by health care market area, support given to enrollees would have to vary across health market areas, but not within them. As indicated below, risk adjustments among insurers based on the characteristics of their clients also would be necessary.

Plans would be required to offer defined services. Insurers would be permitted to sell coverage for additional services not covered under the basic plan, but only if marketing and delivery of these services were divorced from those of the basic plan. To the extent that such supplemental coverage induced use of basic services (for example, cost-sharing supplements), a premium surcharge would be imposed and rebated to Medicare.

The marketing of insurance to Medicare beneficiaries would follow the principles developed for the operation of managed competition.[25] The first step would be to define health care market areas, whose boundaries would be based on the supply of medical care. They typically would be metropolitan areas or large portions of states where population density is low, and they could cover portions of more than one state.

Entities interested in bearing the risk of providing health care for the Medicare population would be invited to submit bids for providing the defined benefit package in a particular market area for the "average" Medicare enrollee. The federal Medicare payment in each market area would be the same regardless of which plan the enrollee chose. If the enrollee chose a plan that cost more than the federal Medicare payment for the area, the participant would pay the balance. This supplementary payment can be thought of as a replacement for the cost of retiree and Medigap insurance.

Local marketing organizations would be established to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private, not-for-profit agencies, would receive information from insurers, ensure that it was presented to Medicare enrollees in a comprehensible and even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail or querulous, to minimize sales abuses. Enrollees would select an insurance plan for the coming year and would be permitted to switch plans during an annual open enrollment period.

Because some participants have much higher than average expected health costs, plans would receive risk-adjusted payments from Medicare based on age, sex, disability status, and other health indicators. Good methods of making such risk-adjusted payments do not now exist.[27] It is uncertain whether today's imperfect methods would suffice to offset attempts by insurers to select favorable risks or if improved methods could be

developed.[28] For this reason, our approach should be introduced gradually and evaluated periodically. For the first few years a blend of cost-based and capitated reimbursement may be necessary. We advocate this approach not because we necessarily believe that managed care and managed competition will produce huge savings. Such savings are highly uncertain and depend on unpredictable developments. Rather, a framework that forces people to face the consequences of their choices in the delivery of medical care should encourage them to choose the plans whose style of care matches their preferences, and we believe that enrollees should bear the financial consequences of their choices. Trends in health care spending are dominated by advances in medical technology, some of which are overused. Further advances in technology are inevitable and welcome, although they will be expensive.[29] Which should be used and how extensively should be determined by the persons who use them. Furthermore, we believe that a market in which plans offering similar benefits compete along dimensions that consumers can understand will promote efficient service delivery.

This framework lends itself to budget control in ways that the current Medicare system does not. Medicare now establishes a variety of price limits—DRG prices for hospital admissions and RBRVS fees for physician services—but since it cannot (and should not) control the quantity of services, it cannot control the total cost of care or federal spending. Under this system, neither health care providers nor patients have any incentive to limit physician services or hospital admissions. The result is the possibility of overuse of medical services.[30] The small area variations in the use of various medical procedures and the cost advantages of some managed health care providers support this possibility.

Problems Of Design And Transition

Converting Medicare from a fee-based reimbursement system into a premium support system will be neither quick nor easy. A number of issues and problems must be addressed before such an alternative can be instituted nationally.

(1) What should be the benefit package in the new plan? It would be a grave mistake, in our view, to use the current Medicare benefit package for the new plan. Instead, the benefit package should combine the current Medicare package with some modest coverage of prescription drugs and catastrophic protection. Plans should be required to offer this new benefit package in one of two standard forms: a low-cost-sharing variant and a high-cost-sharing variant. The expanded benefit package offered in the low-cost-sharing version would provide coverage similar to what many Medicare participants enjoy and pay for in the current hybrid system. They will not willingly accept less and, in our view, should not be expected to. They pay premiums for this package and should continue to do so.

A standard benefit package and standardized cost-sharing regimes are important, at least initially, because they will reduce risk segmentation among plans and help participants to compare the cost and quality of different plans. Numerous benefit packages and cost-sharing arrangements would make comparisons difficult. Furthermore, higher-income, younger, and healthier participants would be attracted to plans with limited benefits and high cost sharing, which would place a greater burden on the yet-to-be-developed mechanism for making risk adjustment payments to the different plans.

(2) How should the federal payment be set? This issue has several dimensions. First, should the federal payment be set at the cost of the least expensive plan capable of covering a substantial portion of the participants in a region, or above that minimum? We believe that, initially at least, payments should be based on a defined benefit package, adjusted for variations in actual costs and use among regions, not on the basis of actual bids or the lowest bid within a region. The low bid in a region might reflect a highly efficient plan. But it also could reflect an unusually spartan delivery system or a low-quality plan; such outliers should not affect the federal support available in a region. If the federal payment were set at the lowest bid, several problems could develop. First, more participants might seek to join the plan whose costs were covered completely by the federal payment than the plan could absorb while maintaining quality. Second, low-income participants might be denied choice and could be concentrated in the one or two plans that required no supplemental premiums.

The initial federal payment should be set at 95 percent of the cost of the current Medicare package in the market area, adjusted to remove indirect medical education, direct medical education, and disproportionate-share payments.[31] If providers charge the Medicare payment plus the premium for a Medigap plan, enrollees now covered by Medigap plans would face a premium that is 5 percent higher than the cost of their current hybrid coverage. But if competing plans are able to provide this level of service at lower cost, enrollees would face a smaller cost increase or might even achieve savings if the reduction in price were sufficient.

During a phase-in period of perhaps five to ten years, the federal payment should grow more slowly than projected baseline costs. If growth of plan expenses slows, costs to enrollees might not increase. In any event, this mechanism would produce some relief for the federal budget. An expert commission should recommend the exact size of this reduction; this recommendation could be reevaluated every two or three years.

In the long run, the federal Medicare payment should grow at the same

rate as per capita spending on health care for the nonelderly. This formula is mechanical and may require periodic adjustment, because the per capita cost of care depends on the average age of the population, the age-specific gradient in health care costs, and the age bias of new medical technology.[32] If Congress found it necessary to reduce federal support for Medicare, it could slow payment increases, thus shifting costs to Medicare enrollees.

The second issue in setting federal payments concerns regional variation in Medicare spending per enrollee. Current cost differences reflect variations in wage rates and other input prices, availability of services, demand, and—more generally—practice patterns. If current variation is larger than is acceptable, over what period should this variation be reduced? Our view is that payment levels initially would have to reflect historical spending patterns, but that differences should be gradually narrowed until payments varied only for differences in wage rates and other input prices. Such payment differences are necessary if Medicare is to avoid penalizing the elderly or disabled for residing in a high-cost area. The objective would be to have the federal payment cover the same services throughout the country. The adjustment should be complete within a decade.

Third, plans in some regions may submit bids below the federal payment. What if enrollees select such plans? Initially, when participants are unfamiliar with the service style, quality, and other dimensions of plans offered to them, it probably would be best to require that these dividends be devoted to such supplemental services as eyeglasses or routine dental care, or to other services.[33] This policy would reduce the possibility that cash rebates would tempt infirm, low-income participants into a low-cost plan that provided unexpectedly inferior care. Over time, as the competitive marketplace developed and as participants became familiar with their options and the consequences of choosing one plan over another, differences between the federal payment and plan cost could be rebated to participants as nontaxable income or split between government and participants.

(3) Will Medicare enrollees segregate themselves, or will plan administrators market plans in ways that result in economic segregation among plans? One of the strengths of the current Medicare program is that all participants—rich and poor alike—come under the same basic plan, and providers are relatively indifferent to the incomes of their Medicare patients. In a world of competing plans, economic segregation could occur in various ways. Plans with high deductibles and high cost sharing probably would attract not only the relatively healthy but also the relatively wealthy, who can self-insure against all but the most costly illnesses. The same is likely to be true of relatively costly plans that offer enrollees an expanded choice of providers or higher-quality amenities. Because health status and income are positively correlated, such segregation will aggravate the risk adjustment problem.[34]

To have some choice of plans, low-income participants would have to be provided with some sort of premium supplement to replace the current Medicaid assistance. These supplements, which would be nonrefundable even in the long run, could be keyed to the distribution of bids in a region. For example, they might be sufficient to allow a person with an income below the poverty threshold to participate at no cost in any plan that charged a premium below the median in the region.

(4) How should a new system be phased in? This question is clearly the most important and the most difficult. Before the plan described here can operate, it is necessary to create an environment of competition among health plans, to construct the apparatus necessary to regulate the marketing of insurance and the risk adjustment procedures for allocating payments based on enrollment, and to overcome the practical difficulties of transferring costs to many current Medicare enrollees. Even in the most prepared regions, it will take years to establish the necessary institutional structure.

The plan also hinges on the availability of enough plans in each market area to create meaningful choice and competition. These plans need not include traditional HMOs, at least at the outset, but the plans must be independent and must compete with one another. HMOs would increase the range of choice available to Medicare enrollees but are not essential. To the extent that aggressively managed care is necessary to reduce the growth of health care spending, the full benefits of the reform approach we have described would be realized only when such plans existed in most places.

The most difficult transitional issues involve beneficiaries themselves. How should they be phased into the new system? This problem would be hard, but manageable, if enrollees could be enticed into the new system by more generous payments. However, the current budget climate renders that option infeasible. The simplest method would be to run the current Medicare system alongside the new system. The new system would be mandatory for everyone who turns sixty-five and becomes eligible for Medicare after a certain date. It would be optional for everyone enrolled in Medicare before that date. Presumably, many who were not required to join the new system would do so anyway because they would prefer one of the alternative plans.

This approach may not be practical everywhere because the number of new Medicare enrollees in some sparsely populated regions may be too small to support even one plan. In such areas it may be necessary to delay the transition and then shift a group—such as all persons under age seventy—into the new system at one time.

(5) What role would Medicare price controls play? Medicare now reimburses most providers according to administered prices. Most of these payments are well below reimbursements from other payers. In addition,

providers cannot bill Medicare participants for charges beyond certain specified and limited amounts.

In the new system, a plan that offered the choice of providers now available under Medicare without these price discounts would have to either charge much higher premiums or leave participants exposed to significant balance billing. This shift would represent a noticeable reduction in the opportunities available to many Medicare beneficiaries, who would find such a shift exceedingly burdensome. For this reason, we believe that the various Medicare fee schedules must be maintained for a transitional period. All plans could use these schedules for paying providers other than those in their own networks. Existing balance billing and assignment restrictions would continue. Because competitive forces would reduce the need for such limits in the new system, fee schedules could be relaxed.

(6) How much regulation will the new system require? Initially, at least, the new system will require a good deal of regulation, and much of it will have to emanate from Washington. The nation should not gamble with health care for the aged and disabled, many of whom are unlikely to be able to do well in an unregulated market. Moreover, if there is a failure, the federal government will be required to step in.

Plans will have to be certified with respect to their medical capabilities and the quality of care they provide, their administrative competence, and their financial soundness. It is reasonable to expect that the same minimum standards should be met by each plan throughout the country. While these standards may be set nationally, state agencies or specialized nonprofit organizations could enforce them.

We have already noted that state, local, or not-for-profit organizations would be responsible for organizing and ensuring the orderly functioning of the health plan market in each area. These organizations would specify, collect, and disseminate information provided by health plans to Medicare enrollees. To help enrollees make informed choices among plans, they would ensure that the information is presented clearly, simply, and uniformly. These organizations also would monitor plans to prevent them from engaging in measures designed to attract good risks.

(7) What of Medicare's other functions? Over the past thirty years Medicare has evolved into more than a system to help pay the medical bills of the aged and disabled. Through its payment system, it has come to play an important role in supporting graduate medical education. The payment system also has sustained institutions in remote locations and helped hospitals serving disproportionate numbers of uninsured persons to bear the costs of uncompensated care. The payments made under our proposed plan would not continue to support these objectives. To the extent that they remain important, they should be funded through separate grants.

Conclusion

The Medicare program, which has served the nation—particularly the elderly and disabled—extremely well during its first thirty years, faces profound changes before it reaches its golden anniversary. Budgetary and demographic developments mean that the program as it is now structured is unsustainable. As this paper goes to press, congressional action on Medicare and Medicaid is not yet complete. The outcome of the wrangling between the president and Congress that will follow is unclear. Nevertheless, if the effort to craft a compromise reconciliation bill does not fail completely, it seems likely that large cuts will be made in Medicare. How much fundamental structural change will emerge is still an open question. Most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will be made even more complex and inequitable. Medicare eligibles will be given more of an impetus to shift into one form or another of managed care. However, the legislation that is likely to emerge probably will not provide strong incentives for participants to reduce their use of low-benefit services or to seek care through efficient delivery systems.

The ultimate response to the budget and demographic pressures could take more extreme forms. The nation could establish a separate national health care system for the aged and the disabled, with its own network of providers and its own limits on use. At the other end of the spectrum, Medicare could be transformed into a pure voucher system, in which the elderly and disabled receive a voucher and are told to fend for themselves in an unregulated or lightly regulated marketplace. We believe that both of these approaches are politically unacceptable and programmatically flawed.

The approach we have presented represents a middle ground. It builds on the strengths of the current program while converting it into a system similar to the employer-sponsored insurance now available to most Americans. A major argument in its favor is that it would strengthen participants' incentives to seek services from cost-effective delivery systems and providers' incentives to operate efficiently. This plan would enable Congress to directly control the per capita budget cost of Medicare. This feature is critical in view of the certainty that the gap between Medicare costs and revenues will be narrowed as part of efforts to balance the budget. But it is important to acknowledge that our plan also facilitates significant savings by shifting costs to Medicare enrollees, a channel that will have to be used if large reductions in Medicare spending growth are to be achieved.

We close with an unfashionable warning. The history of reforms in U.S. social policy is replete with exaggerated claims of the benefits the reform will produce. To muster enthusiasm, supporters of reform paint rosy pictures

of the marvelous benefits that will ensue if only their recommendations are adopted. Reality, as it is wont to do, eventually emerges, disappointment sets in, and the perception of the competence of policymakers takes another dive. We see the makings of just such a cycle with the current enthusiasm about the benefits of managed care and of improved incentives for cost-consciousness by purchasers of health care services. They promise enormous savings if only their reforms are adopted. Careful cost accounting suggests that their claims are grossly exaggerated.[35] But even if the rosiest plausible projections of savings from managed care are realized, benefits approximating those now provided by Medicare cannot be sustained unless revenues flowing into the system are increased. In plain English, that spells "TAXES." To sustain Medicare, payroll or other taxes earmarked for Medicare must be raised, or general revenue subsidies will have to be increased. We believe that having to live within the revenues of an earmarked tax provides some discipline. We urge that this course rather than increased general revenue subsidies be used when, after heroically trying to cut costs, Congress recognizes that the American people want to keep Medicare benefits and that to do so, somebody is going to have to pay for them.

The views expressed in this paper are those of the authors and should not be attributed to The Brookings Institution, its staff, trustees, officers, or funders. The authors thank Linda T. Bilheimer, Sandra Christensen, and Joshua Wiener for their helpful comments and absolve them of the responsibility for any errors remaining in the paper.

NOTES

1. Some who generally agree with this approach to aid argue that in some circumstances the provision of benefits produces unintended side effects that outweigh direct benefits to recipients, through either work disincentive effects or demoralization. This view, which is as old as the English debates over the Poor Laws, has achieved fresh currency in U.S. politics in debates over welfare reform. Thus far, however, it has not been part of the debate on Medicare reform.
2. The disabled and persons with ESRD were not covered by the original legislation.
3. Bipartisan Commission on Entitlement and Tax Reform, *Final Report* (Washington: Bipartisan Commission, January 1995); Concord Coalition, *The Zero Deficit Plan* (Washington: Concord Coalition, 1993); Congressional Budget Office, *Reducing the Federal Deficit: Spending and Revenue Options* (Washington: CBO, February 1995); and D. Bandow and M. Tanner, *The Wrong and Right Ways to Reform Medicare*, Cato Institute Policy Analysis no. 230 (Washington: Cato Institute, 8 June 1995).
4. The annual subsidy provided through Medicare to a male worker who retired from an average wage job in 1992 was $3,874.
5. Robert Meyers has pointed out the several ways in which this comparison is inappropriate and how the original estimate has been misrepresented. See R.J. Meyers, "How Bad Were the Original Actuarial Estimates for Medicare's Hospital Insurance Program?" *The Actuary* (February 1994): 6–7.
6. Health Care Financing Administration, *Medicare: A Profile* (Washington: U.S. Government Printing Office, February 1995), 51; and Congressional Budget Office, *Trends in Health Spending: An Update* (Washington: CBO, June 1993), 44–45. The growth of per capita Medicare spending was below that of private health care spending in every year from 1984 through 1991, except in 1989. M. Moon and S. Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, July 1995).
7. Coinsurance of $358 per day is required for the lifetime allowance of sixty additional days of inpatient care. The Part B deductible is $100 per year, and coinsurance is 20 percent. Coinsurance for days 20–100 of skilled nursing facility care is $89.50 per day.
8. American Association of Retired Persons, Public Policy Institute, and The Urban Institute, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington: AARP, April 1994).
9. Congressional Budget Office, unpublished estimates.
10. According to CBO estimates, approximately 39 percent of Medicare participants have Medigap policies, and 26 percent have retiree plans. For a breakdown of supplemental coverage among aged Medicare participants in 1992, see U.S. Congress, House Committee on Ways and Means, *1994 Green Book*, Committee Print WMPC 103-27 (15 July 1994), 886. The Health Care Financing Administration provides the following estimates of coverage for aged participants in 1993: 11.4 percent of elderly Medicare participants have no other coverage, 36.8 percent have Medigap policies, 33 percent have retiree policies, 11.9 percent are covered by Medicaid, and 2 percent have coverage from another source. Medigap policies are offered in ten standard forms, the most popular of which cover deductibles and coinsurance. See P.D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* (Spring 1995): 31–48.
11. CBO, unpublished estimates.
12. Karen Davis, testimony before the U.S. Senate Committee on the Budget, 3 May 1995.
13. This estimate is from CBO tabulations for the elderly and disabled. The *1994 Green Book* provides an estimate of 22 percent for the elderly in 1992, and HCFA provides an estimate of 11 percent for the elderly in 1995.
14. Persons over age sixty-four who are not eligible for Social Security can obtain Part A coverage by paying the full actuarial cost of the coverage. State Medicaid programs are required to pay this cost for persons with low incomes.
15. Most of those who are covered by Part A but choose not to join Part B are workers over age sixty-four who are covered by an employer policy and can join Part B later without penalty.
16. CBO, "The Potential Impact of Certain Forms of Managed Care on Health Expenditures" (CBO Staff Memorandum, August 1992).
17. Most are probably not aware that they have other options besides the traditional fee-for-service plan.
18. The AAPCC is calculated for county areas and is adjusted for the participant's age, sex, institutional status, reason for entitlement (age or disability), and Medicaid eligibility. Plans often provide additional services because they must not have higher margins on their Medicare business than on their non-Medicare business. The excess must be spent on additional services or returned to the government. Plans have an incentive to locate and market in county areas where the AAPCC is high. Plans can switch annually from being paid on the basis of the AAPCC or on the basis of costs.
19. HCFA, *Medicare: A Profile*, 109, Chart MC-1.
20. The Henry J. Kaiser Family Foundation, "Medicare and Managed Care" (May 1995).
21. In Riverside and San Bernardino, California, and Portland, Oregon, the figure is close to one-half.
22. R.S. Brown et al., "Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs" (Princeton, N.J.: Mathematica Policy Research,

Bob Reischauer's MODEL

WHAT IS PREMIUM SUPPORT?

- A HYBRID SYSTEM WITH

  DEFINED BENEFITS

  FIXED PAYMENTS TO PLANS

THE DEFINED BENEFIT

- BENEFITS SHOULD BE SUFFICIENTLY COMPREHENSIVE SO THAT THE VAST MAJORITY OF PARTICIPANTS DO NOT FEEL A NEED FOR SUPPLEMENTARY INSURANCE.

