

Withdrawal/Redaction Sheet

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|--------------------------|--|---------|-------------|
| 001. briefing paper | [POTUS] Meeting with the Senators Kennedy and Rockefeller and Representative Dingell (4 pages) | 3/3/99 | P5 |
| 002. talking points | POTUS TPs with Senators Kennedy & Rockefeller and Rep. Dingell (1 page) | 3/3/99 | P5 |
| 003. memo | Ricchetti et al. to POTUS re: Recommended telephone call to Senator John Breaux (2 pages) | 2/24/99 | P5 |
| 004. talking points | POTUS TPs for telephone call to Senator Breaux (1 page) | 2/24/99 | P5 |

COLLECTION:

Clinton Presidential Records
 Domestic Policy Council
 Bruce Reed (Subject File)
 OA/Box Number: 21204

FOLDER TITLE:

Health Care-Medicare Commission

r543

RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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Projected 10-Year Savings

HCFA Actuary February 23rd Estimate of Commission Proposal -- Option 1

| | |
|--------------------------------------|----------------|
| • Cutting Number of Seniors Eligible | -\$25 b |
| • Added Beneficiary Payments | -\$127b |
| • Extending Provider Cuts | -\$57 b |
| • Fee For Service Reforms | -\$22 b |
| • Removing DME from Trust Fund | -\$46 b |
| • Premium Support | -\$75 b |
| • <u>Interactions</u> | <u>\$ 5 b</u> |
| • Total | -\$347b |

Added Beneficiary Payments: includes increased cost sharing (including a 10% coinsurance on all home health services and 20% coinsurance on other services like laboratory services); and Medigap reforms prohibiting Medigap from 1st dollar coverage

Cutting Number of Seniors Eligible: raising the age of Medicare eligibility from 65 to 67

Extending Provider Cuts: extends reductions in provider payments and updates from the Balanced Budget Act of 1997 for 5 years

Premium Support: includes savings from managed care reductions in payments to providers; greater efficiencies through competition; and shifting of costs for fee for service beneficiaries.

Removing Direct Medical Education (DME) from the Trust Fund: this is not really a payment reduction, but a budget game. The government will presumably still pay for Direct Medical Education, but it will be moved to another part of the budget.

Interactions: there is a cost to the government because of the way these provisions interact with other programs, like Medicaid.

Cuts to Beneficiaries

| | |
|---|---------------|
| Total Cuts to Beneficiaries | \$141b |
| • Added Beneficiary Payments | |
| – Cost Sharing Increases | \$20b |
| – Income Related Premium | \$96b |
| • Cutting Number of Seniors Eligible for Medicare | \$25b |



Extending Provider Cuts

Extending Provider Cuts **\$57b**

- Five year extension of payment reductions to providers in the BBA 97



Premium Support Savings

- **Premium Support Savings \$75b**

Commission says savings come from:

- greater efficiencies and
- competition

We believe real savings come from:

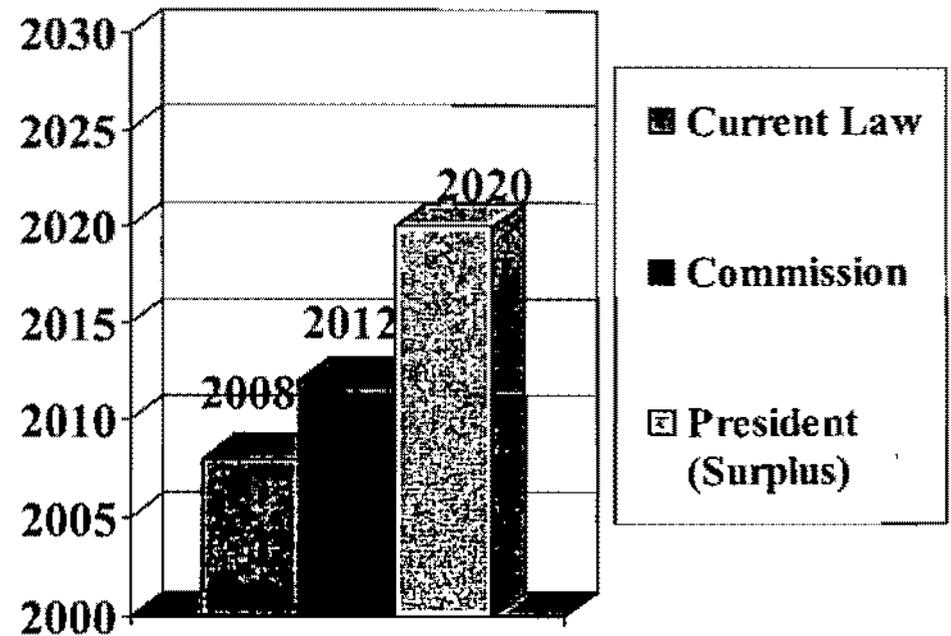
- managed care reductions in payments to providers
- raising premiums for beneficiaries in fee for service



Does Commission Proposal Save Medicare?

- **Trust Fund Expiration Date**

- Current Law 2008
- Commission (best estimate) 2012
- President's Proposal 2020

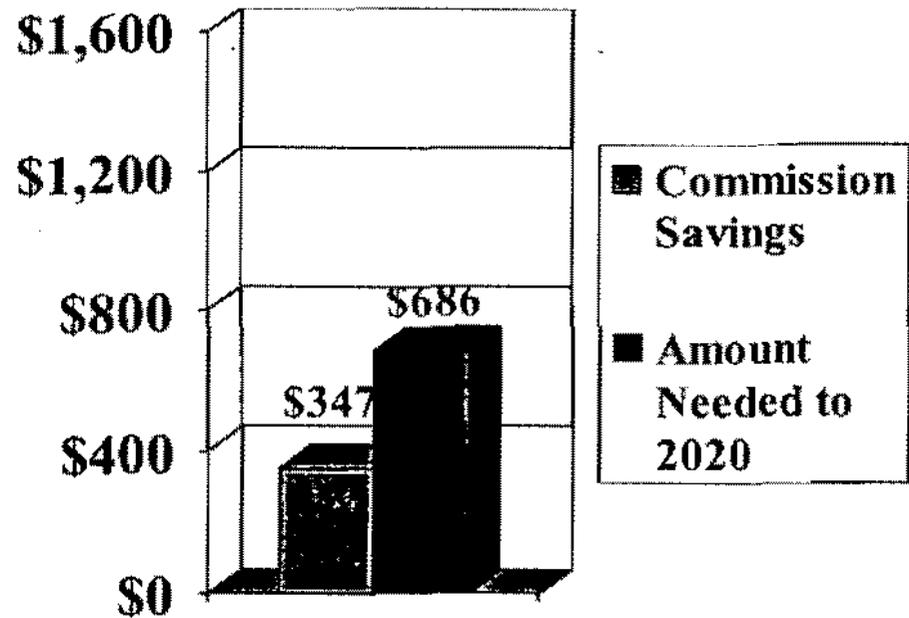


The Commission Proposal Falls Short

- Commission Savings \$347b /10
- Amount Needed to Save

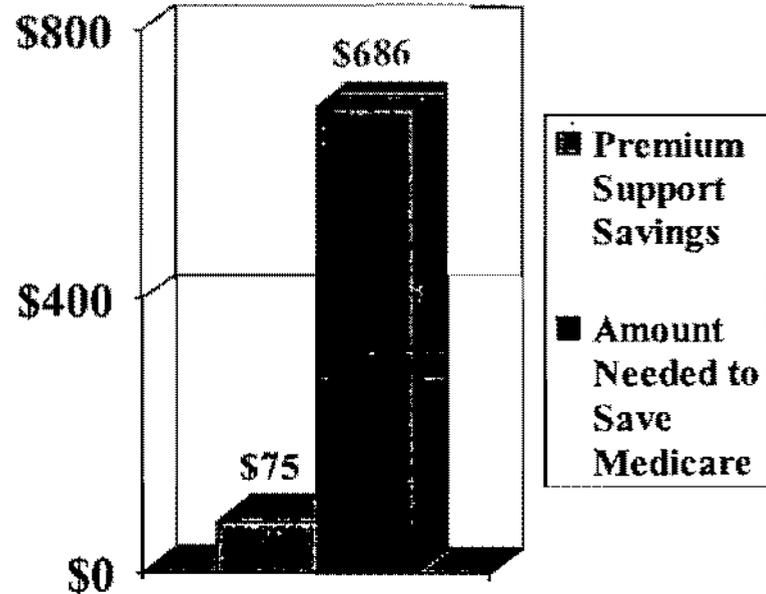
Medicare to 2020 \$686b
/15

Shortfall \$339b



Premium Support Falls Short

- Savings from Premium Support \$75b
- Amount needed to save Medicare to 2020 \$686b



March 5, 1999

Dear Democratic Colleague:

We are about to begin a year's debate on turning Medicare into a privatized Premium Support program. This debate will be a defining issue for our party as we approach 2000, because as your constituents understand it, they will hate it. The key is to let your constituents understand it.

