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The Deputy Secretary of the Treasury

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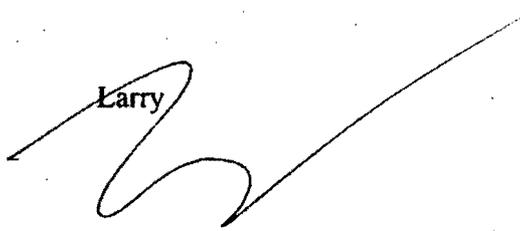
Josh Gotbaum

RE: Our Response on Alicia's Social Security &
Medicare Chapter

Josh,

What do you think we should say on this?

Larry



cc: Sheryl Sandberg

Room 3326

622-1080

increase was fully incorporated in the revisions made to the program at that time. Since 1983, if anything, the demographic developments have been positive--at least from the program's perspective. Life expectancy assumptions have been lowered slightly, thereby reducing long-run costs. The positive impact on long-run costs from changing demographic assumptions were roughly offset, however, by changing economic assumptions. In particular, the Trustees gradually lowered the assumed rate of real wage growth as it became clear that the trend in slower productivity growth was likely to continue. On balance, the economic and demographic changes have roughly offset one another (see Table 2).

Three major factors caused long-term costs to increase. The first factor, which accounts for 25 percent of the problem, is the one discussed earlier. That is, as time passes, the 75-year valuation period ends in a later year, so that more of the higher-cost out-years are included in the projections. Including more deficit years raises the 75-year deficit.

Second, the disability caseload grew much faster than anticipated. This occurred primarily as a result of court rulings that made it easier for individuals to qualify for disability benefits; such rulings could not have been easily anticipated in 1983. Assuming a continuation of higher disability rates this trend raised long-run costs. This factor accounts for about 30 percent of today's 75-year deficit.

The third and biggest source of the post-1983 deficit--45 percent of the problem-- involves changes in the methodology used to project the future. These changes are one-shot occurrences. For example, the large increase in the deficit from 1993 to 1994 is due mainly to new data suggesting that workers have more years of covered employment than previously thought and therefore are entitled to higher projected benefits.

The question is if all these factors went wrong after the 1983 legislation, will the same thing happen again? The first factor--the fact that as time passes, years with large deficits replace years with surpluses--can and should be taken into account in any reform. With regard to the second factor, it is impossible to say whether the actuaries will be forced to make any other major changes. One would expect that as experience piles up and assumptions are tested and retested, the need for major reassessment probably declines. Moreover, changes that do occur are as likely to improve actuarial balance as worsen it. Finally, demographic and economic assumptions may have to be revised, but the Technical Panel viewed these as very reasonable assumptions. Again, they are as likely to be revised in ways that help rather than hurt. In fact, two likely revisions--better measurement of changes in the cost of living and more immigration--would improve the actuarial balance.

THE MONEY'S WORTH ISSUE

In thinking about how to restore balance to the Social Security system, one other issue has emerged as very important--namely, the rate of return on contributions. Young workers now face the prospect of making contributions throughout their working lives at a higher rate than was

required of workers in the past, and increasing attention is being focused on the declining benefit/contribution ratio. The decline in this ratio is the inevitable consequence of the maturation of a pay-as-you-go system. Workers retiring early on in the program had only a few years of wages subject to the Social Security payroll tax. Over time, retirees had more and more years of wages subject to taxation, and the additional tax payments sharply reduced the rate of return. The situation is actually somewhat more complicated in that benefit levels and tax rates were raised several times over the period, but the essence of the story is the maturation of a pay-as-you-go system.

In the future, the rate of return for cohorts as a whole will be in the range of 1 or 2 percent in real terms. In a mature pay-as-you-go system financed by a fixed tax on wages, the amount by which workers as a group can increase their transfer to retirees depends on the rate of growth of aggregate real wages. With a constant or slow growing population, the rate of growth of wages depends primarily on the rate of growth of productivity. Productivity growth is likely to average between 1 and 2 percent.

It is important to note that the low returns paid to future retirees are not the result of poor investment decisions by the government. Contrasting the returns of the Social Security system with the returns that could be obtained under private savings schemes is inappropriate. Given the pay-as-you-go nature of the existing Social Security system, the higher returns are not really available since benefits have to be paid to current retirees. Nonetheless, these concerns about "money's worth" may have a great deal of influence on what solutions are politically acceptable. Increases in contribution rates without compensating increases in the value of benefits may be seen as making further investments in a systems with unattractive returns.

The problem of the decline in the aggregate return is complicated by the fact that Social Security as a *social* insurance system has an important redistributive dimension. Social Security was intended, and has largely succeeded, in removing aged individuals from poverty. This redistributive role means that those at the bottom of the lifetime income distribution receive higher returns on their contributions than their higher paid counterparts. As the overall return declines, paying higher returns to some will mean zero or even negative real returns for others. This will be a particular problem for higher income single individuals and higher income married couples with two earners.

The issue of returns on contributions--so-called "money's worth"--will play prominently in future debates. Proposals for changes in Social Security financing need to address this issue as well as restore long-term balance to the system.

THE QUADRENNIAL ADVISORY COUNCIL RECOMMENDATIONS

The Quadrennial Advisory Council on Social Security was charged in 1994 with finding ways to eliminate the current deficit in the Old-age, Survivors and Disability Insurance (OASDI) program. It released its report in December 1996 after 2 years of deliberations. Instead of

coming up with a single set of recommendations, this 13-person panel split and presented three very different visions for the future of the nation's Social Security system.

All three are designed to restore 75-year balance, fix the problem of the trust fund exhaustion in the 76th year, and address the decline in the rate of return to Social Security. The report characterizes the alternatives as the "Maintain Benefits," "Individual Accounts," and "Personal Savings Accounts" proposals.

The Maintain Benefits Proposal

This plan is designed to eliminate the deficit without altering the basic nature of the program. Roughly half the savings come from proposals that have been around for a long time. Extend coverage to new hires for full-time state and local employees (about 3.7 million workers) not now covered by Social Security. Make Social Security benefits taxable to the extent they exceed worker contributions (comparable to other contributory defined benefit plans). Lengthen the averaging period for the Social Security benefit calculation from 35 years to 38 years. And incorporate the BLS technical corrections in the CPI, which are estimated to reduce inflation by 0.2 percent.

To close the rest of the financing gap requires some more controversial proposals. One is to redirect the funds from taxing Social Security benefits from the HI fund to the OASDI fund, phased in from 2010 to 2019. The second, which addresses not only the financing issue but also the rate of return problem, is to invest 40 percent of trust fund assets in stocks on a graduated basis beginning in 2000. Finally, this plan finances the system more or less permanently by increasing the payroll tax by 0.8 percentage point each on employers and employees starting in 2045, if such an increase is needed to maintain long-run balance.

The Individual Accounts Proposal

This plan begins with the state-local employee, tax, and CPI proposals from above and then raises the retirement age to 67 faster than under current law and indexes it to longevity. Benefits for middle and upper income recipients are then cut further (roughly 30 percent) to bring the 75-year cost within the 12.4 percent current payroll tax rate. Finally, the plan increases the employee's payroll tax by 1.6 percentage points for government-administered individual accounts, beginning in 1998. These accounts would work something like the Federal Employees Thrift Savings Plan, where individuals choose among four or five types of investment accounts administered by the Federal Government. At retirement, the savings would be paid out as an annuity and added to the regular Social Security benefit. As a result, total retirement benefits would depend on the returns achieved through the savings accounts.

The Personal Savings Account Proposal

The third proposal is an aggressive privatization scheme. It diverts 5 percentage points of the 12.4 percent payroll tax into mandatory private individual savings accounts. Unlike the individual savings accounts described above, which would be held by the government and annuitized upon retirement, these accounts could be placed with private investment companies, and individuals would have broader choice over how the savings were paid out during retirement. The remainder of the payroll tax--7.4 percent--would pay for a flat retirement benefit amount--\$410 a month--indexed for future wage growth, and for reduced disability and survivor benefits. The \$410 amounts to about two-thirds of the poverty level.

The plan also reduces outlays using many of the same features as the first and second plans: adjustments to the CPI, expanding coverage for newly hired state and local government workers, increasing the taxation of benefits, and speeding up increase in retirement age and indexing to longevity.

Since Social Security has operated on a pay-as-you-go basis, moving to individual accounts creates large transitional costs. Young workers would have to support those already retired or nearing retirement, as well as contribute to a savings account for themselves. These transitional costs are large. The plan spreads the costs over 72 years, but the costs still would equal 1.52 percent of payroll during this period. In addition, using a level tax rate to finance the transition means it is underfunded in the early years, and overfunded in the later years. This "smoothing" of the cost requires that the trust fund borrow roughly \$1.2 trillion in 1995 dollars from the Treasury between now and 2035, and repay the funds with interest using accumulated surpluses thereafter.

Collective Action or Individual Initiative

Our current Social Security system represents a banding together to create a form of collective protection. People share responsibility not only for their own and their family's welfare, but also for the well being of other members of society. At the beginning of life no one knows whether they will be financially successful or struggle to make ends meet, whether they will die early or become disabled or live long into retirement. To protect against these risks, everyone contributes to a single system. For those who experience a lifetime of low earnings, the system provides redistributive benefits so they can survive adequately in retirement. This type of redistribution can be done only when everyone participates. Without mandatory participation, those who were confident that they would end up with high incomes would withdraw, raising costs on the rest of the population.

The Personal Saving Account proposal represents a dramatic departure from this collective approach. The notion is that some protection in case of death or disability would be provided on a group basis and everyone would be provided a basic minimum benefit. Above

that minimum amount, workers would be--more or less--on their own in terms of saving for retirement. The contributions would be mandatory but the outcome uncertain.

Defined Benefit versus Defined Contribution

The current Social Security system is a defined benefit plan. Individuals contribute over their working lives as they move from job to job. They then receive statutory benefits based on a computation that reflects the growth in wages during their working years. After retirement, they receive an annuity with payments adjusted annually to keep up with inflation.

The Personal Saving Account proposal would shift the nation's basic retirement system to a defined contribution plan. Such a shift would offer no improvement in portability--one of the main arguments in favor of defined contribution plans--since Social Security already follows workers as they move from employer to employer. The major result of the shift would be to increase the risk to the individual family. Payments under this system will depend on the investments selected and on the timing of retirement, disability, or death.

Investment behavior varies significantly among individuals. In the aggregate, the data suggest that people put roughly 40 percent of their holdings in equities. However, any individual can opt for all low yielding investments and end up with much less than anticipated, or load up with high risk assets and be forced to claim benefits at a market low.

In addition to market risk, three other problems are associated with defined contribution plans. First, the administrative costs of individual accounts would exceed the current system, or even the current system with some trust fund assets invested in equities. The Advisory Council estimates that managing the personal saving accounts will cost about 100 basis points. Second, as individuals see their account balances accumulate over their working years, they are likely to pressure Congress to permit pre-retirement withdrawals for education, medical expenses, down payments for homes, or other worthy purposes. To the extent that Congress acquiesces, workers may end up with inadequate retirement income. Third, the fact that participants are not required to annuitize their accumulated funds creates another area of risk. Some people will underestimate the amount of money they need for retirement and use the funds for other purposes. Others will be too cautious. Private annuities will help, but typically they do not offer a fair return for the average person.