PAYMENTS TO PLANS (1)

- MUST BE RISK ADJUSTED
- SHOULD REFLECT DIFFERENCES IN INPUT PRICES

PAYMENTS TO PLANS (2)

- COULD BE SET ADMINISTRATIVELY
- COULD BE SET COMPETITIVELY
- COULD BE SET BY A BLEND OF COMPETITIVE AND ADMINISTRATIVE MECHANISMS

PAYMENTS TO PLANS (3)

- HOW SHOULD THE PAYMENTS TO PLANS BE DIVIDED BETWEEN THE GOVERNMENT'S CONTRIBUTION AND THE PARTICIPANT'S CONTRIBUTION?

QUESTIONS

- WHAT ROLE SHOULD TRADITIONAL MEDICARE PLAY?

- WHAT HAPPENS IN AREAS IN WHICH NO PLAN WISHES TO OFFER SERVICES?

- WHAT HAPPENS IN AREAS IN WHICH ONLY ONE OR TWO PLANS COMPETE?

- WHAT ARE THE POLITICAL CONSEQUENCES OF HAVING DIFFERENT PREMIUMS AND DIFFERENT PLAN TYPES AVAILABLE IN DIFFERENT JURISDICTIONS?

DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED FOR COVERAGE

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

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

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

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

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

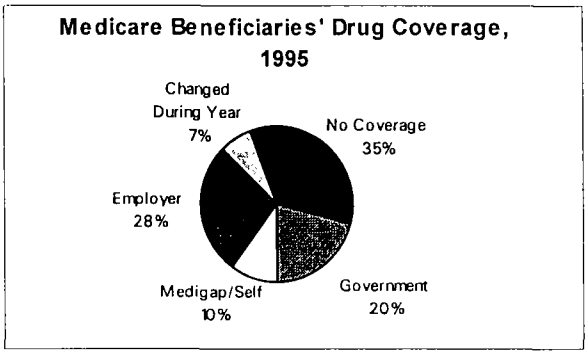
- **Millions of beneficiaries have inadequate coverage**. About 13 million Medicare beneficiaries have no coverage at all. Millions more have drug coverage through Medicare managed care plans, but the amount of that coverage is increasingly low. For example, about one-third of beneficiaries' managed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

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

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

ADDITIONAL INFORMATION ON MEDICARE BENEFICIARIES AND DRUG COVERAGE

- **Only 38 percent of Medicare beneficiaries have private drug coverage.** Employer-based, retiree coverage is the largest source of private coverage, but recent studies show a dramatic decline in this coverage. About 10 percent of beneficiaries have Medigap or other private sources of coverage. Similarly, as the cost of Medigap insurance climbs, the proportion of beneficiaries who can afford it has been declining.



- **Income**: The lack of drug coverage is not just a problem for low-income beneficiaries. Beneficiaries without drugs have only slightly lower income than Medicare beneficiaries in general:

	All Benes	Benes w/o Drug Coverage
- < 100% Poverty:	21%	21%
- 100-199% Poverty:	33%	38%
- 200-299% Poverty:	20%	20%
- > 300 % Poverty:	26%	21%

- **Health Status**: Beneficiaries with drug coverage tend to be sicker than people without drug coverage, although the difference is not large. Fully one in four beneficiaries without drug coverage is in fair to poor health and may need prescription drugs.

	With Drug Coverage	Without Drug Coverage
Excellent/Very Good Health	42%	45%
Fair/Poor Health	29%	26%

Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities do not have any coverage for prescription drugs.

- **Age**: The proportion of beneficiaries without drug coverage rises with age:

  - 38 percent of people ages 80 to 84
  - 41 percent of people ages 80 to 84

- **Rural beneficiaries**: 46 percent of rural beneficiaries do not have drug coverage

Source: Analysis of the Medicare Current Beneficiary Survey, 1995

NATURE OF THE DRUG BENEFIT FOR MEDICARE BENEFICIARIES

- **Employer plans:** Typically, employer plans for retirees offer the same generous coverage that the nonelderly workers receive (e.g., no limits on benefits payments, low deductibles).

- **Medigap**: Three of the 10 standard Medigap plans offer prescription drugs. The benefit includes:

  - $250 deductible
  - 50% coinsurance
  - Cap of $1,250 or $3,000, depending on the plan

  Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996.

  The median premium for a 65-year old choosing a plan with prescription drug coverage (H) to one with virtually identical benefits except for drugs (D) is well over $1,000 or more than twice as costly ($2,073 v 913 in 1998).

- **Medicare Managed Care:** Typical Medicare managed care plans have no deductibles and relatively low copayments, but caps on the benefit:

  - 40 percent of enrollees are in plans with unlimited benefits
  - 18 percent of enrollees are in plans with limits greater than $1,000
  - 17 percent of enrollees are in plans with a limit at $1,000
  - 24 percent of enrollees are in plans with limits less than $1,000

  [Note: these data are for 1998; expectations are that for 1999, the proportion of beneficiaries in plans with caps and deductibles will rise significantly]

  There is a strong relationship between the Medicare payment rate and the generosity of the drug benefit. The average monthly Medicare capitation payment averaged:

  - $491 for beneficiaries with unlimited drug coverage
  - $434 for beneficiaries with limited drug coverage
  - $375 for beneficiaries with no drug options or coverage

LEVEL 1 - 1 OF 1 STORY

SHOW: MORNING EDITION (10:00 AM on ET)

February 5, 1999, Friday

LENGTH: 967 words

HEADLINE: HOUR 2; CONGRESSIONAL COMMISSION TO DEVISE NEW PLAN FOR MEDICARE

ANCHORS: BOB EDWARDS

REPORTERS: JOANNE **SILBERNER**

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards.

There have been disagreements this week within the bipartisan congressional commission charged with devising a new blueprint for Medicare. Democrats on the commission have complained that the proposal now under consideration falls short. They say it would not guarantee help with payments for prescription drugs.

Republicans on the Medicare commission also have expressed interest in doing something about prescription drugs; so has President Clinton. NPR's Joanne **Silberner** reports no consensus is in sight.

JOANNE **SILBERNER** reporting:

There's a reason why the Medicare program didn't pay for prescription drugs when it first began in 1965, says health policy analyst, Stuart Altman.

Mr. STUART ALTMAN (Health Policy Analyst): When Medicare was passed, prescription drugs was a very small item in the health-care expenditure arsenal. Quite frankly, there was very few prescription drugs that did anything that was useful, and it was felt that it was an administrative nightmare. We didn't have computers at the time; everything was done by hand. Why have the government pay

millions of claims for $ 1, or $ 2, $ 3. People can afford to cover it, so let's leave it out and maybe we'll cover it in the future.

SILBERNER: Since the beginning of Medicare, new and effective and costly drugs have come on the market. Medicare beneficiaries now use $ 22 billion worth of prescription drugs a year, an average of $ 600 per person. Some pay several thousand and others, with no way to pay, go without. Altman is a member of the commission that's trying to redesign Medicare and he says, it's time to do something about prescription drugs for the elderly.

Mr. ALTMAN: Right now, we are taking one leg of this three-legged stool away from the medical community. We have good coverage for hospital care and the Medicare, we have decent coverage for physician services and outpatient care and we have very poor coverage, if no coverage at all, for prescription drugs.

SILBERNER: Now two-thirds of Medicare recipients do get some help paying for prescription drugs. According to a new study, some money is from the government for poor people, some is from employee retirement plans, most is from supplemental insurance called Medigap.

But Medigap is expensive and pays only half of all drug costs after policyholders pay the first $ 250. Even the most generous policy cuts off after $ 3,000. While most analysts say Medigap is inadequate, the fact is that many people already buy it and that, plus the people who get benefits from their former employers, makes some members of the Medicare commission reluctant to support a plan that would create new coverage for everyone.

Republican Congressman Bill Thomas of California spoke at the most recent commission hearing.

Representative BILL THOMAS (Republican, California): If we were to simply say we want to take taxpayers' dollars, drive out the private dollars, substitute them with taxpayer dollars, and I think you're going to get very much similar reaction as we got to on the catastrophic.

SILBERNER: The catastrophic is shorthand for Congress' last attempt to provide drug coverage within Medicare. It was back in 1988 Congress passed a law establishing Medicare benefits for people with particularly high health expenses. It included prescription drug coverage. To pay for it, Congress raised the monthly Medicare premium with people with higher incomes paying more. The increase led to vehement protests by Medicare recipients, including an attack on one congressman's car. Congress repealed the law.

John Rother of the American Association of Retired Persons talked about it at a recent briefing.

Mr. JOHN ROTHER (American Association of Retired Persons): Well, I still think it was the right policy. It was certainly justified from a economic point of view. Politically, we found it to be a very tough sell to take people who already had the benefit and ask them to pay in order that lower income seniors could benefit from this. And we all believe in social solidarity, but there are limits.

SILBERNER: In a recent poll by the Kaiser Family Foundation, 68 percent of Americans said they supported prescription drug coverage in Medicare, even if it

meant higher taxes or higher premiums for seniors. Still, Rother says, to make a prescription drug plan acceptable, money would have to come from somewhere else--savings from other parts of the program, perhaps, or maybe the 16 percent of the budget surplus that the president has promised to Medicare: $ 700 billion over the next 15 years.

But pharmaceutical manufacturers are worried that if the federal government starts paying for drugs, it will also try to set prices. Judy Bellow(ph) is with the drug industry trade group. She says if drug companies are to continue to develop new treatments, they need to be able to price their products free of regulation. Just the threat of regulation is enough to stymie research, as she told congressional staffers at a recent briefing. Look at the last decade. Drug companies increased their research and development efforts every year, except one.

Ms. JUDY BELLOW (Drug Industry Trade Group): Our increase in investment, discovery and development plummeted by more than 50 percent, and you know what year it was: 1994 when the government was debating proposals for health care, which included price controls for pharmaceuticals. Price controls simply don't work to control costs. Moreover, they're a dagger aimed at the heart of patients, because they chill innovation.

SILBERNER: The drug company trade group says the best way to provide drug coverage is to let Medicare recipients opt for health plans that include prescription drugs, as some of the Medicare managed-care options do now. But they're not available everywhere and they may become expensive. The commission clearly wants to do something about prescription drugs, it's just not clear if they can agree on a plan. And if they do, it still has to get through Congress and past the president's desk. Joanne **Silberner,** NPR News, Washington.

LANGUAGE: English

LOAD-DATE: February 5, 1999

DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

DATE: January 27, 1999

FROM: Richard S. Foster
Office of the Actuary

SUBJECT: Estimated Year of Exhaustion for the HI Trust Fund under a Proposal To Augment HI Financing with General Fund Transfers

TO: Nancy-Ann Min DeParle
Administrator

This memorandum responds to your request for the estimated year of exhaustion for the Hospital Insurance trust fund under a legislative proposal developed for the President's Fiscal Year 2000 Budget. At this time, we do not know the full specifics of this proposal. It is our understanding that the proposal would create a new transfer of revenues from the general fund of the U.S. Treasury to the HI trust fund for each year from 2000 through 2014. The transfer amount each year would be set equal to a specified percentage of the HI taxable payroll for the year.[1] The applicable percentages would be specified in the legislation and would equal 15 percent of the unified budget surpluses projected for the President's Fiscal Year 2000 Budget, expressed as a percentage of the projected HI taxable payrolls.

Under the proposal, the future transfers from the general fund would depend only on the specified percentages of HI taxable payroll and would not be affected if actual future unified budget surpluses differed from the Fiscal Year 2000 Budget projections. We understand that, in contrast to the associated proposal for the Social Security program, there would be no change in current-law investment practices for the HI trust fund. Similarly, the estimates in this memorandum reflect Medicare's current benefit provisions as specified under present law.

We were provided with projected additional HI revenues under this proposal based on the intermediate set of assumptions from the 1998 Trustees Report, as estimated by the Office of Management and Budget and the Social Security Administration's Office of the Chief Actuary. These amounts are listed below (in billions):

Calendar year									
2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
$17.6	$19.6	$27.2	$26.0	$29.5	$32.6	$40.0	$45.4	$50.0	$55.7
2010	2011	2012	2013	2014		2000-2004	2000-2009	2000-2014	
$60.9	$65.9	$70.2	$73.7	$75.5		$119.9	$343.8	$689.9	

[1] "HI taxable payroll" is the total amount of all wages, salaries, and net income from self-employment that is subject to the HI payroll tax under the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act (SECA).

Based on the intermediate assumptions and the projected general fund transfers listed above, we estimate that the assets of the HI trust fund would be depleted in calendar year 2020 under this proposal, as compared to 2008 under present law. Thus, this Budget proposal would postpone the year of exhaustion by an estimated 12 years.

This estimate is subject to change if our understanding of the proposal is incorrect. In addition, it is important to note that the financial operations of the HI trust fund will depend heavily on future economic, demographic, and health cost trends. For this reason, the estimated year of depletion under this proposal is very sensitive to the underlying assumptions. In particular, under adverse conditions such as those assumed by the Trustees in their "high cost" assumptions, asset depletion could occur significantly earlier than the intermediate estimate. Conversely, favorable trends would delay the year of exhaustion. The intermediate assumptions represent a reasonable basis for planning.

The estimated year of exhaustion is only one of a number of measures and tests used to evaluate the financial status of the HI trust fund. If you would like additional information on the estimated impact of this proposal, we would be happy to provide it.

Richard S. Foster, F.S.A.
Chief Actuary

PREMIUM SUPPORT (For Background Only)

CONCEPT OF PREMIUM SUPPORT Combines elements of defined benefit and defined contribution to improve Medicare's efficiency.

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.

- **Total premium**: Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.

- **Government payment**: The government contribution toward that premium would be limited (e.g., a percent of the premium up to a cap and/or as a flat dollar amount).

- **Beneficiary payment**: Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.

- **Savings**: Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

COMMISSION PREMIUM SUPPORT MODEL

- **Beneficiary payment**: This amount depends on the relationship between the plan's premium and the national average premium. (Note: would be geographically adjusted)

    - Below average plans: 12 percent of the premium
    - Above average plans: 12 percent of the national average plus every dollar that the premium is above the national average.

- **Government payment**: 88 percent of the premium up to 88 percent of the national average.

- **Issues With Commission Model**:
    - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.

    - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. This also means that this model will not reduce Medicare costs.

SOCIAL SECURITY

MEMORANDUM

Date: January 26, 1999 Refer To: TCC

To: Harry C. Ballantyne
Chief Actuary

From: Stephen C. Goss
Deputy Chief Actuary

Subject: Long-Range OASDI Financial Effects of the President's Proposal for Strengthening Social Security--INFORMATION

The President's proposal, presented in the State of the Union address on January 19, would require that transfers be made from the General Fund of the Treasury of the United States to the Old-Age, Survivors, and Disability Insurance (OASDI) trust funds for each year 2000 through 2014. The amount of transfer for each year would be specified in law as a percentage of the OASDI effective taxable payroll. In each year 2000 through 2014, 21 percent of the transfer would be used to purchase stock and 79 percent would be used to purchase special interest-bearing obligations of the Treasury. All dividends would be reinvested in stock until the market value of all stock held by the OASDI trust funds reached 14.6 percent of total OASDI trust fund assets. Thereafter, the percentage of total trust fund assets that is held in stocks would be maintained at 14.6 percent.

The proposal would extend the estimated year in which the combined OASDI trust funds would become exhausted by 23 years, from 2032 to 2055. It would reduce the size of the estimated long-range OASDI actuarial deficit by over one half, from 2.19 to 0.76 percent of taxable payroll. (Due to interaction among provisions, a complete elimination of the actuarial deficit will require additional OASDI changes that would reduce the present law deficit by up to 1.0 percent of taxable payroll.) These estimates are based on the intermediate assumptions of the 1998 Trustees Report and other assumptions described below.

If transfers were invested only in government bonds, the estimated year of trust fund exhaustion would be extended by 17 years, from 2032 to 2049. The estimated long-range OASDI actuarial deficit would be reduced from 2.19 to 1.20 percent

of taxable payroll. This result also provides an indication of the sensitivity of the estimates to variation in the expected yield on stock. If, for example, the actual yield on stock over the next 50 years is no greater than the expected yield on government bonds, the estimated year of trust fund exhaustion would be extended from 2032 to 2049, rather than to 2055 with expected stock yield.

Stock investments would be managed by several brokerage firms, selected by competitive bid. Stock investments would be required to reflect the composition of all publicly-traded stock in the United States (for example, the composition of the Wilshire 5000 index).

Transfers from the General Fund of the Treasury would be made each year 2000 through 2014. The estimated amount of transfer for each year is shown below, based on the intermediate assumptions of the 1998 Trustees Report.

Estimated Amounts To Be Transferred to the OASDI Trust Funds
Billions of Current Dollars

2000	$81.4	2005	117.4	2010	256.4
2001	67.2	2006	148.6	2011	280.0
2002	88.3	2007	174.8	2012	300.0
2003	87.2	2008	203.2	2013	316.0
2004	105.6	2009	232.5	2014	324.4

Amounts transferred would indirectly reflect values for years 2000 through 2014 that are about 62 percent of the expected unified budget surplus estimated by the Office of Management and Budget for the President's Fiscal Year 2000 Budget. Actual transfers for each year would be specified as the product of (a) the values computed under these budget projections, expressed as a percentage of OASDI effective taxable payroll, and (b) the then-current estimated taxable payroll at the beginning of each year of transfer. Revisions in amounts transferred each year would be made as estimates of taxable payroll for the year are finalized.

OASDI Trust Fund Assets in Stock

The 1994-96 Advisory Council on Social Security requested estimates assuming that the total annual real yield on stock investments would ultimately average about 7 percent, approximately the average (geometric mean) yield on stocks so far this century. (Total yield includes dividends as well as capital growth.) Estimates for this proposal are based on a more conservative assumption for the average ultimate total annual real yield of stock at 6.75 percent. The

nearly four-percentage-point difference between this assumed ultimate real stock yield and the Trustees' 2.8-percent assumed ultimate real yield on government bonds held by the trust funds is assumed to be maintained throughout the 75-year projection period.

The table below provides the estimated percentage of OASDI trust fund assets that would be held in stock at the end of each year 2000-14. The stock holdings are estimated to reach the level of 14.6 percent of total trust fund assets at the end of 2014, after which point this percentage would be maintained under the proposal.

Percent of OASDI Trust Fund Assets in Stock, End of year

2000	1.7%	2005	6.6%	2010	11.2%
2001	2.8%	2006	7.6%	2011	12.1%
2002	3.9%	2007	8.5%	2012	12.9%
2003	4.8%	2008	9.4%	2013	13.7%
2004	5.7%	2009	10.3%	2014	14.6%

If the average yield on stocks is greater or less than assumed over the period 2000-14, the year in which the specified level of 14.6 percent of assets in stock is reached would be sooner or later than the end of 2014.

The portion of the total value of publicly-traded stock in the United States that is held by the OASDI trust funds will depend not only on the yield achieved in the market, but also on the rate of growth in the total market value of all stock. The total value of stock represented in the Wilshire 5000 index (a fair representation of all publicly-traded stock in the United States) was $9.3 trillion at the beginning of 1998. Assuming that the total market value of publicly-traded stock will rise generally by the rate of growth in GDP after 1998, the trust funds would hold less than 4 percent of the total market value, on average, over the next 40 years.

Average Percentage of Total Stock Market Value Held by OASDI

2001-14	1.9%
2001-20	2.9%
2001-30	3.7%
2001-40	3.7%
2001-50	3.4%

Stephen C. Goss

The National Bipartisan Commission on the Future of Medicare

Senator John Breaux	Congressman Bill Thomas
Statutory Chairman	Administrative Chairman

Contact: Rusty Jabour, (202) 252-3394
Website: http://medicare.commission.gov

Commission Meeting

Tuesday, January 26, 1999

Cannon Caucus Room, 345 Cannon House Office Building
Washington, D.C.

