

THE WHITE HOUSE

WASHINGTON

July 2, 1999

MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING

SUBJECT: NEC WEEKLY REPORTS

cc: JOHN PODESTA

Y2K Liability Reform: On Thursday, the Conference Committee adjourned to allow for negotiations with the Administration that resulted in little movement on the part of Republicans. After your discussion with Senator Dodd on Tuesday (6/29) he sought to win support from Republicans for a short list of Administration changes. After the House Republicans agreed, the Conference Committee filed its bill without giving Administration staff any opportunity to review the drafted language. The negotiated changes had been translated into legislative language so narrowly as to threaten their effectiveness at providing the sought protections. John Podesta, Larry Stein, David Beier, OMB, and myself concluded that it was not worth blowing the deal up over the subtle differences between the agreement and the Conference Report language. The Conference Report passed the House by a vote of 404-24, with the Democratic leadership and Rep. Conyers arguing that the Administration had obtained improvements. In the Senate, it passed by a vote of 81-18 with the support of Senator Daschle.

Financial Modernization: On Thursday, the House leadership presented its version of H.R. 10, on the House floor which fully satisfies the Administration's concerns on CRA and choice in operating structure for financial conglomerates. The Rules Committee ruled out of order an amendment, by Rep. Barbara Lee, that states that an insurance company may not affiliate with a bank if it has been found (after adjudication) to have violated the Fair Housing Act through redlining or discrimination in homeowner's or mortgage insurance. Most Democrats opposed the rule, which passed by only a slim margin. The House adopted HR 10 by a vote of 343-36. Republicans supported 205-16, Democrats 138-69. Everyone but the Commerce Committee seemed pleased.

Social Security: You should know that on Thursday (7/1) the Senate voted 99-1 to invoke cloture on the motion to proceed to the Thompson emergencies bill on which the Abraham-Domenici lock box amendment is pending (this is the debt limit lock box which caused us such great concerns). Senate Democrats have no objection to proceeding to the bill, but continue to insist on the opportunity to offer amendments to the provision. Nonetheless, the Majority filed cloture on the amendment itself, trying once again to cut off lock box amendments. By consent, the Senate agreed to conduct the vote on cloture on the Abraham-Domenici lock box amendment after recess. We received a great deal of positive press from the new Mid-Session Review Budget numbers and new Social Security framework we announced on Monday (6/28). Throughout the day as well as on Tuesday (6/29) reaction from the press and Hill was generally positive and well balanced. While some Republicans took the opportunity to say that we had moved in their direction with our Social Security lockbox, many said it was a step in the right direction.

Appropriations: You should know that the Senate passed the Treasury/General Government bill by voice vote Thursday (7/1), including a Dewine amendment restoring the FEHB abortion restriction (a motion to table it failed 47-51). The Senate also passed the D.C. bill by voice vote, without adopting the Coverdell amendment prohibiting needle exchange program. Senators Lott and Daschle agreed to attempt during July to restore the prohibition (formerly in Senate rule XVI) on authorizing on an appropriations bill, with a 60 vote waiver of the point of order. The rule they will offer will probably apply only to floor amendments, and thus still allow riders contained in committee-reported bills. The House expects to take up the Interior bill July 13th and 14th. The House and Senate Subcommittees are scheduled to mark up the Labor/HHS/Education bills the week of July 12th. Senate Chairman Specter has said that he intends to produce two bills: one at the low Senate allocation and other at our level (perhaps using a variety of advance funding and other gimmicks).

Oil Antidumping Case: You should know that on Tuesday (6/29) a coalition of small independent oil producers filed antidumping and countervailing duty cases against oil imports from Mexico, Venezuela, Saudi Arabia, and Iraq. The petitioners requested the imposition of dumping duties ranging from 33 percent against Mexico to 170 percent against Venezuela. They also requested the imposition of over six dollars a barrel in countervailing duties. The Department of Commerce has between 20 and 40 days to determine if there is sufficient support in the oil industry for the petitioners to have standing. If they do have standing, Commerce will then initiate an investigation. At this point, the Council of Economic Advisors believes that the case will have limited effect on the price of oil at the pump, due to the ability to substitute target imports with oil from other countries. The trade agencies, however, are concerned about the effect of the case on our trading partners, which have vehemently denied the charge. Mexico, for instance, has announced its intention to withdraw a unilateral plan to eliminate a tariff on the import of natural gas from the United States.

UK Open Skies: To our great disappointment, the UK this week postponed talks scheduled for July 6 on open skies because British Airways (BA) is not prepared to make the concessions (slots at London's Heathrow Airport) required by UK competition authorities for a BA/American Airlines alliance. An open skies agreement is the necessary condition for US (and UK) competition authorities to grant antitrust immunity for such an alliance. Dep. PM Prescott is scheduled to call Secretary Slater this weekend; our sources indicate he will ask for additional time to try to reach a unified UK/BA position. Slater will tell him the talks need to begin this month or it will be impossible to complete them this year. (If this agreement doesn't happen this year, it will not happen until at least 2001, because it would require choices (favoring certain cities over others) that would be difficult in an election year.) This is our highest international aviation priority, because the UK market is so large and our bilateral so very restrictive.

3G: Secretary Daley and Ambassador Barshefsky yesterday sent a strong letter to the EU concerning technical standards for third-generation wireless technology/cell phones (3G). This trade dispute began a year ago when the EU mandated a single 3G standard that would have kept US manufacturers out of its market. Although telecom providers from around the world have now agreed on a plan to harmonize multiple standards, certain EU member countries are still threatening to allocate licenses and spectrum to just the EU-mandated standard. The NEC and USTR coordinate interagency activity on this complex and economically important issue.

July 23, 1999

MEMORANDUM TO GENE SPERLING

FROM: JASON FURMAN

SUBJECT: GRAMM-DOMENICI SOCIAL SECURITY REFORM PROPOSAL

A memo by Jeff Liebman explaining the Gramm-Domenici Social Security reform proposal is attached. It is a revised version of a memo he gave to you in September 1998. Another memo from Treasury providing more detail about the plan is also attached.

Gramm and Domenici Propose a Feldstein-like Plan with Individual Accounts Carved Out and 80 Percent of the Returns Clawed Back

- **Initial payroll taxes.** The combined OASDI tax would continue to be 12.4 percent. Three percent of their wages could be carved out, on an optional basis, and deposited directly in a worker's SAFE (Social Security Savings Accounts for Employees) account.
- **Initial benefits.** Benefits would be guaranteed at current-law Social Security benefits plus 20 percent of the individual account. The 80 percent of the "clawed back" individual account would be used to fund the defined benefit component of the plan.
- **SAFE accounts.** The SAFE accounts could only be invested in qualified SAFE funds, which must be certified by the newly created Social Security Investment Board comprising the Secretary of the Treasury, the Chairman of the Fed, the Chairman of the SEC, and two others. At retirement they must be fully converted into real annuities. If the worker dies before retirement the balance in their SAFE account would be bequeathed to his or her heirs.
- **Transitional costs.** Under this proposal only 9.4 percent of payroll will go toward paying Social Security benefits. It will not be for decades that the full revenue from the clawbacks materializes. Sens. Gramm and Domenici propose to finance this transitional period through: (1) the on-budget surplus; (2) redeeming 29 percent of the Social Security trust fund; and (3) earmarking some of the additional corporate income tax revenues to Social Security.
- **Fully phased-in plan.** Eventually the investment rate will rise to 8 percent and the remaining payroll tax will be cut down to the level necessary to support disability benefits. Individuals would eventually be guaranteed at least 120 percent of current law benefits.

Major Problems with Gramm-Domenici

- **Costly.** The initial phases of the plan would be equivalent to a massive tax cut, costing as much as \$1.4 trillion over the next decade, or 1.2 percent of GDP. Taken together with

the Republican tax cut proposals, this would lead to large deficits and substantially less debt reduction.

(The \$1.4 trillion number is my own estimate of the cost. It represents 3 percent of the Social Security Trustee's projection of taxable payroll from 2000 to 2009. The actual cost would be slightly lower because the clawbacks would begin to bring money into the system, although this effect is relatively minor over the next decade. More importantly, there is a sense that much of the \$1.4 trillion would *eventually* be returned to the government through the clawback.)

- **Could reduce private savings.** Under Gramm-Domenici the payroll tax stays the same and, for the near future, the spending on Social Security benefits stays roughly the same. But relabeling 3 percent of payroll as SAFE accounts could cause people to offset other savings. Because this is a carve out (and not an add on, like Feldstein's 2 percent account) the result would be a decrease in national savings. **USA's, in contrast, encourage more private savings through matching provisions.**
- **Risky.** The government is providing a guarantee: if stock prices go up the individual gets the benefit; if stock prices go down the government bears the cost. This guarantee itself is costly. Furthermore the existence of the guarantee would probably encourage greater investment in stocks, and thus be substantially riskier at the aggregate level than our equity investment proposal which limits equity investments to 15 percent of the trust fund.
- **Less progressive than USAs.** In contrast to the USA's, the contributions in the Gramm-Domenici proposal would be proportional to wages.
- **Administrative costs.** The costs of administering the individual accounts could be substantial, potentially undermining a large fraction of the return projected by Gramm and Domenici.

ISSUES CONCERNING SOCIAL SECURITY LEGISLATION

Issue #1: **Should we write legislation with specific language on the enforcement mechanisms for the Social Security and Medicare debt reduction and trust fund transfers?**

Risks: By writing specific legislation, we would be highlighting double counting and general revenue transfers which could create more of a target for Republicans and drive away some Democrats. These issues might be easier to resolve down the road.

In addition, we might have to decide now on an accounting framework for the transfers. Depending on the approach we took, our transfers might lead us to show large on-budget deficits.

Possible solution: Rather than drafting specific budget enforcement procedures, we instead could write more general legislation that calls for the 77 percent of the surpluses to be used to pay off debt and to extend the Social Security trust funds to 2049 and the Medicare trust funds to 2020. We could appoint a commission of the directors of OMB, CBO, and GAO, the Treasury Secretary, and the Social Security commissioner to develop appropriate mechanisms for the transfers

-- We would need to investigate the constitutionality of such a commission.

Issue #2: **We could lose control of the bills once they were introduced.**

Risk: Republicans could counter with bills that it would be difficult for Democrats to oppose.

-- For example, they might propose setting aside 62 percent of the surplus for debt reduction without transferring extra bonds to the trust fund to extend the trust fund solvency date. Would we oppose this? Some Democrats might support it.

-- An even tougher case would be if Republicans agreed to set aside 77 percent for debt reduction without extending trust fund solvency dates. Would we declare victory in this case?

Issue #3: **Will it look like we have given up on equities and on tough reforms to achieve 75 year actuarial balance?**

Risks: Right now, many elites and some members of Congress think we have created a recipe that will lead people to avoid the tough choices. Locking in the relatively painless parts of our plan before reaching agreement on a complete 75-year package may make it appear that we are trying to preclude more serious structural reforms.

In addition, we probably would not want to include equity investments in the legislation at this point, so we may be seen as abandoning this idea.

Possible Solution: Have the legislation create a commission to reach consensus on 75-year solvency. Have equity investments be one of the issues the commission is required to consider.

Option #1: Lock in the 77 percent now and have the commission make changes to reach 75-year balance.

-- Once we have locked in 50 years, there may not be much impetus to do the remaining 25 years.

Option #2: Ask the commission to come up with the entire 75-year package, but if no solvency legislation is passed by a certain date, then the 77 percent for debt reduction and trust fund solvency would automatically be triggered.

-- Could lead members opposing the commission's reform to try to run out the clock.

Issue #4: **The legislation would likely exclude discretionary spending and USA accounts.**

Risks: The Democratic left is reluctantly going along with allocating only 11 percent of the surpluses to discretionary spending. If we don't even include this amount in the legislation, they may doubt that we are serious about fighting for the NDD spending we have proposed.

Meeting on Social Security Legislation
March 9, 1999

Possible Components of Social Security and Medicare Legislation

- Allocating more dollars to Social Security than the Republicans over 15 years.
- Extending the Social Security trust fund to 2049.
- Allocating \$686 billion to Medicare and extending the Medicare trust fund to 2020.
- OASDI trust funds investments in equities.
- Process for moving forward to bipartisan legislation.

Issue #1: Making sure that we are allocating more dollars to Social Security than the Republicans do.

- We strengthen the OASDI trust fund by \$2.7 trillion. So far they have not come out with any ideas for strengthening Social Security.
- Over 15 years, our combined transfers to Social Security and Medicare are \$3.45 trillion, while Republicans are claiming to be setting aside \$2.82 trillion for Social Security.
- Because CBO surpluses are larger than OMB surpluses in early years, Republicans may claim that they are setting aside more dollars than we are for Social Security over 15 years (\$2.82 under CBO numbers for them versus \$2.76 billion under OMB numbers for the President's plan).¹
- Under consistent numbers, we will be spending more on Social Security over 15 years than they do. Moreover, our combined Medicare and Social Security spending over 10 years will be more than what they set aside for Social Security.