These problems are mitigated under the Individual Account proposal in that it has a much more modest defined contribution component. Critics argue, however, that the Individual Account proposal creates an unstable situation in which workers--particularly, higher income workers--will push for shifting more and more of their retirement funds out of Social Security, where they earn low returns, and into separate accounts, where they earn high returns. They conclude that creating such a situation runs the risk of ending up with a defined contribution plan as the nation's basic retirement system.

Impact of the Proposals on National Saving

When thinking about the impact of the Social Security system on national saving, it is useful to divide the issue into three time periods: the start-up, the current mature system, and the future.

The Start-up. Congress enacted the Social Security system in 1935. Payroll taxes were first collected in 1937, and the first monthly benefits were paid in 1940. In 1939, Congress made a series of decisions that slowed the build up of reserves, so the system operated pretty much on a pay-as-you-go basis.

This meant that the first generation of retirees received benefits far in excess of their tax payments. According to the life-cycle model, whereby individuals or households plan to consume all their income and wealth over their expected lifetimes, an increment to lifetime income would increase consumption and reduce saving. That is, workers perceive that they have received a wage increase in the form of a future annuity, and they would choose to consume part of that increase. To increase their current consumption, they would have to either reduce saving or increase borrowing.

Lower personal saving, without any offsetting accumulation of reserves within the Social Security system, would be expected to reduce national saving and leave future generations with a lower capital stock than they would otherwise have had.

A thorough review of the empirical literature shows no compelling evidence of a sharp decline in saving in the wake of the introduction of Social Security. Several explanations are possible. The first is that Social Security may have changed retirement expectations as well as increased lifetime income. That is, whereas before Social Security workers may have expected to work until they die, after Social Security age 65 became the normal retirement age. To the extent that Social Security encouraged people to retire earlier, they would have been forced to save over a shorter working life for a longer period of retirement. This retirement effect would have served to increase personal saving. Similarly, before Social Security, most elderly people lived with their children; after Social Security they were in a position to maintain their own households. The increased demand for independent living in old age would also have increased saving. Finally, many individuals save little or nothing at all, so that the only way to increase current consumption would be through borrowing. But low- and moderate-income individuals may not be able to borrow enough to achieve their ideal distribution of consumption over time, so the introduction of Social Security would have left their savings unaffected.

In short, the life-cycle model suggests a decline in saving in the wake of the introduction of the Social Security system, and a lower capital stock as a result. Several factors, however, mitigate against this result. Empirical studies cannot document a significant decline in national saving from the introduction of the Social Security system.

The Mature Pay-as-you-go System. Once the Social Security system has matured, the fact that it is financed on a pay-as-you-go, rather than a funded, basis has relatively little impact on the nation's saving rate. The simplest way to think about the saving effect is to consider an economy with no population or income growth. Under a funded system, individuals would accumulate saving over their working lives, but the elderly would draw down accumulated assets in retirement. The result would be zero aggregate net saving. With pay-as-you-go financing, the buildup of assets during the working years does not occur, but then neither does the drawing down of assets in retirement.

The result would be altered somewhat by introducing income growth into the analysis. But, so long as the effects of the introduction of Social Security on national wealth were small, the steady state differences between national saving with funded and pay-as-you-go Social Security systems would also be quite small.

The Future. Theoretically, shifting from a pay-as-you-go to a funded system should increase the nation's saving rate and the capital stock. For the most part, the increase in the saving rate is temporary. Once the transition to a fully funded system is complete, the saving rate should drop back to near its pre-funding level.

A fundamental question may be: If we as a nation want to save more, is the Social Security system necessarily the mechanism through which to accomplish that goal? If Social Security is determined to be the appropriate mechanism, then, in theory, a desired saving objective could be accomplished with any of the approaches. The magnitude of the impact of the three proposals on saving depends on how much is put aside for pre-funding, either in separate accounts or in the trust fund and the assumed rate of return on those contributions.

The Issue of Raising the Retirement Age

Two of the three proposals raise the normal retirement age to 67 more quickly than scheduled under current law and then index for increases in longevity thereafter. The rationale for increasing the normal retirement age is that as life expectancy increases, so should the length of the worklife. In 1935 when Social Security was enacted and the retirement age set at 65, life expectancy at 65 was about 12 years for men and 13 years for women. Today it is 15 years and 19 years, respectively. The projections for 2070 are 18 years and 22 years, respectively. The increase in the number of years over which people receive benefits, as discussed earlier, is a major reason for the increase in costs to date and will add to costs in the future.

The sponsors of the Maintain Benefit proposal do not include any extension of the retirement age. They offer two main reasons. To date, the extension of longevity has not been accompanied by an increase in work; people are retiring earlier and earlier. Therefore, before raising the retirement age further, it would be better to see the impact of the increase to age 67 already scheduled under current law. Second, extending the retirement age further

would hurt those who are forced--either because of poor health or lack of employment opportunities--to retire before 65. The law already provides an actuarial reduction of 20 percent for those who retire at age 62, and this reduction will rise gradually to 30 percent with the scheduled increase in the normal retirement age to 67. Increasing the retirement age beyond 67 will eventually make the age-62 benefit an inadequate source of support.

Two key issues emerge here. The first is how many people who retire at age 62 would find it a serious hardship to extend their work life. A preliminary analysis of the age-62 retirees shows them falling into two groups. One consists of relatively prosperous individuals with some wealth and an employer-provided pension. The other is made up of lower income, less healthy individuals with irregular pre-retirement work histories. Raising the retirement age for the first group creates few problems; raising it for the other group may well produce hardship.

The second issue, therefore, is how to protect low-income individuals with no work possibilities. For those who cannot work because of some form of physical disability, some have suggested that the disability insurance program might be modified to make it somewhat easier for older workers to collect benefits. For those who are physically sound, but who cannot find employment, the unemployment insurance system might be an option. Alternatively, it might be possible to change the benefit formula and reduce the actuarial adjustment for lower income workers.

At this point, the precise option is unclear, but any proposal to increase the retirement age will have to address the plight of those who are unable to work and face severely reduced retirement benefits.

Investing the Trust Fund in Equities

Proponents of the Maintain Benefits proposal suggest serious consideration be given to investing a share of the trust fund in equities. They argue that such investments are necessary to increase the return on the trust funds, which now must be invested only in Treasury securities or government guaranteed securities. The actuaries estimate that Treasury securities will provide an average annual real return of 2.3 percent over the 75-year projection period, significantly below the postwar historical return on equities of about 7 percent. Thus, they conclude that investing 40 percent of the trust funds in equities could raise the ultimate projected return in trust fund assets from 2.3 percent to 4.2 percent. It would also increase the riskiness of the Social Security portfolio, but the Federal government is in a good position to wait out fluctuations in market value, particularly as the size of the trust fund increases (see Box 1).

The higher return on Social Security assets will be matched, however, by lower returns on non-Social Security assets held by the public. The primary effect of the shift in Social Security investment policy is a restructuring of portfolios so that the trust funds hold some higher-return equities and the public ends up holding the lower-return government securities previously held by

the trust funds. The increased demand for equities would initially lower the returns on equities, while the need to attract private sector investors would require higher returns on Treasuries.

Thus, critics charge that the proposal would raise the Federal deficit by raising interest payments. Some respond that these initial effects would be moderated as corporations restructured their finances to take advantage of cheaper equity financing and as international buyers increased their purchases of higher yielding Treasuries. In addition, the much larger trust fund balances under the Maintain Benefits proposal mean that trust fund holdings of Treasuries are ultimately higher, not lower, than under current law. Nonetheless, the effect on the Federal deficit remains an important issue that would have to be explored in any assessment of the equity investment proposal.

Another concern about Social Security investing in equities is that the government will control the market and get in the business of picking winners and losers. Indeed, if 40 percent of Social Security assets were invested in equities, the trust funds might end up owning about 10 to 15 percent of the stock market in the long-run, a sizeable amount for one "player" (see Box 2). Supporters of equity investments argue, however, that concerns about market disruptions and public sector interference in private sector activity could be addressed by having the trust funds hold a portfolio indexed to the overall stock market (such as the Russell 3000 or the Wilshire 5000). They suggest that, as in the case of the Federal Thrift Savings Plan for Federal employees, an expert board could then select, through competitive bidding, one or more private sector managers. Clearly avoiding market disruptions would be a key requirement in considering equity investments for Social Security.

Another concern frequently cited pertains to corporate governance and potential disruption of corporate control. The question is whether the government would vote its shares or simply act as a passive investor. Advocates contend that so long as legislation provided that government shares were either not voted or voted in a pattern that reflected other common shareholders, government ownership should not disrupt corporate control in any way.

One further issue is whether the timing of Social Security purchases could have further market implications when baby boomers retire and the pace of purchases slows, eventually turning negative. Supporters assert that this problem could be alleviated by fixing the long-run financing problem and stabilizing the size of the trust funds. Nevertheless, the administrative aspects of investing in equities would require solving some tough problems.

Despite assurances from proponents, investing a portion of the Social Security trust funds in equities is a dramatic departure from current procedure. Such a departure would require careful scrutiny before being considered for adoption.

Structural Issues

While the advisory Council focussed most of its attention on the fiscal plight of the Social Security system, the structure of the program raises some equity and efficiency issues.

Household Composition. Social Security provides benefits for spouses equal to the greater of the amount that they could receive on their own and 50 percent of the benefits of the primary earner. When the primary earner dies, the surviving spouse receives 100 percent of the primary earner's benefit. Married couples with a single earner do very well under this system, compared to single earners or two-earner married couples. The spouse's benefit was introduced at a time when most wives stayed home and cared for children; today married couples in which both husband and wives work make up the majority of families. Of course, to the extent that two-earner households become the norm, the spouse benefit will cease to be an important issue. In the short term, however, some view this payment as an inequitable anachronism, suggesting that it should be phased out. In order to avoid hardship for nonworking spouses, some have suggested that a non-working spouse be allowed to contribute as self employed individuals on the assumption that they earned 50 percent of the earnings of the primary earner. Such a provision also would recognize that work in the home is just as much work as work in the market place. Even if the spouse benefits were generally phased out, low-wage single earner couples would continue to need some subsidy.

Effect on Labor Supply. Social Security is thought to have little effect on labor supply for two reasons. First, economists believe that labor supply is not very sensitive to changes in after tax wages. Thus, to the extent that Social Security is viewed as a tax, the "substitution effect," by which the lower after-tax wage discourages work in favor of leisure, is roughly offset by the "income effect," whereby lower after-tax wages require individuals to work more to maintain their consumption. Second, to a large extent, individuals view their social security taxes as a form of forced saving, and therefore social security has very little even of the modest incentive effects usually associated with a tax.

One Social Security provision that did provide a strong incentive to withdraw from the labor force was the sharp decline in the present discounted value of benefits after age 65. While the benefits were fully actuarially reduced for retirement before age 65, until 1983 no provision was made for full actuarial adjustment for retirement after 65. The 1983 Amendments raised the delayed retirement credit to a full actuarial adjustment of 8 percent a year for each year benefits are postponed after age 65 and that credit will be phased in by 2008. This credit will remove a major disincentive for postponing retirement beyond 65.

CONCLUSION

Social security retirement and disability benefits now are equal to 4.8 percent of GDP. To hear critics talk, one would think that this fraction would triple or quadruple by the year 2070. According to the intermediate assumptions in the 1996 Trustees Report, Social Security outlays

will amount to only 6.8 percent of GDP in 2070. Social Security spending simply is not out of control.

Social Security is running a deficit over the 75-year projection period, but the deficit is manageable. Many options are available for restoring balance without changing the basic contours of the program. Options are also available for raising the rate of return on contributions so that future policy makers will not constantly be subject to the refrain of "I can do better on my own." The challenge is for people who care about the future of this very successful program to come together and make the required decisions.