It is not Premium Support--it is cuts from beneficiaries! Under the Breaux-Thomas plan, 2/3rds of the cuts come out of beneficiaries' pockets.

The Breaux-Thomas Premium Support proposal was just "scored" by the Medicare Chief Actuary, as saving \$116 billion over 5 years. Following is the percentage of that \$116 billion that comes from each part of the package. The percentages in bold come from beneficiaries.

1. Extending BBA cuts on hospitals-doctors 6%
2. Charging seniors more cost sharing 7%
(10% on home health visits, 20% on labs,
20% on first 20 days in a nursing home,
all areas where there is now no cost-sharing)
3. Giving Medicare more flexibility to
pay providers less (like competitive bidding) 8%
4. Cutting teaching hospitals by
taking the pay of young residents
out of Medicare and transferring it to
the yearly, unpredictable
appropriations process 17%

5. Premium Support--getting seniors to move into cheap HMOs, largely by raising premiums on traditional fee-for-service Medicare 22%
6. Charging individuals above \$24,000, couples above \$30,000 more in monthly premiums 33%
7. Raising Medicare eligibility age from 65 to 67 (this 'savings' grows rapidly in later years) 2%
8. Changing medigap, so that it cannot provide 1st dollar coverage (that helps discourage patients from using services) 4%

68% comes directly from beneficiaries.

Sincerely,

Pete Stark
Member of Congress

THE WHITE HOUSE

WASHINGTON

March 1, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K.
FROM: Chris J. and Jeanne L.
RE: RESPONSE TO BREAUX PLAN BY ALTMAN AND TYSON

Today, Stuart Altman and Laura Tyson sent a list of suggested changes to Chairmen Breaux and Thomas on their reform plan. They have informed us that it is their belief that these changes are not negotiable but, rather, are what would be minimally acceptable for them to even consider voting to report out a Commission plan. Their recommendations are generally consistent with the principles for reform that the President outlined. For example, they suggest including the surplus or an analogous proposal, adding an optional prescription drug benefit accessible and affordable to all beneficiaries, ensuring guaranteed benefits, and allowing 62 to 64 year olds to buy into Medicare.

However, the list also includes controversial elements such as raising the age eligibility from 65 to 67 so long as there is a subsidized Medicare buy-in and adding an income-related premium beginning at \$50,000 (which is twice as high as recommended by the Commission but much lower than most of the Democratic base would contemplate). Although consistent with their past statements, the document reiterates their openness to premium support that meets the goals that they outline (e.g., adequate government payment, defined benefits).

This paper was sent confidentially, but we would be surprised if it doesn't soon become public. If it does, Senator Daschle, Congressman Gephardt and others can be expected to be critical on both substantive and political grounds. They will be particularly upset that the President's appointees continue to negotiate with Senator Breaux and Congressman Thomas at a time when they feel they have disregarded Democratic concerns. Having said this, it is unlikely that Senator Breaux will be able to obtain Republican support for all of Stuart and Laura's recommendations. If this is the case, then the Commission will likely report out with 9 or 10 votes, not the supermajority (11 votes) needed. We will keep you posted on any news.

~~CONFIDENTIAL~~ - NOT TO BE QUOTED

DRAFT 3/1/99

Recommended Changes to the Breaux Medicare Reform Plan

Stuart H. Altman
Laura Tyson

The Medicare program which began in 1965 has been among the most successful programs developed by the Federal government. It has allowed millions of Americans, mostly over age 65, to have access to the best health care our nation offers, and provided critically needed funding to enable the health care system to support its ever changing structure and the use of increasingly expensive technology. But, Medicare has problems, problems which will grow much worse in the years ahead. To greatly simplify these problems can be put into three categories:

A. Inadequate Benefits

Medicare currently covers about 53 percent of the health care spending of Americans 65 years of age and over. Among the benefits not covered, the most important are outpatient prescription drugs and long-term care.

B. Future High Cost

The combination of Medicare spending on a per capita basis growing faster than the growth in GNP and the number of Medicare beneficiaries doubling over the next 30 years, every projection indicates that spending under the current Medicare program will consume an ever larger proportion of our national income. With that said, it should also be emphasized that Medicare will be required to cover a much larger proportion of the US population and that Medicare spending per capita must be related to the medical cost growth in the general economy or the program will cease to provide adequate coverage for "mainstream" medical care.

C. Inflexible Program

Medicare is a major federal program which is governed by the laws of Congress and administered by an agency of the federal government. As a result it is often restricted in its operation and the creation of new programs by political infighting within the Congress and between the Congress and the Administration. These political problems are compounded by the bureaucratic inertia of a large governmental program.

PROPOSED CHANGES TO BREAUX REFORM PLAN

To address the problems listed above and still maintain the integrity and value of this vital program requires that we not replace three of Medicare's critical underlying principles:

1. A government guarantee that a specified set of benefits will be covered by any approved and financed Medicare plan.
2. A sufficient government contribution such that adequate coverage will be available and affordable to all beneficiaries regardless of their income or geographic location.
3. A premium and cost sharing structure that does not invalidate the social insurance aspects of Medicare such that it no longer is a preferred plan for all income groups.

A premium support plan with defined benefits and expanded coverage for outpatient prescription drug expenses that has limited income related premiums and/or co-payments can meet these requirements if it is designed correctly and is adequately financed.

The specifics outlined by Senator BreauX could be the foundation for such a plan but, fails to include a number of important factors and includes other components which could undermine the basic integrity of Medicare as a social insurance program. We have summarized these issues below along with proposed changes we believe are necessary to make the reform plan adequate for the 21st century and meet the high goals originally established for the Medicare program.

1. **Lacks a specified and adequate set of benefits.**

In order for adequate benefits to be available and affordable to all Medicare beneficiaries they must be specified in law and available in all approved Medicare plans including the one administered by the federal government. They also must include sufficient payments to providers that they will in fact be available and sufficient funds from the Medicare program that they will be affordable to all beneficiaries. To that end, we would propose the following additions to the BreauX plan.

- A. All health insurers approved by Medicare including the program operated by the federal government must provide for beneficiaries to select as an option to basic coverage a plan which includes at least the following coverage for outpatient prescription drug expenses.

-- Following a special drug benefit deductible of \$500, the plan will pay 75 per cent of all outpatient drugs prescribed by an approved Medicare provider. After an individual reaches an out-of-pocket payment including the deductible of \$2500 per year, the plan would pay all additional drug expenses. For a couple living together the spending limit would be \$4000. For the basic Medicare plan, the federal government will contract with a limited number of private prescription drug benefit managers to administer the program. It is expected that such PBMs will use the same techniques developed by private health plans to help control spending including volume discounting, mail order dispensing and approved pharmacy formularies. The prescription drug option would require a special premium which would equal 50 percent of its expected costs. Beneficiaries would pay more or less than this average premium based on an income related schedule consistent with the design established for the basic Medicare plan. For low income beneficiaries, the deductible would vary from \$0 up to 135% of poverty to the full \$500 at 300% of poverty.

- B. A detailed set of benefits covered under all Medicare plans must be specified in law. At a minimum, benefits would include all services covered under the existing Medicare program plus an option for outpatient prescription drugs. All plans, including the one administered by the federal government, can establish their own rules as to how these benefits will be provided. Also permitted will be small variations requested by plans from the exact magnitude of the benefits subscribed in law. The Board which will oversee the operation of the premium support plan must approve all benefit designs and develop sufficient oversight competence that it can assure the Congress and the President that all plans do in fact provide the approved benefits and comply with all other aspects of the relevant statutes.

2. **Income related payments could jeopardize social insurance aspects of Medicare**

- A. Any income related aspects of the reform plan will not consider family income below \$75,000 (\$50,000 for an individual) to be subject to a higher than average payment amount. The income related schedule should also recognize that some government payment amount is appropriate even for the highest income groups as they are also the groups which pay the largest tax amounts. Furthermore, any individual whose annual income is equal to or less than 135% of the poverty level will not be required to pay any premium or co-payment amounts.

3. Raising age could increase uninsured

- A. The age when an individual becomes eligible for the full Medicare program will gradually be raised from age 65 to age 67. In tandem with this change all otherwise eligible individuals could buy into the Medicare program at age 62. For those aged 65-67, the premium charged would be income related for the lowest income groups using the same schedule as discussed above.