¹ Because 15-year CBO numbers are not available, the 15-year Republican numbers use CBO surpluses for the first 10 years and OMB surpluses for the last 5 years.

LEGISLATIVE OPTIONS

A. Assume 62% of surplus is transferred to Social Security, focus on Medicare.

1. Sense of Congress would propose, in broad terms, locking in 62% of surplus to advance the solvency of Social Security, without using the word "transfer."
2. Administration would submit legislative language to transfer 15 percent of surplus to Medicare.

Issues:

Are Medicare transfers contingent on enactment of Social Security transfers?

Should the Sense of Congress mention goal of raising the rate of return to the Trust Fund, investing in equities, or ensuring solvency until 2049 or 2055?

Should the Sense of Congress call for a general or specific bipartisan process to develop real reform?

B. Design a framework to reach 75-year deal.

1. Create an Andrews-type group to develop 75-year plan. The 25-person group would consist of five designees chosen by the Administration, Senate Majority and Minority leaders, and House Majority and Minority leaders.
 - a. A CBO/OMB/GAO/etc. technical group would develop appropriate accounting, scoring, and budget enforcement mechanisms related to the use of the 62% for improving solvency, and it would report recommendations to the full panel.
 - b. CRS, CBO, and/or SSA would each develop list of options for programmatic reforms and report list to the full panel. The panel would negotiate which items to use to reach 75-year solvency.
 - c. Treasury, SEC(?), CBO, etc. would develop recommendations for a workable structure for investing in equities.
2. If no 75-year legislation by Sept. 10, 1999, the 62% transfer would automatically occur.
3. Language to direct 15% of surpluses to Medicare.
4. Placeholder language for USAs: create a PAYGO exemption for legislation that creates USAs, contingent on enactment of 75-year reform.
5. Discretionary cap adjustment language: no firewalls, to take effect on a date certain (not contingent on enactment of 75-year reform).

			President's Plan (OMB)			President's Plan using CBO Surpluses	
	Republican Savings for Social Security (CBO)	OMB Off Budget Surplus	Social Security	Medicare	Social Security and Medicare	Social Security Method 1	Social Security Method 2
2000	138	129	65	18	103	96	113
2001	145	134	70	20	90	82	107
2002	153	142	92	28	120	104	138
2003	162	151	90	27	117	106	108
2004	171	158	109	30	139	125	129
2005	184	173	121	33	154	137	141
2006	193	179	152	41	192	166	173
2007	204	190	177	46	223	187	192
2008	212	198	204	50	255	207	209
2009	218	205	232	56	288	226	222
2010	"209"	209	253	60	314		
2011	"211"	211	274	65	339		
2012	"211"	211	281	68	359		
2013	"208"	208	304	71	375		
2014	"203"	203	310	72	382		
5-year	768	714	445	124	569	512	596
10-year	1,779	1,659	1,331	350	1,681	1,434	1,533
15-year	"2,821"	2,701	2,764	686	3,450		

Method 1 assumes Social Security transfers that are the same fraction of the CBO surpluses as our transfers are of OMB surpluses. Method 2 allocates all of the extra CBO surpluses to Social Security (and shifts all of the USA account money not needed in the first three years to Social Security).

Issue #2: Should the transfers to OASDI occur only if Social Security reform is not achieved by a certain date?

- The legislation could set aside 62 percent of the 15-year surplus for Social Security reform.
- The specific provision of transferring the bonds to the trust fund could take effect automatically on a certain date unless legislation is passed which extends the trust fund exhaustion date to 2075.

Issue #3: Should the legislation specify that the trust fund will invest in equities?

Issue #4: Are there ways to specify the transfers of bonds to Social Security so as to avoid the double counting critique?

Option 1:

Instead of transferring bonds between 2000 and 2014, we could specify general revenue transfers to OASDI from 2033 to 2049 of the amount necessary to pay full benefits.

- This is economically identical to our plan. But it avoids double counting since the transfers come from on-budget surpluses in the later years.
- These transfers are already built into the budget baseline. We would simply be giving them a legal status that would allow the actuaries to score them.
- The key would be to establish a link between the debt reduction we are doing over the next 15 years and the ability to pay the benefits in the later years.
 - We could create an administration estimate of the benefits of debt reduction.
 - We could call for a group of independent economists to determine how many bonds we should give to Social Security.
- This approach might be criticized for not doing anything now for Social Security. Estimating the benefits of debt reduction might make it hard to resist dynamic scoring in other contexts.

Option 2: We could alter our plan to make transfers to Social Security using only the on-budget surplus. To reach 2049, we would likely have to make transfers for around 25 years rather than for the 15 in our current plan.

- Most of the Social Security transfers would happen in years 16 to 25.
- We would likely face criticism for relying on surpluses so far into the future.

Issue #5: Can we describe the non-Social Security part of our plan as a phased-in approach to taking Social Security off budget?

- The sum of USA accounts and new discretionary spending exceed the baseline on-budget surplus through 2005.
- Adding in Medicare, the non-Social Security parts of the President's plan exceed the baseline on-budget surplus through 2006.
- If the Social Security transfers occur as currently described, the on-budget surplus will deteriorate relative to the baseline as interest on the additional bonds is charged against the on-budget surplus.

	OMB baseline on-budget surplus	Additional Discretionary Spending	USA Accounts	Medicare	Owed to on budget excluding Medicare	Owed to on budget including Medicare
2000	-12	0	1	18	1	19
2001	0	26	2	20	31	69
2002	44	41	2	28	33	99
2003	31	36	36	27	82	175
2004	50	34	36	30	113	236
2005	58	37	38	33	146	302
2006	103	41	38	41	141	338
2007	131	39	38	46	112	355
2008	156	33	39	50	58	351
2009	188	30	43	56	0	329
2010	221	31	47	60	0	290
2011	253	32	51	65	0	233
2012	284	33	53	68	0	160
2013	312	34	56	71	0	2
2014	333	35	57	72	0	0

Note: After transfers to OASDI, baseline on-budget surplus will be reduced due to interest on extra bonds held by the trust funds.

	CBO baseline on-budget surplus	Additional Discretionary Spending	USA Accounts	Medicare	Owed to on budget excluding Medicare	Owed to on budget including Medicare
2000	-5	0	1	18	1	19
2001	11	26	2	20	20	58
2002	59	41	2	28	7	74
2003	51	36	36	27	36	130
2004	68	34	36	30	49	173
2005	79	37	38	33	61	218
2006	116	41	38	41	43	242
2007	134	39	38	46	11	255
2008	146	33	39	50	0	261
2009	165	30	43	56	0	262
2010	"221"	31	47	60	0	223
2011	"253"	32	51	65	0	166
2012	"284"	33	53	68	0	93
2013	"312"	34	56	71	0	0
2014	"333"	35	57	72	0	0

Note: After transfers to OASDI, baseline on-budget surplus will be reduced due to interest on extra bonds held by the trust funds.

1 SEC. 2. FINDINGS.

2 Congress finds that—

3 (1) the \$69,246,000,000 unified budget surplus
4 achieved in fiscal year 1998 was entirely due to sur-
5 pluses generated by the Social Security trust funds
6 and the cumulative unified budget surpluses pro-
7 jected for subsequent fiscal years are primarily due
8 to surpluses generated by the Social Security trust
9 funds;

10 (2) Congress and the President should balance
11 the budget excluding the surpluses generated by the
12 Social Security trust funds;

13 (3) according to the Congressional Budget Of-
14 fice, balancing the budget excluding the surpluses
15 generated by the Social Security trust funds will re-
16 duce the debt held by the public by a total of
17 \$1,723,000,000,000 by the end of fiscal year 2009;
18 and

19 (4) Social Security surpluses should be used for
20 Social Security reform or to reduce the debt held by
21 the public and should not be spent on other pro-
22 grams.

23 SEC. 3. PROTECTION OF THE SOCIAL SECURITY TRUST
24 FUNDS.

25 (a) PROTECTION BY CONGRESS.—Congress reaffirms
26 its support for the provisions of section 13301 of the Omi-

1 omnibus Budget Reconciliation Act of 1990 that provides
2 that the receipts and disbursements of the Social Security
3 trust funds shall not be counted for the purposes of the
4 budget submitted by the President, the congressional
5 budget, or the Balanced Budget and Emergency Deficit
6 Control Act of 1985.

7 (b) POINT OF ORDER.—Section 301 of the Congres-
8 sional Budget Act of 1974 is amended by adding at the
9 end the following:

10 “(j) SOCIAL SECURITY POINT OF ORDER.—It shall
11 not be in order in the Senate to consider a concurrent
12 resolution on the budget, an amendment thereto, or a con-
13 ference report thereon that violates section 13301 of the
14 Omnibus Budget Reconciliation Act of 1990.

15 “(k) DEBT HELD BY THE PUBLIC POINT OF
16 ORDER.—It shall not be in order in the Senate to consider
17 any bill, joint resolution, amendment, motion, or con-
18 ference report that would—

19 “(1) increase the limit on the debt held by the
20 public in section 253A(a) of the Balanced Budget
21 and Emergency Deficit Control Act of 1985; or

22 “(2) provide additional borrowing authority
23 that would result in the limit on the debt held by the
24 public in section 253A(a) of the Balanced Budget
25 and Emergency Deficit Control Act of 1985 being

4

1 exceeded (except as provided in section
2 253A(b)(3)(C) of that Act);
3 except when a declaration of war by the Congress is in
4 effect."

5 (c) SUPERMAJORITY WAIVER.—Subsections (c)(1)
6 and (d)(2) of section 904 of the Congressional Budget Act
7 of 1974 are amended by striking "305(b)(2)," and insert-
8 ing "301(k), 305(b)(2),".

9 SEC. 4. REDUCTION IN THE DEBT HELD BY THE PUBLIC BY
10 AN AMOUNT EQUAL TO THE SOCIAL SECU-
11 RITY SURPLUSES.

12 (a) AMENDMENTS TO THE CONGRESSIONAL BUDGET
13 ACT OF 1974.—The Congressional Budget Act of 1974 is
14 amended—

15 (1) in section 3, by adding at the end the fol-
16 lowing:

17 "(11)(A) The term 'debt held by the public'
18 means the outstanding face amount of all debt obli-
19 gations issued by the United States Government
20 that are held by outside investors, including individ-
21 uals, corporations, state or local governments, for-
22 eign governments, and the Federal Reserve System.

23 "(B) For the purpose of this paragraph, the
24 term 'face amount', for any month, of any debt obli-
25 gation issued on a discount basis that is not redeem-

1 able before maturity at the option of the holder of
2 the obligation is an amount equal to the sum of—

3 “(i) the original issue price of the obliga-
4 tion; plus

5 “(ii) the portion of the discount on the ob-
6 ligation attributable to periods before the begin-
7 ning of such month.

8 “(12) The term ‘Social Security surplus’ means
9 the amount for a fiscal year that receipts exceed out-
10 lays of the Federal Old-Age and Survivors Insurance
11 Trust Fund and the Federal Disability Insurance
12 Trust Fund.”;

13 (2) in section 301(a) by—

14 (A) redesignating paragraphs (6) and (7)
15 as paragraphs (7) and (8), respectfully; and

16 (B) inserting after paragraph (5) the fol-
17 lowing:

18 “(6) the debt held by the public; and”;

19 (3) in section 310(a) by—

20 (A) striking “or” at the end of paragraph
21 (3);

22 (B) by redesignating paragraph (4) as
23 paragraph (5); and

24 (C) inserting the following new paragraph:

1 “(4) specify the amounts by which the statutory
2 limit on the debt held by the public is to be changed
3 and direct the committee having jurisdiction to rec-
4 ommend such change; or”.

5 (b) AMENDMENTS TO THE BALANCED BUDGET AND
6 EMERGENCY DEFICIT CONTROL ACT OF 1985.—The Bal-
7 anced Budget and Emergency Deficit Control Act of 1985
8 is amended—

9 (1) in section 250, by striking subsection (b)
10 and inserting the following:

11 “(b) GENERAL STATEMENT OF PURPOSE.—This part
12 provides for the enforcement of—

13 “(1) a balanced budget excluding the receipts
14 and disbursements of the Social Security trust
15 funds; and

16 “(2) a limit on the debt held by the public to
17 ensure that Social Security surpluses are used for
18 Social Security reform or to reduce debt held by the
19 public and are not spent on other programs.”;

20 (2) in section 250(c)(1), by inserting “‘debt
21 held by the public’, ‘Social Security surplus’” after
22 “outlays’”; and

23 (3) by inserting after section 253 the following:

24 “SEC. 253A. DEBT HELD BY THE PUBLIC LIMIT.