MEDICARE

Medicare presents a much greater challenge than Social Security, both in the magnitude of projected deficits and in the complexity of the issues. Unlike Social Security, the question is not simply selecting among a list of plausible options but rather figuring out how to control long-run costs and ensure quality care in one component of a very complicated health care system.

Medicare is composed of two parts. Part A covers inpatient hospital services, skilled nursing facilities, and home health care; Part B covers primarily physician and outpatient hospital services. Part A is financed by a 2.9 percent payroll tax, shared equally by employers and employees. The projected 75-year deficit is 4.52 percent of taxable payroll--more than twice the Social Security deficit in absolute terms, and many times relative to the size of the program. As a fraction of GDP, Medicare expenditures are projected to triple, from 1.6 percent in 1996 to about 5 percent in 2070.

Medicare Part A is also facing a pressing short-term problem. If no action were taken, the Part A trust fund is projected to be exhausted by the year 2001, and the gap between taxes and benefit payments widens very rapidly thereafter. Medicare reforms proposed by this Administration would extend the life of the Medicare Part A trust fund for several years. While enacting these reform is an absolutely necessary stop-gap measure, none of the current proposals put forth by either party solves the long-run problem.

Medicare Part B is financed primarily from general revenues and enrollee premiums. General revenues and premiums each contributed about 49 percent of the funds income in 1972. By 1996, the general revenue share was 72 percent and premiums were adding 25 percent. Although spending in this fund has grown rapidly, insolvency is not an issue since general revenues are required to cover any shortfalls. Rather, the growth in Medicare Part B spending increases federal expenditures and contributes directly to the deficit.

Reforming Medicare raises two distinct but inter-related issues--who should bear the costs of health care and how health care should be provided. Since most health care expenditures for the elderly are paid by Medicare and private insurance, individuals have little incentive to seek out

the most cost-effective delivery. Moreover, under the fee-for-service system, which still dominates the Medicare market, providers have an incentive to supply costly services that may have only modest medical benefits. This misalignment of incentives is reinforced by the fact that the relative effectiveness of alternative treatments is often uncertain and consumers generally rely on providers' recommendations of different treatment options.

For the non-elderly, the tendency towards overuse of medical services is increasingly kept in check by employers. The dramatic movement towards managed care reflects efforts to ensure that health care is delivered in a cost-effective manner. Working individuals also have incentives to keep costs down, because they face out-of-pocket payments and because receiving medical services involves a substantial time commitment.

Both forces are attenuated for the elderly. Retired individuals frequently have more free time and virtually complete insurance coverage for at least some services. Similarly, since almost 90 percent of Medicare beneficiaries continue to receive care on a fee-for-service basis, their providers have less incentive to limit costs. Thus, meaningful reform will probably require altering the incentives facing both consumers and providers. In short, incentive issues are likely to be more important for Medicare than for Social Security.

Altering incentives is not a call to reduce benefits. Discussions on Medicare are often framed as if the program were excessively generous and the problem is one of cutting back. In fact, Medicare's coverage is less comprehensive than much private sector insurance. For example, Medicare does not cover prescription drugs and provides only very limited mental health benefits. Moreover, Medicare does not place an upper-bound on cost-sharing responsibilities for hospital stays, skilled nursing facility care, or physician costs. As a result, people with long and complicated illnesses and no Medigap policies can end up owing tens of thousands of dollars. Thus, the challenge is not only to control the costs of the benefits currently provided by Medicare, but also to create some room for improvement in the benefit package.

SOURCE OF FINANCING PROBLEMS

The easiest way to understand the nature of Medicare's financing problems is to compare Medicare with Social Security. Both programs provide a *defined* benefit--in one case cash, in the other a package of medical services--to roughly the same population--the aged and disabled and their families. Since 1983, Congress has not changed significantly either the population covered or the benefits provided under either program. Yet, Social Security is solvent for the next 30 years and faces a modest 75-year deficit, while Medicare's trust fund is projected to be exhausted in 2001 and deteriorate rapidly thereafter, if no action is taken.

This very different performance can be explained by two factors. First, while the cost of Social Security is precisely defined by the benefit provided, the cost of Medicare's bundle of health services depends on health care costs in the economy at large. Thus, even though the

bundle of services has remained substantially unchanged, outlays have soared since 1983 as per capita health care costs rose at twice the rate of inflation. Second, as a result of the accelerating costs, Medicare financing has been aimed at staving off short-term insolvencies, while Social Security was put in long-run actuarial balance in 1983. Thus, Social Security tax rates were set taking into account the upcoming retirement of the baby boom, while Medicare's Part A tax rates were set only to cover short-range outlays and no pre-financing occurs for Medicare Part B. The result is that the demographic shifts, which are scheduled to occur after the turn of the century when the baby boom retires, have a much more profound impact on the long-run outlook for Medicare than for Social Security.

For most of Medicare's history, the increase in per capita outlays reflected the general rise in health care costs, rather than a particular problem with Medicare. As shown in Figure 3, per enrollee Medicare and private health insurance costs have tracked each other closely over time since the late 1960s, despite considerable year-to-year fluctuations. The average annual growth rate of Medicare was actually lower than that of private health insurance between 1969 and 1993 (10.9 percent versus 12.9 percent).

Recently, per capita spending in the private sector has slowed. This is partially due to rapidly increasing enrollments in managed care plans, but the slowing is not limited to these plans. The growth of expenditures in private fee-for-service plans has also declined, as these providers have responded to the greater competition from the managed-cared segment of the market. Medicare spending has not slowed commensurately, probably because only 10 percent of the elderly have shifted to managed care. Also, the Medicare services that have grown the most rapidly typically are not covered by private sector programs and, in some cases (e.g., some types of home health care) they are not really medical services at all. This break between Medicare and private sector health care spending trends is a new development that bears watching.

Two final notes before turning to the short-run and long-run challenges facing the Medicare program. First, in addition to having a much larger financing hole than Social Security and facing much faster rising costs after the turn of the century than Social Security, Medicare presents greater challenges because more players are involved. Social Security has two main stakeholders--the taxpayers and the beneficiaries. In addition to these two, Medicare has the providers--doctors and hospitals--and, to some extent, the insurance industry. More players mean more decision makers and more sets of incentives to consider.

Second, adverse selection plays a far more important role in the Medicare program. Given any premium structure, insurers have a strong incentive to "cherry-pick" the healthiest individuals. Although government can reduce adverse selection by developing "risk-adjusters," which peg the government payment to the health status of the individual, risk-adjustment is currently and is likely to remain very imperfect. Proposals, therefore, must include provisions to limit the extent to which insurers can cherry-pick.

SHORT-TERM OPTIONS

As discussed above, Medicare's short-run problem is driven primarily by the high costs of health care. The long-run problem, which will be discussed in the next section, is driven primarily by the demographics and the increasing beneficiary-to-contributor ratio, as well as by continuing increases in medical costs. Short-run changes are required immediately to extend the solvency of the HI trust fund. These changes, which focus mainly on reimbursement rates and who should pay for Medicare, will also help to balance the federal budget. When the demographics kick in, a broader array of options--including eligibility and benefit design--will probably need to be considered.

In the short run, with the beneficiary population and the benefit relatively fixed, the four major ways to control costs or increase revenues are reducing payments to providers, expanding the prospective payment system, improving managed care, or increasing the Medicare Part B premium.

Controlling Provider Payments

Medicare's major tool for controlling short-run costs is adjusting payments to providers. Indeed, this represents the primary source of Medicare savings in the 1980s. The two important payment innovations during the 1980s were the prospective payment system for in-patient hospital care and the relative value scale for physician services. The prospective payment system substantially altered the incentives of hospitals by providing a fixed payment for an entire episode of care. Since hospitals no longer received additional revenue for additional services, they had a strong incentive to limit length of stays and unnecessary procedures. The reform in physician payments based on relative value scales tied physician payments to a schedule rather than to actual charges.

These innovations have helped control in-patient costs and physician prices, but they have not succeeded in curbing total Medicare spending because they have little effect on the volume of services and because the types of services provided change rapidly. Moreover, spending on the portions of the Medicare program not subject to reform--outpatient services, skilled nursing facilities, and home health agencies--has risen at very high rates. A possible reason for this is that many of these services, particularly home health care, differ from traditional medical services in ways that may make them more amenable to excess use and the demand for them more sensitive to price.

Most previous efforts to hold down price increases have been aimed at in-patient hospital care and physician services. Partially as a result of these efforts, these are now the slowest and the second slowest components of Medicare. Some additional savings are achievable in this area, but squeezing down on prices has limits. If prices become too low, physicians and hospitals could eventually become less willing to accept Medicare patients. Moreover, as noted above, it is hard to curb expenditures by focusing on prices alone. For example, physician payments under

Medicare have been limited since the mid 1990s, yet--until last year or so--Part B spending still increased markedly because of higher volumes and new services.

The limit on how much Medicare can save by controlling provider payments is likely to be determined, in part, by what happens in the private sector. Historically, Medicare payments have been well below the amount allowed by most private insurers. However, as employers have turned to managed care in order to constrain costs, this gap has narrowed considerably in recent years. Between 1991 and 1994, the Medicare-private insurer differential for hospitals fell from 33 percent to 22 percent. The reduction in the gap between public and private sector payments makes providing care to Medicare beneficiaries relatively more attractive than in the past. On the other hand, as profit margins in the private sector are decreased, providers may become less willing to subsidize Medicare patients. Finally, even if Medicare were able to hold down fees, total expenditures could rise if the volume of services provided increased. Specifically, if Medicare remains the primary provider of fee-for-service care, cost containment efforts in the private sector could lead providers to supply extra services to Medicare enrollees in an attempt to maintain their incomes.

Expanding Prospective Payment--Getting the Providers to Control Costs

Medicare has paid for inpatient hospital care on a prospective basis since 1984. Acute-care hospitals receive a fixed fee for most inpatient episodes, regardless of how long the patient stays or how many services are performed. The fixed payment encourages hospitals to control the costs of treatment and has been credited with reducing Medicare inpatient costs. Despite concerns that prospective payment might lead to too little treatment, hospitals do not appear to have compromised quality in their efforts to reduce costs. However, the prospective payment system may also encourage hospitals to transfer patients quickly out of the acute-care hospital and into a skilled nursing facility or long-term care hospital, which continue to be paid on a fee-for-service basis. This could end up increasing total costs.

Some have suggested combating these perverse incentives and control costs is to bundle more services together. In general, the broader the set of services included in the bundle, the stronger the incentive to reduce costs. Some analysts advocate, for example, incorporating services for care following hospitalization into the fixed amount provided under the prospective payment system. Hospitals would be paid a fee for both the hospital stay and for all medical services following a hospitalization (4 weeks for example). This might lower costs by preventing premature discharges that move patients from prospective-payment hospitals into fee-for-service facilities. In recent years, many hospitals have gained experience in managing post-care services and should be able to adapt to such an environment.

In addition to bundling, prospective payment could be extended to those areas of Medicare where the costs are increasing most rapidly. Under the Administration proposals, hospitals with average stays of more than 25 days, which are currently paid on a fee-for-service basis, would become subject to the prospective system. Skilled nursing facilities would also be

gradually moved to prospective payment. Similarly, a prospective payment system would be established for home health services, one of the fastest growing areas of Medicare expenditures. Finally, a prospective payment system for hospital outpatient services is proposed, with implementation beginning in 2002.