4. The core Medicare program must continue to be affordable to all

- A. The modernized Medicare plan operated by the federal government must continue to be primarily a fee-for-service plan open to all qualified and approved providers except for certain select high cost procedures and where clear quality differences are shown to exist. The basic Medicare plan should also be given the necessary authority to engage in the kinds of competitive bidding schemes used by private health plans for laboratory services, durable medical equipment and other similar services. Since this plan will retain much of its current character it should continue to have the power of federal government pricing and contracting authority.
- B. The system used to allocate funds to different regions of the US and to price the national basic Medicare plan must not create a regional bias against particular regions or in favor of the non basic plan except where clear regional or plan inefficiencies exist. To this end, all extra legislated payments to providers beyond what the market for patient care requires should be calculated on a per patient basis (including both basic Medicare and private health plans) and paid by the government from the Medicare trust fund independent of the calculations used to determine beneficiary premiums and the regional payment to private health plans.]

Specifically, the extra payments for Indirect Teaching Costs and Disproportionate Share, or the special subsidies to rural providers should not be paid only by the Basic Medicare plan or required of patients of private plans who live in areas where such programs exist.

5. Need an adequate financing plan

- A. The plan must include a detailed structure on how it will be financed. While the exact dollar amounts need not be included since predictions of future spending become increasingly suspect beyond 10 years, the proportions required from the different sources of funds should be specified and in general how such funds will be generated. Specifically, while the Breaux plan includes a number of provisions which will increase beneficiary liabilities, it does not mention how the additional governmental funds will be raised. This is a serious omission since the legislation which established the Commission required that we develop plans to restore the solvency of the Federal Hospital

Insurance Trust Fund and maintain the financial integrity of the Supplemental Medical Insurance plan. In that connection, the plan should include either the proposal stated by the President to use a portion of the expected federal surplus to help fund Medicare in the future or indicate how the needed federal revenues will be generated. Most importantly, the plan should indicate what proportion of the expected costs of the program should come from beneficiaries and the federal government, and how much should come from reduced payment growth to providers.

6. No discussion of Long-term care needs.

- A. No mention is made in the Breaux plan for how the aged will pay for the increasingly expensive costs of long-term care in the future. At a minimum, recognizing the complex nature of this problem and its very high costs, the plan should contain some general statements about a preferred direction of future policy.

THE WHITE HOUSE
WASHINGTON

February 18, 1999

TO: Gene S., Bruce R., Elena K., Larry S., Steve R.
FROM: Chris J. and Jeanne L.
RE: LATEST MEDICARE COMMISSION PAPER

Attached is a letter and memorandum from CBO on premium support. It does not include any quantitative analysis, but is instead a discussion of issues and questions raised by the proposal.

The cover letter to Senator Breaux is clearly favorable towards premium support, arguing that "the general direction is promising." This rests primarily on the assumption that competition can induce efficiency and lower costs in the long-run. The background analysis itself, while less conclusive, includes generally supportive statements about competition and choice, but raises numerous questions. These are the same questions and issues that our Commission appointees have been raising. Thus, the analysis appears to offer arguments for both proponents and opponents of premium support.

We are in the process of preparing an analysis of Breaux's plan, his estimates and the CBO memo. The HCFA actuaries are also planning on sending their analysis to the Commission tomorrow.

We will forward these to you as they become available.



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20516

Dan L. Crippen
Director

February 18, 1999

The Honorable John B. Breaux
United States Senate
Washington, D.C. 20510

Dear Senator:

I am pleased to respond to your letter of February 4. We do not have specifics on many aspects of your proposal, so our response may be less precise than you or others would prefer. However, I hope that what we say is at least helpful and that we can continue to assist you as you refine your proposal. I believe that the most important piece of the analysis at this stage is to get the questions right and begin to suggest how your proposal might change the Medicare program.

Summary

Under current law, health plans in the Medicare program compete on the basis of covered benefits and quality of service, not on price. Your proposal would foster greater competition among plans and greater choice for beneficiaries. We believe increased competition will reduce costs. As the attached paper indicates, the details that remain to be specified would determine the ultimate effectiveness of the proposal in slowing the growth of Medicare's costs. But the general direction of the proposal is clearly promising.

Reducing Medicare's costs should not be the only goal of reform. Costs could be reduced—without necessarily ensuring Medicare's long-term financial stability—by cutting payments to providers, reducing access to services, or making other changes that are likely to reduce the welfare of Medicare beneficiaries. An effective reform would introduce strong new incentives for efficiency. Other important goals of reform include ensuring an acceptable level of quality and access to services and allowing maximum flexibility for beneficiaries to choose a plan that meets their needs. Needless to say, proposals must also be feasible to implement. Designing a proposal that meets all of those goals is clearly a tall order!

The Honorable John B. Breaux
February 18, 1999
Page Two

Your proposal attempts to address those issues. Its ultimate success will depend on the details of its design and on the interaction of a restructured Medicare program with other programs.

The Congressional Budget Office (CBO) does not have the ability to assess alternative policies with any precision once we move past the 10-year budget window. Like the Medicare trustees, we have projections only over the long term—projections that make assumptions about general changes in policy. By contrast, long-term analyses require a baseline free of unreasonable assumptions about the course of spending without major policy interventions.

Discussion

Although we cannot provide a cost estimate of your proposal, we can offer a preliminary analysis that is perhaps less satisfying but potentially more informative. We suggest a few principles by which to assess the potential for changes in policy to reform Medicare. Those principles are certainly related yet different enough to justify their separate consideration.

First, we believe that introducing competition into the Medicare program could help to reduce costs in both the short and the long run. A premium support system that resulted in effective price competition among plans would most likely lower Medicare costs.

Second, Medicare reforms should also enhance efficiency—the productive use of medical resources. If beneficiaries face choices among health plans, they tend to recognize more readily the trade-offs those choices entail. Allowing greater choice results in a more effective use of health care resources. Another issue related to efficiency is the considerable excess capacity that exists in the U.S. system for delivering health care. In 1997, for example, about 40 percent of all hospital beds went unoccupied on an average day, even though the number of beds had declined by 20,000 from the year before. Similarly, there is some evidence of an oversupply of physicians, at least in particular markets. Your proposal could help to reduce some of the costs associated with the inefficient use of health resources.

Third, reforms that improved efficiency could maintain the quality of health care while reducing its costs. The goal of any change in policy should be to at least maintain the system's quality, if not improve it. Unfortunately, there is little agreement about how to measure the quality of health care, particularly for the

elderly. What is clear is that improving quality is not synonymous with increasing expenditures.

Your proposal would maintain the government's large contribution toward the care of Medicare beneficiaries. That contribution level is well in excess of the level in health insurance programs for federal employees, such as the Federal Employees Health Benefits Program (FEHBP). Expanding pharmaceutical coverage in private plans—to the extent the costs do not squeeze out other, more effective treatment—could improve the quality of care. Again, the specific design aspects of the reform proposal will have a critical bearing on the actual outcome of the policy.

Fourth, allowing beneficiaries to choose among multiple plans will help to modernize the Medicare program and allow the elderly to select benefits that are more closely aligned with their needs. As the commission knows, most Medicare beneficiaries are still enrolled in the traditional program formulated 35 years ago, which has significant gaps in coverage compared with the typical employer-sponsored plan of today.

Finally, it is obvious but true that any reform proposal must actually work—that is, it must create a system of rules under which the intended effects can actually occur. Of course, there are practical limits on how burdensome and intrusive such a system might be. Your proposal is modeled in part on the FEHBP, which could provide useful guidance for implementation. However, a restructured Medicare program would be considerably more complex than the FEHBP. The additional responsibilities of the proposed Medicare Board, the potential expansion of the number of competing plans, and the large number of Medicare beneficiaries make the implementation of reform a formidable challenge.

Medicare's many interactions with current programs will affect the ultimate success of any reform, and two of those interactions merit particular mention. Most fee-for-service enrollees have supplemental insurance coverage through medigap policies, employer-sponsored insurance, or Medicaid. That additional coverage increases Medicare spending by encouraging greater use of services. To the extent reforms mitigate that incentive, Medicare spending could be reduced. In addition, restructuring Medicare would establish a new, complex relationship between the Medicare and Medicaid programs. That relationship could have important implications for federal costs and the quality of care for dually eligible beneficiaries.

The Honorable John B. Breaux
February 18, 1999
Page Four

Estimating Issues

Reforming programs such as Social Security and Medicare is challenging for many reasons, not least because of the need to assess the long-term effects of any change. Although the solvency of Medicare's Hospital Insurance Trust Fund has been the focus of much policy debate, we know that it is not an accurate measure of the fiscal health of the program.

We also know that the Medicare trustees' long-term projections of spending include assumptions about future, unspecified changes in behavior and policy. The trustees essentially assume that Medicare's increasing claim on the economy and the federal budget—following Herb Stein's dictum—"cannot go on forever" and that something will happen to slow the growth in spending.

They are clearly right in that assumption, but by itself, the assumption provides little help in assessing the impact of various policies. Indeed, it may well be your policy proposal that will produce their outcome. However, it is simply not legitimate to "score" or compare any proposal with the trustees' projections. For long-run comparisons, a baseline is needed that is free of unreasonable assumptions about the course of spending without major policy interventions.