25 “(a) IN GENERAL.—

1 “(b) ADJUSTMENTS FOR ACTUAL SOCIAL SECURITY
2 SURPLUS LEVELS.—

3 “(1) ESTIMATED LEVELS.—The estimated level
4 of Social Security surpluses for the purposes of this
5 section is—

6 “(A) for fiscal year 1999,

7 \$127,000,000,000;

8 “(B) for fiscal year 2000,

9 \$137,000,000,000;

10 “(C) for fiscal year 2001,

11 \$145,000,000,000;

12 “(D) for fiscal year 2002,

13 \$153,000,000,000;

14 “(E) for fiscal year 2003,

15 \$162,000,000,000;

16 “(F) for fiscal year 2004,

17 \$171,000,000,000;

18 “(G) for fiscal year 2005,

19 \$184,000,000,000;

20 “(H) for fiscal year 2006,

21 \$193,000,000,000;

22 “(I) for fiscal year 2007,

23 \$204,000,000,000; and

24 “(J) for fiscal year 2008,

25 \$212,000,000,000.

8

"(2) ADJUSTMENT TO THE LIMIT FOR ACTUAL SOCIAL SECURITY SURPLUSES.—After October 1 and no later than December 31 of each year, the Secretary shall make the following calculations and adjustments:

"(A) CALCULATION.—After the Secretary determines the actual level for the Social Security surplus for the current year, the Secretary shall take the estimated level of the Social Security surplus for that year specified in paragraph (1) and subtract that actual level.

"(B) ADJUSTMENT.—The Secretary shall add the sum calculated under subparagraph (A) to—

"(i) the limit set forth in subsection (a) for the year or period of years that covers the budget year; and

"(ii) each limit for subsequent years or periods of years.

"(c) ADJUSTMENT TO THE LIMIT FOR SOCIAL SECURITY REFORM PROVISIONS THAT AFFECT ON-BUDGET LEVELS.—

"(1) ESTIMATE OF LEGISLATION.—

"(A) CALCULATION.—If Social Security reform legislation is enacted, OMB shall estimate:

1 the amount the debt held by the public will
2 change as a result of the impact of Social Secu-
3 rity reform provisions on outlays and receipts
4 excluding the impact on outlays and receipts of
5 the Federal Old-Age and Survivors Insurance
6 Trust Fund and the Federal Disability Insur-
7 ance Trust Fund.

8 "(B) BASELINE LEVELS.—OMB shall cal-
9 culate the changes in subparagraph (A) relative
10 to baseline levels for each fiscal year through
11 fiscal year 2009 using current estimates.

12 "(C) ESTIMATE.—OMB shall include the
13 estimate required by this paragraph in the re-
14 port required under section 252(d) for Social
15 Security reform legislation.

16 "(2) ADJUSTMENT TO LIMIT ON THE DEBT
17 HELD BY THE PUBLIC.—If Social Security reform
18 legislation is enacted, the Secretary shall adjust the
19 limit on the debt held by the public for each period
20 of fiscal years by the amounts determined under
21 paragraph (1)(A) for the relevant fiscal years in-
22 cluded in the report referenced in paragraph (1)(C).

23 "(d) DEFINITIONS.—In this section:

24 "(1) SECRETARY.—The term 'Secretary' means
25 the Secretary of the Treasury.

1 “(2) SOCIAL SECURITY REFORM LEGISLA-
2 TION.—The term ‘Social Security reform legislation’
3 means a bill or joint resolution that is enacted into
4 law and includes a provision stating the following:

5 “() SOCIAL SECURITY REFORM LEGISLA-
6 TION.—For the purposes of the Social Security Sur-
7 plus Preservation Act, this Act constitutes Social Se-
8 curity reform legislation.’

9 This paragraph shall apply only to the first bill or
10 joint resolution enacted into law as described in this
11 paragraph.

12 “(3) SOCIAL SECURITY REFORM PROVISIONS.—
13 The term ‘Social Security reform provisions’ means
14 a provision or provisions identified in Social Security
15 reform legislation stating the following:

16 “() SOCIAL SECURITY REFORM PROVI-
17 SIONS.—For the purposes of the Social Security
18 Surplus Preservation Act, _____ of this Act con-
19 stitutes or constitute Social Security reform provi-
20 sions.’, with a list of specific provisions in that bill
21 or joint resolution specified in the blank space.”.

Issues:

Are Medicare transfers contingent on enactment of Social Security transfers?

How do we generate the will to do real reform without making Medicare, USAs, and discretionary cap adjustments contingent on enactment of legislation that scores as reaching 75-year solvency?

Sticks: wall off 27% of surplus?

Carrots: Social Security programmatic sweeteners? Tax cuts/USAs?

Design of panel: base closure model for the accounting/scoring issues?

Level of detail in proposal: would less specificity as to design of the commission process be advantageous?

C. Non-binding language on reconciliation instructions for the Budget Resolution, and Medicare 15% transfer bill.

1. A Sense of Congress item or Congressional rule would lay out in broad terms that the Budget Resolution should include reconciliation instructions directing that 62% of surplus go to Social Security, 15% to Medicare, 12% to USAs, and 11% to discretionary; and that a panel be created to determine programmatic changes to get us to 2075. A Congressional rule would, for example, require a supermajority vote to pass a budget resolution that does not meet these specifications.
2. The Administration would simultaneously send up a bill to carry out the 15% Medicare transfer.

ISSUES CONCERNING SOCIAL SECURITY LEGISLATION

Issue #1: Should we write legislation with specific language on the enforcement mechanisms for the Social Security and Medicare debt reduction and trust fund transfers?

Risks: By writing specific legislation, we would be highlighting double counting and general revenue transfers which could create more of a target for Republicans and drive away some Democrats. These issues might be easier to resolve down the road.

In addition, we might have to decide now on an accounting framework for the transfers. Depending on the approach we took, our transfers might lead us to show large on-budget deficits.

Possible solution: Rather than drafting specific budget enforcement procedures, we instead could write more general legislation that calls for the 77 percent of the surpluses to be used to pay off debt and to extend the Social Security trust funds to 2049 and the Medicare trust funds to 2020. We could appoint a commission of the directors of OMB, CBO, and GAO, the Treasury Secretary, and the Social Security commissioner to develop appropriate mechanisms for the transfers

-- We would need to investigate the constitutionality of such a commission.

Issue #2: We could lose control of the bills once they were introduced.

Risk: Republicans could counter with bills that it would be difficult for Democrats to oppose.

-- For example, they might propose setting aside 62 percent of the surplus for debt reduction without transferring extra bonds to the trust fund to extend the trust fund solvency date. Would we oppose this? Some Democrats might support it.

-- An even tougher case would be if Republicans agreed to set aside 77 percent for debt reduction without extending trust fund solvency dates. Would we declare victory in this case?

Issue #3: **Will it look like we have given up on equities and on tough reforms to achieve 75 year actuarial balance?**

Risks: Right now, many elites and some members of Congress think we have created a recipe that will lead people to avoid the tough choices. Locking in the relatively painless parts of our plan before reaching agreement on a complete 75-year package may make it appear that we are trying to preclude more serious structural reforms.

In addition, we probably would not want to include equity investments in the legislation at this point, so we may be seen as abandoning this idea.

Possible Solution: Have the legislation create a commission to reach consensus on 75-year solvency. Have equity investments be one of the issues the commission is required to consider.

Option #1: Lock in the 77 percent now and have the commission make changes to reach 75-year balance.

-- Once we have locked in 50 years, there may not be much impetus to do the remaining 25 years.

Option #2: Ask the commission to come up with the entire 75-year package, but if no solvency legislation is passed by a certain date, then the 77 percent for debt reduction and trust fund solvency would automatically be triggered.

-- Could lead members opposing the commission's reform to try to run out the clock.

Issue #4: **The legislation would likely exclude discretionary spending and USA accounts.**

Risks: The Democratic left is reluctantly going along with allocating only 11 percent of the surpluses to discretionary spending. If we don't even include this amount in the legislation, they may doubt that we are serious about fighting for the NDD spending we have proposed.

MEMORANDUM TO GENE SPERLING

FROM: Jeff Liebman

SUBJECT: 1999 Social Security Trustees Report

I. Why Have the Numbers Changed?

- The actuarial imbalance of the Social Security trust fund has improved to -2.07 from -2.19 in last year's report.
- The year of Trust Fund exhaustion has moved from 2032 to 2034.
- The change in the actuarial imbalance can be decomposed into the following components:

1998 75-year actuarial imbalance	-2.19
Addition of another "bad" year to 75-year horizon.	-0.08
Better-than-expected short-term economic performance	+0.03
Revision to the CPI (use of geometric means) and other changes to long-term economic assumptions.	+0.12
Changes in demographic assumptions	+0.03
Miscellaneous methodological changes	+0.02
1999 75-year actuarial imbalance	-2.07

Changes to the Consumer Price Index

Last year, the BLS began using geometric means to combine individual prices at the lower level of aggregation of the Consumer Price Index. This change is expected to offset much of the lower-level substitution bias in the CPI, so as to more accurately reflect the cost of living. This change is expected to reduce the annual growth in the CPI by 0.2 percentage points.

The direct impact of lower inflation is to worsen the actuarial imbalance, since benefit indexation occurs with a lag. However, to the extent that lower inflation implies higher real interest rates, higher real productivity growth, and higher real GDP growth, revisions to the CPI improve the actuarial balance overall. For every 0.1 percentage point reduction in the annual average CPI growth, the full potential improvement in the actuarial imbalance is about 0.15

percent of payroll. Thus, with no other changes to the economic assumptions, the CPI revision would have been estimated to improve the actuarial imbalance by about 0.30 percent.

However, in the process of incorporating the CPI adjustment, the Trustees conducted a thorough review of all of the economic assumptions:

- The 0.2 percentage point CPI change was carried through directly in estimating the real interest rate. Thus, the real interest rate was increased from 2.8 percent to 3.0 percent.
- The Trustees reviewed the evidence on real productivity growth, and decided to retain the previous assumption of a 1.3 percent-a-year growth rate, rather than raising it in response to the revision of the CPI.
- Based on theoretical considerations, it was decided to maintain a 0.1 percentage point wedge between the CPI and the GDP deflator (the GDP deflator better captures upper level substitution because it uses a superlative index rather than a fixed weight index, thus it should grow more slowly than the CPI), even though the CPI is expected to grow more slowly in the future than it has in the past. Consequently, the long-run ultimate growth rate of GDP remained at 1.3 percent as well.
- The assumed natural rate of unemployment (NAIRU) was reduced from 6.0 to 5.5.

On balance, these changes to economic assumptions offset some of the full potential benefits of the CPI change. Thus, on net, changes to long-term economic assumptions improved the 75-year actuarial imbalance by 0.12 (better-than-expected short-term economic performance added another 0.03).

Intermediate Scenario Long-run Economic Assumptions		
	1999 Trustees' Report	1998 Trustees' Report
Annual % change in CPI	3.3	3.5
Nominal interest rate	6.3	6.3
Real interest rate	3.0	2.8
Nominal wage growth	4.2	4.4
Real wage growth	0.9	0.9
Real productivity growth	1.3	1.3
Real GDP growth	1.3	1.3
Unemployment rate	5.5	6.0

II. Previous Trustees' Reports

Trustees Reports from 1990-Present			
Year	75 Year Actuarial Balance	Trust Fund Exhaustion Date	Main Reasons for Change
1993	-1.46	2036	Minor offsetting changes
1994	-2.13	2029	Reduced real wage assumption, higher disability rates, unexpected increases in average benefits for sample of newly entitled beneficiaries.
1995	-2.17	2030	Minor offsetting changes.
1996	-2.19	2029	Improved method for dual-entitlement benefits.
1997	-2.23	2029	CPI formula changes.
1998	-2.19	2032	Real interest rate assumption and better than expected economic performance.
1999	-2.07	2034	CPI use of geometric means and other changes in economic assumptions; better than expected economic performance

III. Economic and Demographic Assumptions

1999 Trustees' Report--OASDI assumptions (percent change per year)

	Intermediate	Low cost	High cost
Labor force growth	0.1 percent	0.6 percent	-0.5 percent
Average hours	-0.1 percent	0.0 percent	-0.2 percent
Output per worker	1.26 percent*	1.56 percent	0.97 percent
Total real GDP	1.3 percent	2.2 percent	0.3 percent

* Output per hour is assumed to grow at 1.26 percent per year, and hours per worker to fall by 0.1 percent per year.