Improving Medicare Managed Care

The dominant form of Medicare managed care is Health Maintenance Organizations (HMOs), which receive a fixed payment for each beneficiary they cover. The payment is 95 percent of per capita fee-for-service Medicare spending in the same county, adjusted for a limited number of risk factors. However, only about 10 percent of Medicare beneficiaries are enrolled in managed care plans, compared to 69 percent of workers in large companies. Moreover, evidence suggests that those Medicare beneficiaries who do switch to managed care probably cost, rather than save, the program money. This is partly due to flaws in the reimbursement formula, which exacerbate the problem of adverse selection, and partly due to the inherent difficulty of preventing adverse selection.

HMOs tend to enroll relatively healthy people with low risk of requiring expensive care (see Figure 4). The per capita reimbursement paid to HMOs for Medicare patients should reflect the lower costs associated with serving this relatively healthy population. To the extent it does not, Medicare payments may be higher than if the patients were in fee-for-service plans. Previous health history is a good indicator of future health expenditures and one study indicates that the medical expenses of seniors shifting into HMOs were 25 to 30 percent lower than those of the average Medicare enrollee in the year or so immediately prior to their enrollment in the plan. Another analysis estimates that the introduction of managed care has increased Medicare costs by 7 percent per HMO beneficiary.

The selection problem is exacerbated by three additional factors. First, if healthier individuals migrate into managed care, the resulting higher average costs in the fee-for-service sector will drive up the HMO per capita payment. Second, HMOs have an incentive to offer coverage in counties with high reimbursement rates and to avoid counties in which the per capita payment is low. The current reimbursement formula results in payments that are almost four times larger in some counties than in others. By contrast, local input prices (labor and supply costs) vary by only a factor of two. Finally, individuals are allowed to switch between plan types as often as monthly. Hence, they may have an incentive to move out of managed care if their health deteriorates. However, evidence on the significance of this factor is weak. Only 12 percent of those newly enrolled in HMOs in 1990 switched back within a year and the percentage of switches has been falling over time.

HMOs have limited incentives to cut costs, since it is difficult for them to earn higher profit margins on their Medicare enrollees than for their private sector enrollees. In cases where the allowed per capita payment would generate too high a rate of profit, HMOs have the option of covering some or all of enrollees' Medicare Part B premiums or providing coverage not

normally included in Medicare (like prescription drugs). But unless HMOs are allowed to keep some of the profit resulting from increased efficiency, they have little incentive to develop more cost-effective methods of providing care.

To address selection bias effects, the Administration has proposed reducing the size of local variations in per capita payments and testing new risk-adjustment methodologies, which are aimed at linking reimbursements more closely to predicted expenses. The use of more uniform payment rates should decrease the tendency of HMOs to locate mainly in high-cost areas. But the likelihood of identifying risk-adjustment mechanisms accurate enough to eliminate the remaining selection bias is poor. The best currently available risk-adjustment mechanisms account for about one-eighth of the individual variation in annual health care spending.

To provide better incentives for cost-reduction, the Administration has proposed some experimentation with competitive price setting and with the creation of partial payments, whereby plans would be paid on an fee-for-service basis but would also share in any cost savings achieved below some limit. The Administration has also proposed to increase the types of managed care plans available to Medicare beneficiaries, including preferred provider organizations, point-of-service plans, and provider service organizations, all of which are increasingly popular in the private sector. The goal in offering these new plans is both to expand the choices available to beneficiaries and to encourage plans to compete on the basis of quality of care rather than risk selection.

Increase Part B Premiums

When Medicare was enacted, Medicare enrollees were required to pay a premium equal to 50 percent of the costs of Part B. The costs of physician services costs rose so quickly, however, that 1972 legislation limited premium increases to inflation. As Medicare costs soared, the premium dropped rapidly to 25 percent. At 25 percent of Part B, the premium represents about 10 percent of total Medicare costs. This is lower than typical private sector premium, but most Medicare beneficiaries also pay a premium for their supplemental "Medigap" policies. These premiums plus co-payments and deductibles bring total out-of-pocket expenses to 20 percent of family income for the elderly, compared to 8 percent for the non-elderly.

Proposals to increase Part B premiums have included both across-the-board increases and income-related options. Because an across-the-board increase would hurt low-income beneficiaries, most proposals have been in the range of maintaining the contribution at 25 percent at Part B costs or increasing it to 30 percent. In the context of broad-based health reform, this Administration proposed an income-related premium which would have added a new 75 percent premium for single persons with incomes over \$105,000 and for couples with incomes over \$130,000. This higher premium would reduce (but not eliminate) the subsidy currently provided by working individuals of relatively modest means to those wealthy elderly who are most able to afford the increased expense. At the same time, it would protect senior citizens who are less well and for whom the higher premiums would be more burdensome.

Shift in the Financing of Home Health Care

Home health care is currently financed under Medicare Part A. The rapidly increasing expenditures for these services are therefore contributing to the deteriorating financial condition of the HI trust fund. The Administration proposes to continue reimbursing the first 100 visits following a hospital stay of three days or more under Part A, but shift the payment for all other home health care services to Part B. This change is consistent with the original allocation of financing responsibility for home health care between Parts A and B. It is also logical, given that Part A is dedicated to hospital-related services, while Part B covers expenditures for ambulatory care. While this shift will not reduce total Medicare spending or address its structural problems, it will extend the life of the Hospital Insurance trust fund.

Global Budget Caps and Medical Savings Accounts

Two options included in some Congressional Medicare proposals are global budget caps and medical savings accounts (MSAs). The proposed budget cap would have limited total Medicare spending per enrollee at a congressionally mandated amount. Separate spending targets would also have been established for HMO and fee-for-service Medicare expenditures. Projected spending would then be calculated by using estimated service volumes and allowable prices. If the total spending estimate exceeded the sector target, prices for all services in the sector would be reduced proportionately to achieve the target level of spending.

Medical savings accounts consist of a high-deductible insurance policy and a special tax-advantaged savings account. Under this plan, Medicare would pay the premium for the high deductible insurance policy and would deposit any remaining funds into the beneficiary's savings account. Withdrawals from the savings account could be made for qualified medical expenses on a tax-free basis or for other types of consumption as taxable income. Since individuals covered by MSAs would be responsible for all medical expenses, up to the deductible, MSA proponents say they would have incentives to avoid high-cost or low-benefit care.

Global targets and medical savings accounts have some attraction but both also have potentially serious problems. In particular, unless risk adjustment methodologies become much more sophisticated than they are presently, selection bias could create grave difficulties. If relatively healthy persons disproportionately enroll in managed care plans, and the risk adjustment methods do not fully capture the differences in expected costs, per capita fee-for-service spending will rise relative to that in the managed care sector. As a result, the fee-for-service budget cap will require relatively large reductions in prices, which will encourage more beneficiaries to enroll in managed care. As the process continues, only the sickest individuals will remain in the traditional Medicare program and the allotted prices will be far too low to address their medical needs. The end result may be to limit choice effectively for most individuals and, if prices are too low, to produce queuing for some types of medical care as some providers become less willing to provide services to Medicare enrollees.

MSAs have a similar problem. Relatively healthy individuals may have a strong incentive to opt for the MSA, since the payment into their savings account will exceed their expected medical costs. However, if these individuals become sick, they may want to switch back into the traditional fee-for-service program. Thus, Medicare would be likely to pay higher costs for the healthy individuals who accept the MSA option than it would if they stayed in fee-for-service, but the program will still have to pay the high expenses of sick individuals. As a result, the Congressional Budget Office projected that expenditures would increase by \$5 billion over 7 years if MSAs were offered as part of the Medicare program.

LONG-RUN OPTIONS

Incremental changes in Medicare, such as those discussed above, can provide substantial budget savings in the short term, supply incentives for more efficient delivery of health care, and extend the life of the HI Trust Fund. Nonetheless, the combination of continued cost pressures and demographic developments in the long run is likely to require a more significant restructuring.

The remainder of this section briefly reviews some of the approaches that have been proposed by those outside this Administration to improve the long-term financing of Medicare. None of them is a "magic bullet," and all of them raise issues that will need to be examined and resolved through a bi-partisan process. Claims of spectacular benefit from any single approach should be viewed with skepticism. Most of the changes are complementary and some combination of them likely will be needed to solve the long-run problem.

Increase the Age of Eligibility

Some have suggested raising the age of first eligibility for Medicare in order to reduce the number of beneficiaries and cut expenses. Retirees are now eligible for Medicare benefits at 65; some have suggested that this age could be extended to 67 to reflect the scheduled increase in Social Security's normal retirement age. The issue here, however, is even more troublesome than in the case of Social Security. Some people who retire early do so because they have good pensions and opt for leisure; others, however, have low incomes, poor job prospects, and/or poor health. Denying cash benefits or health care to the first group causes few problems because they have the option to keep working; denying benefits to the latter group could produce considerable hardship.

The usual problems are compounded in the case of health insurance, because some elderly people may not have access to any protection. As a result, the number of uninsured would probably increase and at least some of those losing coverage would be likely to have high medical costs. Thus, to make an increase in the minimum age for Medicare eligibility workable, persons retiring before the age of 67 would have to be guaranteed some way of getting health insurance. One possibility would be to extend the existing continuation-of-coverage provisions, whereby individuals who leave jobs are able to purchase group health insurance through their previous employer for a limited period of time. This would allow persons retiring at age 62 or later to

maintain continuous coverage until they become eligible for Medicare. Since individuals using this option would pay the full premium plus a small administrative charge, this method of providing coverage would have little impact on employer health insurance costs.

Alternatively, Social Security beneficiaries between the ages of 62 and 67 could be provided the ability to buy Medicare coverage at unsubsidized rates. This would improve access to insurance since currently Social Security beneficiaries under age 65 are not entitled to Medicare benefits. Some provision would have to be made, however, to reduce the burden on low-income individuals. Another possibility is easing for older individuals the criteria for Disability Insurance and decreasing the period that Disability Insurance beneficiaries must wait before coming eligible for Medicare. This would limit the burden on those individuals unable to continue working through because of poor health.

Increased Cost-Sharing

The Medicare deductible for physician services is \$100, which is relatively low by historical and private sector standards. The deductible for inpatient hospital care is \$736, which is relatively high, especially when combined with substantial co-payments for lengthy hospital stays. Home health care has no deductibles or copayments of any kind. That means that Medicare has very high cost sharing on those services where inappropriate use is unlikely--namely, inpatient hospital services--and very low cost sharing where individuals have a lot of discretion--namely, physician visits and home health care. Since the goal of cost sharing is to give individuals the incentive to use services carefully, the current premium structure cries out for restructuring.

The difficulty is that Medicare does not operate in isolation. Approximately three-quarters of seniors have some type of Medigap coverage either provided by their employer or purchased directly. Medigap insurance pays for some or all of the cost-sharing requirements of Medicare and often covers services not included in Medicare, such as prescription drugs or preventive care. In addition, around 12 percent of enrollees with low incomes have secondary coverage through Medicaid. Medicaid covers all of their Medicare copayments and deductibles, as well as the entire premium. Those with slightly higher incomes can also have their Part B premiums paid through Medicaid but are responsible for the other types of cost-sharing.

Since so many beneficiaries have secondary sources of insurance, changes in cost sharing arrangements are likely to save little money unless accompanied by changes in the structure of the supplemental coverage.

Secondary Insurance Reform

Because Medigap policies and Medicaid provide first dollar coverage for most services, they shield individuals from the incentive effects of cost sharing. When individual are not

responsible for any of the costs, they tend to use more health care and incur higher expenses. Thus, Medigap policies and Medicaid coverage raise Medicare costs.