This package contains the:

Agenda
List of Commissioners
Discussion Materials

PLEASE NOTE: The draft proposal presented at this meeting by Chairman John Breaux does not represent a Commission recommendation.

The National Bipartisan Commission on the Future of Medicare

Senator John Breaux Statutory Chairman	**Congressman Bill Thomas** Administrative Chairman

Meeting Agenda

Tuesday, January 26, 1999

Cannon Caucus Room, 345 Cannon House Office Building, Washington, D.C.

PLEASE NOTE: The draft proposal presented at this meeting by Chairman John Breaux does not represent a Commission recommendation.

Presentation of Draft Proposal and Discussion

Chairman John Breaux has authored a draft working document which outlines a proposal to reform the Medicare program. He will present his proposal to the Commission for discussion.

The National Bipartisan Commission on the Future of Medicare

Senator John Breaux Statutory Chairman	**Congressman Bill Thomas** Administrative Chairman

List of Commission Members

Stuart H. Altman
Professor of National Health Policy
Brandeis University, Waltham, Massachusetts

Michael Bilirakis
U.S. House of Representatives
Florida

John Breaux
United States Senate
Louisiana

Colleen Conway-Welch
Dean of the School of Nursing
Vanderbilt University

John Dingell
U.S. House of Representatives
Michigan

Bill Frist
United States Senate
Tennessee

Illene Gordon
Mississippi Congressional Staff
Honorable Trent Lott

Phil Gramm
United States Senate
Texas

Samuel H. Howard
Chairman, Xantus Corporation
Nashville, Tennessee

Robert Kerrey
United States Senate
Nebraska

James A. McDermott
U.S. House of Representatives
Washington

John D. Rockefeller, IV
United States Senate
West Virginia

Deborah Steelman
Attorney
Washington, D.C.

Bill Thomas
U.S. House of Representatives
California

Laura D'Andrea Tyson
Dean of the Haas School of Business
University of California at Berkeley

Bruce Vladeck
Professor of Health Policy
Mt. Sinai School of Medicine, New York, N.Y.

Anthony L. Watson
Chairman and CEO, Health Insurance Plan
New York, N.Y.

Photos and biographical sketches of the Commission members are available through our website at http://medicare.commission.gov

DRAFT WORKING DOCUMENT
Medicare Commission

January 22, 1999 (9:30 am)

This document is guided by the statute creating the National Bipartisan Commission on the Future of Medicare and is a product of what the Chairman learned through the process of the Commission's meetings and work over the past year.

As directed by statute, the Commission must address Medicare's financial instability and make recommendations addressing the solvency crisis facing the program. Once Medicare is on firmer fiscal footing, our first priority should be to modernize and rationalize Medicare's benefit package. Using a portion of any budget surplus that materializes to shore up Medicare can help, but it won't solve the problem. Premium or tax increases should not be considered until the Commission addresses the government's ability to meet its commitment to fund Medicare's current benefit package.

One of our early witnesses, Robert Reischauer, expressed the problems facing the Medicare program in terms of the four "i's": insolvency, inadequacy, inefficiency and inequity. In terms of its solvency, there are many indicators of Medicare spending and its projected impact on the budget. For example, Medicare will grow from 12 percent of the federal budget to 28 percent in 2030 under our most optimistic baseline. Medicare's Hospital Insurance (HI) trust fund, which is funded primarily with payroll taxes, will be insolvent beginning in 2008.

The program is inadequate insofar as its benefits package does not reflect modern notions of comprehensive health care coverage and isn't comparable in scope, quality and structure to the health benefits generally available to employed persons and their dependents. The system of government-administered pricing causes inefficiencies in the way health care services are delivered to seniors and providers have little incentive to provide the most cost-effective care. Lastly, the current program is inequitable in that there is no geographically uniform or constant set of benefits. If a beneficiary lives in southern California or Florida, Medicare will pay for prescription drugs or dental benefits if the person joins an HMO. If a beneficiary lives in rural Nebraska, he or she gets nothing approaching such benefits. Additionally, Medicare only covers approximately half of the health care costs of beneficiaries and one survey indicates that the actuarial value of Medicare's benefit package is in the 20th percentile of those of most private employers.

The proposal outlined below, which is based on a premium support model, aims to modernize Medicare's benefit design and correct the four "i's". It will allow beneficiaries to combine in an integrated and comprehensive form all sources of support for their health care coverage while ensuring that Medicare is more efficient and more responsive to beneficiaries needs. It also guarantees low-income protections so that all beneficiaries have meaningful access to quality health care, including the traditional Medicare fee-for-service plan.

These recommendations should be a blueprint for Congress to enact comprehensive legislation to fundamentally restructure Medicare over the next several years. Our nation's health care delivery system is constantly evolving and given the uncertainty of long-term health care spending projections and the advances in medical technology, Medicare will have to be revisited at regular intervals.

SUMMARY

- This proposal would model Medicare on a system patterned after the Federal Employees Health Benefits Program (FEHBP). It would allow for a blend of existing government protections and market-based competition. It would also guarantee financial protection for low-income beneficiaries.
- Medicare's fee-for-service program will operate as part of this new system and HCFA will be given the tools it needs to modernize and compete accordingly.
- This proposal will reform the Medigap program to make it more efficient and to try to minimize the adverse effects of first dollar coverage.
- The eligibility age for Medicare will increase to conform with the eligibility age increase scheduled for Social Security. A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.

I. PREMIUM SUPPORT

A. Administrative Structure

- A Medicare Board will be established to oversee and negotiate with private plans and the government-run fee-for-service plan and to approve plan service areas. The board will have authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries.

B. Benefits Package

- Plans participating in Medicare would be required to offer a standardized core benefit package defined in statute (e.g., hospital, surgical, inpatient, etc.).

Participating plans would have some flexibility on design details (i.e. cost-sharing, copays) but the Medicare Board would have final approval. Private plans participating in premium support will be required to offer benefits at least equivalent to the package offered in the government-run fee-for-service plan.

- Plans can offer additional benefits beyond the core package. Much like the negotiations process between plans and OPM in FEHBP, benefits will be updated through the annual negotiations process between plans and the board. The board will be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan will be revamped by modernizing cost-sharing and by combining the Parts A and B deductibles. One example of a modernized cost-sharing structure would be to have a combined deductible of $350, charging 20% coinsurance for everything except hospital and preventive care and charging 10% coinsurance for home health.

C. Calculating Medicare's Premium

The government-run fee-for-service plan will bid nationally based on its actual and projected claims costs. Other plans can choose to bid nationally, regionally or in local areas. The Board would oversee the designation of service areas to ensure access in areas that would otherwise have limited plan availability.

- Under an FEHBP system, total Medicare premiums for plans in a given area will be based on a national schedule similar to that used in the FEHBP system. The overall cost of plans will be based directly on their bids and the negotiations process with the Medicare Board.

a) Government's Contribution

- The government's contribution will be based on a percentage of the national weighted average premium. Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental costs of choosing more expensive plans. The government's contribution as it is made to the plan that the beneficiary chooses will be adjusted for health risk and other factors.

b) Beneficiary's Contribution

- The beneficiary's contribution will be based on the cost of the plan chosen with beneficiaries paying a minimum percentage of the premiums based on their income. The government contribution will stop increasing and beneficiaries will pay the full incremental costs for plans above a certain threshold (e.g., 100% of the cost of average plan). Both the beneficiary and government contribution toward the cost of the average plan will rise and fall in the same proportion as the cost of that plan changes from year to year.
- Higher-income Medicare beneficiaries should be required to pay a larger share

of their Medicare premiums than moderate and low-income beneficiaries. Income-related premiums will apply to both private plans and the government-run fee-for-service option.

- Premium support subsidies should be sufficient to ensure that low-income beneficiaries have access to necessary health services and have a meaningful choice of plan options. The revenue generated by income-relating the premium for upper-income beneficiaries will be primarily dedicated to subsidizing premiums for low-income beneficiaries.

II. MODERNIZING MEDICARE FEE-FOR-SERVICE

- The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries. In accordance with Congressional and Board oversight and approval, the government-run plan will have flexibility to modify its payments rates and its arrangements with contractors as well as offering benefit enhancements if they are financially feasible in a competitive environment.
- The government-run fee-for-service plan will have a premium just like the private plans participating in a premium support system. To enable the government-run fee-for-service plan to compete with private plans in a premium support system, HCFA would be given management tools adopted by the private sector. These reforms include things such as enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

III. MEDIGAP REFORM

- In order to keep fee-for-service costs affordable, Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost.

IV. MISCELLANEOUS

- Medicare's eligibility age will be gradually increased to match the Social Security retirement age. It is also recommended that Social Security and Medicare be reformed in conjunction with each other because of the interrelated effects of these programs on the retirement security of older Americans.
- A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.
- Graduate Medical Education: Payments for Direct Medical Education (DME) would be carved out of the Medicare program--financed and distributed

independent of a premium support system. The Chairman assumes that federal support for DME would continue through either a mandatory or discretionary appropriations program. Since the funding source would shift from the HI payroll tax to general revenue, the Chairman believes that it is appropriate to include institutions not currently eligible for Medicare GME support that conduct approved residency programs, such as free-standing children's hospitals. Similarly, the long-term solution for indirect medical education (IME) may involve a carve-out from Medicare. For now, however, the Chairman believes that the Medicare program should continue to pay for differences in costs between teaching and non-teaching hospitals through the indirect medical education (IME) adjustment. However, the Chairman recognizes that the level of the Medicare IME adjustment may need to be aligned gradually over several years with what analyses show is the actual statistical difference between teaching and non-teaching hospital costs. The Chairman believes that Disproportionate-Share Hospital (DSH) payments and other subsidies within the Medicare program should be revisited to ensure that Medicare's support is reasonable and appropriate. The Chairman notes that these subsidies could be carved out of the Medicare program and financed through a mandatory or discretionary appropriation program. However, the Chairman recognizes that any changes in federal support should continue to recognize the additional costs to hospitals of treating large numbers of low-income individuals.

V. REVENUE AND FINANCING

- The primary source of income to the Hospital Insurance (HI) trust fund is the payroll tax. The 2.9 percent tax on all earned income accounts for 88.3 percent of the total $121.1 billion in income in 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.
- The Supplementary Medical Insurance (SMI) trust fund is financed from premiums paid by the users of Part B and from general revenues. When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Premiums over time dropped to 25% of program costs because Part B costs increased much faster than the inflation computation that was used to compute the upward premium adjustment.
- Under current law, the proportion of financing sources are expected to change over time, with the portion represented by payroll taxes decreasing and the portion represented by general revenue increasing. By 2030, premiums and payroll taxes are expected to fund only 31-35 percent of Medicare's

expenditures compared to 63 percent in 1997. In 2030, 64-70 percent of Medicare will be funded through general revenue (or other funding) as compared to approximately 28 percent in 1997.

- The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms will result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and will enhance our ability to stand by our commitment to today's and future beneficiaries. Even if projected budget surpluses materialize, without these changes, significantly greater revenues and/or beneficiary sacrifices will be required in the future and beneficiaries will not receive the greatest value for the total health dollars spent on their behalf.

VI. AREAS THAT NEED RESOLUTION

- DRUGS--open issue--the Chairman is exploring several options for including a prescription drug coverage.

- Changes to provider payments

VII. ALTERNATIVE DESIGN OPTIONS

The following are examples of elements of a premium support system that could be changed to arrive at a different model than the one described above.

- National vs. Regional Bidding: Under a national bidding structure, a geographic adjuster is necessary to create a fair and equitable system. A geographic adjuster would also address the fact that Medicare spending varies by a factor of more than three across regions with seemingly similar populations and with no demonstrable differences in health outcomes. Under a national schedule, national plans such as the government-run fee-for-service could compete in a straightforward and fair way. Beneficiaries in national plans would pay the same amount regardless of where they lived. Under a regional bidding system, a geographic adjuster would not be required but some provision would have to be made to allow fair competition between local and national plans such as fee-for-service and to prevent regional inequities in beneficiary premiums.
- Benefits Package: Plans would be required to offer and compete on a core benefits package. Unlike the model described above, additional benefits could only be offered in a supplemental plan that would have to be sold and marketed separately from the core package. This would ensure that plans compete on the basis of cost and quality, not on the basis of the benefits offered.

COMPARISON BETWEEN COMMISSION MODEL AND REGIONAL BIDDING

	FEHBP Model	Regional Bidding Model
Are benefits standardized?	No: FFS would be marginally improved Private plans would offer the actuarial equivalent of FFS plus any supplemental benefits they choose	Yes: All plans (FFS and private plans) would offer the same standardized benefits. Private plans could offer supplemental benefits under limited circumstances.
Basis of the government contribution	Rate schedule based on a formula linked to the national average premium	Median (or other type of) bid in a region
Does the government contribution include supplemental benefits?	No in FFS Yes in private plans	No: In both FFS and private plans, beneficiaries would pay the full amount (note: it could be subsidized)
Is the government contribution regionally adjusted?	Yes: half of the total geographic variation in costs would be taken into account through a formula; the beneficiaries would pay the other half	Not explicitly: All bids in the region automatically include local costs.
How is the beneficiary premium set?	Rate schedule based on a formula linked to the national average premium	Dollar amount that is the sum of a national Part B-like premium, a premium for extra benefits, and the difference between the median and bid (if higher)
What would a beneficiary pay to stay in FFS?	National amount based on rate schedule. Because the schedule is linked to the national average premium that includes FFS, it will probably not be very different than the national average premium (12%) so long as FFS enrollment remains high.	Regional amount (same as private plans). Because the total would be the sum of the national Part B-like premium and regional amounts, it would be a blend of a national and regional rate

PREMIUM SUPPORT (For Background Only)

CONCEPT OF PREMIUM SUPPORT Combines elements of defined benefit and defined contribution to improve Medicare's efficiency.

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.

- **Total premium**: Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.

- **Government payment**: The government contribution toward that premium would be limited (e.g., a percent of the premium up to a cap and/or as a flat dollar amount).

- **Beneficiary payment**: Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.

- **Savings**: Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

COMMISSION PREMIUM SUPPORT MODEL

- **Beneficiary payment**: This amount depends on the relationship between the plan's premium and the national average premium. (Note: would be geographically adjusted)

    - Below average plans: 12 percent of the premium
    - Above average plans: 12 percent of the national average plus every dollar that the premium is above the national average.

- **Government payment**: 88 percent of the premium up to 88 percent of the national average.

- **Issues With Commission Model**:
    - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.

    - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. This also means that this model will not reduce Medicare costs.

November 17, 1998

The Uncovered

Drug Costs Can Leave Elderly a Grim Choice: Pills or Other Needs

When a Trip to the Pharmacy Costs $400, and Medicare Doesn't Pay for Any of It

Buying Medicines on Credit

By LUCETTE LAGNADO
Staff Reporter of THE WALL STREET JOURNAL

An aging black-and-white photograph sits on a coffee table in Jewel Brown's immaculate home on a quiet street in Durham, N.C. It shows her as she was half a century ago, a dazzlingly pretty young woman with dark, wavy hair and a hopeful smile.

Today, Mrs. Brown is elderly, ailing and all but broke. She suffers from chronic emphysema, high blood pressure and arthritis. She nearly died from pneumonia earlier this year, and in October was hospitalized for major complications. Now age 70, she qualifies for Medicare, the federal government's massive program that is supposed to insulate the elderly from the devastating costs of health care.

Jewel Brown

Yet Medicare has always had a glaring hole in the safety net: With few exceptions, it doesn't cover the costs of prescription drugs—the single largest health-care expense for the elderly.

As a result, some months Mrs. Brown spends up to $400 for medications, more than 30% of her income. Prilosec calms her stomach but sets her back $102.59 for a 30-day supply. Then there are Norvasc for her blood pressure ($43), two inhalers to help her breathe easier ($88 total), two pain medications ($70), nitroglycerin patches for angina ($27.89) and Theophylline to clear her lungs (a bargain at $16.37). Recently, her doctor prescribed Miacalcin, a nasal spray that helps strengthen her bones but depletes her purse by $55.43 a month.

"I need help, I need help real badly," Mrs. Brown says in a raspy voice. She worked for years as a short-order cook and as a caretaker for Alzheimer's patients but gets no pension, living on $780 a month in Social Security and $500 a month in rent from a boarder. She ran up more than $12,000 in credit-card charges between 1994 and 1996 to buy the medications she otherwise couldn't afford. Her daughter, Rebecca, who lives with her, took a second mortgage on their home to pay off her mother's high-interest debt, but Mrs. Brown has had to charge another $2,500 in drugs. She recently resorted to applying for food stamps, but was given only $10 a month in benefits.

Pricey prescription drugs are driving a new surge in health-care costs, but most Americans don't feel it: Their employer insurance plans typically cover most of the expense. But for Mrs. Brown and millions of people in the ranks of "the uncovered," the impact is far more severe.

HARD TO SWALLOW

America's Soaring Drug Costs

PART OF A SERIES

About 19 million elderly people in the U.S. have little or no drug coverage at all, according to the Congressional Budget Office. Nor do an estimated 43 million younger Americans—the unemployed, the working poor, immigrants, illegal aliens, single mothers in part-time jobs—who lack health insurance of any kind.

"There is an absolute inequity in our system," says Aaron Miller, a neurologist who treats multiple-sclerosis patients at Maimonides Medical Center in Brooklyn, N.Y. "The sickest patients are also the most disadvantaged when it comes to drugs." Many of his patients can't afford the $10,000 a year that the newest MS drugs cost, so he tries to get them into clinical trials—even though they have only a 50% chance of getting the real thing rather than a placebo.

The drug crunch is worst for America's elderly. People age 65 or older make up 12% of the U.S. population but consume almost 35% of all prescription drugs. Excluding insurance premiums, drugs account for 34% of older people's total health-care bill, more than doctor visits (31%) and hospital admissions (14%), according to David Gross, a senior policy adviser at the American Association of Retired Persons.

What's more, about 65% of people 65 ar older have two or more chronic diseases, do 80% of people over 85, the AARP says. As result, one in five elderly people takes at lea five prescription drugs a day. About 2.2 m lion seniors shell out more than $100 a mon for medication, and many pay even more.

Yet Medicare pays for none of Medicare, the Great Society program e acted under President Johnson in 19 now covers health care for nearly 40 m lion people, including millions with disab ities, at a cost of $200 billion a year. E panding it to pay for drugs would cost extra $20 billion annually, according to t CBO. But in an era when balancing the fe eral budget has been a top priority, Co gress has consistently resisted such a tion—in no small part because of inten opposition from the drug industry, whic fears that Medicare coverage might ope

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Soaring Drug Costs Can Leave Elderly With Grim Choice

Continued From First Page

the way for government price controls.

Five of the 10 top-selling prescription drugs in the U.S. are products heavily used by elderly patients. The aged account for 33% of the sales of No. 1-ranked Prilosec, the anti-ulcer remedy, and generate almost 50% of the sales of the No. 9 entry, Norvasc for high blood pressure, according to Scott-Levin, a research firm in Newtown, Pa.

Roughly half of Medicare-covered patients get some drug assistance, because they are also covered under employer-sponsored insurance plans for retirees, are members of HMOs or are poor enough to qualify for state Medicaid programs, which do pay for prescriptions. But the other half go it alone, and the sicker they are, the less likely they are to get any kind of prescription benefits from insurers. "They don't sell insurance plans to houses already on fire," says Michael Knipmeyer, a lawyer at a legal clinic for seniors run by the George Washington University Law School in Washington, D.C.

Left to their own devices, millions of these elderly resort to resourceful but dubious solutions. They rack up big credit-card debts, plead with their doctors for free samples and forgo basic necessities and little luxuries. Some cross the border into Mexico or Canada, where some drugs are much cheaper because of government price controls. Others go without their prescriptions altogether or skip doses to stretch out their supply, often resulting in medical complications that can send them to the hospital.