Senator, I am sure this is both more and less than what you expected as a response. Issues of health care are unusually complex, but we can also get lost in the complexity and in the elegance of our analysis. I think it is important to keep in mind a set of principles for reform and to try to assess the desirability of any plan relative to those principles. We certainly have not cornered the market on defining such principles, or assessing the impacts, but I hope this response provides a useful template for further consideration.

If you have any question about CBO's analysis, please call me. If your staff has any questions, they may call Joseph Antos or Linda Bilheimer at 226-2666.

Sincerely,



Dan L. Crippen
Director

c: The Honorable William M. Thomas

Enclosure

**A PRELIMINARY REVIEW OF THE PREMIUM SUPPORT MODEL
AS A FOUNDATION FOR MEDICARE REFORM**

**Congressional Budget Office
February 1999**

OVERVIEW

The aging of the baby boomers will place unprecedented demands on the Medicare program. Between 2010 and 2030, the elderly population will grow at an annual rate of almost 3 percent, rising from 39 million to 69 million. Medicare costs are likely to grow considerably faster than program enrollment because costs per beneficiary are also likely to increase rapidly. To reduce the growing share of the nation's resources that the Medicare program would otherwise absorb, major policy changes are necessary to slow the rise in costs per beneficiary.

The Bipartisan Commission on Medicare Reform is considering a premium support model as a basis for restructuring the Medicare program. That approach, which adopts some of the attributes of the Federal Employees Health Benefits Program (FEHBP), is intended to produce greater competition among health plans serving the Medicare population and greater choice for beneficiaries. A premium support system that resulted in effective price competition among health plans would have the potential to lower Medicare's costs.

BACKGROUND

Under current law, Medicare beneficiaries may enroll in the traditional fee-for-service plan or in private health plans that serve Medicare beneficiaries in the Medicare+Choice (M+C) market. The large majority of enrollees have chosen to remain in the fee-for-service program, but the Congressional Budget Office (CBO) projects that the percentage of beneficiaries in private plans will double over the next 10 years, rising from 15 percent in 1999 to 31 percent in 2009. By contrast, more than 85 percent of workers with employer-sponsored health coverage are currently in some form of managed care plan.

Most beneficiaries in the traditional program have some form of supplemental coverage to pay for their deductibles and copayments. Almost one-third of those beneficiaries pay for private medigap insurance; a similar proportion obtains supplemental coverage as a retirement benefit from former employers. Supplemental coverage raises Medicare's costs because beneficiaries who do not face cost-sharing requirements use more of the services covered by the program. Medigap premiums are rising rapidly, however, and employers are becoming less willing to provide coverage for retirees. Those factors will contribute to growth in the proportion of beneficiaries enrolling in managed care plans that have low cost-sharing requirements and provide additional benefits, such as prescription drug coverage.

Before enactment of the Balanced Budget Act of 1997 (BBA), Medicare's payments to health plans were based on average fee-for-service costs in each county.

That system resulted in wide variations in payments to plans and considerable volatility in payments from year to year. It also meant that plans had incentives to compete on the basis of the benefits they covered rather than on price.

The BBA introduced Medicare+Choice with the intent of reducing payment variation and volatility. In each county, the payment that health plans now receive is the highest of:

- A blend of the local rate and a price-adjusted national average rate;
- A floor amount; or
- A rate 2 percent higher than the previous year's rate for that county.

The annual growth in the components of the blended rate and in the floor amount is determined by the projected growth in per capita spending in the fee-for-service sector, less a statutory reduction for 1998 through 2002. Other payment changes in the BBA will also lower payments to health plans. Thus, before the act, Medicare paid plans about 95 percent of per capita costs in the fee-for-service sector, but that rate will drop to about 90 percent when the BBA provisions are fully phased in. Nonetheless, the rate of increase in payments to plans remains tied to growth in per capita spending in the fee-for-service sector. More fundamentally, the payments that plans receive are still unrelated to their performance.

Program rules foster competition among M+C plans on the basis of expanding benefits rather than lowering premiums. If an M+C plan makes profits that are higher than the Medicare rules allow, the excess must be returned to enrollees as additional benefits. Plans may not offer rebates to enrollees. (Excess profits could be returned in the form of a rebate to the federal government, but all plans prefer to offer additional benefits because of the obvious marketing advantage.) Beneficiaries pay a premium (in addition to the Medicare Part B premium, which all beneficiaries pay) only if the cost of the plan that they select is higher than Medicare's payment. However, only a minority of health plans currently charge an extra premium.

THE PROPOSAL

The premium support approach would tie the government's contribution for each health plan, including traditional Medicare, to the national weighted average premium. Beneficiaries selecting lower-cost plans would have a larger share of their premium subsidized by Medicare than those selecting higher-cost plans, and the core benefits offered by plans could vary only within a limited range. Two options are

under consideration; they differ only in the schedule of federal premium contributions.

This preliminary assessment of the proposal is based on the following assumptions, which CBO staff developed after discussions with commission staff and receipt of a letter dated February 4, 1999, from Senator Breaux.

Medicare would offer beneficiaries a choice of enrolling in a private health plan or a government-run fee-for-service program. The traditional program would receive capitation payments like any other participating plan, and the federal government would refrain from bailing it out even if the program ran into financial difficulties. Moreover, the federal government would regulate the Medicare market without giving preference to the traditional program, thus ensuring a level playing field for all plans.

In order to survive in a competitive environment, the fee-for-service program would be allowed to compete aggressively with private plans. Traditional Medicare would adopt the same tools that private plans use to manage costs. Cost-cutting or revenue-raising strategies might include:

- Authority to negotiate prices with providers;
- Exclusive contracting;
- Restricted provider panels;
- Increases in premiums and cost-sharing requirements; and
- Reductions in covered benefits.

The government's contribution would depend on the premium charged by each health plan but would be capped. The maximum premium contribution paid by the government would equal about 88 percent of the national average.

Under Option I of the proposal, beneficiaries would pay:

- 10 percent of the total premium for plans with premiums set at 90 percent of the national average or below.
- Approximately 33 percent of the additional costs for plans with premiums that were between 90 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average.)

- 100 percent of the additional costs for plans with premiums that were above the national average.

(Option II is discussed later in this attachment.)

Under both options, the premium contributions made by beneficiaries would depend solely on the plan that they chose. People choosing the same plan in different parts of the country would make the same contribution, regardless of the local cost differences. By the same token, plans seeking to serve a particular market would quote a premium to Medicare that reflected their charges for a national average population.

A newly created Medicare Board would oversee the program. It would have greater responsibilities than the Office of Personnel Management (OPM) exercises in its oversight of the FEHBP.

- The board would negotiate with the private plans regarding their core benefits and the premiums they charged for those benefits. The government's contribution would be based on the national weighted average of those premiums and the premium charged by the traditional fee-for-service program. The board would ensure that the actuarial value of the core benefits varied by no more than 10 percent among plans.
- For the purpose of calculating the government's contribution, private plans could include prescription drugs among their core benefits. The costs of dental, vision, and hearing benefits would not be included in the calculation, even though many M+C plans now offer those benefits as an integral part of their coverage. The traditional fee-for-service plan would not offer a drug benefit.
- The board would adjust payment amounts to plans to reflect the costs of doing business in different geographic locations. Whether that adjustment would incorporate some of the cost differences that result from differences in the use of health services is unclear. But the proposal's intent is for per capita payments to vary less among plans than they do today.
- Payments to health plans would be adjusted for risk as well, but the proposal does not specify the form of risk adjustment. CBO has assumed the same course for risk adjustment as

under current law. That is, risk adjustment would initially reflect use of inpatient hospital services, and a broader system that incorporated the use of other services would be developed at some time in the future.

KEY ISSUES REQUIRING CLARIFICATION

Those assumptions, and other design elements not listed above, would determine the effectiveness of the commission's premium support approach in slowing the growth of Medicare spending. Changing any key element of the proposal could have a profound impact on program costs. Some of the more important aspects of the proposal that need further clarification include:

- *The terms on which the traditional fee-for-service program would compete with private plans.* Would the traditional program have to survive on the capitation payments it received, without the possibility of receiving additional federal subsidies were losses to occur? Would it be able to use all of the management tools that private plans employ, including the ability to contract with providers on a selective basis?
- *The authority and capability of the Medicare Board, which would play a critical role in controlling spending growth in both the short and long terms.* To what extent would the board oversee the traditional fee-for-service program? Would the board retain Medicare's existing authority to set rates and limit payments? What authority would it have to negotiate premiums with plans? How would it adjust rates for risk and geographic factors? (Effective risk adjustment would be important for the stability of a competitive Medicare market.)
- *How plans' premiums and the federal contribution would be determined.* Would the contribution be tied strictly to the premium charged for core benefits, or would there be circumstances under which plans could receive a contribution for noncore benefits as well?