Several methods have been suggested to avoid the problems associated with current Medigap policies. One possibility would be to require any Medigap policy to cover Medicare's basic package as well as any supplemental coverage. The insurance company would receive a payment from Medicare equal to the expected costs of the basic package and would bear any additional cost caused by incentives for overuse. This approach is quite similar to that currently used in Medicare's managed care plans, which frequently combine Part A and Part B coverage with additional insurance, and is fully consistent with efforts to increase the use of managed care arrangements.

Alternatively, some have argued that Medigap policies could continue to be used as a supplement to Medicare but with a payment assessed to compensate for the overuse caused by first-dollar coverage, or with restrictions to prevent the policies from covering the initial copayments or deductibles.

Others have suggested that Medicare require at least some cost-sharing for Medicare beneficiaries who also receive Medicaid. They argue that even modest deductibles are associated with significant reductions in health expenditures for individuals with average incomes. Deductibles and copayments Medicaid beneficiaries could be set at levels considerably below those faced by other Medicare enrollees. Even low levels of cost-sharing may be sufficient to induce more careful use of services among those with limited incomes.

Switch From a Defined Benefit to a Defined Contribution Plan

Medicare currently offers a defined package of services to all enrollees. This places the government at significant risk for any rise in the cost of these services, whether it is related to changes in technology, prices, or volumes. Some have suggested that the government could limit future expenses by guaranteeing a specified contribution towards health insurance expenses for the elderly, and leave the choice of the specific insurance plan to the individual.

The key to the viability of such a proposal depends crucially on how the fixed amount was determined. If the amount were set in a base year and then simply indexed thereafter, it could quickly become inadequate. Such a system might put the elderly seriously at risk.

On the other hand, if the amount were determined in reference to the cost of providing a given bundle of health care services, it might spur competition and save money. For example, suppose insurance providers in a given geographical market were asked to bid on the cost of insuring a minimum package of services. The average of those bids could then be used to set the dollar payment to each Medicare beneficiary in that market. Beneficiaries who wanted lower deductibles or co-payments or more doctor or hospital options could use their own money to buy

more expensive policies. Beneficiaries who wanted to save money could join cheaper plans and receive the difference between the amount of the fixed payment and their premium contribution.

Proponents argue that moving to such a defined contribution system would have several advantages. First, the government would be better able to determine the Medicare expenditures based on the level of the payment. Second, beneficiaries would be able to choose from a wide variety of types of health insurance. In principle, they could select insurance coverage that closely matched their preferences with regard to the type of health care delivery and services insured. Third, individuals would have strong incentives to use health care efficiently, since they would bear the full costs of any copayments and premiums, above the amount set by the government.

Despite these advantages, switching to a defined contribution system has some potentially serious problems, the most serious of which is selection bias. Unless sophisticated risk-adjustment methods could be used to vary the government payment rate with the level of expected medical expenses, market forces would put those in poor health at particular risk. Healthy individuals would have incentives to take policies with low premiums and limited coverage, which would drive up costs in the more comprehensive plans favored by less healthy persons. Better risk adjustment mechanisms are going to have to be a part of any comprehensive solution for Medicare. But potential solutions should be constructed with an understanding that the degree of potential risk adjustment may be inherently limited.

CONCLUSION

The conclusion that emerges from this brief overview of Medicare is that, while short-term savings are achievable, long-run viability will require a bipartisan process and innovative reforms. At this point, however, we really do not know what will work and what will not. Robert Solow, a Noble Prize winning economist, once said, "When you don't know what you're doing, do it slowly." That is good advice with respect to Medicare. The most constructive approach would be to establish a number of experiments that explore different approaches to reigning in costs and ensuring protection. The Administration's proposals to extend the life of the HI Trust Fund and to control Part B spending should buy enough time to evaluate carefully a range of alternatives. With some evidence under our belt, we will be able to proceed with more confidence.

MEDICAID

Medicaid began as a program for the destitute and continues to finance much of the medical care of low-income people. Medicaid also pays for nursing home care for persons who have low incomes and few assets. Since nursing home residents are typically quite old, the program provides significant financial support to the sick elderly. In 1995, roughly one-third of total Medicaid expenditures went to those aged 65 and over (with the remaining two-thirds split about equally between people with disabilities and the nonelderly, nondisabled poor).

Medicaid expenditures have been growing very rapidly over time. As with Medicare increases in overall program costs have resulted from a rise in the number of beneficiaries combined with higher costs per enrollee. The nursing home component of Medicaid has risen even faster than other program expenses over the last 25 years, with relatively more of the increase due to a rise in enrollments and relatively less due to increases in costs per beneficiary.

The continued aging of the population is bound to lead to a significant increase in the number of people needing long-term care assistance, particularly as the baby boom passes through retirement and into old age. Not only will the number of old people increase, but so will the average age of those over 65. People over 85 made up about 11 percent of the elderly population in 1995; according to the Social Security Administration's projections, by 2050, they will make up over 16 percent. Older people are much more likely to be in a nursing home: in 1993, 31 percent of those 85 and older spent time in a nursing home, compared to just 7 percent of the general population over 65. If this rate of nursing home utilization is maintained, population aging will bring significant increases in the nursing home population and in expenditures on long-term care.

One way to hold down future Medicaid outlays is to shift the financing of nursing home care to some form of insurance. Insurance is particularly desirable for events that are rare but expensive. The need for long-term nursing home care is such an event. A majority of persons reaching age 65 can expect never to receive care in a nursing home. Of the rest, most are likely to stay a relatively short time. Just 24 percent of those reaching age 65 can expect to spend more than a year in a nursing home and only 9 percent will spend more than 5 years (see Figure 5). With the cost of skilled nursing home care averaging \$36,000 per year and rising over time, a lengthy stay can be extremely expensive.

Despite the relatively rare and expensive nature of nursing home stays, the market for private nursing home insurance is underdeveloped. Just 3 percent of nursing home expenditures were paid by private insurance in 1994. Several factors are likely to account for the limited importance of private long-term care policies.

First, Medicaid pays the expenses of persons who have no financial assets or who spend down their assets after entering a nursing home. To the extent that people think government will pick up the tab, they have less incentive either to engage in precautionary saving or to purchase insurance for long-term care.

Second, premiums for private insurance are relatively high. One reason is that the vast majority of long-term care policies are individual rather than group policies, and individual policies have higher administrative costs. Another is that those purchasing long-term care insurance, especially when they are older, may be less healthy than others their age, and this will be reflected in premiums. Finally, premiums will be higher to the extent that people with insurance use nursing home care in situations when it is not appropriate.

Third, many disabled elderly persons are currently cared for by family members. Elderly persons who consider nursing homes less desirable than living with family might not be interested in purchasing insurance that reduces out-of-pocket nursing home expenses if this makes their families less willing to care for them (as evidence suggests).

A limited private insurance market means most people reaching age 65 remain vulnerable to catastrophic nursing home costs that could substantially erode their assets. It also means Medicaid outlays are larger than they would be if the private insurance market were more extensive. Medicaid outlays are also higher to the extent that seniors needing long-term care have an incentive to find ways to transfer assets to family members rather than spend them down before becoming eligible for the program.

If the government wanted more people to purchase long-term care insurance, it could require universal coverage, either directly through Medicare or indirectly through the purchase of private insurance (ideally at a young age and possibly through their employers). Alternatively, government could create greater incentives for people to buy insurance within the current voluntary system. To some degree, the recently enacted Kennedy-Kassebaum legislation does so by offering the same tax advantages for some long-term care insurance expenses as were previously provided to other medical costs or health insurance premiums. A second possibility would be to increase the ability of individuals to partially exempt their assets from the "spend-down" requirements of Medicaid if they purchased sufficient amounts of long-term care insurance.

Public financing of nursing home care for individuals with a lifetime of low incomes provides a good example of a program that the private sector is unable or unwilling to supply. However, the safety net for poor persons may also reduce the incentives for those who are better off to save for nursing home expenses. Unless people can be encouraged to put aside more money for this purpose, the aging of the baby boom is likely to put an increasing burden on the Medicaid system--and thus on the finances of the Federal Government and the states. And to the extent that more Medicaid funds are needed to support the elderly, less will be available to provide health care for poor children and the disabled.

CONCLUSION

Each of the government programs for the elderly represent different policy challenges. The costs of providing future Social Security benefits is going to increase markedly as the population ages. Although this has been taken into account to a large extent through 75-year budgeting, the system needs additional revenue or benefit changes to restore long-run balance. The options are fairly well understood, we just need to decide what to do.

The problems facing Medicare and Medicaid are more severe and the solutions to them more elusive. The HI trust fund will be exhausted by 2001, and the program faces enormous and growing deficits thereafter. No provisions have been made for Part B spending increases,

nor for future Medicaid outlays. The problems in the health programs are big, complicated, and difficult to solve. Experimentation is needed so that we can find innovative ways to provide quality health care and nursing facilities to an increasing number of elderly Americans.

On a conceptual basis, we already know many of the key components of any solution. We must improve the incentives for individuals to receive and providers to supply quality care in a cost-effective manner. Improved risk-adjusters are needed to mitigate the effects of adverse selection. And, where possible, market mechanisms should be relied upon to determine the size and form of the third-party reimbursements.

In combination, the various government programs supporting our elderly represent different ways in which each generation of taxpayers offer assistance to their parents. These intergenerational transfers affect the resources available for other worthwhile purposes. Historically, Federal revenues have averaged around 18 to 20 percent of GDP. In 1970, Social Security and Medicare accounted for 4 percent of GDP; in 1995 they stood at 7 percent; they are projected to grow to 14 percent of GDP in 2030. Without substantial increases in taxes, these programs, as currently structured, will crowd out virtually all other forms of government spending.

Examining how society distributes its resources between for the aged and the rest of the population provides one lens by which to view the programs discussed in this chapter. Economics cannot answer how the allocation should be made, but it does offer the fundamental lesson that society faces choices. The choices are often difficult because the tradeoffs are between two or more worthy objectives. Economics can help illuminate the nature of the choices and provide theoretical arguments and empirical evidence about the impacts of alternative policies. Having this information, we must then make hard decisions with full awareness of the difficult tradeoffs that they imply. The choices that are made say a great deal about the kind of society we are and the kind of society we aspire to become.

BOX 1--How Much Equity Would the Social Security Trust Fund Hold?

One important issue in evaluating the purchase of equities by the Social Security trust fund is the total share of the equity market that the fund would end up controlling. To estimate this share, one must make two calculations. First, what happens to the Social Security Trust Fund under the "Maintain Benefits" proposal between now and 2070, and, second, what happens to the capitalization of U.S. equity market over the same interval.

Projections of the Maintain Benefits plan under the Social Security Administration's intermediate cost assumptions show the trust fund rising to 4.4 year's annual outgo by the end of the projection in 2070. As a percent of GDP, the trust fund is projected to be about 29 percent. Since 40 percent of the fund would be invested in equities, equity holdings would be about 11.5 percent of GDP.

The second issue is what total stock market capitalization will be as a share of GDP in 2075. The total value of the firms listed on the New York Stock Exchange, the American Stock Exchange, and NASDAQ is currently over 100 percent of GDP. But this ratio is an all time high: it was only about half as large in the mid-1980s, and was as low as 40 percent in the mid-1970s. Over the period from 1953 to 1995, the average ratio was 68 percent. Since the future level of this ratio is uncertain, three values are considered. First, if the ratio remains about as it is today, then the Social Security Trust Fund will hold less than 11 percent of market capitalization in 2070. If, however, market capitalization falls back to its average level since 1953, the trust fund's share would be about 17 percent of the market. Finally, if market capitalization rises further, the trust fund's share would be lower. For example, if market capitalization rose to 150 percent of GDP, then the trust fund would own less than 8 percent of the market.