Cora Albright

Cora Albright, an 84-year-old widow who lives 10 minutes away from Jewel Brown, sometimes skips her medications to make them stretch, a classic habit of the "near poor" elderly. Mrs. Albright, who worked for more than 30 years in a hospital laundry, subsists on a pension of about $90 a month and $700 a month in Social Security. But she spends $200 a month—more than 25% of her income—to stock her medications, including Prilosec, the Astra anti-ulcer drug that costs her more than $100 out-of-pocket, Megace to increase her appetite and Remeron, an antidepressant.

"Then there is the oil bill, the telephone bill, the water bill, the light bill. I have to pay them, and it is a struggle," says Mrs. Albright, who spends much of the day in a wheelchair in her dark living room, her swollen legs swathed in bandages. "It takes about everything I get to make ends meet."

"People are making big-time decisions on what medicines they'll take versus what utility bills they will pay," says Gina Upchurch, director of Senior PharmAssist, an organization she founded in Durham that helps seniors who make too much to qualify for Medicaid but are too poor to afford their medicines. Yet hers is a small program, and there is a long waiting list of people hoping to get in, including Mrs. Brown and Mrs. Albright.

"The system makes no bloody sense," says Frank Larkin, president of Good Samaritan Hospital in Brockton, Mass. "Does it make sense that we give people costly surgeries but we can't give them prescriptions?"

The uncovered elderly, moreover, can end up paying higher prices than the rates paid by HMOs and drug-benefit programs. The drug industry has always denied that such "cost-shifting" occurs. But experience reveals otherwise. At Upchurch Drugs, an independent pharmacy in Durham, owner David Upchurch notes that HMOs get a month's supply of Norvasc, for hypertension, for $33.80—25% less than what Jewel Brown pays.

"Prices are going up for those people who pay cash," Mr. Upchurch says. "We don't have any choice. If you are forced to raise prices, it will happen only where you can—and that tends to be the elderly."

In the absence of a federal drug-benefit program, the poorest of the elderly get some help from Medicaid programs for the indigent. In the past four years, Medicaid's costs have grown by 6% a year, while the cost of drug benefits rose at more than twice that rate, according to data collected

Fixed-Income Busters

Among the top-selling drugs are used heavily by seniors, one of the groups least able to afford them. Sales and ranking data are for January through September 1998.

DRUG	USAGE	PRICE (one-month supply)	SALES (billions)	% OF SALES TO SENIORS
Prilosec	Anti-ulcer	$116.09, 20 mg	$2.1	33%
Prozac	Antidepressant	$75.04, 20 mg	1.7	8
Lipitor	Controls cholesterol	$84.60, 20 mg	1.2	38
Zocor	Controls cholesterol	$105.48, 20 mg	1.2	47
Zoloft	Antidepressant	$71.41, 50 mg	1.1	18
Claritin	Anti-allergy medication	$69.57, 10 mg	1.0	12
Paxil	Antidepressant	$71.84, 20 mg	0.9	16
Prevacid	Anti-ulcer drug	$107.83, 30 mg	0.9	28
Norvasc	Controls high blood pressure	$70.23, 10 mg	0.9	49
Augmentin	Antibiotic	$97.34*, 875 mg	0.7	7

*10-day

Source: Scott-Levin, Pa.; Upchurch Drugs & Optical, Durham, N.C.

ministration, [illegible] one of the fastest-growing parts of the Medicaid budget and a part that is exceptionally hard to control," says James Verdier, a Medicaid expert at Mathematica Policy Research Inc., a Washington, D.C., social-service research firm.

But even Medicaid is a patchwork. In North Carolina, people's earnings must be 26% below the poverty level to qualify for Medicaid (the federal poverty level is pegged at $8,052 a year for an individual and $10,860 a year for a couple). In Illinois, an older person's earnings must be 46% of the poverty level. In Massachusetts, patients can earn 33% *more* than the federal poverty level and still get state benefits: that, however, doesn't apply to the elderly, who have to be at the poverty level to qualify, according to Health-Care for All, a Boston advocacy group.

So in some states, thousands of older and disabled people are too poor to afford their prescriptions, yet not impoverished enough to receive coverage. Experts use a buzz-phrase for these patients: the near poor.

Roland and Bessie Pennington, who have been married for 57 years and live in a modest housing project in the shadow of the Capitol in Washington, would seem to be a slam-dunk for Medicaid. Mr. Pennington is 84 and has been retired from his boiler-repairman job for 26 years. He takes 10 prescription drugs to quell high blood pressure, gout, arthritis pain and angina, meticulously tracking every expense and saving every receipt. Last February, for example, he spent $235.09 on drugs, 32% of his monthly Social Security payment of $739. Mrs. Pennington's $350-a-month Social Security check is used by the couple to buy groceries and pay $255 in monthly rent, which was recently reduced to $83.

Yet Mr. Pennington has applied for—and been rejected by—Medicaid four times. Under local Medicaid rules, the couple's combined income is $154 a month over the limit.

So Mr. Pennington improvises. Early each month, he buys only half the prescribed quantity of his most expensive drugs, such as Nitrodur for angina ($51.29 for a full month's supply); then he buys the rest two weeks later—his fear is that he will run low on cash, and so this is his way of budgeting. And rather than use the drugstore a block away from his home, he drives his temperamental 1987 Chevrolet six miles to his old neighborhood and the Safeway he has patronized for 20 years. When he is short of money, the Safeway pharmacist advances him some pills, knowing Mr. Pennington will promptly return to pay up when his Social Security check arrives. The pharmacy near his current home refused to do that.

Sue Andersen, a lawyer at the George Washington University legal clinic, has been trying to help the Penningtons qualify for Medicaid. "The very poor get a free ride, but it is the lower-middle classes who are stuck with bills of $2,000 or more a year," she says.

Even aging patients who are financially better-off can feel the pressure. Nathaniel Ashkenaz, 79, a retired appliance repairman, and his wife Thelma, 75, live in El Paso, Texas, on a comfortable pension of $22,800 a year. Yet he worries constantly about how to pay $300 a month in drugs to treat his ulcer and Thelma's diabetes. He crosses the border into Juarez, Mexico, each month to buy 100 Zantac tablets for his ulcer for $24, one-fourth the price he would pay in Texas. But [illegible] cost-lowering Zocor, $33 for Norvasc.

To offset some of the cost, Mrs. Ashkenaz tried to purchase through the AARP a "Medi-gap" insurance policy which typically covers half of drug costs. But she was turned down because she was on too many medicines, her husband says. "They said 'Sorry, we can't accept you.'" Then in September, his wife underwent an emergency quintuple-bypass operation, and since has required a slew of additional medications, including Coumadin, at $47, and Amaril for diabetes, at $23.29.

"We are retired and we are getting by, but we aren't rich," Mr. Ashkenaz says. "We can't afford luxuries. We would like to take a trip or go on a cruise, but it isn't feasible."

The high cost of drugs also shakes the lives of the young and uninsured. In Brockton, a depressed mill town in eastern Massachusetts, local churches and synagogues have banded together to raise money to dispense free drugs to the poor. On a recent evening, the small waiting room of the Brockton Neighborhood Health Center is crowded with two dozen people hoping to snare free prescriptions—mothers struggling to rein in their children, young men, elderly couples—most of them immigrants from Haiti, Cape Verde, Puerto Rico, Swaziland and the Caribbean.

Maria Chadderton, 41, sits nervously fingering the six prescriptions she has never filled. They are dated from June, and include drugs she needs to manage her diabetes and high blood pressure. "I couldn't fill them. I scarcely have money to get to work," she says. Her take-home pay for working up to 12 hours a day as a home health-care aide has been at most $800 a month, she says. Filling the prescriptions, which include pricey drugs such as Vasotec for blood pressure and Glucophage for diabetes, would set her back a couple of hundred dollars, leaving her unable to pay the rent and buy groceries, she says.

As someone who cares for the ill, Ms. Chadderton has no illusions about the risks she is taking by forgoing the drugs. "I can go into a coma," she says.

"We see this all the time," says Sue [illegible] comes a choice between filling a prescription and eating." Even so, she says, clinic doctors are under strict orders to give out free medication only to those who expressly state they can't afford it. "If we met all the demand, we would go bankrupt," she says.

Yet even higher costs loom when people don't get adequate access to prescription drugs, says Stephen Soumerai, who has studied the issue and is chairman of Harvard University's Drug Policy Research Institute. Elderly people who don't get sufficient medication often get too sick to stay independent and end up in the hospital or a nursing home, where care is far more expensive, he says. About 75% of doctor visits result in prescriptions, yet Medicare pays for the visit but won't pay for the resulting therapies, he complains.

"Drugs are the glue that holds the medical system together," Dr. Soumerai says. "We can't afford not to cover people with chronic illnesses, or whose independence rests on access to medications."

Four hours away from Brockton, in the quaint Norman Rockwell country of western Massachusetts, day laborer Ralph Carsno is learning the hard way what it means to be both unhealthy and uninsured. A 38-year-old diabetic, he returned to North Adams, his hometown, a year ago after losing his job in Florida. In July he underwent emergency surgery to clear blocked heart arteries. The surgery was free under a Massachusetts program for the uninsured, but he balked when the pharmacy wanted to charge him more than $200 out of pocket for two pricey medications—Lipitor and Zestril—to manage his cholesterol and hypertension problems.

"It was a pretty good chunk of money to spend the day I got out of the hospital, and it really would have put a dent in my budget," Mr. Carsno recalls. He purchased only half the prescription, hoping to scrape together enough money to fill the rest later on. So far, though, he has been recuperating and hasn't earned enough to follow through.

A local aid group, Ecu-Health Care, which comprises local doctors, hospital executives and volunteers, has been trying to help Mr. Carsno. Officials successfully prevailed upon the two companies that make Lipitor and Zestril—the Parke Davis division of Warner-Lambert Co. and Zeneca Group PLC—to hand out free supplies to tide Mr. Carsno over for several months until he can find a job with full drug benefits.

The industry pledged to redouble its efforts to help the indigent even as it fought the Clinton health-reform plan in the early 1990s, but progress has been uneven. The industry says it helped nearly a million people last year with drug giveaways, but the application and approval process differs from company to company.

But Ecu-Health Care officials see the Carsno victory as merely a temporary and unsatisfactory solution. "It's hit and miss—we don't know what we are going to do for folks from month to month," says Charles Joffe-Halpern, Ecu's director. He offers people hope only "on a temporary basis," he says.

Drug Dependency

U.S. Has Developed An Expensive Habit; Now, How to Pay for It?

Scores of Pricey New Pills Improve Quality of Life, But Bust Health Budgets

Toenail-Fungus Cure: $500

By ELYSE TANOUYE
Staff Reporter of THE WALL STREET JOURNAL

America has a new drug problem.

A revolution in pharmaceutical research, a billion-dollar marketing blitz and Americans' voracious appetite for Viagra, Claritin and a host of other pricey pills are driving drug spending to record-high levels. And nobody, it seems, knows what to do about it.

Retail pharmacies will rack up an estimated $102.5 billion in sales of prescription drugs by year end, up 85% in just half a decade. Drug sales in the U.S. are rising 16.6% this year, more than four times the increase in health-care spending overall. And at a time when prices of other manufactured goods have declined by 1%, some generic drug makers have raised the prices of many medications by 10% or more in the past year.

For pharmaceutical companies and their shareholders, the news could hardly be better: Profits for U.S. drug makers are expected to grow 16% to 18% a year for the next four years, far outpacing the 4%-to-7% growth forecast for the nation's top 500 companies.

But the surge is ominous for plenty of others: companies looking to get a handle on employee prescription costs; government-funded health plans weighing the benefits of new therapies against other medical expenditures; uninsured patients who must choose between ever-more-expensive prescriptions and forgoing treatment altogether.

At auto maker Chrysler, spending for employees' prescription drugs has risen 86% in five years to more than $220 million. At Blue Cross Blue Shield of Michigan, drug outlays now represent 28% of total expenditures—more than the amount spent by the health plan on doctor visits. California's Medicaid program for the poor is expected to run 10% over its $1.4 billion pharmaceutical budget for the year because of a spike in drug spending.

HARD TO SWALLOW
America's Soaring Drug Costs
FIRST IN A SERIES

The reasons behind the run-up are many and complex. Great advances in research have allowed drug makers to crank out a profusion of new—and expensive—chemicals aimed at treating diseases that were once invincible: AIDS, arthritis, breast cancer, schizophrenia, Alzheimer's, as well as less grave conditions like baldness, wrinkles, toenail fungus and impotence. But with the new drugs have come soaring development costs, especially for clinical trials, the most expensive part of drug development. At the same time, the growth in generic drugs has failed to bring about a much-anticipated drop in pharmaceutical spending overall.

"Given the rate of innovation in the industry, this situation is going to continue," says Raymond Gilmartin, chairman and chief executive of Merck & Co., maker of the AIDS therapy Crixivan, the cholesterol-lowering Zocor and osteoporosis treatment Fosamax.

Medicating an Aging Population

The pharmaceutical frenzy is expected to get worse in coming years, as drug giants crank out more new medications to salve an aging population. The ranks of people over age 65 will double to about 70 million by the year 2030, growing to 20% of the U.S. population from 13% now. On average, people over 65 fill between nine and a dozen prescriptions a year, compared with two or three for people between the ages of 25 and 44.

"We have a very short window to fix this," says Woodrow Myers, director of health-care management at Ford Motor Co., where drug costs consumed 19% of the $1.5 billion the auto maker spent last year on employee medical costs, up from 14% in 1994. "It will get to a point in a couple of years where there will be so many great new products that more and more people can't afford."

While prices of some drugs are rising sharply, higher prices are contributing only 3.2 percentage points of the 16.6% increase in drug spending this year, according to IMS Health Inc., Plymouth Meeting, Pa. A far more important factor: Americans are increasingly demanding the latest brand-name drugs in a ferocious attempt to preserve their health—and their youth.

Marketing Muscle

That owes largely to the marketing might and research prowess of drug makers. They have spent billions building their prescription portfolios, which they once promoted only to doctors, into some of the hottest and most heavily advertised consumer products of the 1990s.

A decade ago, advertising prescription drugs directly to consumers was deemed unseemly. Print advertising began to take off a few years ago after some campaigns, such as Schering-Plough Corp.'s for the antihistamine Claritin, fueled big sales increases. A change in regulatory restrictions on television ads last year unleashed a flood of new commercials.

This year, drug marketers will spend $1.3 billion on consumer ads, seven times what they spent five years ago, according to IMS. In the process, Americans, once merely passive recipients of prescriptions, have turned into savvy and demanding consumers who insist on getting the latest and greatest drugs, even when older and cheaper medications might suffice. And why not? About 192 million Americans, or about three-quarters of the U.S. population, have some sort of prescription-drug insurance that requires them to put up only a small "co-payment" of several dollars to $25 for each prescription.

Pharmaceuticals once were a relatively cheap part of health costs, commonly no more than $2 a pill a few years ago. The new-generation drugs cost $4, $11, even $15 per pill, and they tend to be used far more widely than their predecessors, over longer periods and for a broader range of long-lasting diseases.

The way pharmaceutical companies, as well as many caregivers and patients, see it, investing in drugs now helps avoid far more expensive medical procedures down the road. "Pharmaceuticals are the most cost-effective, value-added, least-invasive part of the health-care system," says Alan F. Holmer, president of the industry's trade group, Pharmaceutical Research and Manufacturers of America, or PhRMA.

The logic is akin to the commercial for one brand of automobile oil filters: "Pay a little more now—or pay a lot later." In recent years, employers and insurers have bought heavily into the pay-me-now premise. But as their drug budgets swell, they will look harder at whether this premise is actually true.

Drug Rations

"All of the new designer technologies . . . have the capacity to increase the quality of life. All are going to be very expensive, and it's going to literally break our bank around the year 2005," says Alan L. Hillman, director of the center for health policy at the University of Pennsylvania. Society will then have to decide how to ration the new technologies, he says.

But how does society calculate the value of drugs that let a 70-year-old woman stave off osteoporosis and spend five more years gardening, when she otherwise might have withered away in a wheelchair? New AIDS drugs have sent mortality rates plunging and pared hospital and other costs, but in the short-term the total costs of treating HIV-infected patients haven't fallen much, according to one study by Merck, maker of Crixivan. The dollars have simply been redirected from hospitals to drug makers.

The federal government has largely left it to private enterprise to hammer out these issues. America is virtually alone among major industrial countries in forgoing controls and letting the market set drug prices. The United Kingdom imposes profit controls, France has a complex system of price controls, and Japan orders broad price cuts every year.

No. 1 in New Remedies

As a result, U.S. firms lead the world in drug development. U.S. companies produced almost half of the new drugs introduced around the world between 1975 and 1994, far more than the next-largest contributor, the U.K. with 14% of the output,

according to figures cited by PhRMA. And the pace is accelerating: The drug industry put out new medications from to 1997, and 30 or so are expected to have made their debut by the end of this year. Merck has introduced eight new drugs and vaccines since 1996, among them Crixivan and the baldness drug Propecia; Warner-Lambert Co. eight, including the cholesterol-lowering Lipitor and diabetes drug Rezulin; and Pfizer five, including the impotence pill Viagra and antibiotic Trovan.

America, says Pharmacia & Upjohn Inc. Chief Executive Fred Hassan, "is the locomotive of growth not only for our company but the entire industry. It is the best market for new products and innovation." Which is why Pharmacia, maker of incontence treatment Detrol and baldness treatment Rogaine, recently relocated its headquarters from London to New Jersey.

But that also means that "the U.S. consumer is subsidizing that investment for the rest of the world. And it isn't fair," says Stephen J. Mock, a spokesman at Warner-Lambert.

Pushing a new drug through years of human trials can run up bills of $150 million or more, and only a tiny fraction ever make it to market. In the U.S., drug prices are typically one-third higher than in Canada and 60% higher than in Britain, according to government studies.

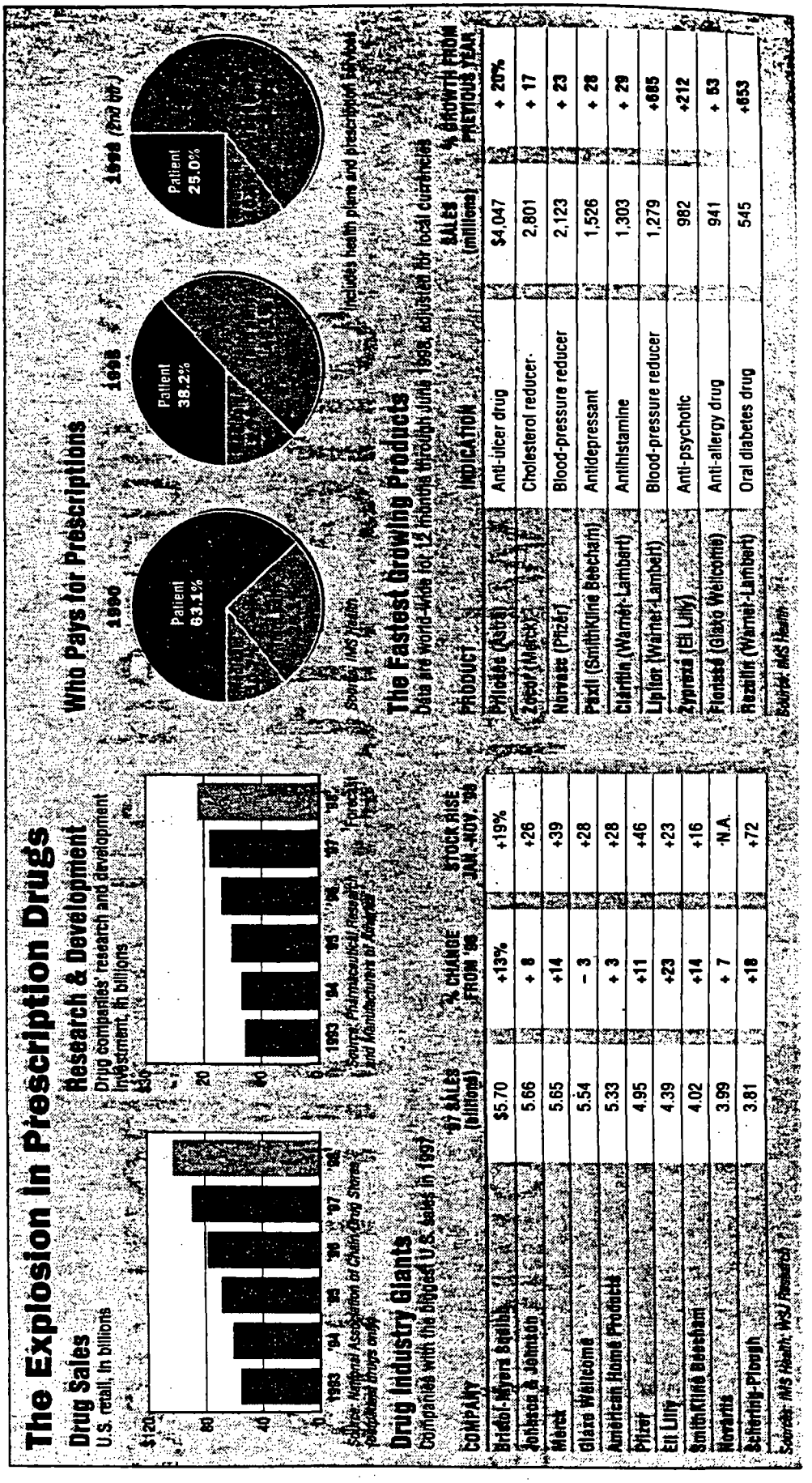
Beating the Generics

"It is the national strategy to rely on a competitive health-care system, and that relies on higher prices in the early phases" of a drug's life, says Patricia Danzon, a professor and drug-pricing expert at the University of Pennsylvania's Wharton School. Prices usually don't come down until later years, after a drug loses patent protection and generic copies start selling at a fraction of the price.