Historical experience: productivity and labor force growth

	1960 II to 1973 IV	1973 IV to 1990 III	1993 I to 1998 IV
Civilian employment	2.0 percent	1.9 percent	percent
Output per worker	2.4 percent	0.8 percent	percent
Total real GDP growth	4.2 percent	2.7 percent	percent

Impact of higher productivity growth

1999 Trustees' Report

Productivity growth (output per worker)	Actuarial imbalance in OASDI
1.26	2.07
1.56	1.76
2.37	0.98
3.3 (rough estimate)	0.00

1998 Trustees' Report--Exhaustion dates and actuarial imbalances

	Date of OASDI Trust Fund exhaustion	75-year actuarial imbalance
Intermediate	2032	-2.19
Low cost	NA	+0.25
High cost	2022	-5.42

1999 Trustees' Report--Exhaustion dates and actuarial imbalances

	Date of OASDI Trust Fund exhaustion	75-year actuarial imbalance
Intermediate	2034	-2.07
Low cost	NA	+0.23
High cost	2024	-4.97

1999 Trustees' Report--Other economic and demographic assumptions

	Intermediate	Low cost	High cost
CPI (percent per year)	3.3	2.3	4.3
Unemployment rate (percent of labor force)	5.5	4.5	6.5
Fertility rate (now 2.01)**	1.9	2.2	1.6
Male life expectancy for 2075 at age 65 (now 15.8 years)	18.9	16.7	21.9
Net immigration (persons per year), including both legal and illegal	900k	1,150k	750k
Covered workers per beneficiary in 2075 (currently 3.4)	1.8	2.5	1.3

** Defined as average number of children who would be born to a typical woman in her lifetime if she were to survive the entire childbearing period. The 1998 level is 2.04.

1999 Trustees' Report--Impact of immigration rate under other intermediate assumptions

Net immigration per year (including illegal immigrants, but also netting out emigrants)	Actuarial imbalance in OASDI
900,000	2.07
1,150,000	1.90
750,000	2.18

1999 Trustees' Report--Worker-beneficiary ratio

	Intermediate assumptions	Low cost	High cost
1960	5.1	5.1	5.1
1980	3.2	3.2	3.2
1998	3.4	3.4	3.4
2010	3.1	3.2	2.9
2020	2.5	2.7	2.3
2030	2.1	2.3	1.9
2070	1.9	2.5	1.4

1999 Trustees' Report--Life expectancy at age 65

Year turning age 65	Male	Female	Total
1945	12.6	14.4	13.6
1998	15.7	19.2	17.5
2030	17.1	20.2	18.7

August 13, 1999

MEMORANDUM FOR GENE SPERLING

FROM: JASON FURMAN

RE: BUDGET MEETING WITH THE PRESIDENT, 8/12/99

THE MAIN POINTS THAT I TOOK AWAY FROM THE MEETING WERE

1. Debt reduction, and eventual debt elimination, is a key priority.
2. Since a lockbox would be easier to undo than a tax cut, and since it is already at least nominally a Republican priority, we should not trade anything for one.
3. We should ensure that Medicare solvency should be extended into the 2020s with some prescription drug benefit.
4. We should not try to get anything that looks like more than \$328 billion in discretionary spending.
5. We might potentially use some of the off-budget surplus for Medicare as part of a "global deal." We should look at ways that do this by phasing in, or delaying the beginning of, a lockbox or strictly on-budget world.

NOTES FROM THE MEETING (MY OWN WORDS, NOT A LITERAL TRANSCRIPT)

POTUS: The Republicans should not have done what they did with the Social Security surplus, they are shooting themselves in the foot.

Sperling: This is not where the Republicans started. They were spending heavily out of the surplus – with a big tax cut in the first year. Your State of the Union terrified them.

Podesta: Domenici got them off that – he is a budget hawk.

Lew: Putting a stake in his plan.

Stein: Domenici was also trying to constrain the Republicans.

Jack Lew's Presentation on Budget Sensitivity and Discretionary Spending

Lew: Chart 1 speaks for itself.

- Realistic sense of the risk, and the probabilities that reality is different from our projections.
- Extrapolating from the pre-OBRA 1993 prediction errors we would have a wide band of uncertainty around the deficit projections.
- When we simulate two scenarios: a severe recession w/ downward receipts technicals and stronger growth with positive receipts technicals, we get a much smaller band of uncertainty.

Sperling: You should appreciate how much you have accomplished. The unified deficit would have been \$1 trillion in 2009 according to pre-OBRA projections. The worst case scenario is for a \$100 billion deficit.

Lew: The next chart shows that you get an on-budget deficit very quickly if things go badly.

Podesta: Does this line use a capped baseline? Would breaking the caps put us below this line?

[note: The line is the Mid-Session Review policy pending reform. It is slightly different from a capped baseline.]

Lew: Yes, spending above the caps would get us there more quickly. The next table shows the sensitivity of the budget to different factors. The main point I would like you to take from this is that interest rate movements do not have that big an effect anymore.

POTUS: That's because we have a lot less debt.

Sperling: This shows one consequence of your economic policies: lower levels of debt result in more stability in government finances.

Lew: Your economic advisers disagree on the likelihood of different scenarios and the overall magnitude of the risk. We wanted to present you something emphasizing the sensitivity and the different things that could happen.

The Analysis of Alternative Discretionary Levels (see Table) shows how you go from CBO to OMB. Going from CBO you need to add money for different CPI projections and technicals; then from the capped baseline you need to add \$142 billion financed by offsets and \$328 billion financed by the surplus. The table then shows purely hypothetical numbers for the cost of Veterans, agriculture, and emergencies.

POTUS: That is a very conservative number for agriculture. Do these numbers include Medicare fixes?

Lew: No, we were sticking with discretionary levels. The issue then becomes, do we want to rely on our offsets? Our offsets may not be realistic at this moment. But experience shows that when you need to find offsets, you can find them. If the tobacco tax is in our future, then our offsets are reasonable.

POTUS: [Based on "Potential Discretionary Requirements" table]. When you are done with our requirements, if we do not have the offsets that leaves about \$150 billion for tax cuts or Medicare – that's nothing.

Lew: If we funded enacted inflation, the discretionary costs would be \$6.7 trillion with or without offsets (see table "Potential Discretionary Requirements") In past budgets, when we were moving defense down, there was less pressure on NDD. Now much more pressure on NDD due to the defense buildup. There is less scope to shift from defense to non-defense.

If we look at the offsets: the tobacco tax we could get eventually, the tobacco recoupment we have lost already, and the others are all like year-to-year business revenue. The big question is whether we could rely on future tobacco taxes.

The point of this presentation is that in negotiating, we would want to raise the bar, not lower the bar. Especially when we count veterans and agriculture. In past budget agreements the outyears always fell off a cliff. In our budget the outyears are still low, but they are much more reasonable than past budgets.

Under a CBO baseline there is virtually nothing for solvency. We need to end up using our economics – otherwise we can't fit all this in. That sort of thing usually happens at the end of budget agreements.

POTUS: What do we do about our offsets?

Lew: Could have an agreement that had offsets without specifying them. Then it would be up to the future to come up with them.

Sperling: Remember, that if we only get about \$300 billion gross, most of this would go to defense – it would put a lot of pressure on NDD.

POTUS: Off CBO there's nothing for Medicare. CBO thinks our Medicare plan is much more expensive than we think it is. Do people take their estimates seriously? Or is it politics?

Jennings: People think our numbers are quite conservative. They come from the actuaries. They also provide the data that CBO uses to estimate the costs.

POTUS: What would all of this be like with a \$792 billion tax cut?

Sperling: To give you an idea of what they are doing, Chaffee said that the tax cut would keep spending \$600 billion below inflation – then he went ahead and voted for it. The Republicans also turn off their tax cut in the last year, using a 10 year \$792 billion number for what is really a 9 year tax cut.

POTUS: We need to explain all of this on a chart.

Lew: Their plan is totally unrealistic – just a rhetorical device.

Question 1: How Large Must the On-Budget Surplus Allocation for Discretionary Spending Be? Is \$328 Billion Enough?

Sperling: The \$328 billion is very public – if we ask for more it will look very bad.

POTUS: If you want my answer, (1) [asking for up to \$470 billion] is untenable; and (2) [asking for something like \$328 billion] is right.

Question 2: What is the Test For Whether We Have Satisfied the Fiscal Discipline Test? Is a Lock-box a Strong Enough Fiscal Achievement To Justify a Larger Tax Cut?

Sperling: A lock-box is the most likely outcome of the budget process. Would that be enough for us? There are three answers:

1. Yes, lock-boxes are significant. With \$2 trillion in debt-reduction securely locked away, a somewhat larger tax cut is no big deal.

2. No, lock-boxes are not significant. The only thing irrevocable is a tax cut.

3. No, we do not need a lockbox. Social Security surpluses are protected by the politics of “not spending Social Security money,” not specific procedural rules.

POTUS: Does a lock-box mean that you need 60 votes to break it? Isn't it just the same as shifting Social Security off budget?

Stein: There is a qualitative difference between procedural protections and voting on a tax cut. It would be much easier to vote on the procedural issue to break a lock-box than to vote to eliminate a tax cut.

POTUS: No matter what, a lock-box would not be as powerful as a tax cut. We should not bargain anything away for it, especially because they want a lock-box also.

When I talk to people they do not understand that the Republican lock-box does not add 1 day to the life of the Social Security trust fund. And they don't have any of the Medicare solvency transfers. Therefore their plan has to pay down less

debt. We should be able to say that their plan pays down \$x billion less of the debt.

They want to destroy the Federal government, except for concrete and defense, and have rich people pay no taxes. They want us to look more like Brazil – everyone living behind iron gates and paying for their own security. That would be fine for people like me, but terrible for the country.

We need a chart showing how you cannot have a \$792 billion tax cut and pay down the debt. We need to do more on this.

The problem with doing a deal is that they won't do \$250 billion, and they probably wouldn't do \$300 billion either, although they might if they got to choose every aspect of it. For them to do \$300 billion they would have to admit that everything they have been saying about the budget is wrong.

I don't see any way out of this. Do you?

Question 3: Does a Strong Social Security Lock-box Pose Too Much Stockman Risk for Domestic Discretionary Spending?

Sperling: This is one of the most agonizing choices. Would a strong lock-box put pressure on non-defense discretionary spending? In the 1980s President Reagan was spending out of deficits. Today, we would be paying for spending out of Social Security. Does this create too much Stockman risk, even without a tax cut?

POTUS: If there is a fix – we want to do something that takes Medicare past 2020. Maybe we could do that by putting in a lock-box a few years down the line, and leave some more room for now.

Question 4: What Represents a Substantial Medicare Accomplishment?

Sperling: There will be a lot of trouble getting the Senate Democrats to accept solvency transfers for Medicare.

Lew: They view them as IOUs – they don't want to see this.

Sperling: The irony is that we are doing it the right way – we give Medicare an IOU for \$1 and at the same time we pay down \$1 of debt. The Senate Democrats are all hung up on the accounting issues, but we are doing more than accounting – we are actually doing something to pay down the debt.

POTUS: What if we got \$150 billion of the \$328 billion for Medicare solvency? What does it do to the trust fund? With the \$150 billion less in debt reduction – and the extra interest costs – when would you get rid of publicly held debt? What year?

There is a tremendous rhetorical power in telling people that we will fully pay down the debt by 2015. We need to know how these different pieces fit together.

The Republicans will want to do something small for Medicare prescription drugs. How much more modest can we get, while achieving our goals and not appearing to cave?

Question 5: Are We Willing to Use Social Security Surpluses for Medicare Reform and Solvency?

Sperling: What if Congress comes and says, we can do the Medicare out of the Social Security surplus? Their lock-box allows this – it only locks away the money for “Retirement Security” – it would not be a big change for them.

POTUS: If there is a global deal, this is it. Senate Democrats would not like it, but this would be it.

Podesta: [I believe he indicated his enthusiasm for this course.]

Sperling: Larry Summers wanted me to say that this would be scary for markets. It would result in less debt reduction, and they would perceive that we were already opening up a large pot of off-budget money to be potentially used.

POTUS: What we need to see is what would it do for debt reduction? What would it do for solvency?

Sperling: If you can get a real, major reform – take it. It is a major accomplishment.

POTUS: Don't give them anything for a lock-box.

[At this point the meeting ended]

October 4, 1999

MEETING WITH SENATORS MOYNIHAN AND ROTH

DATE: October 5, 1999
LOCATION: The Oval Office
TIME: 11:30 AM
FROM: Larry Summers
Larry Stein
Chris Jennings

I. PURPOSE

To meet with Senators Roth and Moynihan to discuss the status of Medicare reform.

II. BACKGROUND

Medicare

Because any hope of passing meaningful Medicare reform must start with the Senate Finance Committee, we have scheduled you to meet with Chairman Roth and Ranking Member Moynihan. It is more clear than ever that the House cannot and will not move any broad-based Medicare reform unless the Senate moves first (the House continues to be mistrustful of us and the Senate ever since the 1995-1996 budget debate). It is important to note that the Finance Committee is the only Committee of jurisdiction in which there is even the possibility of bipartisan consensus around Medicare reform. This is because Chairman Roth is up for re-election next year and faces a tough race against Governor Carper and because Senator Moynihan has indicated that Medicare reform might be the best way to end his legislative career in the Senate.

In the last few weeks, John Podesta, Larry Stein, Gene Sperling and Chris Jennings have engaged in a series of conversations with Senator Roth, Senator Moynihan, and their staffs. For the reasons outlined above, both have indicated their interest in working on a bipartisan reform initiative. They have indicated that the Committee seems very open to your proposals on competitive reforms also both in fee-for-service and managed care. Moreover, they both believe there is an increasing desire on the Committee to provide for a meaningful prescription drug benefit. Senator Roth, however, contends there is little support for our proposal to dedicate a significant percentage of the surplus to extend the life of the Medicare Trust Fund.