While the current level of market capitalization is very high by historical standards, an even higher level of capitalization in the future cannot be ruled out. Such growth might occur if Social Security purchases of equities drove stock prices higher, inducing firms to shift financing from bonds to stocks. In addition, the estimated total value of all corporate equity is about one-sixth larger than total market capitalization, reflecting the existence of unlisted corporations. Thus, if financial market improvements lead some closely held corporations to go public, they could substantially raise market capitalization. Finally, one would expect some capital deepening over time as the economy grows.

These simple projections of the trust fund's share of the market do not take account of the possible link between growth in market capitalization and growth in the trust fund. If market capitalization rises rapidly, this rise will likely reflect, in part, in higher stock market returns. These higher returns would boost the size of the fund relative to the baseline projection of 4.4 times GDP, offsetting to some degree the effect of the higher market capitalization on the ratio. On the other hand, if market capitalization declines, this may mean that stock market returns turn out low, cutting the size of the trust fund and reducing the share of equity it holds. Taking account of these effects would reduce the range of the estimates of the trust fund share of equity markets in 2070.

BOX 2--The Implications of Uncertain Asset Returns for Social Security Projections

All three options in the report of the Quadrennial Advisory Council on Social Security involve equity holding, either by the Social Security Trust Fund or in individual accounts. The financial implications of the options are based primarily on the assumption that the returns on equities and Treasury securities do not fluctuate from year to year. In fact, equity investments regularly post large annual gains and losses.

The implications of fluctuations in returns can be addressed by calculating a large number of projections each of which allows the returns on investments to fluctuate randomly in a realistic way. These projections can then be interpreted by looking at the distribution of the outcomes. We undertook such an analysis based on the future levels of income and outgo under current law, as calculated by the Social Security Administration and simple statistical models of asset returns estimated using data on actual returns since 1950. In each case, 100 projections were calculated.

The average outcome of the projections depends a great deal on the share of the trust fund invested in equities. If all of the trust fund is assumed to be invested in Treasury securities, then the average year the trust fund is exhausted is 2030--about the same as in the non-stochastic projection in the 1996 Trustee's report. The variation in the year of exhaustion across projections is fairly minor, with the standard deviation equal to just 4 years. All of the projections show the fund being exhausted between 2023 and 2041. If, however, the share of the trust fund invested in equities is increased smoothly to 40 percent between 2001 and 2015 (as in the "Maintain Benefits" proposal in the Advisory Council report), then in a few of the projections the system is still solvent in 2075. In those cases where the system fails, the average year in which the fund is exhausted is 2039, about 9 years later than in the case where the fund is invested only in bonds. Although the variance of the exhaustion date is higher when the fund includes equities, the earliest exhaustion date is 2025, two years later than in the projections with no equity investment. Finally, if 100 percent of the trust fund is shifted to equities between 2001 and 2015, then in about three-quarters of the projections the system is solvent in 2075. The one quarter of the projections that end in failure prior to 2075 have an average year of trust fund exhaustion of 2040, with a standard deviation of 10 years. The earliest date of trust fund exhaustion in this case is 2026, three years later than the earliest failure when the trust fund is invested only in bonds.

These are very simple projections, and some of the results might change if different methods were employed. In particular, the results depend importantly on the assumed statistical model for asset returns. The future validity of the model is difficult to assess, especially because the Social Security fund have not invested in equities in the past. Nonetheless, these results suggest that the increased risk associated with investing trust fund assets in equities may be more than compensated for by the higher returns that equities are likely to earn.

Table 1
Projections of the Deficit and Debt Held by the Public
(as a percentage of GDP)

	Preliminary 1995	2000	2005	2010	2015	2020	2025	2030	2050
Discretionary Spending Grows with Inflation After 2006									
Without Economic Feedbacks									
NIPA deficit	2	3	3	4	6	8	10	12	19
Debt held by the public	51	53	57	64	77	97	124	157	311
With Economic Feedbacks									
NIPA deficit	2	3	3	4	6	9	15	26	n.c.
Debt held by the public	51	53	57	63	78	104	148	229	n.c.
Discretionary Spending Grows with the Economy After 2006									
Without Economic Feedbacks									
NIPA deficit	2	3	3	5	7	9	12	15	24
Debt held by the public	51	53	57	65	81	106	139	180	373
With Economic Feedbacks									
NIPA deficit	2	3	3	5	7	11	19	37	n.c.
Debt held by the public	51	53	57	65	83	116	174	293	n.c.

Source: Congressional Budget Office

Notes: Projections without economic feedbacks assume that deficits do not affect either interest rates or economic growth. Projections with feedbacks allow deficits to push up interest rates and lower the rate of economic growth.

Table 2
Impact on 75-Year Trust Fund Balance, 1983 to 1996
(Percent of Taxable Payrolls)

Balance in 1983	0.02
Changes in:	
Assumptions	
Economic	-0.83
Demographic	0.80
Disability Projections	-0.73
Valuation Period	-0.63
Methodological Changes	-0.79
Legislation	0.13
Other	<u>-0.16</u>
Balance in 1996	-2.19