By the time the generics get to market, however, brand-name drug makers have often cranked out a new generation of higher-priced replacements. Case in point: Merck and Monsanto Co. are competing to develop a new class of arthritis painkillers called "Cox-2" inhibitors that promise relief without the severe indigestion that current medications can cause. Such side effects afflict only about 2% to 4% of patients treated for a year with pills currently on the market, several of which are generics. But many people are expected to switch anyway.

Indeed, fully half of the arthritis patients in Michigan's Blue Cross Blue Shield plan are expected to switch when the new medicines hit the market next year, says Marianne Udow, a Blue Cross senior vice president. At an anticipated $2 to $5 a pop, the pills will cost up to 17 times as much as current generic arthritis medications.

Left on their own, drug manufacturers charge rates that often have little to do with actual costs of development. Drugs that can prevent hospital visits carry a big ticket because of the purported savings they offer; others are pricey because they treat such common conditions as baldness or impotence.



Take Merck's baldness treatment, Propecia, which is made from the same chemical, but in a different dosage form, as the company's prostate-shrinking product Proscar. A one-milligram daily dose of the baldness treatment costs $1.25, while a five-milligram daily dose of the prostate medicine costs only 35 cents per milligram, or $1.73 per pill.

"The total amount of active ingredient in a product is only one of many factors in the pricing," says David Anstice, the Merck executive who runs the company's Americas pharmaceutical unit. Other considerations, he says, include competition, the drug's effectiveness, the cost of additional clinical trials, and what the company thinks the patient will perceive as the product's value.

The most important factor, however, is profit. Profit margins in the drug trade are the envy of the corporate world. Prescription pharmaceuticals boast gross profit margins of 90%, and the cost of the raw materials runs only a few cents in pills that often sell for up to $15 apiece. (At the corporate level, of course, profit margins are much lower: Gross margins, which include manufacturing costs, but not selling, research and other expenses, are around 70% industrywide. Net profit margins, after all corporate costs, are about 18% for the industry.) Viagra is pegged by one manufacturing expert at a gross profit margin of 98%, although Pfizer won't comment on that estimate.

The drug giants plow a hefty portion of their returns back into the business. Their research spending runs about 20% of total revenue, compared with 6% at International Business Machines Corp. and about 4% at Boeing Co. The drug industry will spend about $17 billion on research in the U.S. this year, more than the National Institutes of Health's budget of $13.6 billion for fiscal 1998.

Beefing Up the Sales Ranks

The business invests billions more—about $11 billion this year, according to IMS Health—to market the newest drugs to doctors and consumers. In the past two years, pharmaceutical companies have hired 40% more sales representatives, called detail people, to pitch prescriptions to doctors, pharmacies and other providers, in large part because of the huge number of new products that the firms have launched.

The recent use of direct-to-consumer advertising has also brought a remarkable change in social perceptions about prescription drugs. "Patients today don't fear them as much as they used to," says Mr. Myers of Ford, almost lamenting the trend. In fact, "patients are specifically looking for a pharmaceutical product as an easy way to deal with whatever malady they have," he says.

Alarmed at the cost, employers and health plans are trying to curb the growth in drug spending by reminding consumers and doctors about cheaper generics. They are also raising co-payments for some drugs and refusing to cover others, such as Viagra and Propecia. More than half of the employers surveyed late last year by William M. Mercer Inc. said they hoped to adopt programs that will better manage their drug costs. In Michigan, a task force of employers, labor unions, health plans, doctors and pharmacies was formed earlier this year specifically to look at ways to control pharmaceutical costs.

Health plans are taking aim first at expensive "lifestyle" drugs that make things more pleasant but don't necessarily tackle life-threatening diseases, such as Viagra, Claritin and rival allergy medicines. Not to mention Lamisil, which was heavily advertised to consumers as "the ultimate pedicure"—truth in advertising, given its cost of about $500 for a 12-week treatment for toenail fungus. A recent "Let Your Feet Get Naked" Lamisil campaign lamented, "People with nail fungus are, well, embarrassed by how their nails look."

'Good Use of Heath-Care Dollars?'

"In some cases with respect to the new pharmaceuticals, we are paying lots of money for products that marginally increase the quality of someone's life. Is that a good use of health-care dollars?" asks Bruce Bullen, the Massachusetts Medicaid commissioner and chairman of the National Association of State Medicaid Directors. Five years ago, his state's Medicaid program spent three times as much on hospital stays as it did on drugs. But drug costs are rising so rapidly they will exceed hospital costs within five years, he says.

As a rebuttal, the pharmaceutical industry often cites a 1991 study showing that when New Hampshire restricted the number of prescriptions reimbursed by Medicaid, drug use in the program declined by 35%, but admissions to nursing homes rose by 80%; admissions later returned to normal levels when the restrictions were lifted.

For the time being, the pharmaceutical industry seems more inclined to keep pumping out new drugs and impressive profits than to fret about runaway spending. But that complacency poses risks. Drug companies were vilified for high prices and handsome profits five years ago as the nation debated Clinton health reform, and were impelled to hold back price increases until the furor died down. The business could get whipsawed again if spiraling drug costs once more raise the ire of the public and politicians.

"The pharmaceutical industry is being very shortsighted by not working directly on this problem," says Ford's Mr. Myers. "I hope they don't assume that the pot is limitless, that costs can go up forever."

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

February 3, 1999

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

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

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

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

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

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

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

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. report	re: medical stories (4 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:
Medicare Reform Event [Folder 2]

2012-0463-S
rc701

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) 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]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
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]

Democrats pledge to fight GOP on 'convict-but-don't-evict' plan

Proposal might be offered on Monday

By Wendy Koch and Jessica Lee
USA TODAY

WASHINGTON — Senators of both parties are looking for a dignified way to end President Clinton's impeachment trial, but Democrats vowed Wednesday to fight a Republican approach that would condemn the president's conduct without removing him.

Republicans might offer as soon as Monday a "findings-of-fact" statement that says Clinton committed wrongdoing but does not convict him of criminal acts.

That statement would require a simple majority to pass. A conviction and removal from office requires a two-thirds majority, which almost no one expects the Senate could muster.

Republicans do not want the White House to trumpet Clinton's expected acquittal on the two articles of impeachment as a vindication.

Some were annoyed by what they called a White House "pep rally" that occurred after the House voted in December to impeach Clinton for perjury and obstruction of justice in trying to conceal his affair with Monica Lewinsky. "I call that the Rose Garden jubilee," Sen. Olympia Snowe, R-Maine, said. It was her Maine GOP colleague, Sen. Susan Collins, who first suggested the findings-of-fact concept.

White House spokesman Joe Lockhart pledged Wednesday that the White House, which objects to the findings of fact as unconstitutional, would not gloat upon an acquital.

Republicans say that their statement would give senators who do not believe Clinton should be removed from office a chance to express their dismay with his conduct.

Still, they have been split on exactly what the statement should say and whether to offer it. They met behind closed doors Wednesday but reached no consensus.

"It's not soaring. It's not falling either. It's up in the air," Sen. Robert Bennett, R-Utah., said about the plan.

Some conservatives favor a more detailed list of Clinton's alleged offenses. But a few moderates, eager to win Democratic backing, suggest a broader statement that says Clinton "willfully provided false and misleading testimony" to the grand jury.

A draft statement by Snowe, which appeared to be gaining ground, would say Clinton "engaged in a course of conduct designed to alter, delay, impede, cover up, and conceal" evidence.

Republicans, who hold a 55-45 edge in the Senate, would not need Democrats to approve the statement.

But Snowe said she would not offer her statement without support from at least five Democrats. "It really does depend on what happens with the Democrats," she said. She expects it will be much easier to woo them, now that she has precise language to offer them.

But so far, Connecticut Sen. Joe Lieberman is the only Democrat who has stated publicly he would consider a findings of fact.

By Tim Dillon, USA TODAY

'It will prolong the trial': Democratic Sens. Carl Levin, left, and Tom Harkin speak against the Republicans' planned 'findings-of-fact' statement.

By Joe Marquette, AP

Collins: The Republican senator from Maine was the one who introduced the 'findings-of-fact' strategy.

Many other Democrats, who prefer to censure Clinton after the trial, say the GOP statement is unconstitutional. They say senators must, during the proceedings, vote to acquit or convict, not do something in between that is a permanent part of the trial record.

Sen. Robert Byrd, D-W.Va., an expert on Senate rules and history, says the GOP plan amounts to a "convict-but-don't-evict" strategy that is "ersatz articles" in disguise.

"There's no constitutional or historical precedent for any findings of fact," says Sen. Tom Harkin, D-Iowa. He says if Republicans offer it, Democrats will push to amend it with their own facts and to guarantee that the White House has enough time to prepare its defense.

"If this door is opened," Harkin warns, "it will prolong the trial."

Some Republicans also expressed opposition to the GOP statement. "It gives people a middle way out. It's a bad precedent," Sen. Mike DeWine, R-Ohio, said.

The Senate has never considered a findings-of-fact statement in any of its prior 16 impeachment trials, only one of which involved a president — Andrew Johnson in 1868.

But the Senate rules do not preclude it, and the Constitution is vague about how such trials should be handled. A few times before 1936, the Senate did cast separate votes on conviction and removal.

The Senate legal counsel, though, has recently said such separation of votes is not constitutional. Republicans say that their statement is not tantamount to a conviction.

USA TODAY · THURSDAY, FEBRUARY 4, 1999

Clinton argues for saving Medicare

President, GOP tangle over surplus

By Susan Page
USA TODAY

WASHINGTON — With a consensus emerging in Congress to use much of the projected federal budget surplus for Social Security, President Clinton sharpened the debate Wednesday over how to use the rest.

He said a significant share should go into Medicare, not the across-the-board tax cuts Republicans propose.

"This is the latest in a rather long series of large and risky tax proposals that we have heard over the years," Clinton said in a speech to the AARP (American Association of Retired Persons), a lobby for the elderly. "If we had adopted even one of the large ones, we wouldn't have the surplus we enjoy today."

He criticized as "the wrong choice" a proposal by the House and Senate GOP leadership to use some of the surplus for a 10% across-the-board tax cut.

Clinton's comments reflect evolving surplus politics. In the two weeks since he outlined a proposal for using projected surpluses over the next 15 years, Republican leaders generally have accepted the idea of devoting 62% to protecting the fiscal stability of the Social Security system.

But the GOP hasn't endorsed his plan to devote another 15% to bolstering Medicare, proposing instead to finance tax cuts.

"The American people expect us to meet a combination of important goals," says Ari Fleischer, spokesman for House Ways and Means Committee Chairman Bill Archer, R-Texas. "No one should have the right to take one goal hostage because a different goal has not been met."

For instance, couples whose combined incomes push them into a higher tax bracket shouldn't have to wait for tax relief until Medicare's problems are solved, Fleischer says.

Clinton argued that the proposed tax cut "would benefit clearly the wealthiest Americans — who have, I might add, done quite well as the stock market has virtually tripled in the last six years."

The White House released calculations that show benefits in Medicare, the federal health-care program for the elderly, cannot be expanded or even maintained without an infusion of funds. A bipartisan commission is preparing recommendations.

"Anyone who hopes to invest the surplus or to spend it on other programs, or to spend it with a tax cut, must first tell America's families: What is your plan to preserve and strengthen Medicare in the 21st century?" Clinton told the legislative council of AARP.

He said any Medicare reform proposal should tap part of the surplus, modernize Medicare's management, guarantee a defined set of benefits without "excessive" new costs to beneficiaries and fund a new benefit to cover prescription drugs.

▶ Fading tax-cut support, 1A

By Paul Richards, Agence France Presse

AARP speech: President Clinton criticizes a Republican proposal to use part of the budget surplus for tax cuts, calling the plan 'the wrong choice.'

AARP NATIONAL LEGISLATIVE COUNCIL ADDRESS

DATE:	February 3, 1999
LOCATION:	The Willard Hotel
BRIEFING TIME:	1:00 pm - 1:25 pm
EVENT TIME:	1:40 pm - 2:30 pm
FROM:	Gene Sperling
	Ben Johnson

I. PURPOSE

To underline the importance of investing the surplus to meet America's long-term challenges. In particular, Republicans in Congress have essentially acceded to your demand that we reserve 62% of the surplus for Social Security. While they continue to press for more military spending, they have allocated virtually the entire 38% of the surplus for an across-the-board tax cut. You will speak to AARP about why it is important that we dedicate some of that surplus to Medicare. Without new funding, the changes we need to make to restore Medicare's solvency would be severe. That is why we should balance our need for tax cuts (USA accounts) with the need to do more to strengthen and protect Medicare.

II. BACKGROUND

AARP, the largest and most influential senior organization, is convening its annual National Legislative Council in Washington this week. AARP's National Legislative Council, composed of 43 volunteer leaders from across the country, meets annually to establish the Association's public policies for the coming year. The group's recommendations will be reviewed and approved by the AARP Board of Directors. Social Security and Medicare have dominated most of the Council's discussion.

AARP continues to maintain a non-partisan posture on many issues. AARP says the Administration's budget proposal contains several intriguing proposals to address the future retirement security needs of the boomers. They look forward to seeing and exploring the all-important details of the Social Security proposal, especially its effect on reducing the public debt. On our Medicare proposal, they say the reductions should be scrutinized to ensure that they will not jeopardize beneficiaries. They support your USA accounts proposal as a creative approach and merits further discussion. They are pleased with our Long Term Care Proposal as an important first step.

AARP President Joseph Perkins will thank you for participating in their National Legislative Council, reaffirm AARP's support to continue a national dialogue on Social Security and Medicare, and to strengthen the prospects for a healthy and financially secure retirement.

At this week's annual meeting (February 1-5), AARP's Council has been addressed by Janet Yellen, Representatives Richard Gephardt, Jim McDermott, Bill Archer and Bill Thomas,

and Senators Phil Gram and John Breaux, among others.

You have spoken to the AARP National Legislative Council in 1993, 1996, and 1997. Vice President Gore addressed the Council last year.

III. PARTICIPANTS

Pre Brief Participants
Gene Sperling
Chris Jennings
Barbara Woolley

John McManus, Chairman, AARP National Legislative Council
Joseph Perkins, President, AARP

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

-**YOU** will be greeted by John McManus, Chairman, National Legislative Council; Joseph Perkins, President; Esther Canja, President-Elect; Horace Deets, Executive Director; Margaret Dixon, Immediate Past President; Kevin Donnellan, Director, Advocacy and Management.
-Off-stage announcement of **YOU** accompanied by John McManas and Joseph Perkins.
-John McManas, Chairman, AARP National Legislative Council, proceeds to the podium, welcomes and introduces Joseph Perkins.
-Joseph Perkins, President, AARP, makes remarks and introduces **YOU**.
-**YOU** will make remarks and depart.

VI. REMARKS

Provided by Speech writing.

VII. ATTACHMENTS

* Seating Chart
* Bio on Joseph Perkins, President, AARP
* Bio on John McManas, Chairman, AARP National Legislative Council

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

February 3, 1999

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

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

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The National Bipartisan Commission on the Future of Medicare

Senator John Breaux	Congressman Bill Thomas
Statutory Chairman	Administrative Chairman

Contact: Rusty Jabour, (202) 252-3394
Website: http://medicare.commission.gov

Commission Meeting

Tuesday, January 26, 1999
Cannon Caucus Room, 345 Cannon House Office Building
Washington, D.C.

This package contains the:

Agenda
List of Commissioners
Discussion Materials

PLEASE NOTE: The draft proposal presented at this meeting by Chairman John Breaux does not represent a Commission recommendation.

The National Bipartisan Commission on the Future of Medicare

Senator John Breaux Statutory Chairman	**Congressman Bill Thomas** Administrative Chairman

Meeting Agenda

Tuesday, January 26, 1999

Cannon Caucus Room, 345 Cannon House Office Building, Washington, D.C.

PLEASE NOTE: The draft proposal presented at this meeting by Chairman John Breaux does not represent a Commission recommendation.

Presentation of Draft Proposal and Discussion

Chairman John Breaux has authored a draft working document which outlines a proposal to reform the Medicare program. He will present his proposal to the Commission for discussion.

The National Bipartisan Commission on the Future of Medicare

Senator John Breaux Statutory Chairman	**Congressman Bill Thomas** Administrative Chairman

List of Commission Members

Stuart H. Altman
Professor of National Health Policy
Brandeis University, Waltham, Massachusetts

Michael Bilirakis
U.S. House of Representatives
Florida

John Breaux
United States Senate
Louisiana

Colleen Conway-Welch
Dean of the School of Nursing
Vanderbilt University

John Dingell
U.S. House of Representatives
Michigan

Bill Frist
United States Senate
Tennessee

Illene Gordon
Mississippi Congressional Staff
Honorable Trent Lott

Phil Gramm
United States Senate
Texas

Samuel H. Howard
Chairman, Xantus Corporation
Nashville, Tennessee

Robert Kerrey
United States Senate
Nebraska

James A. McDermott
U.S. House of Representatives
Washington

John D. Rockefeller, IV
United States Senate
West Virginia

Deborah Steelman
Attorney
Washington, D.C.

Bill Thomas
U.S. House of Representatives
California

Laura D'Andrea Tyson
Dean of the Haas School of Business
University of California at Berkeley

Bruce Vladeck
Professor of Health Policy
Mt. Sinai School of Medicine, New York, N.Y.

Anthony L. Watson
Chairman and CEO, Health Insurance Plan
New York, N.Y.

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DRAFT WORKING DOCUMENT
Medicare Commission

January 22, 1999 (9:30 am)

This document is guided by the statute creating the National Bipartisan Commission on the Future of Medicare and is a product of what the Chairman learned through the process of the Commission's meetings and work over the past year.

As directed by statute, the Commission must address Medicare's financial instability and make recommendations addressing the solvency crisis facing the program. Once Medicare is on firmer fiscal footing, our first priority should be to modernize and rationalize Medicare's benefit package. Using a portion of any budget surplus that materializes to shore up Medicare can help, but it won't solve the problem. Premium or tax increases should not be considered until the Commission addresses the government's ability to meet its commitment to fund Medicare's current benefit package.