Both Senator Roth and Moynihan believe, however, that the only initiative that can emerge this fall from their Committee is a package of post-BBA 1997 provider give-backs. In fact, Senator Moynihan co-sponsored Senator Daschle's 10-year, over \$20 billion provider give-back proposal. Senator Roth has signaled his willingness to pass a smaller package with the stated intention of continuing to create pressure for a broader Medicare reform package next year. He has not publicly stated this strategy because of his fear of being blamed for "killing" Medicare reform this year.

This evening, Senator Moynihan is meeting with Senator Roth in an attempt to seek his agreement to propose that you work on a package of provider give-backs with a commitment to mark-up a broader Medicare reform package by the spring of next year.

If you agreed to this proposal, it would be an explicit acknowledgement that Medicare reforms are not possible this year. Your advisors believe that, rather than accepting this proposal as is, you should suggest that the Committee work with the Administration to develop this package but also should include in this legislation your proposals for modernizing the traditional Medicare programs. These proposals have received bipartisan support and were included in the Breaux-Thomas package. Although their savings would not be sufficient, according to CBO, to fully offset the likely give-back package, it would be considered a down-payment and a step towards comprehensive reform. To fully offset the costs, some amount from tax loophole closings or other sources would be necessary. Rather than talk about sources of financing or explicit numbers, we recommend simply emphasizing the desire that no changes harm the solvency of the Medicare trust fund.

Given the fact that Members want to leave Washington as soon as possible, it is not clear whether the Committee, let alone the Congress, could pass these reforms. Because the Congress is desperate for any type of offsets, however, it is possible they may respond to this challenge. Having said this, our unstated fall-back position would be a low-cost, one-year provider give-back package. This would be purely a stop-gap measure that would ensure that the provider community would put pressure on the Finance Committee to carry through on their commitment to take up broader Medicare reforms – including additional give-backs – next year.

TALKING POINTS ON MEDICARE

- I've invited you here today because I believe you are literally the key to our chance of developing a bipartisan consensus to advance Medicare reform. There can be no doubt that the demographic and health care challenges facing the program can only become more difficult to address the longer we wait. I want to work with you two to see if we can achieve a consensus on how to modernize and strengthen the program.
- I well recognize that you are under significant pressure to produce a package of provider give-backs in the wake of significant reductions in reimbursement included in the BBA. As you know, I have continued to state my belief – and I still believe today – that these

issues can be best addressed in the context of broader Medicare reform.

- Having said this, I recognize the time is short and that there is little serious chance of passing comprehensive Medicare reform this fall. I understand that this is why you are proposing to take a two-step approach to the challenges facing Medicare: provider give-backs first and broader reforms this spring.
- I believe that this approach has potential but think that we can and should take the opportunity this year to put a down-payment on reforms. One element of reform that was in both the Breaux-Thomas and my proposal is reforming the traditional fee-for-service Medicare. These proposals give Medicare the quality improvement and cost containment tools that the private sector now uses. And I believe that there is no reason why we shouldn't enact these provisions into law this year. They would have the added benefit of providing some help in financing the give-back package. I also believe that whatever we do, we should not undermine the solvency of the trust fund. This would help in that regard.
- I think that if we can be successful in working together this Fall, it will build trust and confidence in both parties to pass the broader reforms that are necessary for the Medicare program.

Extension of Expiring Tax Provisions

As you know, a number of tax provisions have expired. First, a provision allowing the use against the AMT of nonrefundable personal tax credits—such as the child credit, Hope Scholarship and lifetime learning credits, and the adoption credit—expired at the end of tax year 1998. If that provision is not extended, nearly a million taxpayers will receive only a partial benefit (or none at all) from these credits. Moreover, nearly ten million more will be required to undertake complex calculations to determine whether their credits are reduced. Second, the research and experimentation (R&E) credit expired at the end of June. The business community is pushing hard for retroactive reinstatement of the credit this year, to prevent a gap in coverage as occurred in 1996. In addition, the welfare-to-work tax credit, work opportunity tax credit, and wind and biomass credit expired at the end of June this year. In the FY 2000 budget, you proposed to extend for one year most of the provisions that expired this year. You did not propose extending the exemption from subpart F for active financing income. (You line-item vetoed a similar version of this provision in 1997.)

The House Ways and Means Committee recently passed a package of extenders, including: a permanent extension of the waiver of individual AMT limitations on nonrefundable personal credits; five-year extensions of the R&E credit, the exemption from Subpart F for active financing income, and the suspension of net income limitations on percentage depletion for marginal oil and gas wells; and 2 ½ year extensions of the Work Opportunity and Welfare-to-Work credits. At the markup, Treasury testified that

Secretary Summers would recommend a veto of the bill because it does not include any revenue offsets against its cost of \$23 billion over 5 years and \$52 billion over 10 years.

The Democratic alternative extended the various expiring provisions through December 31, 2000 and was fully paid for with revenue offsets. In addition, it included the first year's bond authority under the Administration's two-year school modernization bond proposal, and two provisions that do not expire until next year -- the exclusion for employer-provided educational assistance and the wind and biomass tax credit. At the markup, Treasury testified that the Democratic alternative was consistent with the framework you have set forth because it contained revenue raising provisions that fully offset the cost of the package.

It is currently unclear what package will emerge. The House has not yet scheduled floor action. Earlier this week, there was talk of adding the wind and biomass credit with a modification pushed by Senator Roth to allow the credit for electricity produced from poultry litter before voting on the House floor and then moving the package directly to the Senate floor without consideration by the Finance Committee. Now, however, it appears that the Finance Committee will hold a markup on extenders this Friday. No details have emerged as to Chairman Roth's proposed mark or whether he intends to offset any package he offers.

Bringing a separate tax bill to the Senate floor without budget rule procedural protections is very difficult. As a result, an extenders package is only likely to pass the Senate as part of an omnibus spending bill or by unanimous consent agreement. The Senate Finance Committee Democratic members bridled at inclusion of the extenders package in last year's omnibus spending bill. Thus, the SFC Democrats may attempt to prevent that from happening this year. The possibility of a unanimous consent agreement will depend on whether any offsets are provided, and, if so, which offsets are included. In light of these issues, Senators Lott and Gramm have stated that there is no guarantee of an extenders bill this Fall.

Recommendation. In light of the foregoing, we believe that, in your meeting tomorrow with Senators Roth and Moynihan, you should advance the following three principles regarding passage of an extenders package:

1. An extenders bill should be passed this year. There are several important provisions -- the AMT credit provision, the R&E tax credit, the wind and biomass tax credit, the work opportunity tax credit, and the welfare-to-work tax credit -- that should be reinstated retroactively.
2. Because the extenders package that passed the House Ways and Means Committee contained several multi-year extensions, it was too large and should have been paid for with revenue offsets.
3. Any extenders package should be fully paid for with revenue offsets.

THE WHITE HOUSE
WASHINGTON

November 8, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings
SUBJECT: Proposal to Create a Medicare Board
CC: Bruce Reed, Gene Sperling

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Secretary Shalala has drafted the attached memorandum to respond to a proposal by Senator Breaux and Congressman Thomas to create an independent board to supervise the Health Care Financing Administration's (HCFA) administration of the Medicare fee for service system, as well as to separately oversee operation of private plans participating in the Medicare program. Although it appears that proposals for a Medicare board will not be passed by this Congress, the ongoing frustration of the Congress and its constituents regarding HCFA's role in administering the Medicare program are certain to lead to future discussions about this issue.

Recognizing this, we have been strongly encouraging the Department to integrate a series of private sector practices that would hopefully lead to better coordination and administration of the agency's substantial responsibilities. Nancy-Ann Min DeParle has indicated her willingness to advocate for and implement these initiatives because she thinks that they will improve the agency's operational status and credibility, making it possible to fend off unconstructive initiatives that undermine the agency's ability to manage the program effectively.

BACKGROUND

HCFA remains one of the most passionately reviled agencies in the Federal government. This is logical, as it is responsible for denying reimbursement for desired claims from providers and state and local agencies alike. In addition, HCFA's numerous responsibilities makes it difficult for it to effectively manage, and there tends to be little time available for anything other than crisis management. Long-term planning is rare and frequently altered substantially by Congress and other outside entities, making stable and predictable management impossible.

Congressman Thomas and Senator Breaux believe that an independent board would help facilitate better management and utilize the best private sector management techniques. They believe the agency is inherently biased against private insurance plans participating in the program, causing the frustration and problems HMOs participating in the Medicare program have experienced. They also view this board as a possible vehicle to develop and implement benefit coverage and policy changes in a process independent of political intervention from the Congress and other outside sources.

THE PRESIDENT HAS SEEN

11-9-99

do not
HCFA
In the memo from the Secretary, she counters that a Medicare board would reduce beneficiary protections, dilute Presidential authority, and provide the infrastructure to end the Medicare entitlement. The Department also argues that such a structure would lead to limited accountability by the Medicare program to both the White House and the Congress, and create extreme difficulties in managing program integrity initiatives, including anti-fraud and abuse efforts, within all aspects of the agency. While these are valid arguments and should be taken seriously, the same effort that was exerted to make these arguments should also be applied to the Department's commitment to reform the agency.

While we concur with the Secretary's memo that proposals such as those developed by Congressman Thomas and Senator Breaux would be detrimental to the Medicare program and the beneficiaries it serves, this type of proposal should serve as a warning to the agency to be more efficient and responsive to both the White House, the Congress, and the various advocacy, provider, and insurer communities it deals with.

do not
We believe that we should use this opportunity as a means to strengthen the Medicare program and push HCFA to ensure that it is more prudently managed. In so doing, the agency will have the additional benefit of strengthening its credibility when opposing harmful and poorly thought out reform proposals.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 25 1999

MEMORANDUM FOR THE PRESIDENT

I am writing to express my deep concern over discussions occurring in Congress that could result in creation of a new, independent Medicare board. As envisioned by its proponents, this board would operate as an independent entity designed to oversee the Medicare+Choice program, including the competition among private plans and between private plans and fee-for-service Medicare. The creation of such a board seriously undermines your authority over Medicare, the beneficiary protections that you have worked hard to establish for this program, and the significantly improved refocused management which has reduced the Medicare error rate by over fifty percent. This new board also sets the stage for capping government expenditures for Medicare, threatening Medicare beneficiaries' entitlement to first-class medical care.

The board's advocates say they want to bring private-sector expertise into the administration of the program and say they want to avoid conflicts of interest in running a competitive system. Their first goal is being accomplished without undermining the current strengths of Medicare and their second contention is a false promise. Not only will their proposals not achieve their goals, but, for the reasons stated below, they would substantially undercut our ability to serve beneficiaries and efficiently administer the program. At the end of this memorandum, I will describe the activities that we have already undertaken to garner additional private sector expertise in administering Medicare.

Medicare Board Leads to Reduced Beneficiary Protections. Under your leadership and through the hard work of this Department, we have ensured that Medicare includes the beneficiary protections outlined in your Patients' Bill of Rights. Medicare was one of the first programs in the country to incorporate these protections and remains a model program. This would not have been possible if the Medicare+Choice program were administered by an independent board.

Given the hostility we have seen in the private sector to even the modest proposals in the Patients' Bill of Rights, I do not believe that a board comprised of private sector health officials would have taken a strong, pro-beneficiary stance. It is not surprising that the strongest proponents of a Medicare board, including managed care interests, are among the most active opponents of strong patient rights legislation. I believe that we must maintain our ability to keep Medicare in the forefront of beneficiary protection. Creation of an independent Medicare board is not consistent with that imperative.

Medicare Board Dilutes Presidential Authority. Placing the Medicare+Choice program under the control of an independent board splits accountability for the program and substantially dilutes your authority over a substantial portion of Medicare. This is a significant loss given that Medicare serves 39 million beneficiaries and makes up 11 percent of the Federal budget.

The Administration's ability to make changes to Medicare in the context of the President's Budget would be limited. This is especially true since proposals for treating traditional fee-for-service Medicare as a health plan under the structure of Medicare+Choice would allow a new board to exercise substantial authority over the entire program. In particular, a board could be given substantial authority over what private health plans would be paid by Medicare. It could also be given authority to oversee aspects of traditional Medicare, including benefits and, under some proposals, total spending by traditional Medicare.

As a result, the presence of a board would have hampered our ability to exert strong budget discipline, such as the steps we have taken to extend the life of the Medicare Part A Trust Fund to 2015. Similarly, it would not have been possible to use Medicare changes to help finance key domestic initiatives to improve the health of the nation, such as the Children's Health Insurance Program.

Furthermore, creation of a board would limit the Administration's authority to make key program changes to address Medicare problems identified by beneficiaries, providers, or other segments of the American public.