Figure 1
Fertility Rates in the United States

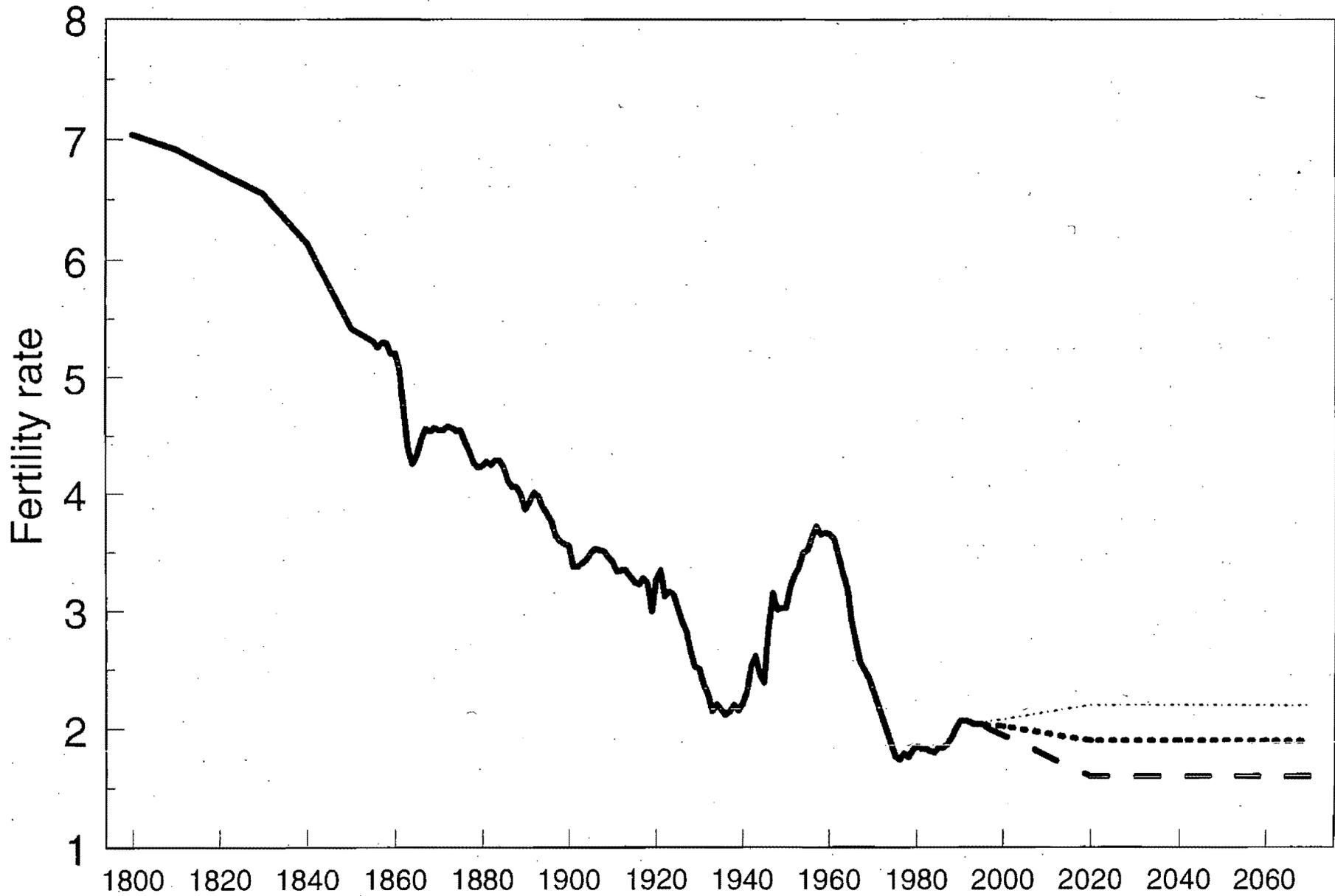


Figure 2

Life Expectancy at Age 65

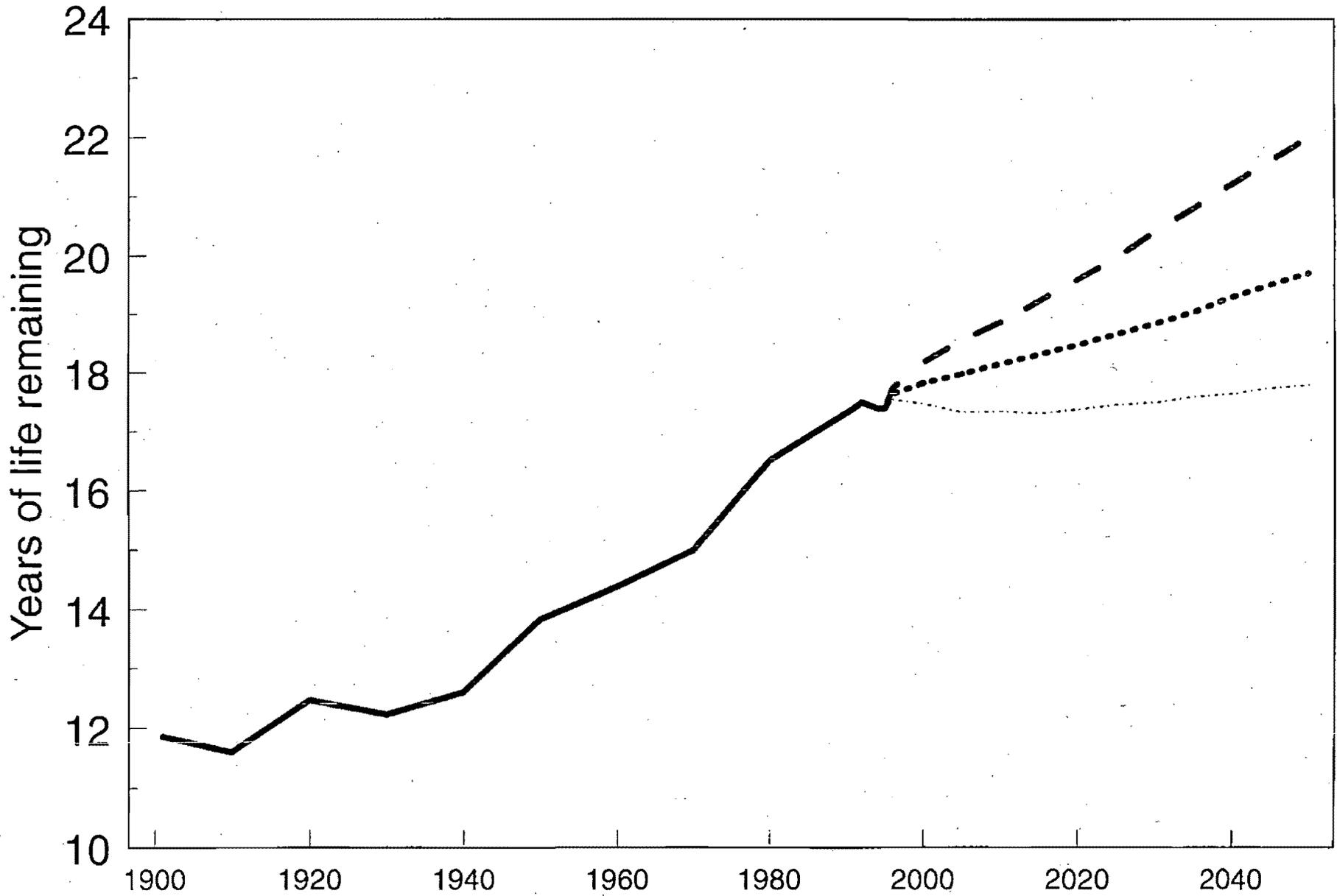


Figure 3

Growth in Per-Enrollee Health Insurance Cost

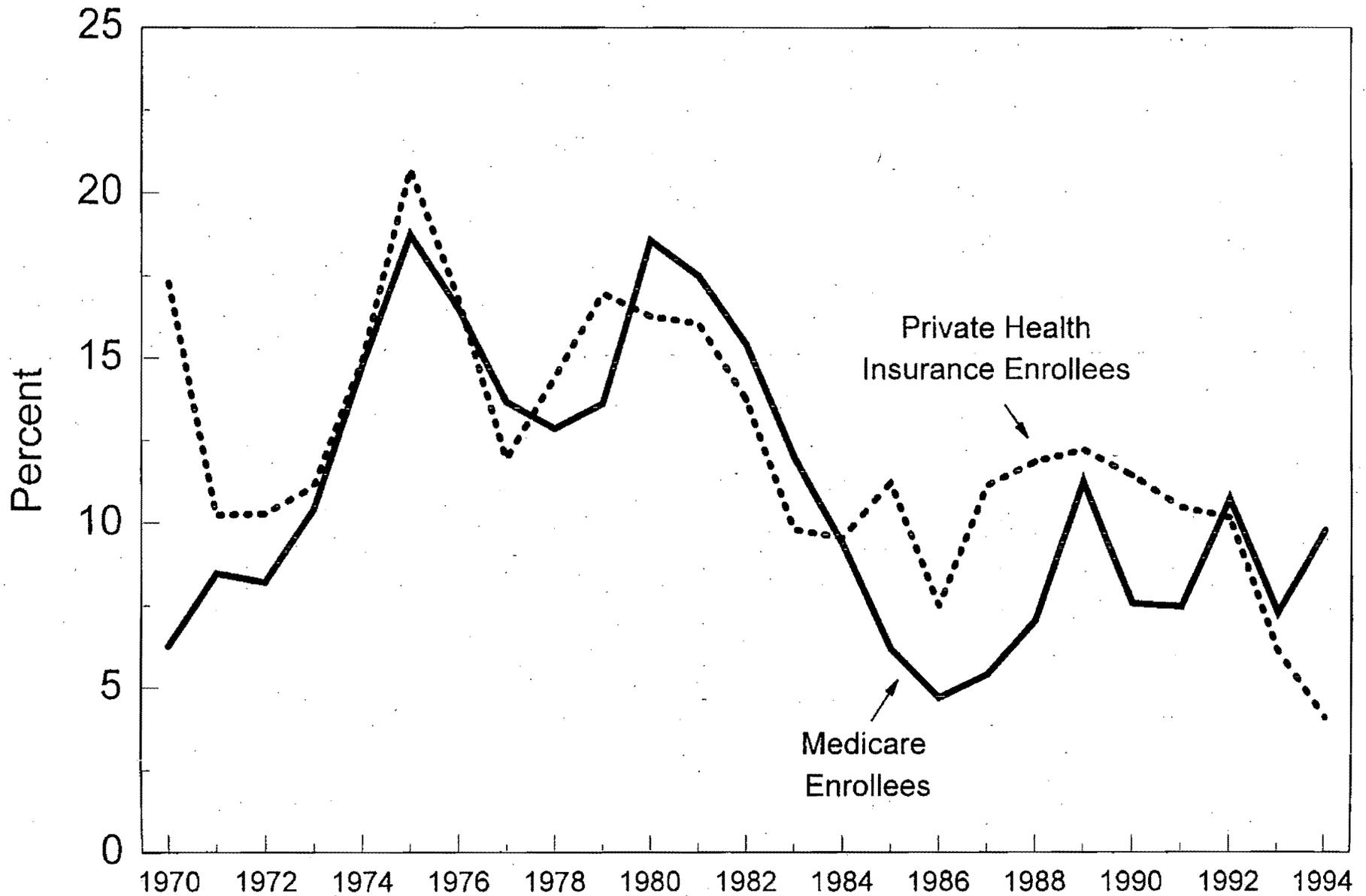


Figure 4

Self-Described Health Status (Medicare Enrollees)

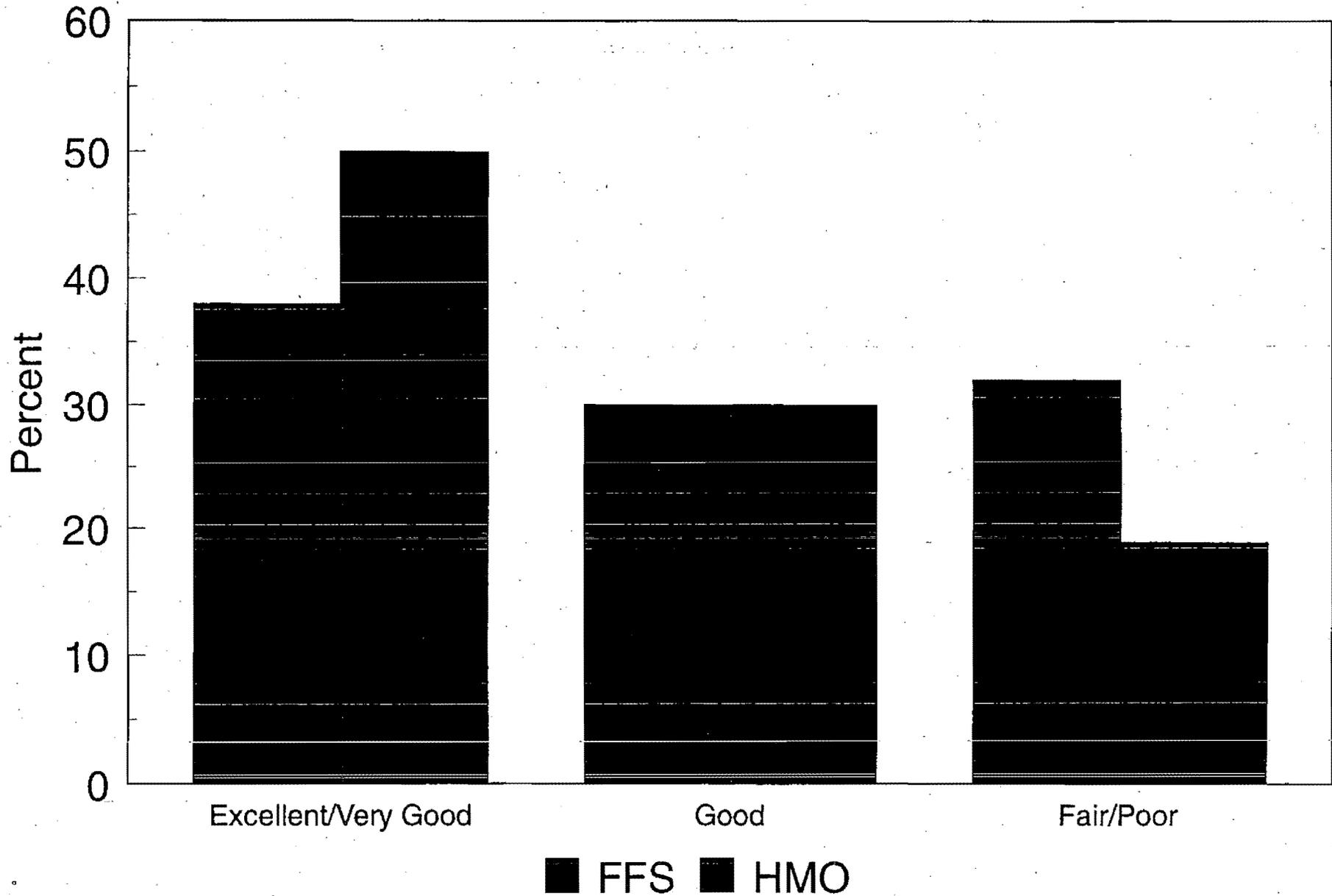
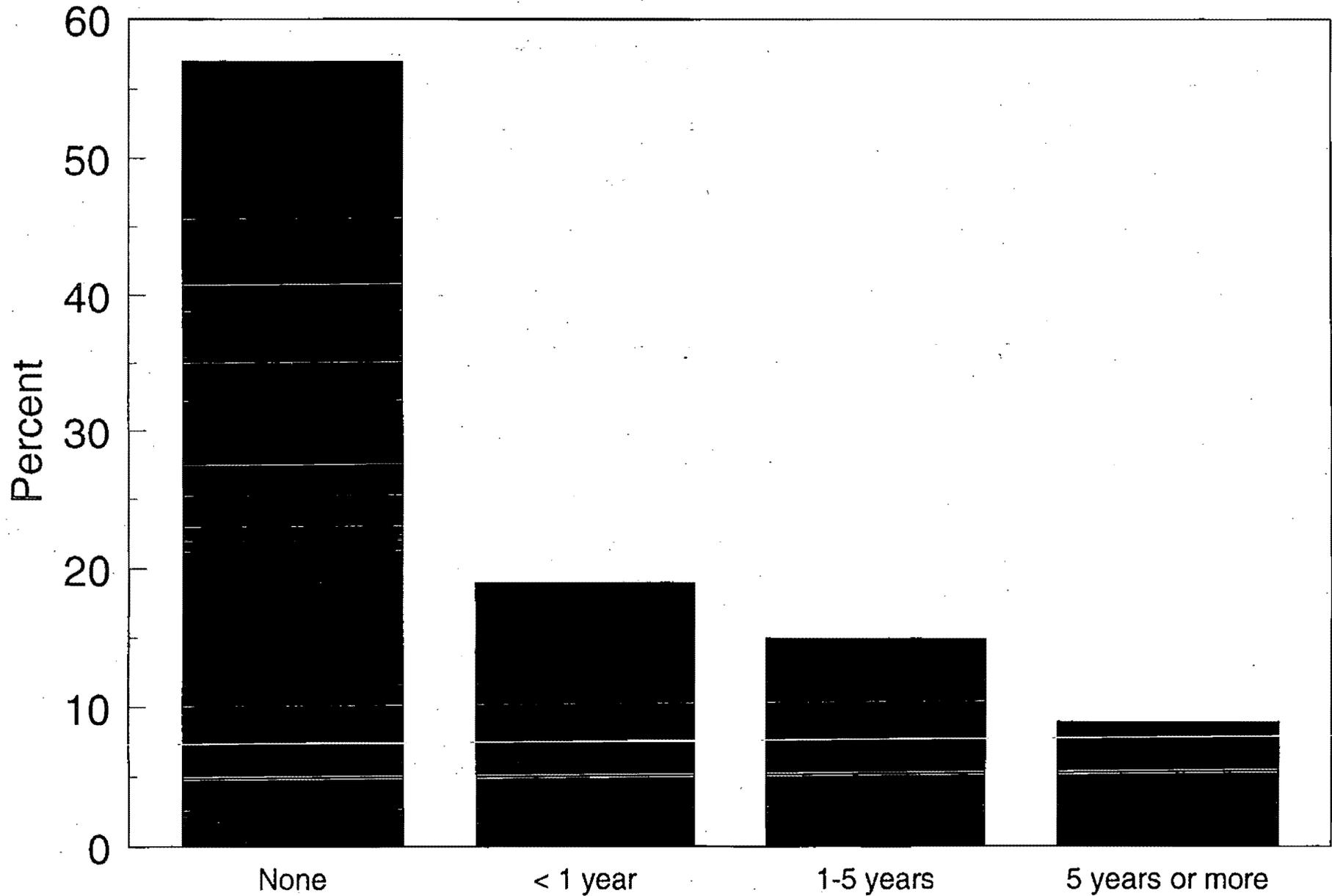