One of our early witnesses, Robert Reischauer, expressed the problems facing the Medicare program in terms of the four "i's": insolvency, inadequacy, inefficiency and inequity. In terms of its solvency, there are many indicators of Medicare spending and its projected impact on the budget. For example, Medicare will grow from 12 percent of the federal budget to 28 percent in 2030 under our most optimistic baseline. Medicare's Hospital Insurance (HI) trust fund, which is funded primarily with payroll taxes, will be insolvent beginning in 2008.

The program is inadequate insofar as its benefits package does not reflect modern notions of comprehensive health care coverage and isn't comparable in scope, quality and structure to the health benefits generally available to employed persons and their dependents. The system of government-administered pricing causes inefficiencies in the way health care services are delivered to seniors and providers have little incentive to provide the most cost-effective care. Lastly, the current program is inequitable in that there is no geographically uniform or constant set of benefits. If a beneficiary lives in southern California or Florida, Medicare will pay for prescription drugs or dental benefits if the person joins an HMO. If a beneficiary lives in rural Nebraska, he or she gets nothing approaching such benefits. Additionally, Medicare only covers approximately half of the health care costs of beneficiaries and one survey indicates that the actuarial value of Medicare's benefit package is in the 20th percentile of those of most private employers.

The proposal outlined below, which is based on a premium support model, aims to modernize Medicare's benefit design and correct the four "i's". It will allow beneficiaries to combine in an integrated and comprehensive form all sources of support for their health care coverage while ensuring that Medicare is more efficient and more responsive to beneficiaries needs. It also guarantees low-income protections so that all beneficiaries have meaningful access to quality health care, including the traditional Medicare fee-for-service plan.

These recommendations should be a blueprint for Congress to enact comprehensive legislation to fundamentally restructure Medicare over the next several years. Our nation's health care delivery system is constantly evolving and given the uncertainty of long-term health care spending projections and the advances in medical technology, Medicare will have to be revisited at regular intervals.

SUMMARY

- This proposal would model Medicare on a system patterned after the Federal Employees Health Benefits Program (FEHBP). It would allow for a blend of existing government protections and market-based competition. It would also guarantee financial protection for low-income beneficiaries.
- Medicare's fee-for-service program will operate as part of this new system and HCFA will be given the tools it needs to modernize and compete accordingly.
- This proposal will reform the Medigap program to make it more efficient and to try to minimize the adverse effects of first dollar coverage.
- The eligibility age for Medicare will increase to conform with the eligibility age increase scheduled for Social Security. A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.

I. PREMIUM SUPPORT

A. Administrative Structure

- A Medicare Board will be established to oversee and negotiate with private plans and the government-run fee-for-service plan and to approve plan service areas. The board will have authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries.

B. Benefits Package

- Plans participating in Medicare would be required to offer a standardized core benefit package defined in statute (e.g., hospital, surgical, inpatient, etc.).

Participating plans would have some flexibility on design details (i.e. cost-sharing, copays) but the Medicare Board would have final approval. Private plans participating in premium support will be required to offer benefits at least equivalent to the package offered in the government-run fee-for-service plan.

- Plans can offer additional benefits beyond the core package. Much like the negotiations process between plans and OPM in FEHBP, benefits will be updated through the annual negotiations process between plans and the board. The board will be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan will be revamped by modernizing cost-sharing and by combining the Parts A and B deductibles. One example of a modernized cost-sharing structure would be to have a combined deductible of $350, charging 20% coinsurance for everything except hospital and preventive care and charging 10% coinsurance for home health.

C. Calculating Medicare's Premium

The government-run fee-for-service plan will bid nationally based on its actual and projected claims costs. Other plans can choose to bid nationally, regionally or in local areas. The Board would oversee the designation of service areas to ensure access in areas that would otherwise have limited plan availability.

- Under an FEHBP system, total Medicare premiums for plans in a given area will be based on a national schedule similar to that used in the FEHBP system. The overall cost of plans will be based directly on their bids and the negotiations process with the Medicare Board.

a) Government's Contribution

- The government's contribution will be based on a percentage of the national weighted average premium. Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental costs of choosing more expensive plans. The government's contribution as it is made to the plan that the beneficiary chooses will be adjusted for health risk and other factors.

b) Beneficiary's Contribution

- The beneficiary's contribution will be based on the cost of the plan chosen with beneficiaries paying a minimum percentage of the premiums based on their income. The government contribution will stop increasing and beneficiaries will pay the full incremental costs for plans above a certain threshold (e.g., 100% of the cost of average plan). Both the beneficiary and government contribution toward the cost of the average plan will rise and fall in the same proportion as the cost of that plan changes from year to year.
- Higher-income Medicare beneficiaries should be required to pay a larger share

of their Medicare premiums than moderate and low-income beneficiaries. Income-related premiums will apply to both private plans and the government-run fee-for-service option.

- Premium support subsidies should be sufficient to ensure that low-income beneficiaries have access to necessary health services and have a meaningful choice of plan options. The revenue generated by income-relating the premium for upper-income beneficiaries will be primarily dedicated to subsidizing premiums for low-income beneficiaries.

II. MODERNIZING MEDICARE FEE-FOR-SERVICE

- The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries. In accordance with Congressional and Board oversight and approval, the government-run plan will have flexibility to modify its payments rates and its arrangements with contractors as well as offering benefit enhancements if they are financially feasible in a competitive environment.
- The government-run fee-for-service plan will have a premium just like the private plans participating in a premium support system. To enable the government-run fee-for-service plan to compete with private plans in a premium support system, HCFA would be given management tools adopted by the private sector. These reforms include things such as enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

III. MEDIGAP REFORM

- In order to keep fee-for-service costs affordable, Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost.

IV. MISCELLANEOUS

- Medicare's eligibility age will be gradually increased to match the Social Security retirement age. It is also recommended that Social Security and Medicare be reformed in conjunction with each other because of the interrelated effects of these programs on the retirement security of older Americans.
- A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.
- Graduate Medical Education: Payments for Direct Medical Education (DME) would be carved out of the Medicare program--financed and distributed

independent of a premium support system. The Chairman assumes that federal support for DME would continue through either a mandatory or discretionary appropriations program. Since the funding source would shift from the HI payroll tax to general revenue, the Chairman believes that it is appropriate to include institutions not currently eligible for Medicare GME support that conduct approved residency programs, such as free-standing children's hospitals. Similarly, the long-term solution for indirect medical education (IME) may involve a carve-out from Medicare. For now, however, the Chairman believes that the Medicare program should continue to pay for differences in costs between teaching and non-teaching hospitals through the indirect medical education (IME) adjustment. However, the Chairman recognizes that the level of the Medicare IME adjustment may need to be aligned gradually over several years with what analyses show is the actual statistical difference between teaching and non-teaching hospital costs. The Chairman believes that Disproportionate-Share Hospital (DSH) payments and other subsidies within the Medicare program should be revisited to ensure that Medicare's support is reasonable and appropriate. The Chairman notes that these subsidies could be carved out of the Medicare program and financed through a mandatory or discretionary appropriation program. However, the Chairman recognizes that any changes in federal support should continue to recognize the additional costs to hospitals of treating large numbers of low-income individuals.

V. REVENUE AND FINANCING

- The primary source of income to the Hospital Insurance (HI) trust fund is the payroll tax. The 2.9 percent tax on all earned income accounts for 88.3 percent of the total $121.1 billion in income in 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.
- The Supplementary Medical Insurance (SMI) trust fund is financed from premiums paid by the users of Part B and from general revenues. When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Premiums over time dropped to 25% of program costs because Part B costs increased much faster than the inflation computation that was used to compute the upward premium adjustment.
- Under current law, the proportion of financing sources are expected to change over time, with the portion represented by payroll taxes decreasing and the portion represented by general revenue increasing. By 2030, premiums and payroll taxes are expected to fund only 31-35 percent of Medicare's

expenditures compared to 63 percent in 1997. In 2030, 64-70 percent of Medicare will be funded through general revenue (or other funding) as compared to approximately 28 percent in 1997.

- The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms will result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and will enhance our ability to stand by our commitment to today's and future beneficiaries. Even if projected budget surpluses materialize, without these changes, significantly greater revenues and/or beneficiary sacrifices will be required in the future and beneficiaries will not receive the greatest value for the total health dollars spent on their behalf.

VI. AREAS THAT NEED RESOLUTION

- DRUGS--open issue--the Chairman is exploring several options for including a prescription drug coverage.

- Changes to provider payments

VII. ALTERNATIVE DESIGN OPTIONS

The following are examples of elements of a premium support system that could be changed to arrive at a different model than the one described above.

- National vs. Regional Bidding: Under a national bidding structure, a geographic adjuster is necessary to create a fair and equitable system. A geographic adjuster would also address the fact that Medicare spending varies by a factor of more than three across regions with seemingly similar populations and with no demonstrable differences in health outcomes. Under a national schedule, national plans such as the government-run fee-for-service could compete in a straightforward and fair way. Beneficiaries in national plans would pay the same amount regardless of where they lived. Under a regional bidding system, a geographic adjuster would not be required but some provision would have to be made to allow fair competition between local and national plans such as fee-for-service and to prevent regional inequities in beneficiary premiums.
- Benefits Package: Plans would be required to offer and compete on a core benefits package. Unlike the model described above, additional benefits could only be offered in a supplemental plan that would have to be sold and marketed separately from the core package. This would ensure that plans compete on the basis of cost and quality, not on the basis of the benefits offered.

Medicare Analysis

The Medicare Reform Debate: What Is the Next Step?

by Henry J. Aaron and Robert D. Reischauer

Abstract: Medicare costs are rising faster than projected revenues. Action to close the emerging deficit is inescapable. We propose converting Medicare from a "service reimbursement" system to a "premium support" system. These changes would resemble many that are now reshaping private employer-based insurance. Our reform would encompass not just the "public" Medicare program but also the "real" Medicare, which includes the supplemental plans to which most Medicare beneficiaries have access. Approved plans would have to offer stipulated services. We review numerous technical issues in moving to a new system that cannot be solved quickly and that preclude quick budget savings.

Medicare is at the core of two current policy debates. One centers on the steps needed to balance the federal budget over the next seven to ten years. The other focuses on how existing entitlement programs might best be modified to cope with the retirement of the baby-boom generation, which will begin at the end of the first decade of the twenty-first century. Cuts in Medicare undertaken to balance the budget now will probably contribute only modestly to meeting the second, more serious challenge; realistically, measures designed to deal with the consequences of the baby-boom generation's retirement will contribute little to short-run deficit reduction. This paper describes a reform proposal designed to address the second of these issues: the long-range future of Medicare.

Five central facts will shape the debate on the future of Medicare. First, Medicare enjoys overwhelming support among the American electorate, a popularity that is well deserved because the program has achieved all of its designers' major objectives. Second, the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts. Third, legislative reform of the entire health care system is now off the political agenda and likely will remain so for years to come. Fourth, there exists a strong and broad consensus against raising taxes. Fifth, dramatic changes are taking place in the way health care is financed and delivered for the non-Medicare population.

The implications of these facts are straightforward. First, before changes are made in Medicare, policymakers will have to assure the general population and beneficiaries alike that the reforms will not compromise the attributes of the program that the public values so much. Second, Congress will have to act soon to restore Medicare's financial viability. Third, the measures that Congress adopts will not be part of any major legislative effort to reform the overall health care system. Fourth, most, if not all, of the budgetary savings on Medicare will come from reducing federal payments to providers and raising costs to beneficiaries, not from raising Medicare payroll taxes. Fifth, congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.

Henry Aaron is director of the Economic Studies Program at The Brookings Institution. Robert Reischauer, formerly head of the Congressional Budget Office, is a senior fellow in that program.

Health Affairs, Volume 14, Number 4

Popularity And Success: A Brief History Of Medicare

Two views on how to provide assistance. Before the enactment of Medicare, few retired elderly or nonworking disabled persons had reliable health insurance coverage. The private insurance that was available to these groups was expensive and often inadequate, and renewal was not guaranteed. The elderly and disabled feared bankruptcy from the costs of treatment for serious illness or the inability to receive treatment because they could not pay for it. To address these problems, President Lyndon Johnson proposed the Medicare program in February 1964.

The debate around this initiative displayed two conflicting principles about how government should act when private-sector services are inadequate. One view is that government should assist only those persons who are too poor to buy the service. The principle behind this approach is that, with few exceptions, markets should be permitted to allocate all goods and services. A compassionate society should provide aid to the destitute. But this assistance should disturb the operation of markets as little as possible, it is argued, because markets have intrinsic virtues, such as efficiency and consistency with the principles of personal autonomy and freedom.[1]

The other view holds that the best way, on balance, to provide some types of assistance is through a universal entitlement—aid available without regard to personal income or means but based on some more or less objective indicator of need. Advocates of this approach invoke arguments based on social solidarity or efficiency; they simply assert that, despite the value of markets in other contexts, certain goods and services should be provided to everyone at some basic level.

When Congress approved Medicare, it embraced the second philosophy by establishing a universal entitlement to stipulated benefits for everyone age sixty-five and older who has worked in a job subject to payroll taxation or who is a spouse of an entitled worker.[2] At the time, some Republicans and southern Democrats opposed this view and agreed to support Medicare

only if other Democrats would embrace a companion program of health care benefits available only to those with incomes and assets below quite modest levels. The Republican program, Medicaid, replaced various state programs of health care assistance for the poor with an open-ended federal matching grant that imposed various federal mandates and restrictions. The compromise legislation, which incorporated both programs, passed in the House of Representatives by a vote of 307 to 116 on 27 July 1965 and in the Senate by a vote of 70 to 24 the next day. President Johnson signed the Social Security Amendments of 1965, as this momentous legislation was so ingloriously called, on 30 July 1965.

Political alignments have changed over time. A new cadre of conservative representatives and senators now sees Medicaid not as the preferred method of financing health care for the indigent but as federal meddling in a domain in which states should not be hindered and as an element of a welfare system that works to the long-term disadvantage of those whom it is intended to help. They would like to see Medicaid transformed into a block grant under which each state would be given a fixed sum that it could use with few federal restrictions to provide health care services to the indigent. Some also would convert Medicare from a universal entitlement into means-tested assistance. Several proposals along these lines would impose higher costs on participants with high incomes; others would provide a voucher to assist participants who wanted to leave the program to buy private coverage in the marketplace.[3]

Growth in popularity and costs. Together with supplemental (Medigap) policies, Medicare has provided elderly and disabled persons with access on a nondiscriminatory basis, and with an unrestricted choice of providers, to the same health services that workers and their families enjoy. Moreover, beneficiaries are heavily subsidized.[4] Thus, the program's extreme popularity is understandable. The public's support for Medicare is reflected in the positions taken by politicians, few of whom seem prepared to acknowledge that Medicare benefits may need to be cut. However, it is clear that something fundamental will have to be done to modify the program because of the unsustainable growth of its projected costs.

The explosive growth of Medicare costs is neither new nor mysterious. Almost from its inception, Medicare has proved to be more costly than anticipated. The projection that the Health, Education, and Welfare actuaries made in 1965 that in 1990 the Hospital Insurance part of Medicare (Part A) would cost $9.061 billion, less than one-seventh of its actual level, has often been used to underscore this point.[5] Over the 1970s Medicare expenditures grew at an annual rate of 17.5 percent and in the 1980s at 12.1 percent; costs are projected to grow at a rate of 10.3 percent in the 1990s. While growth per enrollee has been rapid, Medicare grew less rapidly than national or private health care spending over 1984–1993.[6]

Some of the program's overall growth is attributable to increases in the number of beneficiaries, which has expanded by about 2.5 percent per year since 1968. Not all of the increase in beneficiaries reflects increased numbers of aged persons—the original focus of the program; legislation passed during the 1970s added disabled persons and persons suffering from end-stage renal disease (ESRD) to the program.

Benefit expansion also has contributed some to the growth in costs. For example, to the list of covered services Congress has added hospice care; mammography; Pap smears; hepatitis, influenza, and pneumococcal pneumonia vaccines; and kidney dialysis and transplants. Administrative actions also have expanded services; the redefinition of allowable home health and skilled nursing facility services has contributed significantly to cost increases in recent years.

Although benefits have increased somewhat over the program's thirty years, the Medicare benefit package remains comparatively parsimonious. In contrast to typical employer-sponsored insurance, Medicare provides no benefits for outpatient drugs and provides poor catastrophic coverage. In addition, Medicare deductibles and copayments for inpatient hospital services—currently $716 for the first day of hospitalization and $179 per day for hospitalization of more than sixty but fewer than ninety-one days per year—are far higher than those of typical private insurance plans.[7] Like most private health plans, Medicare does not cover long-term nursing home services and does not provide dental or vision coverage. It does, however, pay for home health services and short-term skilled nursing facility services. Medicare's benefit package is less generous than about 85 percent of private health plans. The program covers only about 45 percent of the total annual health care bill of the elderly, who, on average, spend considerably more out of pocket on health care than the nonelderly spend.[8] Medicare benefit cuts would only increase these disparities.

The major contributor to the explosive growth of both Medicare and other health care costs has been the increased capabilities of medicine. The proliferation of medical technology has produced many new diagnostic tools, procedures, treatments, and drugs. Few people advocate policies that might dampen this source of cost growth, nor would it be reasonable to deny Medicare participants the fruits of medical advances available to those with employer-sponsored or private health insurance.

Some Considerations Relevant For Reform

Successful and sensible Medicare reform must build on an appreciation of the way in which the current program operates, of its central charac-

teristics, and of the larger health care environment of which it is a part. Reformers must be aware of the limited contribution Medicare now makes to covering the health care expenditures of the aged and disabled, the program's bifurcated structure, the limited role of managed care, the potential under the existing payment structure for pernicious competition on risk selection, the uncertainty of cost projections, and the interaction between Medicare and Medicaid.

Public Medicare and "real Medicare." The federally financed Medicare benefit package is not the health insurance plan that most Medicare participants actually live with. Approximately 65 percent of elderly and disabled Medicare participants also are covered by employer-sponsored retiree plans or private Medigap plans, or both.[9] These plans supplement Medicare, usually by covering deductibles, copayments, some prescription drugs, and hospitalization beyond ninety days.[10] In addition, approximately 16 percent of Medicare participants also have some sort of Medicaid coverage. About 12 percent are categorically eligible (Supplemental Security Income recipients) or meet state Medicaid eligibility standards.[11] For these "dual eligibles," Medicaid pays Medicare Part B premiums, deductibles, and copayments and covers services—primarily prescription drugs and long-term care—that are covered by Medicaid but not Medicare. For those with incomes below the poverty line who are not dually eligible (qualified Medicare beneficiaries, or QMBs), Medicaid pays Part B premiums, deductibles, and coinsurance. The key point is that persons who are covered one way or another by Medicaid, like those with Medigap and retiree policies, face low or no deductibles and little or no cost sharing.

The public Medicare system, therefore, does not define the health care system in which most Medicare-eligible persons participate. Instead, most live with a hybrid system that comes in two forms, both of which have the public Medicare program as their base. For most, the hybrid is a blend of Medicare, which is available to most elderly and disabled persons for very modest premiums (now $46.10 per month), and employer-sponsored retiree coverage or private Medigap insurance. This version has a benefit package that is much more generous than that of Medicare alone. However, if a former employer is not paying at least part of the cost of the supplemental coverage, the cost of this version of the hybrid is considerably more than the cost of Medicare alone. Monthly Medigap premiums average about $70.[12] The second form of the hybrid, a blend of Medicare and Medicaid, offers even more generous benefits and costs the beneficiary less than Medicare alone or the other form of the hybrid.

Most discussion of Medicare reform focuses on the public program alone, not the hybrid system. But because the large majority of beneficiaries live with the coverage and incentives of the hybrid system, sensible policy

change can be formulated only by considering how best to transform the entire system. Not doing so risks adopting ineffectual reforms or reforms that have unintended consequences, which can be illustrated by examining a commonly advocated policy for reducing Medicare costs: increasing the Part B deductible and raising coinsurance.