Medicare Board Diffuses Accountability for Medicare. Authority over certain key functions would be unnecessarily complicated by bifurcating control of Medicare between a board and the Health Care Financing Administration (HCFA).

For example, Administration efforts to reduce fraud and abuse in Medicare have been successful because we have provided clear, consistent policy guidance and because we have been willing to take the political heat generated by our aggressive stance. I do not believe that an independent board (especially one that includes private sector health care executives, as would be likely with any congressionally created board) would have initiated or sustained such a controversial, yet productive, program. Specifically, the HCFA actuaries credit aggressive fraud control efforts with bringing down the Medicare baseline through reducing either the rate of growth or the actual level of spending on inpatient hospital services, home health, and lab services. Our efforts have also led to the first-ever decline in hospital upcoding since the inception of a prospective payment system in 1984. The bifurcation of authority under a board would threaten the significant advances made by this Administration by complicating the relationship between the program and the HHS Inspector General and between Medicare and the Department of Justice.

Similarly, this Administration has taken significant steps to measure and hold health plans and providers accountable for quality of care for seniors and other vulnerable populations. The diffusion of accountability threatens our ability to move aggressively in this area as we have on the Patients' Bill of Rights.

Medicare Board Creates Potential Confusion of Authority That Would Be Detrimental to Beneficiaries. HCFA is currently responsible for a wide range of activities that might become the responsibility of either the board or HCFA, or both. These functions include beneficiary education, procedures for appeals and grievances, provider enrollment, survey and certification of providers, and quality assurance. If these functions were assigned to HCFA, their applicability to private plans would become uncertain; if assigned to the board, more functions would be removed from the lines of public accountability. If assigned to both, there would be confusion and uncertainty among all parties involved.

A Medicare Board Provides the Infrastructure for Ending the Medicare Entitlement. Although the proponents of a board deny that they intend to fundamentally change Medicare, it is clear that creation of an independent board would establish the administrative framework for a defined contribution plan, which specifies the government's financial contribution toward beneficiaries' health care but does not specify the benefits to which beneficiaries are entitled. Creating an independent board is an ideal first step toward capping government contributions for Medicare, and beneficiary advocates will see it as such. It is not surprising that some of the strongest advocates in Congress for a board are the same Members who tried to cap Medicare spending in the 1995 budget bill that you vetoed.

Claims About Current Conflicts of Interest in Managing Medicare Are Not Legitimate. Advocates for a board argue that HCFA has an inherent conflict of interest in both managing the competition among private health plans and fee-for-service Medicare and operating the fee-for-service Medicare program. In fact, the risk of conflict of interest could be greater if managed care executives, hospital administrators, physicians, durable medical equipment suppliers, or any other individual who benefits from Medicare payments were given statutory powers through participation on the board.

Today, HCFA manages both original Medicare and Medicare+Choice, having successfully supervised the growth of Medicare+Choice to a program that enrolls about one of every six beneficiaries. HCFA's role is not unique – conflicts of interest are successfully avoided by CalPERS and many private employers that run self-insured plans while contracting with competing health plans.

The assertion that HCFA's dual role creates a conflict of interest may stem from certain decisions that private plans may find onerous, such as those in setting standards for consumer protection and quality assurance. Such decisions stem directly from HCFA's primary concern for serving the needs of beneficiaries, not from any desire to bias the competition. If a Medicare board also places serving the needs of beneficiaries as its core mission, it will inevitably make similar decisions. Thus, it will also be subject to the same charges of conflict of interest.

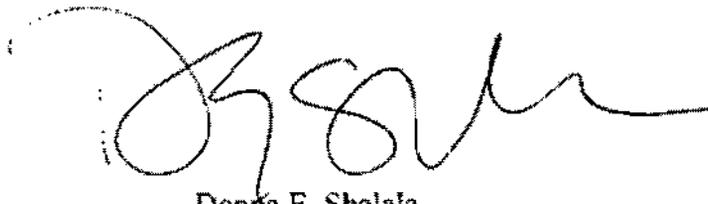
Under your proposal for a competitive defined benefit, traditional Medicare and private health plans would compete on an equal footing, allowing both Medicare and beneficiaries to save when beneficiaries choose efficient health plans. As discussed above, I believe that many board proponents are using the conflict of interest accusation as an excuse to take the first step toward ending the entitlement.

Private Sector Involvement Can be Achieved Without a Medicare Board. While I am deeply concerned about the proposals to create an independent board to administer a portion of Medicare, I am committed to expanding the program's access to private sector expertise. In September, we chartered a Management Advisory Committee for HCFA. This step was part of HCFA management modernizations contained in your budget. The committee allows HCFA to get expert advice from individuals in the public and private sector regarding innovations in management practices. It also will allow HCFA to maintain critical relationships with public and private sector experts in management, leadership, and purchasing strategies. The committee will address issues including how HCFA can better manage its private sector contractors and how it can be a more prudent purchaser of fee-for-service Medicare services. The committee need not make recommendations regarding payment or coverage policy, because the Medicare Payment Advisory Commission (MedPAC) and the recently established Medicare Coverage Advisory Committee already fulfill these functions.

I will chair the committee, which will include up to 11 additional members that I will appoint. The members will be selected from among nationally recognized authorities in academia, private consulting, public and private sector health purchasing entities, and private companies. The committee would not include provider or beneficiary representatives since they are already represented in many advisory committees to the Congress and the Department.

If Medicare reform is successful, this committee could also easily be adapted to serve as an advisory body for the implementation of the fee-for-service modernization reforms included in your Medicare plan. Experts from private and public sector organizations that purchase health care for their employees and beneficiaries, as well as experts in public administration, would provide recommendations to the Secretary on how to implement these reforms to purchase services more competitively. HCFA would benefit from the advice of these experts in a forum open to public participation.

In Conclusion, Creation of a Medicare Board to Oversee a Portion of the Program Would Be a Grave Mistake. It would be a disservice to our successors and to future generations of beneficiaries if we were to weaken the executive management of Medicare, not only because it is a substantial and growing proportion of federal outlays, but because older and disabled Americans are particularly vulnerable and need government protection. This Administration has strengthened Medicare in innumerable ways: extending solvency, increasing benefits, advancing new beneficiary protections, and strengthening program integrity. The Medicare program would most likely not be experiencing the benefits of the Administration's improvements had the Medicare board, as proposed, been in existence.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', with a large, sweeping flourish at the beginning.

Donna E. Shalala

December 13, 1999

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

CC: JOHN PODESTA

SUBJ: HEALTH CARE IDEAS FOR STATE OF THE UNION/BUDGET

Strengthening and Modernizing Medicare

- 1. Plan To Strengthen and Modernize Medicare.** Your plan from June will need to be modified since the re-estimate for the prescription drug benefit is considerably higher, savings on the new baseline are lower (as is the appetite for savings in Congress), and the April Trustees' report will likely show an improvement in Medicare solvency absent any actions. Changes to the plan are being considered and will be discussed separately with you.
- 2. Medicare Preventive Benefit Authority.** This proposal would allow HHS to add new preventive benefits to Medicare and is consistent with a recommendation by the Institute of Medicine released this week. (Also under consideration is a limit on all allowable cost expansions). It builds on the preventive initiative in the Medicare plan, which eliminates cost sharing for preventive services, authorizes additional studies and a smoking cessation demonstration. (Cost: not yet estimated).
- 3. Immunosuppressive Drug Extension Adjustment.** Currently, Medicare pays for immunosuppressive drugs that prevent rejection of transplanted organs. This coverage extends for three years after the transplant. The Balanced Budget Refinement Act added a flawed, dollar-limited 8-month extension on coverage of immunosuppressive drugs. This proposal would make the extension one year rather than 8 months, would remove the funding cap, and remove the time limit. (Cost: roughly \$100 million over 5 years).
- 4. Cancer Clinical Trials.** This three-year demonstration would cover the patient care costs associated with certain clinical trials for Medicare beneficiaries. This proposal was in the President's FY 1999 and 2000 budgets, and has been a Vice Presidential priority. (Cost: \$750 million for 2002-04).

Improving Access to Affordable Health Insurance Coverage

5. Family Health Insurance Initiative. Over 85 percent of the parents of uninsured children in families with income below 200 percent of poverty are themselves uninsured. This option, included in the Gore health proposal, would provide states with the same incentives to cover parents as children under Medicaid and the Children's Health Insurance Program (CHIP). Specifically, a state could receive a higher federal matching rate for expanding coverage to the parents of children currently eligible for Medicaid or CHIP, if that state has expanded to 200 percent of poverty for children. This enhanced matching rate would be drawn from the CHIP allotments that would be increased to help pay for the entire family. States would cover the parents in the same program as their children. Since most uninsured children also have uninsured parents, this is an efficient way to bring down the numbers of the uninsured. It could also increase enrollment of children, since parents are more likely to enroll their children if they, too, can get health coverage. (Cost: from \$5 billion to \$18 billion over 5 years depending on who receives the enhanced match and whether the allotments are raised).

6. Medicaid Option to Cover Poor Adults. Currently, states can cover only adults who are parents through Medicaid. This policy would remove this "categorical" eligibility, replacing it with a straight income-related eligibility. This approach has been taken by several states through Medicaid 1115 waivers, and fully moves Medicaid to an income-related – rather than welfare-related – health insurance program. HHS has developed this as a possible alternative to the parents' initiative. (Cost is unknown, but likely less than the family initiative since there is no higher matching rate and states would prefer to expand to working parents than all poor adults).

7. Tax Credit for Individual Insurance to Address Current Tax Inequity. Unlike employees who work at firms that provide coverage, workers who have no access to employer-based insurance and who buy it for themselves receive absolutely no tax subsidy. To address this inequity, this policy (supported by the Vice President) would give people without access to employer-based insurance a tax credit, equal to 25 percent of the cost of coverage and similar in value to the 100 percent tax deduction employers now receive, for purchasing individual insurance. This credit could only be used for qualified individual insurance plans or Medicare, Medicaid, or CHIP buy-in options. Because the credit is relatively small, it likely would not have an adverse incentive impact on employers now offering to drop coverage. But while it would be popular, it would not be expected to increase take-up in coverage for the currently uninsured. (Cost still being estimated but about \$15 over 5 years, \$35 over 10 years).

8. Encouraging Small Businesses To Offer Health Insurance. Workers in small businesses are more likely to be uninsured. This initiative would encourage small businesses to offer health insurance through: (1) a new tax credit for small businesses who join coalitions; (2) tax-exempt status for foundation contributions to create coalitions; and (3) technical assistance. It would be different from last year's proposal because the credit would be increased to 25 percent of the employer contribution, and all firms (not just those that previously did not offer coverage) would be eligible for the credit. (Cost still being estimated, but about \$1 billion over 5 years, \$2.5 billion over 10 years).

9. Medicare Buy-In for Certain 55 to 65 Year Olds. The fastest growing group of uninsured are those ages 55 to 65. Between 1997 and 1998, the proportion of people in this age group who were uninsured increased by 5 percent, from 14.3 to 15.0 percent. All of this increase occurred among people above poverty, with a dramatic jump for those with income between 300 and 400 percent of poverty. This initiative expands the health options available for older Americans by: enabling Americans aged 62 to 65 to buy into Medicare; providing a similar Medicare buy-in for vulnerable displaced workers ages 55 and older; and providing COBRA to Americans ages 55 and older whose companies reneged on their commitment to provide retiree health benefits. This proposal was in the last two budgets. (Cost: \$1.8 billion over 5 years, \$2.9 billion over 10 years).

10. Medicaid Coverage for Certain Women with Breast Cancer. This proposal is the Breast and Cervical Cancer Prevention Act (HR 1070) that has 272 House cosponsors and passed unanimously by the House Commerce Committee (a Senate bill has not yet been marked up). It would give states the option to provide temporary Medicaid coverage to uninsured women who have learned that they have breast or cervical cancer through a CDC screening program. States would get the CHIP match rate for this group. It is important to note that most policy analysts think that covering selected disease categories and/or people participating in a particular program is a troubling precedent. However, if there are no coverage expansions for this group, it would hard not to include this initiative in our budget. (Cost: about \$300 million over 5 years).

11. Ensuring that All Workers Paid by the Federal Government Have Access to Employer-Based Insurance. This policy would allow all types of temporary government employees to access the Federal Employees' Health Benefits Program. Currently, FEHBP serves only permanent federal employees. (Cost estimate and more details pending).

12. Tax Credit for COBRA Continuation Coverage. Currently, employers must offer departing employees the option of buying into their health plan at a premium of 102 percent. Intended to ensure coverage during the transition to new jobs, this policy has proven unaffordable to some people and burdensome to employers. To address these concerns, our new proposal would provide a tax credit of 30 percent for this coverage to the employer whose employee takes this option. This subsidy would be split equally between reduced employer cost and lower premiums for participants (87 percent). (Cost estimate pending).