In addition, it has been suggested that the premium support proposal might include a provision that would require higher-income beneficiaries to make larger premium contributions. The specifications that CBO analysts discussed with commission staff did not include a provision for means-tested premiums, and that issue is not discussed in this attachment. However, such a provision could have a significant effect on Medicare costs under a premium support system.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE SHORT TERM

As described above, the payments that M+C plans receive bear no relationship to their performance, and the plans have no incentives to compete on the basis of price. By contrast, under the premium support model, health plans would be given new flexibility to compete by reducing premiums or enhancing benefits. That additional element of price competition might result in beneficiaries having a broader array of plans from which to choose, thus enabling them to select a plan that meets their needs more appropriately than the choices currently available to them.

The interaction between beneficiaries' choices of health plans and decisions by plans about what benefits to offer and what premiums to charge would affect program costs in complex ways. Many beneficiaries would make decisions that would leave government costs unchanged. For example, beneficiaries who did not change plans would not generally increase government costs. (They could cost Medicare more, however, if their plans were not already receiving the maximum government contribution and chose to raise their premiums.) In addition, as is similar to the situation in M+C today, some beneficiaries enrolled in traditional Medicare who purchased medigap policies might find a competing plan that would be an attractive alternative. Switching to a private plan might lower their own costs because they would no longer be paying a separate medigap premium, but it would not necessarily change federal costs.

Some plans might seek to expand their enrollment by enhancing their benefits while still remaining competitive in terms of price. Some M+C plans, for example, have costs below those of the fee-for-service program and charge no additional premiums. Those plans could upgrade their benefits, raise their premiums to the level of the national average, and still compete with the fee-for-service plan. Plans currently offering benefits that cost between 90 percent and 100 percent of the national average, for instance, might find that opportunity quite attractive. Their enrollees would pay only 33 cents for every dollar of increased benefits, up to the national average. Such increases would boost the national average premium in the short term.

To capitalize on the demand for lower-cost coverage, other plans might decide to reduce their benefits and market themselves as low-cost alternatives. It is reasonable to assume that some beneficiaries would move from traditional Medicare—whose premiums would be close to the national weighted average in the short term—to a more preferable plan with premiums below the national average. Government costs would fall for beneficiaries who chose less expensive health plans only if they selected plans that would receive a lower government contribution than their current plan.

The ongoing shift from the traditional fee-for-service sector to managed care that is occurring under current law could accelerate under a premium support system. With premium support, costs in the fee-for-service program would largely determine the national average premium for several years, that is, until the majority of beneficiaries were enrolled in competing plans. If people moved from traditional Medicare into lower-cost plans—those with premiums below the national weighted average—the average premium would fall. That outcome would lower the government's total contribution for premiums. In addition, the traditional program would become an increasingly costly option for beneficiaries unless it could lower its premiums as well.

The adjustments that the Medicare Board made to premiums to reflect geographic differences in health care costs could also affect the government's costs. If the adjustments reflected only differences in input costs and did not incorporate the effects of differences in service utilization, plans operating in high-cost markets might face significantly lower payments than they currently receive and might have to reduce their benefits. Conversely, plans in low-cost markets would gain from such adjustments and have more flexibility to enhance their benefits and raise their premiums. How local plans might change their benefits is uncertain, as is the resulting net effect of those changes on the national average premium.

The premium adjustments would also influence the number of plans electing to participate in different markets. The adjustments would, at best, only approximate the underlying cost differentials among geographic areas. Consequently, as they do today, plans would seek out markets in which their projected per capita costs would be significantly lower than the adjusted per capita payment—and avoid markets in which the converse was the case.

EFFECTS OF THE PROPOSAL ON MEDICARE'S COSTS IN THE LONG TERM

If the Medicare program became more competitive, with a much higher percentage of beneficiaries enrolled in private plans that competed on the basis of price and quality, the future growth of program spending would be more closely tied to trends in private health care markets. A major incentive for restructuring Medicare is to generate the same competitive forces within the program that the private sector experienced in the mid-1990s. Between 1993 and 1996, the growth of employer-sponsored health insurance premiums slowed dramatically as a result of the shift to managed care and increasing competition among health plans. By contrast, Medicare spending per enrollee continued to rise rapidly.

Whether recent experience in the private sector reflects longer-term spending trends is uncertain, however. Over the past year, premiums for employer-sponsored insurance have once again begun to grow more rapidly, as health plans that had held down premiums to capture a larger market share have sought to improve their profit margins. As a result, controversy has arisen about the long-term effects of managed care on prices and costs in the private health care market and whether slower cost growth associated with the shift to managed care is a one-time phenomenon.

Analysts generally agree that part of the recent slowdown in private health insurance premiums did, indeed, reflect a one-time change in the level of premiums, as employers switched their employees from higher-cost to lower-cost plans. But most analysts do not anticipate a return to the double-digit rates of growth in premiums that occurred before 1993. Both employers and health plans now function in a much more competitive health care environment than existed 10 years ago. Purchasers are likely to continue to be aggressive in pressuring plans to hold down premium growth, and plans will continue to seek innovative ways to control costs while constraining payments to providers. Moreover, persistent excess capacity in the health care system will continue to give plans leverage with providers.

If, however, the current trend toward consolidation among health plans continues, so that only a few plans operate in any market, the incentives for price competition among plans may be reduced. (The number of plans operating in a market does not necessarily predict how competitive that market will be.) But whether consolidation will continue in the long term or whether new patterns of market organization may emerge is still uncertain.

As in the private sector, analysts do not anticipate a return to double-digit growth in Medicare's per capita costs over the next decade. CBO projects that per capita spending growth in the program will be slower, on average, over the next 10 years than in the 1990s. But that projection primarily reflects payment policies affecting the traditional fee-for-service program. After 2010, the program will begin to experience the extraordinary demographic pressures associated with the retirement of the baby boomers. Addressing that boost in demand will require growth in per capita spending that is slower than the growth that will occur under current policies.

Whether a more competitive approach slowed Medicare spending in the long term would depend in part on the competitive environment that existed more generally in health care markets. It would also depend on how aggressive the Medicare Board was in its negotiations with health plans and whether the board would be allowed to negotiate with the traditional fee-for-service program.

THE ROLE OF THE BOARD

Commission staff compare the Medicare Board's role to that of OPM in overseeing the FEHBP. But if the board had limited authority to negotiate with the traditional program, its task could be much more difficult than OPM's because the traditional program would be the market leader—at least in the early years of the program. OPM exerts considerable control over the national plans that offer services under the FEHBP, especially Blue Cross and Blue Shield, which is the market leader and accounts for more than 40 percent of federal enrollment. Within the FEHBP, the national plans are the major competition for local health plans, just as the fee-for-service program is the major competition for private health plans under Medicare.

OPM seems to use its market power in modest ways to extract favorable terms from local health plans. The plans are required to provide OPM with detailed information on their premiums, and how they were developed, for the two employer groups that are closest in size to their federal employees' group. OPM uses the lower of those two rates to establish the premium for the FEHBP. Whether the Medicare Board would be able to fully exploit its considerably greater market power is uncertain.

How effective the board was in limiting the expansion of covered benefits would be of critical importance for long-term spending growth. The rate of growth of the national average premium would be a function, in part, of the services that plans included in their premiums for core benefits. There would be tremendous pressure to continue to expand those benefits as a result of the rapid development of medical technology. That pressure exists today but is likely to increase in the future, especially considering that many future medical breakthroughs will probably be targeted toward the elderly market.

Under the proposal, the board's authority with respect to prescription drugs would apparently be limited, which could have a sizable effect on program costs. The proposal would allow private plans to include the costs of prescription drugs in their premiums for core benefits. Thus, a new service with rapidly rising costs would be built into the base for determining the government's contribution, potentially causing Medicare's long-term costs to grow more rapidly as well. Initially, the effects on the national average premium would be small because most beneficiaries are in the traditional program, which would not offer drug coverage. But over time, the effect could be compounded if more beneficiaries shifted to private plans that offered drug coverage, which in turn could cause prescription drugs to become an increasingly important component of the national average premium.

Pressure by beneficiaries to expand covered benefits is also likely to grow over the next decade and beyond, regardless of any policy actions taken to reform

Medicare. When the baby boomers retire, they are going to be wealthier, on average, than previous generations of retirees. They are therefore likely to be more willing to pay for plans charging higher premiums if those plans offer richer benefits or are judged to be of higher quality. Under a premium support model, many of those plans would also have higher federal contributions. If the demand for new benefits was strong and was backed up by beneficiaries' willingness to pay for them, the board's ability to limit "benefit creep" could be compromised.