In most private insurance plans, deductibles and coinsurance serve to discourage the use of low-benefit care. Deductibles also spare insurers the administrative cost and spare the insured person the added premiums to cover the cost of processing many small claims. Because the Medicare Part B deductible is relatively low, its effect in these respects is limited. At $100 a year, it is well below the typical deductible for private insurance and only one-eighth what it was in 1967 relative to annual average per capita charges. The coinsurance for most Part B services, 20 percent, is similar to that of private plans. However, some services, such as clinical laboratory, home health, and skilled nursing facility services for the first twenty days, require no coinsurance. Some critics of the current system have suggested that increasing the Part B deductible, extending coinsurance to all services, and raising it to 25 percent would curtail the use of low-benefit services and reduce administrative costs. Federal spending thereby would be held down and concentrated on more costly episodes of illness.

Under current arrangements, however, Medicare deductibles and coinsurance do not serve their intended purposes, and increasing them would not have the intended effects. Except for the 18 percent who lack supplemental coverage, Medicare beneficiaries do not face coinsurance because retiree supplements, Medigap, or Medicaid typically pays it.[13] Many supplementary policies also pick up the Part B deductible. Increases in coinsurance or deductibles, therefore, would not materially reduce use of low-benefit care or deter nuisance claims. Instead, retiree policies and Medigap vendors would liberalize their coverage of coinsurance and deductibles and would boost premiums. A few people might drop Medigap coverage or buy less-generous coverage, and they might demand somewhat fewer medical services. But most Medicare beneficiaries would either keep their supplemental coverage and pay the higher premium or let Medicaid pay the higher coinsurance and deductible.

While doing little to reduce low-benefit services and nuisance claims, increases in coinsurance and deductibles would transfer costs from the Medicare trust fund to Medicare eligibles (for those with Medigap insurance), their former employers, or other accounts in the federal budget and the states. While such transfers may or may not be desirable, there may well be better ways to accomplish them.

One implication of the foregoing discussion is that retiree, Medigap, and Medicaid coverage actually increase the budget cost of Medicare, by short-

circuiting the economizing effects of deductibles and cost sharing on demand and administrative costs. Supplemental insurance increases Medicare costs by raising the use of Medicare-covered services, but these added costs do not show up in the premiums for these policies.

To reform the hybrid, public/private Medicare system that people actually use and pay for, it will be necessary to consider the systemic effects of changes in the public program. Reform of Medicare should not be confined to the public program but should encompass rules affecting the sale and pricing of supplemental policies.

The A and B of Medicare reform. Part A of Medicare pays for inpatient hospital care, home health care, hospice care, and limited skilled nursing services; Part B pays for physician services, outpatient hospital and clinic care, laboratory and other diagnostic tests, and other services. Persons age sixty-five and older who are eligible for Social Security or Railroad Retirement benefits, those who have received disability benefits for two or more years, and those with ESRD are automatically entitled to Part A benefits.[14] Whether or not they are eligible for Part A, all persons age sixty-five and older may join Part B by paying a monthly premium; so too may disabled and ESRD participants in Part A.

Whatever rationale may once have existed for the distinction between services in Parts A and B, medical technology, the development of new forms of service delivery, and new payment structures have rendered it obsolete. Services once provided only in hospitals on an inpatient basis are now provided routinely on an outpatient basis, in physicians' offices, or even at home. The line between care provided during a hospital stay and that provided after discharge is increasingly blurred. Yet reimbursement for inpatient hospital care under the diagnosis-related group (DRG) system and that for outpatient hospital and physician services under the resource-based relative value scale (RBRVS) system and other fee schedules remain distinct and serve to reinforce a structure for the delivery of care that is becoming anachronistic. This payment system is not easily integrated with managed care arrangements and capitated payment systems.

No good case can be made, in our judgment, for perpetuating Parts A and B of Medicare. To the extent that the public sector has a legitimate role to play in the financing of health care for the elderly and disabled, that interest is common across the range of covered medical services. The distinction that Part B is "voluntary" is close to meaningless, because 97 percent of the participants in Part A elect to participate in Part B.[15]

The distinct methods of financing Parts A and B—the former with a payroll tax and the latter through premiums and regular appropriations—have created different political and economic dynamics for the two parts. Part A enjoys the advantage of an earmarked tax and is subject to the

discipline that stems from the fact that outlays cannot, in practice, exceed revenues from that tax plus accumulated reserves and the interest earnings of those reserves. Congress originally declared that it intended to charge eligible households half of the cost of Part B. However, Congress lacked the political will to deliver on that promise, thereby freeing Part B from the budgetary discipline that has driven the debate about Part A. Any major reform of Medicare should unify Parts A and B. The consolidation should not, however, be used as an opportunity to relax the limited fiscal constraints under which the program now operates and tap into general revenues to support Part A.

Fee-for-service and risk contracts. Medicare is rapidly becoming the last remnant of relatively unmanaged fee-for-service care in the United States. As of 1995 a majority of nonelderly Americans with private health insurance were covered under one form or another of managed care.[16] This extremely elastic term includes health maintenance organizations (HMOs) in their various forms and preferred provider organizations (PPOs). Health care delivery, financing, and risk-sharing arrangements are blooming in huge numbers and riotous diversity.

Except in Medicare. Medicare participants can enroll in one of three delivery and financing arrangements. More than 90 percent "choose" the traditional fee-for-service arrangement.[17] Managed care plans that are reimbursed on the basis of reasonable costs serve another 2 percent, and managed care plans that are paid on a capitated basis (risk contracts) serve 7 percent. Under these risk contracts, plans provide the Medicare benefit package for 95 percent of the average cost of fee-for-service Medicare benefits in their county (adjusted average per capita cost, or AAPCC).[18] The number of Medicare beneficiaries covered by such plans is increasing, but their penetration is projected to lag far behind the penetration of this form of payment for the nonaged population.

The use of Medicare risk contracts varies widely across the United States, reflecting the huge geographical variation in the availability of managed care plans, the limited information that is provided to participants about their options, and the lack of familiarity among the elderly population with managed care delivery systems. Overall, about three-quarters of the Medicare population live in an area in which a managed care option is available.[19] Nevertheless, there is no significant Medicare enrollment by risk contractors in twenty-eight states.[20] These plans have no incentive to market aggressively in counties in which the AAPCC is low. The AAPCC's year-to-year volatility also represents a deterrent. The highest penetration of risk contracts is found in California and Arizona, where close to 30 percent of all Medicare participants get their care from such plans.[21] All of this implies that reforms that propose to move Medicare

beneficiaries into managed care plans will take time. Institutional capabilities will have to be developed, and participants will have to learn more about and become more comfortable with managed care delivery systems.

The "cherry-picking" potential in Medicare. Insurance carriers or managed care plans can increase their profits either by providing services more efficiently or by seeking to insure persons with lower-than-average health care costs. In the case of employer-sponsored plans, the potential of the latter approach is limited because the sponsor is generally seeking coverage for an entire employee group and its dependents. The opportunity to "cherry pick" is greater under Medicare because beneficiaries enroll as individuals, and the stakes are higher because variability of the costs of care among Medicare enrollees—the disabled and the elderly—is far greater than that among the general population.

Medicare risk contractors must accept any Medicare participant who wants to join their plan. Nevertheless, disproportionate numbers of participants who have lower-than-average costs have signed up for these plans under the current Medicare program. Estimates suggest that Medicare's current payments to risk contractors, which are set at 95 percent of the AAPCC, are roughly 6 percent more than the costs that these lower-than-average-risk participants would incur in the standard Medicare program.[22] In other words, risk contracting raises costs to the government, although the risk contractors may produce health care more efficiently than other providers do and therefore may save money for the nation.

The extent to which vendors consciously try to attract only better-than-average risks to their plans is not known. To date, these vendors have been able to maintain acceptable profit margins and even offer additional benefits because they generally can provide services more inexpensively than the fee-for-service sector can, competition among risk contractors is low, and Medicare payment is generous. But if profit margins narrow, competitive pressures to engage in marketing and other administrative practices that attract low-cost enrollees and repel high-cost enrollees could intensify.

The profit-boosting potential of such efforts could be substantial, given the skewed nature of health care costs. Roughly 5 percent of Medicare participants account for more than half of the program's total cost; one-quarter of the program's participants account for more than 90 percent of the costs.[23] Under the existing payment system, a provider can boost profits significantly by small reductions in high-risk enrollments. A plan might attract a disproportionate number of healthy or younger elderly enrollees by offering exercise classes or other services that such participants find attractive or by locating its facilities in certain geographic areas. Similarly, subtle differences in the availability of services might make a plan unattractive to people with certain chronic health problems or might encourage participants who become heavy users to leave a plan. The current policy of permitting Medicare participants to switch from managed care plans into the traditional Medicare delivery system with a month's notice facilitates such practices.

All of this suggests that if Medicare is going to move from a fee-for-service reimbursement system toward one that emphasizes capitation, payments made to the plans will have to be better calibrated to the health risks of persons covered by those plans. Care will have to be given to ensure that plans do not engage in subtle practices to ward off high-risk participants.

Cost variations. The Medicare benefit package is uniform nationwide, but its cost is not. In 1992 reimbursements nationally averaged $4,341 per person served but varied from a low of $3,048 in Nebraska to a high of $5,114 in Louisiana.[24] The variations across substate areas are even greater: Cost per enrollee in Miami, Florida, is 2.4 times that in Waco, Texas.[25] Such differences reflect interstate variations in DRG prices and RBRVS fees, salary levels, and medical practice patterns and the propensity to use services. Such variations survive without serious scrutiny in a system that simply pays for services rendered or that pays fixed fees to providers based on local costs. But such variations would be hard to justify or sustain if Medicare shifts from paying for services to paying for insurance. Pressure would arise to justify variations in payments per person. While variations associated with differences in input prices could be rationalized, it is doubtful that a persuasive case could be made for per person reimbursements that are 68 percent higher in Louisiana than in Nebraska.

Uncertainty about costs. Actuarial projections that Part A of Medicare will be insolvent in a few years add a sense of urgency to the need to "do something" to fix Medicare. The impossibility of balancing the budget in seven (or even ten) years without large reductions in Medicare raises this sense of urgency to almost frantic levels.

Two aspects of the actuarial projections are relevant to the process of reform. The first is that the actuarial projections are extremely volatile. The period until projected insolvency has changed by many years from one trustees' report to another (Exhibit 1). Some of these changes are attributable to legislation, but many are not, such as the change from 1992 to 1993. The estimated cost of Part A benefits, measured as a percentage of taxable payroll, also has oscillated widely. To illustrate, the trustees' reports of 1982, 1987, 1994, and 1995 placed the cost of Part A, as a share of taxable payroll, at 6.7 percent, 3.65 percent, 4.52 percent, and 4.17 percent, respectively. The change from 1994 to 1995 is particularly noteworthy, because no relevant legislation was enacted between the two projections. We know of no methodological breakthroughs to suggest that similar variations will not occur in the future. Thus, the magnitude of reductions in Medicare

Exhibit 1
Number Of Years From Medicare Hospital Insurance (Part A) Trustees' Projection Until Insolvency

Year of trustees' report	Years until insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20[a]
1976	About 15[a]
1977	About 10[a]
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

Source: Intermediate projections of various Hospital Insurance trustees' reports, 1966–1995.
[a] Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

costs or of increases in payroll taxes necessary to close projected deficits is not known with any certainty.

The second aspect of the projections that is relevant to reform is that the gap between current revenues and current benefits is so large that even the large fluctuations in projected costs shown in Exhibit 1 give no hope that the current system can be sustained. In 1995 actuaries projected that the Part A trust fund would be insolvent in 2002. The large cuts in Medicare Part A implied by the budget resolution for fiscal year 1996 would only delay insolvency by a few years. The twenty-five-year actuarial projections

indicate that Part A outlays would have to be cut 30 percent or revenues increased 43 percent to balance the program. Since any legislative changes would be small at first, the changes in the terminal years of the projection period would have to be considerably larger.

The growth of spending under Part B is considerably higher than under Part A, in large measure because many services that were once provided in hospitals can now be provided on an outpatient basis or in physicians' offices. As a share of gross domestic product (GDP), Part A is projected to increase from 1.62 percent in 1995 to 2.83 percent in 2020, a 75 percent increase. Part B is projected to increase from 0.93 percent of GDP to 3.18 percent over the same period, a 242 percent increase.

Medicaid and Medicare. State Medicaid programs, as has already been pointed out, have been called upon to supplement Medicare for low-income participants. Dually eligible participants have whatever benefits their state's Medicaid program provides and assistance to pay their Medicare Part B premiums, coinsurance, and deductibles. Medicaid programs also have been required to cover the Part B premiums, coinsurance, and deductibles of QMBs. State Medicaid programs pay the full actuarial cost of Part A for elderly and disabled persons who have incomes below the poverty line but do not have sufficient work histories to be eligible for Part A. As of January 1995 Medicaid also pays Part B premiums for those with incomes between 100 percent and 120 percent of the poverty threshold.

Congress has adopted these requirements over the past decade because Medicare's coverage, by itself, is not overly generous. Low-income participants in poor health who lack this supplemental protection could find most of their limited income absorbed by out-of-pocket spending for health care. But these requirements also have imposed a significant burden on states, which, on average, pay 43 percent of the costs of Medicaid.

As Medicare evolves or is changed, the logic of dividing the responsibility for health care for the low-income aged and disabled between these two programs will weaken. As more participants have the opportunity to join plans that offer benefit packages that include prescription drug coverage and catastrophic protection and that have low cost-sharing requirements, the need for the QMB protection will diminish. Furthermore, if premium subsidies must be provided, equity suggests that they should be uniform nationwide. Estimates suggest that fewer than half of persons eligible for QMB subsidies have received them. The take-up rate is thought to vary considerably because of differences in states' outreach efforts. The possibility that Medicaid payments per recipient might be capped or transformed into a block grant reinforces the logic of having Medicare assume full responsibility for covering the acute health care costs of low-income aged and disabled persons.

A Program For Medicare Reform

Goals and principles. Any fundamental social policy reform should be guided by clear principles and goals. The following four should direct the changes that Medicare will require. (1) Reforms should deal not just with "public" Medicare but with the full package of benefits most Medicare beneficiaries use. (2) Under a reformed Medicare program, the quality of health care provided to the elderly and disabled should not be materially different from that available to the general population. Nor should the delivery system for this population be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care). (3) Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide high-quality care at the lowest possible cost. This does not necessarily mean, as some advocates of managed care seem to suggest, that the least costly providers are the best, nor does it define the limits of care that public financing should support. (4) Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population.

Designing an entirely new program is usually easier than reforming an existing one. Program designers need to concern themselves with objectives and feasibility. Program reformers must attend not only to these concerns but also to current entitlements and people's sense of ownership in these entitlements. For Medicare, the political acceptability of proposed changes hinges not just on whether they are, in some sense, objectively fair, but also on how they affect the access of two very vulnerable groups, the elderly and the disabled, to choices and services they regard as rights. Furthermore, creating new administrative and institutional frameworks is typically easier than transforming existing ones. Established institutions and bureaucracies that feel threatened typically resist reform. The reforms described here, which we believe would have to be phased in over a considerable period of time, attempt to reflect these constraints.

A new Medicare system. We propose converting Medicare from a "service reimbursement" system into a "premium support" system. Rather than paying for all services on a stipulated menu, Medicare would pay a defined sum toward the purchase of an insurance policy that provided a defined set of services. As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a PPO, or operate through an HMO. Plans could manage care in any of the ways now in use or that might arise in the future. All Medicare beneficiaries ultimately would receive a predetermined amount to be applied to the purchase of a health plan providing defined services. Because health care costs differ by health care market area, support given to enrollees would have to vary across health market areas, but not within them. As indicated below, risk adjustments among insurers based on the characteristics of their clients also would be necessary.

Plans would be required to offer defined services. Insurers would be permitted to sell coverage for additional services not covered under the basic plan, but only if marketing and delivery of these services were divorced from those of the basic plan. To the extent that such supplemental coverage induced use of basic services (for example, cost-sharing supplements), a premium surcharge would be imposed and rebated to Medicare.

The marketing of insurance to Medicare beneficiaries would follow the principles developed for the operation of managed competition.[25] The first step would be to define health care market areas, whose boundaries would be based on the supply of medical care. They typically would be metropolitan areas or large portions of states where population density is low, and they could cover portions of more than one state.

Entities interested in bearing the risk of providing health care for the Medicare population would be invited to submit bids for providing the defined benefit package in a particular market area for the "average" Medicare enrollee. The federal Medicare payment in each market area would be the same regardless of which plan the enrollee chose. If the enrollee chose a plan that cost more than the federal Medicare payment for the area, the participant would pay the balance. This supplementary payment can be thought of as a replacement for the cost of retiree and Medigap insurance.

Local marketing organizations would be established to handle the sale of insurance. They would assist Medicare enrollees in buying insurance, discourage insurers from using marketing to attract superior risks, and keep marketing costs to a minimum. These entities, which could be public or private, not-for-profit agencies, would receive information from insurers, ensure that it was presented to Medicare enrollees in a comprehensible and even-handed manner, and handle enrollment. They would counsel Medicare enrollees, some of whom are frail or querulous, to minimize sales abuses. Enrollees would select an insurance plan for the coming year and would be permitted to switch plans during an annual open enrollment period.

Because some participants have much higher than average expected health costs, plans would receive risk-adjusted payments from Medicare based on age, sex, disability status, and other health indicators. Good methods of making such risk-adjusted payments do not now exist.[27] It is uncertain whether today's imperfect methods would suffice to offset attempts by insurers to select favorable risks or if improved methods could be

developed.[28] For this reason, our approach should be introduced gradually and evaluated periodically. For the first few years a blend of cost-based and capitated reimbursement may be necessary. We advocate this approach not because we necessarily believe that managed care and managed competition will produce huge savings. Such savings are highly uncertain and depend on unpredictable developments. Rather, a framework that forces people to face the consequences of their choices in the delivery of medical care should encourage them to choose the plans whose style of care matches their preferences, and we believe that enrollees should bear the financial consequences of their choices. Trends in health care spending are dominated by advances in medical technology, some of which are overused. Further advances in technology are inevitable and welcome, although they will be expensive.[29] Which should be used and how extensively should be determined by the persons who use them. Furthermore, we believe that a market in which plans offering similar benefits compete along dimensions that consumers can understand will promote efficient service delivery.

This framework lends itself to budget control in ways that the current Medicare system does not. Medicare now establishes a variety of price limits—DRG prices for hospital admissions and RBRVS fees for physician services—but since it cannot (and should not) control the quantity of services, it cannot control the total cost of care or federal spending. Under this system, neither health care providers nor patients have any incentive to limit physician services or hospital admissions. The result is the possibility of overuse of medical services.[30] The small area variations in the use of various medical procedures and the cost advantages of some managed health care providers support this possibility.

Problems Of Design And Transition

Converting Medicare from a fee-based reimbursement system into a premium support system will be neither quick nor easy. A number of issues and problems must be addressed before such an alternative can be instituted nationally.

(1) What should be the benefit package in the new plan? It would be a grave mistake, in our view, to use the current Medicare benefit package for the new plan. Instead, the benefit package should combine the current Medicare package with some modest coverage of prescription drugs and catastrophic protection. Plans should be required to offer this new benefit package in one of two standard forms: a low-cost-sharing variant and a high-cost-sharing variant. The expanded benefit package offered in the low-cost-sharing version would provide coverage similar to what many Medicare participants enjoy and pay for in the current hybrid system. They will not willingly accept less and, in our view, should not be expected to. They pay premiums for this package and should continue to do so.

A standard benefit package and standardized cost-sharing regimes are important, at least initially, because they will reduce risk segmentation among plans and help participants to compare the cost and quality of different plans. Numerous benefit packages and cost-sharing arrangements would make comparisons difficult. Furthermore, higher-income, younger, and healthier participants would be attracted to plans with limited benefits and high cost sharing, which would place a greater burden on the yet-to-be-developed mechanism for making risk adjustment payments to the different plans.