Finishing the Job of Targeting and Enrolling Uninsured Children

13. Enrollment. Sites like schools and child care centers are natural places to reach out to uninsured children. To tap into these resources, this proposal would (1) allow school lunch application information to be shared with Medicaid and CHIP for outreach; (2) let enrollment in the school lunch program serve as a proxy for Medicaid or CHIP eligibility while formal applications are being processed; and (3) more broadly apply the presumptive eligibility option in Medicaid to homeless programs, TANF and CHIP eligibility workers, and others who are in a position to do preliminary assessments of children's eligibility for Medicaid or CHIP. (Cost: estimate pending – likely about \$1 billion over 5 years, nearly \$3 billion over 10 years).

14. Simplifying and Coordinating Enrollment. To ensure that children do not fall through the cracks of different eligibility rules for Medicaid and CHIP, this proposal would require that states conform Medicaid eligibility for children to that of CHIP in the following respects: (1) assets tests; (2) mail-in application; (3) redetermination period; and (4) eligibility to age 21. Thus, a state could not have simpler enrollment and redetermination processes for its CHIP program than it has for its Medicaid program. (Cost: pending – likely less than \$500 million over 5 years).

Long-Term Care

15. Long-Term Care Initiative. An initiative that has already been well received and has already begun to receive bipartisan support is the long-term care proposal. Last year, you proposed a major, seven-part initiative that would: (1) provide a \$1,000 tax credit for people with long-term care needs or their families to offset the costs of care; (2) create a new Family Caregivers Program that offers respite services, information, and other assistance; (3) offer private long-term care insurance to Federal employees; (4) improve nursing home quality; (5) expand Medicaid options for community-based services; (6) encourage assisted living facilities for Medicaid beneficiaries; and (7) conduct a \$10 million education campaign on long-term care for Medicare beneficiaries. (Cost: about \$6 billion over 5 years)

Discretionary Initiatives

16. Preventing Medical Errors. This initiative will develop new avenues for the prevention of medical errors. It will include the IOM's recommendation of \$35 million to establish a Center for Patient Safety at HHS and include new efforts to strengthen FDA's voluntary adverse event reporting system from health professionals and consumers, and implement new requirements for the naming, labeling, and packaging of drugs that are designed to prevent medical errors. FDA estimates that with adequate funding, it could reduce adverse events by 10 percent and save approximately 10,000 lives annually. This initiative could be combined with regulatory actions to ensure patient safety, including requiring hospitals participating in Medicare to implement error reduction programs. (Cost: \$60 million).

17. Internet Drug Sales. We would provide new funds for the investigation, identification, and prosecution of entities selling over the Internet unapproved new drugs, counterfeit drugs, prescription drugs without a valid prescription, expired or illegally diverted pharmaceuticals, and products based on fraudulent health claims. It would establish new certification requirements for all Internet pharmacy sites to ensure that they meet all state and federal requirements. It would create new civil money penalties of up to \$100,000 for dispensing without a valid prescription over the Internet or for selling drugs without federal certification; and provide FDA with new administrative subpoena authority to build a case against offenders. (Cost: \$10 million).

18. Preventing Breast and Prostate Cancer. This initiative will fully fund the National Environmental Health Laboratory, which evaluates the exposure of men, women, and children to toxic substances that cause cancer. Funds will also be used to assist state and local public health officials to ensure thorough investigation of cancer clusters and to rapidly evaluate the local

impact of public health disasters, such as chemical spills and groundwater contamination. (Cost: \$15 million).

19. Improving Nursing Home Quality. This initiative provides mandatory and discretionary funds to HCFA to help States strengthen nursing home enforcement tools and increase federal oversight of nursing home quality and safety standards. Funding will be provided for new enforcement provisions and increased surveys of repeat offenders and improve surveyor training. (Cost: \$31 million).

20. Providing Education Funds to Children's Hospitals. Medicare has invested billions of dollars in graduate medical education to hospitals since 1966. However, because of its current distribution formula, free-standing children's hospitals are forced to shoulder the majority of the cost of training pediatricians, placing them at a severe financial disadvantage. This initiative will augment last year's investment in these critical health care providers. (Cost: \$104 million).

21. Addressing Mental Illness. This proposal will increase funding for treatment for the severely mentally ill and establish a new local mental health enhancement program that would provide new prevention, early intervention, and treatment services for Americans with less severe mental illnesses. (Cost: \$100 million).

22. HIV and AIDS. This initiative would increase our current proposed investment in the Ryan White program and the AIDS Drug Assistance Program (ADAP), which provide critical services for people with HIV/AIDS. In addition, it would establish a strategic plan designed to reduce new HIV infections by 50 percent in three years. The new prevention initiative would: help 150,000 individuals not aware of their infection learn of their status and find prevention counseling and treatment services; expand community prevention planning, with a special emphasis on racial and ethnic minorities, women, injection drug users and their partners, and young gay men; and build a data infrastructure to assist local public health officials in targeting their prevention efforts. The new investment in Ryan White and ADAP would shorten the waiting time needed to access the comprehensive range of drugs needed to effectively treat this disease. (Cost: \$150 million).

23. Access for Uninsured Americans. This proposal would create a new grant program for community-based providers to develop comprehensive systems of care, develop linked financial and telecommunication systems, and fill the service gaps that exist in many communities, especially primary care, mental health, and substance abuse services. It would: hold providers accountable for health outcomes by helping them develop the systems to appropriately monitor and manage patient needs; preserve access to critical tertiary care services financial support to large public hospitals; and provide new services to the uninsured, including primary care, and mental health services. (Cost: \$75 million).

24. Investment in Biomedical Research. The potential breakthroughs in diagnoses, treatments and cures resulting from the nation's increasing investment in biomedical research are impressive. They include: decoding the complete gene sequence by the spring of 2000, developing new treatments to delay the onset of Parkinson's, Alzheimer's and cancer, and new

interventions to prevent paralysis with spinal cord injuries. The Administration's last budget dedicated a \$360 million increase to the NIH, which is far short of the over \$2 billion that was included in the final budget. This has resulted in criticism from the scientific and patient advocacy communities. (Cost: \$500 million to \$1.5 billion).

25. Safeguards Against Scientific and Biomedical Abuses. This package addresses the perils of some of the new scientific breakthroughs of our day. These include inappropriate patenting and licensing of genetic material, the insufficient provision of protections to human subjects in clinical trials, and the continuing threat of bioterrorism. Under consideration are a host of initiatives to address these potential problems, including legislation to prohibit the use of genetic information in all health insurance policies and employment decisions.

Medicaid and SCHIP Proposals Requiring Year-by-Year, 10 Year Actuarial Estimation Using PB 2001 Medicaid and SCHIP Baselines

I. OMB Recommended Proposals from Last Year's Budget

Restore Medicaid and SCHIP to Immigrant Children and Pregnant Women. The Director recommends again proposing the FY 2000 President's Budget initiative that would give States the option to serve children and pregnant women who entered the U.S. after the enactment of welfare reform (8/22/96). The FY 2000 Budget proposed eliminating the 5-year ban, deeming, and affidavit of support provisions. An estimated 65,000 children and 25,000 pregnant women would be helped by the proposal in FY 2005, the last year in the budget window. (Pregnant women would be eligible for Medicaid only).

Restore SSI and Related Medicaid to Disabled Immigrants. The Director recommends reproposing the FY 2000 President's Budget initiative that would require States to provide Medicaid coverage to disabled immigrants made eligible for SSI by the FY 2000 budget's SSI restoration proposal. An estimated 48,000 disabled immigrants would have Medicaid restored by FY 2005. (The number of individuals who would have Medicaid newly restored by the proposal is lower than the number that would have SSI restored -- 55,000 -- because HCFA assumes some of those made eligible for SSI would already be served in Medicaid, where the current law ban -- 5 years followed by deeming until citizenship -- is shorter than the current law SSI ban until citizenship.)

Asthma Disease Management Initiative. The Director recommends again proposing the FY 2000 President's Budget initiative that would provide grants to states, on a competitive basis, to test and evaluate the effectiveness of innovative disease management approaches to identify and treat pediatric asthma. Senator Durbin included \$100 million for the President's Medicaid disease management proposal (S. 805) in his asthma legislation, which was referred to the Finance Committee. This year, the Director recommends \$20 million per year, over five years.

Demonstration funds would cover start-up costs for new or expanded efforts in Medicaid to develop: a current practices asthma baseline, an intervention model with appropriate disease treatment protocols, and for beneficiary and provider outreach and education. The grant funds provide an incentive for more effective application of existing spending for outreach, case management, and treatment benefits to reduce costly asthma-related medical crises (such as emergency room visits and hospital stays) and to improve quality of life (such as school attendance) for children with asthma and their families.

In addition, the Director recommends allowing up to 20 percent of the disease management grant funds be used as a performance bonus fund to provide awards to states that document a reduction in Medicaid costs and/or improved health outcomes through disease management efforts. States would be required to demonstrate success against a pre-disease management baseline, developed by a third party and/or approved by the Secretary. The award would be linked to the success and size of the state's program. For example, if a state reduces its Medicaid expenditures related to pediatric asthma by 5 percent, the state could be awarded the Federal Medicaid share it saved

through the bonus fund. While the disease management start-up grant funds proposed in last year's budget may only be used for new disease management programs, the performance bonus could reward states that have mature Medicaid asthma disease management programs.

300% Eligibility Expansion. The Director recommends again proposing the FY 2000 President's Budget initiative that would give States the option of expanding Medicaid eligibility for people with incomes up to 300 percent of the SSI level (about \$1500/month in 1999) who need nursing home care but choose to live in their community. Current law allows States to provide Medicaid coverage to people with incomes up to 300 percent of the SSI level as long as they are living in a nursing home. This initiative would help address the perception of "institutional bias" in Medicaid by allowing States to treat people the same regardless of whether or not they choose to live in a nursing home or in the community -- as long as their income does not exceed 300 percent of SSI and they need nursing home care.

II. OMB Recommended New Proposals

Extend Transitional Medicaid. Transitional Medicaid provides up to a year of health coverage to families who lose eligibility for welfare-related Medicaid due to earnings from employment. It is believed to be a key support to low-income families who work their way off welfare.

The provision was reauthorized by the 1996 welfare reform law, sunsets after FY 2001, and, if extension is desired, requires reauthorization again starting in FY 2002. The provision is not continued in the baseline after FY 2001. The Director recommends removing the sunset and making the provision permanent. In addition, the Director proposes the simplification of transitional Medicaid that was included in last year's budget.

Presumptive Eligibility. The Director recommends expanding the presumptive eligibility provision in the Balanced Budget Act to authorize additional entities to make presumptive eligibility determinations for children and pregnant women.

Currently, only "qualified providers" can make presumptive eligibility determinations. For pregnant women, qualified providers are those which: 1) are eligible to receive payments under an approved State plan; 2) provide services such as those provided in outpatient hospitals, rural health clinics, and clinics defined by statute; and 3) receive funds under one of a list of government health programs (e.g., Public Health Service demonstration grants, MCH Block grants). Presumptive eligibility for children can be determined by Medicaid providers and entities authorized to make eligibility determinations for WIC, Head Start or for services financed under the Child Care and Development Block Grant.

Under this proposal, qualified entities could include: schools, school health clinics, child care centers, homeless shelters, locations that determine eligibility for Medicaid, TANF, and CHIP, and other entities approved by the Secretary.

Extend Coverage to the Parents of Children Enrolled in CHIP and Medicaid. This proposal would allow a state to claim the enhanced match rate for providing coverage to parents of CHIP-

eligible children, provided that: 1) the state has expanded CHIP coverage for children to the maximum income eligibility threshold allowed under the law (e.g., 200% of the federal poverty level for most states), and 2) the state has expanded Medicaid coverage to parents of Medicaid-eligible children (at regular Medicaid matching rates). This approach would encourage family coverage by offering the enhanced match rate for parents, while preserving CHIP's commitment to children by requiring states to expand up to the maximum allowable income level for children before their parents can be covered. Extending coverage to parents of CHIP-eligible children would not be an entitlement, and the CHIP-related costs of this proposal would be contained by the size of the state's CHIP allotment. This proposal assumes parents receive the same benefits package as their children (i.e., CHIP parents receive CHIP).

III. Offsets

Generic Drug Rebate – FY 2000 PB proposal

Provide Secretary with New Enforcement Tools when States are not in Compliance with Federal Requirements (HHS A-19) This proposal would provide the Secretary the authority to reduce FMAP by .5% when the Secretary finds that a State agency administering or supervising the administration of a State plan fails to comply in a non-substantial manner with Federal requirements. Reductions would be imposed for each violation and would remain in effect until the State has corrected the violation and is in compliance.

Under current law, the Secretary has the authority to withhold payments to the State for failure to comply **substantially** with federal requirements. With one limited exception related to enforcement of certain nursing home standards, the statute does not provide authority to penalize or otherwise withhold payments for non-substantial compliance. HCFA notes that advocates, providers, and Congress have suggested that when States fail to comply with Federal requirements, and the failure to comply is not substantial, the Secretary has no effective tool to penalize the State for the violation. As a result of this gap in federal authority, HCFA notes that an aggrieved party will often sue the State directly to force compliance with the federal requirements.