THE ALTERNATIVE OPTION

The commission has developed a second option for consideration that differs from the first only in having a different structure of government subsidies for Medicare. Beneficiaries would pay:

- Nothing for plans with premiums that were below 85 percent of the national weighted average premium.
- Approximately 75 percent of the additional costs for plans with premiums that were between 85 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average premium.)
- 100 percent of the additional costs for plans with premiums that were above the national average.

The steepness of the schedule could discourage benefit creep somewhat because beneficiaries would pay a larger share of the costs of additional benefits than they would under Option I. But given the high percentage of the premium that the government would pay—regardless of the plan a beneficiary chose—it is unclear whether small changes in beneficiaries' contributions would have much effect on their choice of health plans. The schedule might also encourage plans to establish premiums that were about 85 percent of the national average. Because such plans would probably have "lean" benefits, however, it is unclear whether they would capture a significant share of the market.

MEASUREMENT AND BASELINE ISSUES

Estimates of the long-term effects on costs of any proposal to restructure the Medicare program depend critically on the baseline against which the proposal is measured. Ideally, such a baseline would assume that current policies would continue without the introduction of significant program reforms. It is reasonable to

assume that over the long term, without restructuring the Medicare program, the government would continue to adjust its administered prices, as it has in the past, in an attempt to slow the growth in outlays.

CBO does not currently have a baseline that extends beyond a 10-year window. The Medicare trustees make long-term projections for the program that might be considered for such a purpose, but those projections assume that growth in per capita spending will decline to the rate of growth of hourly wages by 2020. Such a reduction in the rate of growth is unlikely to occur in the absence of policy actions that go significantly beyond the adjustment of administered prices.

THE WHITE HOUSE

WASHINGTON

February 24, 1999

TO: Gene S., Bruce R., Elena K., Larry S., Steve R.
FROM: Chris J. and Jeanne L.
RE: HCFA MEDICARE COMMISSION ANALYSIS

Last night, Senator Breaux released an analysis from the HCFA actuaries on the latest version of Senator Breaux's Medicare Commission reform packages. Senator Breaux's cover note suggests that premium support saves \$347 to 372 billion over 10 years.

A closer reading of the analysis shows that premium support by itself saves about \$75 to 100 billion over 10 years (\$26 to 37 billion over 5 years). The \$347 to 372 billion "savings" also includes about \$100 billion in revenue from an income-related premium that is earmarked in its entirety for low-income protections and about \$50 billion in reduced Medicare liability from transferring direct medical education out of the Medicare Trust Fund. As a consequence, almost one half -- about \$150 of the \$347 to 372 billion -- does not represent Federal savings.

The following is a brief description of the package and analysis:

SENATOR BREAUX'S PACKAGE

- **Premium support (\$26 to 37 billion over 5, \$75 to 102 billion over 10).** The actuaries estimated savings from Senator Breaux's "alternative" model that was described for the first time in a memo from the Commission on 2/17. The higher savings estimate assumes that there is no ability for private plans to vary their benefits. The lower savings estimate assumes a limited amount of variation. These savings are higher than expected because Senator Breaux has made important modifications in his proposal, specifically reducing the benefits flexibility, even in the more "flexible" model.
- **Income-related premium (\$36 to 38 billion over 5, \$95 to 96 billion over 10).** This plan would start increasing the Medicare premium for beneficiaries with income at \$24,000 for singles, \$30,000 for couples. These income thresholds are half as high as the 1997 Chafee-Breaux proposal, and would affect more than twice as many people -- about 30 percent of beneficiaries (about 12 million beneficiaries) would pay higher premiums. Assuming 1999 costs, this premium would be \$125 a month each for an elderly couple with \$50,000 annual income -- more than a 100 percent increase. All \$38 billion in revenue from this income-related premium, according to the description, would be reinvested in a yet-to-be designed low-income protections and therefore would be budget neutral (no savings).

- **Raising the age eligibility (\$2 billion over 5, \$25 billion over 10).** The real savings from this proposal are in the long-run -- a separate analysis indicated that this policy alone would produce as much savings as premium support over the 30-year period. The analysis does not include any proposal to assist people losing Medicare eligibility in finding new sources of coverage (e.g., Medicare buy-in).
- **Cost sharing and Medigap changes (\$14 billion over 5, \$31 billion over 10).** This plan would make a number of changes to Medicare cost sharing which, in total, would increase the amount that beneficiaries pay out-of-pocket (\$9 billion over 5, \$20 billion over 10). This primarily results from a new 10 percent home health copay. The plan would also prohibiting Medigap from covering Medicare's deductible (\$5 billion over 5, \$11 billion over 10).
- **Fee-for-service reforms (\$16 billion over 5, 79 billion over 10):** This includes extending most Balanced Budget Act proposals from 2003 to 2007 (\$7 billion over 5, \$57 billion over 10) (note: since the BBA expires in 2002, only 2003 and 2004 savings count toward the 5 year savings). The plan would also modernize Medicare fee-for-service by giving it additional flexibility used by private health plans (\$9 billion over 5, \$22 billion over 10). These savings are more than we expected, and probably are more than CBO would estimate.
- **Transferring direct medical education out of Medicare (\$20 billion over 5, \$46 billion over 10).** This proposal does not actually save the Federal government any money -- it simply moves DME spending from Medicare to some other, unnamed place in the budget.

WHAT IS NOT IN SENATOR BREAUX'S PACKAGE

- **Surplus:** The plan contains no revenue proposals.
- **Prescription drug benefit:** Under the more flexible benefits version of premium support, plans could offer a limited drug benefit and possibly receive a government subsidy for it if its premium is below average. People in traditional Medicare or without access to a low-cost private plan would have no drug option.
- **Defined benefit:** Despite improvements in their structure, both premium support options allow some flexibility around the core benefits (e.g., offer varying but actuarially equivalent levels of physician visit coverage, home health, outpatient care). The more flexible option allows plans to offer whatever additional benefits they desire, so long as the value of those benefits doesn't exceed a limit. Benefits variability not only reduces effective competition, but could cause risk selection and confusion among beneficiaries faced with a wide array of slightly different benefits options.
- **Medicare buy-in:** The proposal raises age eligibility without offering any options whatsoever for people who lose Medicare eligibility as a result of the change.

There are also unanswered questions, like whether beneficiaries choosing private plans will pay more or less depending on where they live. We will you posted as we learn more.

SENATOR BREAUX'S MEDICARE REFORM PROPOSALS
(Calendar years, dollars in billions)

| | 00-04 | 00-09 |
|--|--------------|-------------|
| Premium Support | | |
| Limited Flexible Benefits | -26 | -75 |
| No Flexible Benefits | -37 | -102 |
| Income Related Premium (Begins \$24/30 ends \$40/50) | | |
| Limited Flexible Benefits | -36 | -96 |
| No Flexible Benefits | -38 | -95 |
| Raising Age Eligibility | -2 | -25 |
| Cost Sharing / Medigap Changes | | |
| Cost sharing changes (including unlimited home health copay) | -9 | -20 |
| Medigap: Prohibiting coverage of deductible | -5 | -11 |
| Subtotal | -14 | -31 |
| Medicare Fee-For-Service Reforms | | |
| BBA Extenders | -7 | -57 |
| Modernizing fee-for-service | -9 | -22 |
| Subtotal | -16 | -79 |
| Removing direct medical education from Medicare | -20 | -46 |
| Drug Coverage | Not Included | |
| Surplus | Not Included | |
| Interactions | 1 | 6 |
| MEDICARE SAVINGS | | |
| Total Package Plus Premium Support #1 | -114 | -346 |
| Total Package Plus Premium Support #2 | -126 | -373 |
| FEDERAL SAVINGS (Minus Income-Related Premium; DME) | | |
| Total Package Plus Premium Support #1 | -58 | -204 |
| Total Package Plus Premium Support #2 | -69 | -231 |

Feb-23-99 06:47pm

From: COMMERCE COMMITTEE DEMOCRATIC STAFF

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MEMORANDUM

TO: Medicare Commission
FROM: Senator John Breaux
DATE: February 23, 1999
SUBJECT: Premium support estimate from the HCFA Actuary

Attached is the estimate from HCFA's Office of the Actuary on the premium support proposal I put forward at the Commission meeting last month. I am pleased that HCFA's actuaries have joined Commission staff in confirming that a premium support model would result in savings to the Medicare program.

The HCFA actuaries have produced estimates under two alternative versions: one assuming a core, standardized benefit package with no more than 10 percent variation and a second option assuming a benefit package with no variation at all. Under the first scenario, HCFA estimates that my proposal would save \$347 billion through 2009 and produce savings equivalent to 11.2 percent of what Medicare expenditures otherwise would have been through 2030. If no variation were allowed in the benefit package, the proposal would save \$372 billion through 2009 and produce savings equivalent to 11.9 percent of what Medicare expenditures otherwise would have been through 2030. Please note that savings from the income-related premium would be used to pay for enhanced low-income protections, thereby reducing total savings.