(2) How should the federal payment be set? This issue has several dimensions. First, should the federal payment be set at the cost of the least expensive plan capable of covering a substantial portion of the participants in a region, or above that minimum? We believe that, initially at least, payments should be based on a defined benefit package, adjusted for variations in actual costs and use among regions, not on the basis of actual bids or the lowest bid within a region. The low bid in a region might reflect a highly efficient plan. But it also could reflect an unusually spartan delivery system or a low-quality plan; such outliers should not affect the federal support available in a region. If the federal payment were set at the lowest bid, several problems could develop. First, more participants might seek to join the plan whose costs were covered completely by the federal payment than the plan could absorb while maintaining quality. Second, low-income participants might be denied choice and could be concentrated in the one or two plans that required no supplemental premiums.

The initial federal payment should be set at 95 percent of the cost of the current Medicare package in the market area, adjusted to remove indirect medical education, direct medical education, and disproportionate-share payments.[31] If providers charge the Medicare payment plus the premium for a Medigap plan, enrollees now covered by Medigap plans would face a premium that is 5 percent higher than the cost of their current hybrid coverage. But if competing plans are able to provide this level of service at lower cost, enrollees would face a smaller cost increase or might even achieve savings if the reduction in price were sufficient.

During a phase-in period of perhaps five to ten years, the federal payment should grow more slowly than projected baseline costs. If growth of plan expenses slows, costs to enrollees might not increase. In any event, this mechanism would produce some relief for the federal budget. An expert commission should recommend the exact size of this reduction; this recommendation could be reevaluated every two or three years.

In the long run, the federal Medicare payment should grow at the same

rate as per capita spending on health care for the nonelderly. This formula is mechanical and may require periodic adjustment, because the per capita cost of care depends on the average age of the population, the age-specific gradient in health care costs, and the age bias of new medical technology.[32] If Congress found it necessary to reduce federal support for Medicare, it could slow payment increases, thus shifting costs to Medicare enrollees.

The second issue in setting federal payments concerns regional variation in Medicare spending per enrollee. Current cost differences reflect variations in wage rates and other input prices, availability of services, demand, and—more generally—practice patterns. If current variation is larger than is acceptable, over what period should this variation be reduced? Our view is that payment levels initially would have to reflect historical spending patterns, but that differences should be gradually narrowed until payments varied only for differences in wage rates and other input prices. Such payment differences are necessary if Medicare is to avoid penalizing the elderly or disabled for residing in a high-cost area. The objective would be to have the federal payment cover the same services throughout the country. The adjustment should be complete within a decade.

Third, plans in some regions may submit bids below the federal payment. What if enrollees select such plans? Initially, when participants are unfamiliar with the service style, quality, and other dimensions of plans offered to them, it probably would be best to require that these dividends be devoted to such supplemental services as eyeglasses or routine dental care, or to other services.[33] This policy would reduce the possibility that cash rebates would tempt infirm, low-income participants into a low-cost plan that provided unexpectedly inferior care. Over time, as the competitive marketplace developed and as participants became familiar with their options and the consequences of choosing one plan over another, differences between the federal payment and plan cost could be rebated to participants as nontaxable income or split between government and participants.

(3) Will Medicare enrollees segregate themselves, or will plan administrators market plans in ways that result in economic segregation among plans? One of the strengths of the current Medicare program is that all participants—rich and poor alike—come under the same basic plan, and providers are relatively indifferent to the incomes of their Medicare patients. In a world of competing plans, economic segregation could occur in various ways. Plans with high deductibles and high cost sharing probably would attract not only the relatively healthy but also the relatively wealthy, who can self-insure against all but the most costly illnesses. The same is likely to be true of relatively costly plans that offer enrollees an expanded choice of providers or higher-quality amenities. Because health status and income are positively correlated, such segregation will aggravate the risk adjustment problem.[34]

To have some choice of plans, low-income participants would have to be provided with some sort of premium supplement to replace the current Medicaid assistance. These supplements, which would be nonrefundable even in the long run, could be keyed to the distribution of bids in a region. For example, they might be sufficient to allow a person with an income below the poverty threshold to participate at no cost in any plan that charged a premium below the median in the region.

(4) How should a new system be phased in? This question is clearly the most important and the most difficult. Before the plan described here can operate, it is necessary to create an environment of competition among health plans, to construct the apparatus necessary to regulate the marketing of insurance and the risk adjustment procedures for allocating payments based on enrollment, and to overcome the practical difficulties of transferring costs to many current Medicare enrollees. Even in the most prepared regions, it will take years to establish the necessary institutional structure.

The plan also hinges on the availability of enough plans in each market area to create meaningful choice and competition. These plans need not include traditional HMOs, at least at the outset, but the plans must be independent and must compete with one another. HMOs would increase the range of choice available to Medicare enrollees but are not essential. To the extent that aggressively managed care is necessary to reduce the growth of health care spending, the full benefits of the reform approach we have described would be realized only when such plans existed in most places.

The most difficult transitional issues involve beneficiaries themselves. How should they be phased into the new system? This problem would be hard, but manageable, if enrollees could be enticed into the new system by more generous payments. However, the current budget climate renders that option infeasible. The simplest method would be to run the current Medicare system alongside the new system. The new system would be mandatory for everyone who turns sixty-five and becomes eligible for Medicare after a certain date. It would be optional for everyone enrolled in Medicare before that date. Presumably, many who were not required to join the new system would do so anyway because they would prefer one of the alternative plans.

This approach may not be practical everywhere because the number of new Medicare enrollees in some sparsely populated regions may be too small to support even one plan. In such areas it may be necessary to delay the transition and then shift a group—such as all persons under age seventy—into the new system at one time.

(5) What role would Medicare price controls play? Medicare now reimburses most providers according to administered prices. Most of these payments are well below reimbursements from other payers. In addition,

providers cannot bill Medicare participants for charges beyond certain specified and limited amounts.

In the new system, a plan that offered the choice of providers now available under Medicare without these price discounts would have to either charge much higher premiums or leave participants exposed to significant balance billing. This shift would represent a noticeable reduction in the opportunities available to many Medicare beneficiaries, who would find such a shift exceedingly burdensome. For this reason, we believe that the various Medicare fee schedules must be maintained for a transitional period. All plans could use these schedules for paying providers other than those in their own networks. Existing balance billing and assignment restrictions would continue. Because competitive forces would reduce the need for such limits in the new system, fee schedules could be relaxed.

(6) How much regulation will the new system require? Initially, at least, the new system will require a good deal of regulation, and much of it will have to emanate from Washington. The nation should not gamble with health care for the aged and disabled, many of whom are unlikely to be able to do well in an unregulated market. Moreover, if there is a failure, the federal government will be required to step in.

Plans will have to be certified with respect to their medical capabilities and the quality of care they provide, their administrative competence, and their financial soundness. It is reasonable to expect that the same minimum standards should be met by each plan throughout the country. While these standards may be set nationally, state agencies or specialized nonprofit organizations could enforce them.

We have already noted that state, local, or not-for-profit organizations would be responsible for organizing and ensuring the orderly functioning of the health plan market in each area. These organizations would specify, collect, and disseminate information provided by health plans to Medicare enrollees. To help enrollees make informed choices among plans, they would ensure that the information is presented clearly, simply, and uniformly. These organizations also would monitor plans to prevent them from engaging in measures designed to attract good risks.

(7) What of Medicare's other functions? Over the past thirty years Medicare has evolved into more than a system to help pay the medical bills of the aged and disabled. Through its payment system, it has come to play an important role in supporting graduate medical education. The payment system also has sustained institutions in remote locations and helped hospitals serving disproportionate numbers of uninsured persons to bear the costs of uncompensated care. The payments made under our proposed plan would not continue to support these objectives. To the extent that they remain important, they should be funded through separate grants.

Conclusion

The Medicare program, which has served the nation—particularly the elderly and disabled—extremely well during its first thirty years, faces profound changes before it reaches its golden anniversary. Budgetary and demographic developments mean that the program as it is now structured is unsustainable. As this paper goes to press, congressional action on Medicare and Medicaid is not yet complete. The outcome of the wrangling between the president and Congress that will follow is unclear. Nevertheless, if the effort to craft a compromise reconciliation bill does not fail completely, it seems likely that large cuts will be made in Medicare. How much fundamental structural change will emerge is still an open question. Most likely, an already parsimonious system will be made even stingier, the need for supplemental insurance will grow, and the existing hybrid system will be made even more complex and inequitable. Medicare eligibles will be given more of an impetus to shift into one form or another of managed care. However, the legislation that is likely to emerge probably will not provide strong incentives for participants to reduce their use of low-benefit services or to seek care through efficient delivery systems.

The ultimate response to the budget and demographic pressures could take more extreme forms. The nation could establish a separate national health care system for the aged and the disabled, with its own network of providers and its own limits on use. At the other end of the spectrum, Medicare could be transformed into a pure voucher system, in which the elderly and disabled receive a voucher and are told to fend for themselves in an unregulated or lightly regulated marketplace. We believe that both of these approaches are politically unacceptable and programmatically flawed.

The approach we have presented represents a middle ground. It builds on the strengths of the current program while converting it into a system similar to the employer-sponsored insurance now available to most Americans. A major argument in its favor is that it would strengthen participants' incentives to seek services from cost-effective delivery systems and providers' incentives to operate efficiently. This plan would enable Congress to directly control the per capita budget cost of Medicare. This feature is critical in view of the certainty that the gap between Medicare costs and revenues will be narrowed as part of efforts to balance the budget. But it is important to acknowledge that our plan also facilitates significant savings by shifting costs to Medicare enrollees, a channel that will have to be used if large reductions in Medicare spending growth are to be achieved.

We close with an unfashionable warning. The history of reforms in U.S. social policy is replete with exaggerated claims of the benefits the reform will produce. To muster enthusiasm, supporters of reform paint rosy pictures

of the marvelous benefits that will ensue if only their recommendations are adopted. Reality, as it is wont to do, eventually emerges, disappointment sets in, and the perception of the competence of policymakers takes another dive. We see the makings of just such a cycle with the current enthusiasm about the benefits of managed care and of improved incentives for cost-consciousness by purchasers of health care services. They promise enormous savings if only their reforms are adopted. Careful cost accounting suggests that their claims are grossly exaggerated.[35] But even if the rosiest plausible projections of savings from managed care are realized, benefits approximating those now provided by Medicare cannot be sustained unless revenues flowing into the system are increased. In plain English, that spells "TAXES." To sustain Medicare, payroll or other taxes earmarked for Medicare must be raised, or general revenue subsidies will have to be increased. We believe that having to live within the revenues of an earmarked tax provides some discipline. We urge that this course rather than increased general revenue subsidies be used when, after heroically trying to cut costs, Congress recognizes that the American people want to keep Medicare benefits and that to do so, somebody is going to have to pay for them.

The views expressed in this paper are those of the authors and should not be attributed to The Brookings Institution, its staff, trustees, officers, or funders. The authors thank Linda T. Bilheimer, Sandra Christensen, and Joshua Wiener for their helpful comments and absolve them of the responsibility for any errors remaining in the paper.

NOTES

1. Some who generally agree with this approach to aid argue that in some circumstances the provision of benefits produces unintended side effects that outweigh direct benefits to recipients, through either work disincentive effects or demoralization. This view, which is as old as the English debates over the Poor Laws, has achieved fresh currency in U.S. politics in debates over welfare reform. Thus far, however, it has not been part of the debate on Medicare reform.
2. The disabled and persons with ESRD were not covered by the original legislation.
3. Bipartisan Commission on Entitlement and Tax Reform, *Final Report* (Washington: Bipartisan Commission, January 1995); Concord Coalition, *The Zero Deficit Plan* (Washington: Concord Coalition, 1993); Congressional Budget Office, *Reducing the Federal Deficit: Spending and Revenue Options* (Washington: CBO, February 1995); and D. Bandow and M. Tanner, *The Wrong and Right Ways to Reform Medicare*, Cato Institute Policy Analysis no. 230 (Washington: Cato Institute, 8 June 1995).
4. The annual subsidy provided through Medicare to a male worker who retired from an average wage job in 1992 was $3,874.
5. Robert Meyers has pointed out the several ways in which this comparison is inappropriate and how the original estimate has been misrepresented. See R.J. Meyers, "How Bad Were the Original Actuarial Estimates for Medicare's Hospital Insurance Program?" *The Actuary* (February 1994): 6–7.
6. Health Care Financing Administration, *Medicare: A Profile* (Washington: U.S. Government Printing Office, February 1995), 51; and Congressional Budget Office, *Trends in Health Spending: An Update* (Washington: CBO, June 1993), 44–45. The growth of per capita Medicare spending was below that of private health care spending in every year from 1984 through 1991, except in 1989. M. Moon and S. Zuckerman, "Are Private Insurers Really Controlling Spending Better than Medicare?" (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, July 1995).
7. Coinsurance of $358 per day is required for the lifetime allowance of sixty additional days of inpatient care. The Part B deductible is $100 per year, and coinsurance is 20 percent. Coinsurance for days 20–100 of skilled nursing facility care is $89.50 per day.
8. American Association of Retired Persons, Public Policy Institute, and The Urban Institute, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington: AARP, April 1994).
9. Congressional Budget Office, unpublished estimates.
10. According to CBO estimates, approximately 39 percent of Medicare participants have Medigap policies, and 26 percent have retiree plans. For a breakdown of supplemental coverage among aged Medicare participants in 1992, see U.S. Congress, House Committee on Ways and Means, *1994 Green Book*, Committee Print WMPC 103-27 (15 July 1994), 886. The Health Care Financing Administration provides the following estimates of coverage for aged participants in 1993: 11.4 percent of elderly Medicare participants have no other coverage, 36.8 percent have Medigap policies, 33 percent have retiree policies, 11.9 percent are covered by Medicaid, and 2 percent have coverage from another source. Medigap policies are offered in ten standard forms, the most popular of which cover deductibles and coinsurance. See P.D. Fox, T. Rice, and L. Alecxih, "Medigap Regulation: Lessons for Health Care Reform," *Journal of Health Politics, Policy and Law* (Spring 1995): 31–48.
11. CBO, unpublished estimates.
12. Karen Davis, testimony before the U.S. Senate Committee on the Budget, 3 May 1995.
13. This estimate is from CBO tabulations for the elderly and disabled. The *1994 Green Book* provides an estimate of 22 percent for the elderly in 1992, and HCFA provides an estimate of 11 percent for the elderly in 1995.
14. Persons over age sixty-four who are not eligible for Social Security can obtain Part A coverage by paying the full actuarial cost of the coverage. State Medicaid programs are required to pay this cost for persons with low incomes.
15. Most of those who are covered by Part A but choose not to join Part B are workers over age sixty-four who are covered by an employer policy and can join Part B later without penalty.
16. CBO, "The Potential Impact of Certain Forms of Managed Care on Health Expenditures" (CBO Staff Memorandum, August 1992).
17. Most are probably not aware that they have other options besides the traditional fee-for-service plan.
18. The AAPCC is calculated for county areas and is adjusted for the participant's age, sex, institutional status, reason for entitlement (age or disability), and Medicaid eligibility. Plans often provide additional services because they must not have higher margins on their Medicare business than on their non-Medicare business. The excess must be spent on additional services or returned to the government. Plans have an incentive to locate and market in county areas where the AAPCC is high. Plans can switch annually from being paid on the basis of the AAPCC or on the basis of costs.
19. HCFA, *Medicare: A Profile*, 109, Chart MC-1.
20. The Henry J. Kaiser Family Foundation, "Medicare and Managed Care" (May 1995).
21. In Riverside and San Bernardino, California, and Portland, Oregon, the figure is close to one-half.
22. R.S. Brown et al., "Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs" (Princeton, N.J.: Mathematica Policy Research,

Bob Reischauer's MODEL

WHAT IS PREMIUM SUPPORT?

- A HYBRID SYSTEM WITH

  DEFINED BENEFITS

  FIXED PAYMENTS TO PLANS

THE DEFINED BENEFIT

- BENEFITS SHOULD BE SUFFICIENTLY COMPREHENSIVE SO THAT THE VAST MAJORITY OF PARTICIPANTS DO NOT FEEL A NEED FOR SUPPLEMENTARY INSURANCE.

PAYMENTS TO PLANS (1)

- MUST BE RISK ADJUSTED
- SHOULD REFLECT DIFFERENCES IN INPUT PRICES

PAYMENTS TO PLANS (2)

- COULD BE SET ADMINISTRATIVELY
- COULD BE SET COMPETITIVELY
- COULD BE SET BY A BLEND OF COMPETITIVE AND ADMINISTRATIVE MECHANISMS

PAYMENTS TO PLANS (3)

- HOW SHOULD THE PAYMENTS TO PLANS BE DIVIDED BETWEEN THE GOVERNMENT'S CONTRIBUTION AND THE PARTICIPANT'S CONTRIBUTION?

QUESTIONS

- WHAT ROLE SHOULD TRADITIONAL MEDICARE PLAY?

- WHAT HAPPENS IN AREAS IN WHICH NO PLAN WISHES TO OFFER SERVICES?

- WHAT HAPPENS IN AREAS IN WHICH ONLY ONE OR TWO PLANS COMPETE?

- WHAT ARE THE POLITICAL CONSEQUENCES OF HAVING DIFFERENT PREMIUMS AND DIFFERENT PLAN TYPES AVAILABLE IN DIFFERENT JURISDICTIONS?

Question

Federal: Coverage

PLAN Payments

Federal

TRIGON Virginia

ROBERT WOOD JOHNSON FOUNDATION

PROVIDER

L

A

N

Bid: Includes:

Benefits

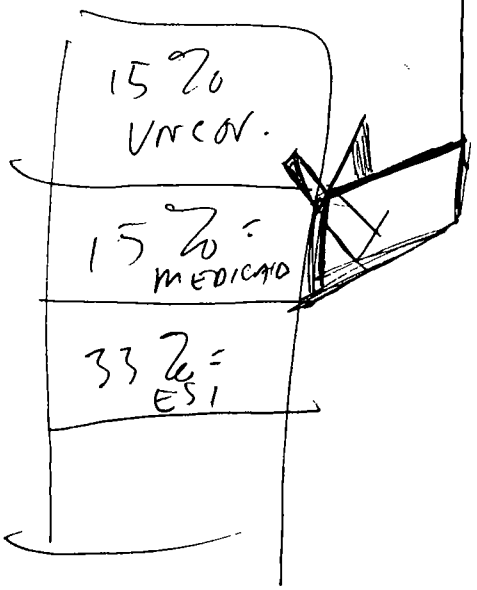
Bid - Part B Premium -

- Actuarial Value of Suppl =

Risk Adjusting =

Who pays?

Utilization Adjustment:



COMPARISON BETWEEN COMMISSION MODEL AND REGIONAL BIDDING

	FEHBP Model	Regional Bidding Model
Are benefits standardized?	No: FFS would be marginally improved Private plans would offer the actuarial equivalent of FFS plus any supplemental benefits they choose	Yes: All plans (FFS and private plans) would offer the same standardized benefits. Private plans could offer supplemental benefits under limited circumstances.
Basis of the government contribution	Rate schedule based on a formula linked to the national average premium	Median (or other type of) bid in a region
Does the government contribution include supplemental benefits?	No in FFS Yes in private plans	No: In both FFS and private plans, beneficiaries would pay the full amount (note: it could be subsidized)
Is the government contribution regionally adjusted?	Yes: half of the total geographic variation in costs would be taken into account through a formula; the beneficiaries would pay the other half	Not explicitly: All bids in the region automatically include local costs.
How is the beneficiary premium set?	Rate schedule based on a formula linked to the national average premium	Dollar amount that is the sum of a national Part B-like premium, a premium for extra benefits, and the difference between the median and bid (if higher)
What would a beneficiary pay to stay in FFS?	National amount based on rate schedule. Because the schedule is linked to the national average premium that includes FFS, it will probably not be very different than the national average premium (12%) so long as FFS enrollment remains high.	Regional amount (same as private plans). Because the total would be the sum of the national Part B-like premium and regional amounts, it would be a blend of a national and regional rate