IV. DPC Recommended New Ideas

Option for using school lunch information for children's health insurance outreach.

Currently, school lunch programs are allowed to share enrollment information with other social programs, but not health insurance programs. The proposal would allow schools to elect to share school meal applications with Medicaid and CHIP staff unless parents opt not to have such information disclosed. When shared, application information may be used only for the purpose of child health insurance outreach and enrollment.

Family coverage initiative. This proposal is similar but broader than the OMB recommended option for extending coverage to parents of CHIP and Medicaid-eligible children. This proposal would allow states to use their enhanced Federal match rate from their CHIP allotments to cover parents of eligible children. This has the benefit not only of efficiently enrolling uninsured

adults (since most parents of uninsured children are also uninsured) but could increase enrollment of children since there is a greater incentive for the family to enroll them.

This plan would encourage states to expand coverage for the entire family, not just children, by:

- **Providing enhanced Federal matching payments for targeted low-income parents.** This option would allow states to access the CHIP enhanced matching rate from an increased CHIP allotment for covering parents of Medicaid or CHIP-eligible children whose income exceeds the current Medicaid eligibility level and is no higher than the current CHIP upper eligibility limit in the state. This option would only be available to states that have expanded CHIP to at least 200 percent of poverty and no waiting list.
- **Increasing CHIP allotments.** To ensure adequate funding for this option, the state CHIP allotments would be increased, beginning in 2002, so that the 2002 total is 50 percent higher than the 2001 allotment, and the total allotment increases at 5 percent annually. States would only get this allotment if they file a state plan for parents.

	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>2001-05</u>
CHIP:	4.275	3.150	3.150	3.150	4.050	17.775
Addition:	0	3.263	3.583	3.920	3.373	14.139
New total:	4.275	6.413	6.733	7.070	7.423	31.914

This total allotment would be allocated to states using a similar formula as that (modified by the Balanced Budget Refinement Act). In addition, **the current provision that reallocates unused allotment amounts after 3 years would be changed to 5 years**, to help in the transition to the new system. The rules for what happens when the allotments are used up would remain the same, with one exception: states would have to reduce eligibility levels for parents before reducing eligibility levels for children (they could only reduce eligibility levels for children if they no longer drew the enhanced matching rate from the allotment for any parents).

- **Benefits and entitlement.** Parents would be covered in the same program as their children; states could not cover a parent in a state-designed program when their children are currently eligible for Medicaid and vice-versa. States must cover lower-income parents before covering upper-income parents, as in CHIP.

Medicaid option to cover any low-income person. This proposal would give states the option to fully convert their Medicaid eligibility to an income-only standard, irrespective of age, work or family status. This approach has been take by several states through Medicaid 1115 waivers. To access this option, states would have to file a state plan, as in CHIP, that includes a description of current state-only spending on health care, proposed income definitions, etc. States with current state-only spending would have maintenance of effort (modeled on CHIP). This option would be limited to 150 percent of poverty.

Option for Medicaid-only CHIP states to convert to one matching rate.

[Chris and Jeanne: For simplicity, we are not planning to send this proposal to the actuaries]

Currently, 23 [check] states have chosen to use Medicaid as their CHIP option. For these states, the only difference between traditional Medicaid and CHIP is the matching rate. This proposal would allow these states to simplify their system and get the same Federal matching rate for enrolling a child in traditional Medicaid or CHIP. It would do so by allowing states to convert, in a budget-neutral way, to a single combined matching rate for all children. This rate would be calculated using the weighted average total costs in the latest year for which data are available. The formula would be:

$$\frac{[(\text{Total Medicaid costs}) * (\text{FMAP-Medicaid}) + (\text{Total CHIP costs}) * (\text{FMAP-CHIP})]}{(\text{Total Medicaid} + \text{Total CHIP costs})}$$

The enhance match (the difference between the Medicaid FMAP and the new FMAP) would be drawn from the allotment as under current Medicaid CHIP expansions.

Medicaid and CHIP age expansion. At state option, increase the eligibility age for Medicaid and CHIP up to, but not including, age 21.

Aligning Medicaid and CHIP and eliminating barriers to enrollment. States would be required to use the same application and income verification process for children eligible for Medicaid and CHIP. Specifically, states would be required to use mail in applications and drop the assets test for children in Medicaid or CHIP. States also must use a 12 month eligibility redetermination process for both programs. An alternate option would be to require states to be consistent in their treatment of children enrolled in Medicaid and CHIP (i.e., not be more restrictive their eligibility requirements for Medicaid than they are for CHIP).

May 8, 2000

Sable for me to review
46s
5/10/00

MEMORANDUM FOR GENE SPERLING

FROM: JASON FURMAN

SUBJECT: BIPARTISAN SOCIAL SECURITY COMMISSION AND DETAILS ON THE MOYNIHAN AND KERREY SOCIAL SECURITY PLANS

This memo provides some background on the Kerrey-Moynihan-McCain proposal for a bipartisan, bicameral Social Security commission that would come up with a specific legislative proposal to reform Social Security. I have also included some background detail on the Social Security reforms proposed by Senator Moynihan and Senator Kerrey.

Social Security Commission

The details we know are:

- The Social Security Commission would be appointed on February 1st 2001 and report back specific legislation by September 1st 2001.
- Congress would have to vote on the legislation before it adjourned in 2001. A series of procedural rules would expedite the process of bringing the reform proposal to a floor vote and expediting the conference (most points of order would be waved, if the bill were not reported out of Ways and Means or Finance it would go straight to the floor, the time for debate would be limited, etc.)
- The Social Security reform commission would include 12 members of Congress, drawn equally from the two parties:
 - Chairman and ranking members of Senate Finance and House Ways and Means;
 - Each of the four leaders would appoint 2 members;
 - The Commissioner of Social Security would be a non-voting member.
- The President would not be involved in the Commission.
- The Commission would make its reform proposal based on a majority vote.

The commission is virtually designed to either stalemate or come up with a proposal that involves individual accounts (since these are supported by most Republicans and at least some Democrats).

Background on Moynihan-Kerrey Social Security Reform Proposal

Senator Moynihan, with Senator Bob Kerrey as a cosponsor, has proposed S. 21, "The Social Security Solvency Act of 1999." This Act would bring the Social Security system into 75-year actuarial balance and establish 2 percent voluntary individual accounts. The proposal is a voluntary "carve out" paid for with benefit cuts in the traditional program. (Aaron and Reischauer gave a similar predecessor to this plan a grade of D, the worst of any Social Security plan.)

The key features of this approach are:

- **Benefit cuts.** Based on analysis by the Social Security actuaries, Senator Moynihan's proposal would cut average benefits by 22 percent by 2070. This benefit cut is the result of a number of programmatic changes including:
 - Index benefits at CPI minus 0.8 percentage point, the consensus estimate of members of the Boskin Commission according to a recent GAO report. For an 85 year old, this would be a 17 percent benefit cut (0.8 percentage point cumulated over 20 years);
 - Base Social Security benefits on the highest 38 years of earnings instead of the highest 35 years as under current law. By including lower earning years in the average, this would lower benefits for everyone;
 - Effectively increase the Normal Retirement Age to 68 in 2017 and 70 in 2065. (Senator Moynihan implements this by phasing in a reduction in the Social Security benefits formula that exactly mimics an increase in the retirement age; his legislation actually keeps the official Normal Retirement Age at 65, reversing the increase to 67 in current law).
- **Income increases.** Senator Moynihan's proposal would increase the income for the Social Security trust fund by:
 - Subjecting Social Security benefits to tax in the same manner as other retirement benefits, instead of the reduced taxation under current law;
 - Increase the wage base for Social Security taxes from \$72,600 in 1999 to \$99,000 in 2004. It is indexed to average wages (instead of CPI) thereafter to ensure that the tax base does not erode in the future. This would be described as a roughly \$3,000 tax increase on employees and employers;
 - Bring all State and local workers into Social Security after 2001.
- **Eliminate the retirement earnings test at 62 and over.**
- **Move payroll taxes toward pay-as-you-go.** Senator Moynihan's proposal sets payroll taxes to keep Social Security in year-by-year balance. This means the tax rate is cut from 12.4 percent today to 10.4 percent from 2002-2029 (a period when Social Security is in surplus)

and then raised gradually to 14.0 percent by 2060. In 2070, this would be a 12 percent increase in Social Security taxes, not including the "voluntary" individual account contribution. Pay-as-you-go payroll taxes have been a feature of all of Senator Moynihan's Social Security proposals in recent years; virtually no other Social Security proposals have this feature.

- **Voluntary 2 percent accounts.** Senator Moynihan's proposal allows employees to designate that up to 1 percent of their payroll goes into an individual account. This would be matched by an employer contribution. If employees did not choose to contribute to these accounts, they would simply get more take home pay (just like a Federal Employee who does not make voluntary contributions to the TSP). Everyone would get the reductions in the base Social Security benefits, regardless of whether or not they contributed to the voluntary accounts – the current Social Security system would not be an option.
- **Kidsave Accounts.** In addition, Senator Moynihan's legislation follows Kerrey's proposal in adding "kidsave" accounts whereby the government makes contributions to the retirement accounts of children: \$1,000 at birth and \$500 annually until age 5.

Background on Kerrey-Gregg

Senator Kerrey is also a co-sponsor of S. 1383, "The Social Security Reform Act of 1999," along with Gregg, Breaux, Grassley, Thompson, Robb, and Thomas. This is similar to Moynihan although it has a clawback of some of the individual account, a much deeper benefit cut, some general revenue transfers, and less increased income. Kolbe and Stenholm have a very similar plan, although some of their parameters are slightly different. Kerrey-Gregg achieves 75-year solvency. The key details are:

- **Benefit cuts.** Based on analysis by the Social Security actuaries, Gregg-Kerrey proposal would cut average benefits by 42 percent by 2070 – substantially higher than the Moynihan proposal. This benefit cut is the result of a number of programmatic changes including the following and a clawback described below:
 - Includes a cost-neutral proposal to make Social Security benefits more progressive. Currently average earnings are turned into the Primary Insurance Amount used to calculate Social Security benefits through a progressive formula with a 90 percent, 32 percent, and 15 percent bracket. This proposal splits the 32 percent bracket into a 70 percent bracket and a 20 percent bracket. It also lowers the 15 percent bracket to 10 percent.
 - Gradual across-the-board benefit reduction, reaching a 19.5 percent reduction by 2065. Equivalent to raising retirement age.
 - Eliminate the hiatus in raising the normal retirement age from 66 to 67.
 - Index benefits at CPI minus 0.5 percentage point (more moderate than Moynihan's proposal);

- Base Social Security benefits on the all years of earnings divided by 40 (for most people this would result in a benefit cut, although some people that have worked since they were teenagers could see a benefit increase);
- **Income increases.** Senator Moynihan's proposal would increase the income for the Social Security trust fund by:
 - Ensure that the wage base for Social Security at 86 percent of the previous years wage. (This would effect the taxable maximum by the end of the decade.)
 - (No proposal for state and local workers or greater taxation of Social Security benefits.)
- **Elderly female poverty.** Kerrey-Gregg has a measure to reduce widow poverty and ameliorate the consequences of their benefit cuts for women:
 - 75 percent widow benefit. Unlike the proposal considered by the Administration, this is not capped.
 - Benefits for low-earnings spouse are based on 35 years of earnings, not 40 years. This holds some women harmless from the proposal to raise the computation years to 40. But with the median woman working 27 years, this does nothing to help. It would also do nothing for single mothers, would help child-less women, and would be less progressive than a fixed credit for child raising years.
- **Eliminate the retirement earnings test at 62 and over.**
- **New transfers for Social Security.**
 - Currently the revenue from taxation of Social Security benefits goes to the Social Security and Medicare trust funds (tax on the first 50 percent of benefits goes to Social Security and on the next 25 percent of benefits goes to Medicare). Kerrey-Gregg would transfer all of this revenue to Social Security, improving Social Security solvency but hurting Medicare solvency by an equivalent amount.
 - Would reduce the indexation in the tax system and other benefit programs by 0.5 percentage point. This would raise revenue and reduce spending. Kerrey-Gregg have hardwired transfers that are designed to approximate the savings from reduced indexation. These amounts rise from \$23 billion in 2000, to \$36 billion in 2010, to \$623 billion in 2060.
- **Mandatory 2 percent accounts with clawback.** Gregg-Kerrey cuts payroll taxes to 10.4 percent and puts 2 percent of payroll into individual accounts. Some of the base Social Security benefit is clawed back, based on the amount the account would have accumulated if it had invested in Treasury specials.

- **Kidsave accounts.** Adds "kidsave" accounts whereby the government makes contributions to the retirement accounts of children: \$1,000 at birth and \$500 annually until age 5.
- **Additional tax-advantaged savings.** Would allow up to an additional \$2,000 to be contributed annually to the account in a tax advantaged manner, the government would provide a highly progressive match for low-earners.