I look forward to discussing this and other premium support analyses at tomorrow's meeting.

Package 1—Draft Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting¹

| Category | Provision | Comment |
|---|---|-----------------------|
| Fee-for-service: Cost sharing Modernization HBA extenders Medical education DSH Medicaid reforms | Combined A & B deductible of \$350 (indexed to CPI) 0% coinsurance on inpatient and preventive care; 10% coinsurance on home health care; present law OPD coinsurance; 20% coinsurance on all other services Standard BCV package NRCFM "temporary" package (through 2007) except: no M+C / no DSH Remove DME funding from Medicare: no DME provision No provision Prohibit coverage of Medicare deductible(s) | |
| Premium supports: Administration Benefit packages Premium allocation Income related premium | Medicare Board would have considerable authority to negotiate premiums & benefit packages, enforce financial & quality standards, approve service areas, etc. Option (1): Standardized "core" package required as minimum Additional benefits beyond core package are allowed Private plan packages must be a government FFS plan Actuarial value of package may not exceed 110% of core value Peripheral benefits such as dental care, cosmetic surgery, vision care, OTC drugs, are not permitted Option (2): Standardized "core" package only; no benefit package flexibility Gov't FFS plan must bid nationally; others may bid nationally or regionally Partial geographic adjustment of payments; full risk adjustment 2-benchmark premium allocation formula; based on full plan bids: At or below 85% of WAP, 100% / 0% Medicare / beneficiary allocation At 100% of WAP, 88% / 12% Above 100% of WAP, gov't contrib = 88% of WAP Single ben's: 12% at \$24,000 - 25% at \$40,000+ Bene couples: 12% at \$30,000 - 25% at \$50,000+ Brackets indexed by CPI Revenue earmarked for improving low-income beneficiary coverage | No specific provision |
| FFS and PS: Eligibility age Voluntary coverage Drug coverage Budget surplus revenue | Increase age of eligibility following OASDI schedule No provision No provision No provision | |

¹ Specifications reflect clarifications and modifications received from Robby Jindal, Daris Romfo, and Sarah Lyons on 1-29-99, 2-11-99, 2-12-99, 2-17-99 and 2-22-99.

Estimated costs (+) or savings (-) under two alternative versions of Medicare legislative package introduced by Senator Breaux at January 23 Explanatory meeting
(Calendar year estimates; amounts in billions)

—Option (1): Limited variations in benefit package—

| Proposal | Total savings, annual \$ | | | | | | | | | | Total savings, % of P.L. expense ¹ | | | | |
|------------------------------|--------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|---|---------------|--------------|---------------|---------------|
| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2000-04 | 2000-09 | 2000-09 | 2000-09 | |
| SEA additions | \$0.0 | \$0.0 | \$0.4 | \$2.1 | \$2.1 | \$3.5 | \$3.9 | \$11.0 | \$11.3 | \$12.2 | \$7.1 | \$57.1 | -0.5% | -1.7% | 2.4% |
| Cost sharing changes | -1.8 | -1.8 | -4.8 | -4.9 | -1.9 | -2.8 | -2.6 | -2.1 | -2.1 | -2.1 | -2.2 | -19.5 | -0.7% | -0.7% | -1.7% |
| Medicare proposals | -1.7 | -1.7 | -1.8 | -1.9 | -2.1 | -2.2 | -2.3 | -2.5 | -2.7 | -2.9 | -8.2 | -21.8 | -0.7% | -0.7% | -0.6% |
| Repeal of DIME | -3.8 | -3.8 | -4.0 | -4.2 | -4.5 | -4.7 | -4.9 | -5.2 | -5.4 | -5.7 | -20.1 | -48.1 | -1.4% | -1.4% | -0.8% |
| Partum support | -2.4 | -2.4 | -2.4 | -2.7 | -2.7 | -2.9 | -3.0 | -3.7 | -3.8 | -3.8 | -28.1 | -74.9 | -1.9% | -1.9% | -2.4% |
| Income-related premium | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -2.5 | -25.5 | -63.7 | -2.7% | -2.7% | -3.1% |
| Change in age of eligibility | 0.0 | 0.0 | 0.0 | -0.7 | -1.4 | -2.2 | -3.0 | -4.2 | -5.0 | -5.9 | -2.1 | -25.2 | -0.1% | -0.1% | -1.7% |
| Medicare legislative changes | -1.0 | -1.0 | -1.0 | -1.1 | -1.3 | -1.1 | -1.2 | -1.2 | -1.3 | -1.3 | -5.2 | -11.3 | -0.4% | -0.4% | -0.2% |
| Transactions | 0.1 | 0.1 | 0.1 | 0.3 | 0.4 | 0.5 | 0.7 | 0.8 | 1.0 | 1.1 | 1.0 | 8.2 | 0.1% | 0.1% | 0.2% |
| Total savings | -17.0 | -19.2 | -21.8 | -23.0 | -21.4 | -25.0 | -27.1 | -30.6 | -30.7 | -30.0 | -116.2 | -316.6 | -0.2% | -10.1% | -11.5% |
| Total premium expense | 254 | 264 | 279 | 297 | 321 | 348 | 373 | 404 | 438 | 475 | | | | | |
| Savings as % of expense | -6.8% | -7.3% | -7.8% | -8.0% | -6.8% | -10.4% | -11.8% | -11.6% | -11.2% | -11.5% | | | | | |

Notes: 1. Refers to specification parameters for description of proposals.
 2. Estimates shown for each provision are on a "stand alone" basis, that is, the theoretical impact of that provision only, relative to provisions. Total savings for the package reflect interactions.
 3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
 4. Estimates are preliminary and subject to change pending improved data and more refined methodology. In particular, estimates of interactions among programs are very rough.

Estimated costs (+) or savings (-) under alternative versions of Medicare legislative package
 Introduced by Senator Brown at January 20 Combinations meeting
 (Calendar year estimates; amounts in billions)

--Option (2): No variation in benefits package--

| Proposed | Total savings, combined \$ | | | | | | | | | | Total savings, % of PL expenditure | | | | | | |
|-------------------------------|----------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|------------------------------------|---------|---------|---------|---------|---------|---------|
| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020-24 | 2025-29 | 2030-39 | 2040-49 | 2050-59 | 2060-69 |
| BDA estimates | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 | 30.0 |
| Total savings | -1.8 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 |
| Medication proposals | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 | -1.7 |
| Removal of DME | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Partisan support | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 | -4.1 |
| Volume-related problem | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 | -0.5 |
| Changes in age of eligibility | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Low-dose regulation changes | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 | -1.0 |
| Insurers | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Total savings | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 | -18.6 |
| Total present law expenditure | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 | 251 |
| Savings as % of expenditure | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% | -7.4% |

- Notes: 1. Refer to spreadsheet annexes for description of provisions.
 2. Estimates shown for each provision are on a "stand alone" basis, that is, the fiscal impact of that provision only, relative to present law. Total savings for the package reflect interactions.
 3. "Savings" are defined as either expenditures reductions or increases in premium revenues.
 4. Estimates are preliminary and subject to change pending approved data and more refined methodologies. In particular, estimates of interactions among provisions are very rough.

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|--------------------------|---|---------|-------------|
| 003. memo | Ricchetti et al. to POTUS re: Recommended telephone call to Senator John Breaux (2 pages) | 2/24/99 | P5 |

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rs43

RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
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- b(1) National security classified information [(b)(1) of the FOIA]
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- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|--------------------------|---|---------|-------------|
| 004. talking points | POTUS TPs for telephone call to Senator Breaux (1 page) | 2/24/99 | P5 |

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SENATOR BREAUX'S MEDICARE COMMISSION PLAN, 2/23/99

OVERVIEW OF SENATOR BREAUX'S PACKAGE

- **Total Savings.** The Commission staff are distributing charts and press releases stating that the Actuaries projected that Senator Breau's "premium support" plan would save \$347 to 372 billion over 10 years. However, this is misleading because:

- Premium support only achieves \$75 to 102 billion -- a fraction of the total savings;
- \$100 billion in revenue from an extremely aggressive income-related premium that is supposed to be reinvested in low-income protections -- but is counted as savings in the Commission press paper; and
- \$50 billion in direct medical education that is transferred out of the Medicare Trust Fund but into a new mandatory grant program in a budget-neutral way.

| SAVINGS UNDER BREAUX'S PLAN (Calendar Years, Dollars in Billions) | | |
|--|-------|-------|
| | 00-04 | 00-09 |
| Premium Support | | |
| Limited Extra Benefits | -26 | -75 |
| No Extra Benefits | -37 | -102 |
| Income-Related Premium (Not counted as savings) | | |
| Limited Extra Benefits | -36 | -96 |
| No Extra Benefits | -38 | -95 |
| Raising Age Eligibility | -2 | -25 |
| Cost Sharing / Medigap Changes | -14 | -31 |
| Medicare Fee-For-Service Reforms | | |
| BBA Extenders | -7 | -57 |
| Modernizing Fee-For-Service | -9 | -22 |
| Removing DME from Medicare (Not counted as savings) | -20 | -46 |
| Interactions | 1 | 6 |
| FEDERAL SAVINGS | | |
| Low Premium Support | -58 | -204 |
| High Premium Support | -69 | -231 |

This means that the Federal savings are really \$204 to 231 billion over 10 years (\$58 to 69 billion over 5 years).

- **About one-fourth to one-half of savings from beneficiaries.** The package includes:
 - \$31 billion from cost sharing increases (i.e., home health coinsurance) and Medigap reforms;
 - \$25 billion from raising age eligibility with no options to prevent the uninsured from rising;
 - \$96 billion from an aggressive income-related premium; and
 - Tens of billions from higher fee-for-service premiums under premium support.
- **Does not include:**
 - **Surplus:** The plan does not include your 15 percent surplus proposal nor any other revenue proposals.
 - **Prescription drug benefit:** Although Senator Breau has indicated a willingness to work on a benefit, the current proposal has no prescription drug coverage.

SPECIFIC PROPOSALS IN SENATOR BREAU'S PLAN

- **Premium support (\$75 to 102 billion over 10).** The actuaries estimated savings from Senator Breau's premium support because beneficiaries have a financial incentive to choose lower-cost plans, thus lowering the Medicare average spending over time. The higher savings estimate assumes that there is no ability for private plans to vary their benefits, encouraging competition on price. The lower savings estimate assumes that plans can offer some extra benefits, thus reducing savings. In both models, the actuaries estimate that the premium for fee-for-service will be 10 to 20 percent higher than current law since low-cost plans will make fee-for-service a higher cost -- and thus higher premium -- plan.
- **Income-related premium (\$95 to 96 billion over 10).** Beneficiaries with income above \$24,000 for singles, \$30,000 for couples would pay an increasing higher premium. These income thresholds are half as high as the 1997 Chafee-Breau proposal, and would affect more than twice as many people -- about 30 percent of beneficiaries (about 12 million beneficiaries). Assuming 1999 costs, this premium would be \$125 a month a single beneficiary with \$40,000 and a married beneficiary with \$50,000 in income. All revenue from this income-related premium, according to the description, would be reinvested in a yet-to-be designed low-income protections and therefore would be budget neutral (no savings).
- **Raising the age eligibility (\$25 billion over 10).** The real savings from this proposal are in the long-run -- a separate analysis indicated that this policy alone would produce as much savings as premium support over the 30-year period. The analysis does not include any proposal to help insure people losing Medicare eligibility OR a proposal to allow people under age 65 buy into Medicare.
- **Cost sharing and Medigap changes (\$31 billion over 10).** This plan would make a number of changes to Medicare cost sharing which, in total, would increase the amount that beneficiaries pay out-of-pocket (\$20 billion over 10). This primarily results from a new 10 percent home health copay. The plan would also prohibiting Medigap from covering Medicare's deductible (\$11 billion over 10).
- **Fee-for-service reforms (\$16 billion over 5, 79 billion over 10):** This includes extending most Balanced Budget Act proposals from 2003 to 2007 (\$57 billion over 10). The plan would also modernize Medicare fee-for-service by giving it additional flexibility used by private health plans (\$22 billion over 10). These savings are more than we expected, and probably are more than CBO would estimate.
- **Transferring direct medical education out of Medicare (\$46 billion over 10).** This proposal does not actually save the Federal government any money -- it simply moves DME spending from Medicare to some other, unnamed place in the budget.

To: Povey + Elson
Fr: Jeanne + Chris

- will add question on NYT Article

Medicare
Commission

DRAFT: MEDICARE QS AND AS, January 22, 1999

Q: Isn't the *Washington Post* editorial right -- that the President's plan to reserve part of the surplus for Medicare is a "pass" on real Medicare reform?

A: Absolutely not. Medicare reform is not only about solvency -- it is about making Medicare more efficient, equitable, and adequate in terms of benefits. This move by the President should allow the Medicare Commission and Congress in general to focus on these critical objectives rather than worry about Trust Fund solvency alone.

Q: Isn't the President's plan to use part of the surplus for Medicare just throwing more money at the problem without any long-overdue structural reforms?

A: The President cannot be more clear about the fact that he wants this proposal to be considered in the context of broader reforms. However, virtually all independent experts confirm that demographics and health costs require more financing. All the structural reforms in the world won't change this fact.

Q: Could the surplus just be used for drugs?

A: The President believes that a new prescription drug benefit should be included as part of, not independent from, a broader set of reforms for the Medicare program. He believes that it would be irresponsible to focus only on expanding benefits without addressing the financial challenges facing the program.

Q: Will the President reject the Commission's plan if it does not include a prescription drug benefit for Medicare?

A: It would be difficult to imagine a major reform proposal on Medicare that ignores the largest and most clearly indefensible benefit shortcoming of the Medicare program -- its lack of prescription drug coverage. It is clear that most members of the Commission agree with the President that there should be increased access to prescription drugs for Medicare beneficiaries. The outstanding questions remain how it should be structured and financed. We hope that the Commission report addresses these issues.

Q: Do you support the Medicare proposal being released by Senator Breaux?

A: We just received this document late last night and, as such, it would be premature to reach any conclusions about it. While we cannot comment on the specifics of the document, it appears to acknowledge that there are many questions yet to be resolved.

Before we come to any conclusion, we need to more details about the policies as well as the impact on Medicare beneficiaries and providers. We look forward to working with the Commission as it moves forward.

Q: What do you think of the premium support / voucher proposal that the Commission is considering?

A: "Premium support" is actually not a voucher program -- it contains a guarantee of a defined set of benefits, which is unlike the voucher proposals that the President has opposed in the past. It is a concept worth considering but, as with any initiative, the devil is in the details. We will carefully review the proposal and see whether it meets goals like improving efficiency, assuring an adequate benefits package, modernizing Medicare and protecting low-income beneficiaries.

Q: The Medicare Commission is proposing to raise the Medicare eligibility age from 65 to 67 -- making it consistent with phase up for Social Security. What is the Administration's position on this?

A: As we have consistently stated, we would be seriously concerned about raising the Medicare eligibility age, particularly in the absence of a mechanism to assure this does not increase the number of uninsured Americans. Recent data reaffirm Americans between ages 55 and 65 are the most rapidly growing group of uninsured Americans and are some of the hardest to insure. Americans ages 65 to 67 could face similar problems. The Commission's draft plan states that it will develop a plan to ensure protections for the affected population. We anxiously await the details of this plan.

Q: Would your Medicare buy-in proposal make it possible to raise the eligibility age?

A: The President's plan is designed to assure that vulnerable Americans ages 55 to 65 have access to insurance, but it does not subsidize their health care costs. By contrast, people over 65 in the Medicare program receive subsidies for much of their medical costs. Therefore, any move to increase the eligibility age would have to be combined with additional policy to assure the availability of access to affordable coverage.

Q: What is your position on [graduate medical education reform, Medigap reforms, etc.] that are being considered by the Commission?

A: The President and the Congress created the Bipartisan Medicare Commission in recognition of the complexity of addressing Medicare's problems. He believes it would be premature and inappropriate to contemplate any specifics prior to the conclusion of the Commission's work.

Q. Is it possible for this Medicare Commission to finish its work on time, and if not, would you support an extension past its March 1 deadline?

A. It would be inappropriate for us to comment on the Commission's timeframe before consulting with Senator Breaux and Mr. Thomas on this matter. At this moment, they have not requested an extension for their deadline.

→ Ask re NCSL / Shalala
Satcher

Medicare
Commission

THE WHITE HOUSE
WASHINGTON

MEDICARE COMMISSION PRINCIPALS' MEETING
Roosevelt Room; 4:00pm
January 26, 1999

AGENDA

I. MEDICARE REFORM: WHAT IS GOOD REFORM

Donna: R's-D's blocked competitive
quality reforms
we're pro-reform, not anti-
No larger remaining costs

- Improves Efficiency
- Modernizes and Rationalizes Benefits, While Ensuring Guarantee to a Defined Set of Benefits for All Beneficiaries and Protections for Low-Income Beneficiaries

- S: - More market oriented purchasing power
- Premium support possible
- Add New Revenues through the Surplus
- Better low-income protections
- GOP wants to privatize, shift risk to beneficiaries

II. MEDICARE COMMISSION

PREMIUM SUPPORT - just like Alliances

- Update
- How the Commission Policy Fits with Our Idea of Good Reform

III. POLITICAL CONCERNS

IV. GUIDANCE

- Work with Commission on Good Reform Package
- Work Outside of Commission on Good Reform Package
- Do Not Propose Good Reform Package/Stick to Principles
- Process for POCUS Information / Decisions