Figure 5

Projected Nursing Home use of 65 Year-Olds





DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.
January 30, 1997

GOOD MEMO

ASSISTANT SECRETARY

**MEMORANDUM FOR SECRETARY RUBIN
DEPUTY SECRETARY SUMMERS**

INFORMATION

FROM: Joshua Gotbaum *JG*
SUBJECT: Medicare and the FY98 Budget

This memo begins by providing basic summary statistical information of changes in the Medicare budget and a table of aggregate program savings by category. Next a short discussion of the impact on beneficiaries is presented followed by a brief exposition of the savings achieved from changes in the provider section of the program.

Overall Medicare Savings And The Part A Trust Fund

Medicare savings amount to approximately \$100 billion over 5 years; \$138 billion over 6 years. The HCFA Chief Actuary has certified our proposals will extend the life of the HI Trust Fund until early in calendar year 2007.

Medicare And The FY98 Budget (Approximate Five Year Totals)

Program Categories	\$Billions
Hospitals	33
Managed Care	34
Home Care	15
Physicians	7
Skilled Nursing Facilities	7
Fraud and Abuse	9
Subtotal Provider Savings	105
Beneficiaries	10
Total	115
Medicare Investments	-15
Net Total 5 Year Savings	100

Impact on Beneficiaries

Current law would be extended so that Part B premium would remain at 25% of program costs. This policy achieves \$10 billion in savings over five years. Note that the Part B premium would fall below 25 percent after 1998 without this change and that the home health transfer is netted out from this calculation.

The Administration's Medicare program would also invest in preventive health care to improve seniors' health status and reduce the incidence and costs of disease by covering colorectal screening, diabetics management, and annual mammograms without copayments. The program also increases reimbursement rates for certain immunizations which would help protect seniors from pneumonia, influenza, and hepatitis.

Prepared by Glen Rosselli

EXECUTIVE SECRETARIAT

Also, a new Alzheimer's respite benefit would be established starting in 1998 to assist families of Medicare beneficiaries with Alzheimer's diseases.

Medigap protections such as new open enrollment requirements and prohibitions against the use of pre-existing condition exclusions would be put in place. This should increase the security of Medicare beneficiaries who wish to opt for managed care but fear they will be unable to access Medigap protections if they decide to return to the fee-for-service plan. This provision is consistent with bipartisan legislation pending before Congress.

Impact on Providers

Hospitals Through a series of traditional savings (reductions in hospital updates, capital payments, etc.), achieves about \$33 billion in savings over 5 years.

Establishes new provider service networks (PSNs), which will allow hospitals (and other providers) to establish their own health care plans to compete with current Medicare HMOs.

Establishes a new pool of funding, about \$11 billion over 5 years for direct payment to academic health centers by carrying out medical education and disproportionate share (DSH) payments from the current Medicare HMO reimbursement formula to ensure that academic health centers are compensated for teaching costs.

Managed care Through a series of policy changes, the plan will address the flaws in Medicare which will reduce reimbursement to managed care plans by approximately \$34 billion over 5 years.

Savings will come from three sources:

(1) The elimination of the medical education and DSH payments from the HMO reimbursement formula (these funds will be paid directly to academic health centers).

(2) A phased-in reduction in HMO payment rates from the current 95% of fee-for-service payments to 90%. A number of recent studies have validated earlier evidence that Medicare significantly overcompensated HMOs. The reduction does not start until 2000 and it accounts for a relatively modest \$6 billion in savings over 5 years; and

(3) Indirect savings attributable to cuts in the traditional fee-for-service side of the program -- to the extent that HMO payments are based on a percentage of fee-for service payments, HMO payments are reduced as the traditional side of the program is cut.

Home Care Saves about \$15 billion over 5 years through the transition to and establishment of a new prospective payment system and a number of program integrity (anti-fraud and abuse) initiatives.

Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. Originally designed as an acute care service for beneficiaries who had been hospitalized, home health care has increasingly become a chronic care benefit not linked to hospitalization. The President's proposal restores the original split of home health care payments between Part A and B of Medicare. The first 100 home health visits following a three day hospitalization — would be reimbursed by Part A. All other visits — including those not following hospitalization — would be reimbursed by Part B.

Beneficiaries will not be affected by this restoration of the original policy; nor will it count toward the \$100 billion in savings in the President's plan. The policy avoids the need for excess in reductions in payments to hospitals, physicians, and other health care providers while helping to extend the solvency of the Part A Trust Fund.

Physicians Saves about \$7 billion over 5 years through a modification of physician updates. Note: This reduction is relatively small because Medicare has been relatively effective in constraining growth in reimbursement to physicians.

Skilled Nursing Facilities Saves about \$7 billion over 5 years through the establishment of a prospective payment system.

Fraud and Abuse Saves about \$9 billion over 5 years through a series of provisions to combat fraud and abuse in areas such as home health care, and by repealing the provisions Congress enacted last year that weaken fraud and abuse enforcement.

Structural Reform Makes the following modifications in the Medicare program:

1. Establishes new private health plan options (such as PPOs and Provider Service Networks) for the program;
2. Establishes annual open enrollment for all Medicare plans within independent third party consumer consulting.
3. Establishes market-oriented purchasing for Medicare including the new prospective payment systems for home health care, nursing home care, and outpatient hospital services, as well as competitive bidding authority and the use of centers of excellence to improve quality and cut back on costs;
4. Adds new Medigap protections to make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to opt for managed care because it addresses the fear that such a choice would lock them in forever.

Rural Health Care The plan will have a very strong package of rural health care initiatives, including continuation and improvement of sole community and Medicare dependent hospital protections, the expansion of the so-called RPCH facilities that allow for designation of and reimbursement to facilities that are not full-service hospitals, and the modification of managed care payments to ensure they are adequate for rural settings. The rural hospital investment alone is \$1 billion over 5 years.

THE WHITE HOUSE
WASHINGTON

June 23, 1997

MEMORANDUM FOR ERSKINE BOWLES

FROM: GENE SPERLING
SUBJECT: Medicare commission

As you requested, I chaired an inter-agency meeting today on the Administration's strategy about a Medicare commission. We spent most of the meeting discussing the specifics of the Ways & Means, Commerce, and Roth/Moynihan proposals for a Medicare commission (see attached chart). Several crucial points were raised:

1. Maintaining the President's flexibility to act on Social Security. A key concern is that we not allow a Medicare commission to limit the President's opportunities for advancing Social Security reform. We concluded that the Medicare proposals need not undermine -- and may strengthen -- the benefits of a presidentially-appointed, separate commission on Social Security. Since many of the options are better understood, a Social Security commission could even report before the Medicare commission. As discussed below, the Ways & Means and Commerce commissions would not report until May 1, 1999 -- enough time to allow a Social Security commission to report first.

2. Balancing the membership of the Medicare commission. As the chart shows, all three proposals involve 15 members -- six chosen by the Senate Majority Leader in consultation with the Senate minority leader, six chosen by the Speaker in consultation with the House minority leader, and the three ex officio members of the HI and SMI Boards of Trustees who are "Cabinet level officers." (The four ex officio members of the Boards are the Secretary of Treasury, the Secretary of Labor, the Secretary of HHS, and the Commissioner of Social Security. The three ex officio members who are Cabinet level officers are therefore the three Secretaries.) The inter-agency group was concerned about two issues:

- ***Proposals don't give the President the same flexibility as congressional leaders.*** The proposals grant flexibility to the congressional leadership, but not to us, over appointments. We should insist either on full discretion for the President's appointments, or at least on symmetric treatment (e.g., insisting that the congressional appointments be the chairs and ranking minority members of the relevant congressional committees). Given the personalities involved and our desire for a more advisory-type commission, the full discretion option seems preferable.

- **Membership includes more Republicans than Democrats.** The proposals include provisions that no more than eight of the 12 commission members appointed by the Hill be from the same party. In practice, that means that the commission would include 8 Republicans and 7 Democrats. We should insist on a truly bipartisan commission, with equal numbers of Republicans and Democrats.

3. Changing the commission's focus to an advisory one. From the perspective of both substance and tactics, we may want to push for a Gramlich-type advisory commission on Medicare. Since the questions involved are so complicated and the best path forward is not at all clear -- even to experts -- it may be better to form a commission to study the issues, without tasking it to formally submit policy recommendations.

Certainly not my style

- **Relation to membership.** The focus of the commission is related to its membership. A commission including top Administration officials, Senators, and Representatives, would almost automatically involve statements of policy. But a commission comprising outside specialists and academics may be more amenable to an advisory role.
- **Lack of "base closing" or other fast-track-type rule.** None of the three proposals includes a mechanism for ensuring congressional passage of the commission's recommendations. The lack of such a mechanism may ensure that, in practice, this commission turns out to be an advisory one -- especially if the membership does not include any Hill representatives.

Should have the President

4. Insisting on a super-majority voting rule. We should insist on super-majority (3/5 or 2/3) voting for any of the commission's recommendations. Unfortunately, even super-majority voting may not be able to prevent bad outcomes, given the most likely makeup of the commission: a super-majority could likely be achieved even if only two of the congressionally-appointed minority members vote with the majority.

5. Having the President appoint the chair. Unlike almost all previous commissions, none of the congressional proposals allows the President to appoint the Chair of the commission. We should insist that the President appoint the Chair.

6. Not relying on CBO scoring. Previous commissions have relied on cost estimates from the HCFA and SSA actuaries. But the Ways & Means and Commerce commissions (but not the Roth-Moynihan commission) would rely on cost estimates by the CBO. Some participants in the meeting were unsure that CBO had the technical expertise to undertake this assignment. The group preferred that HCFA and SSA actuaries be responsible for the cost estimates.

7. Evaluating the time line. The Ways & Means and Commerce proposals include a May 1, 1999 deadline. The Roth-Moynihan proposal sets a deadline of one year after passage of the act -- implying a likely deadline of August 1998. There were concerns raised about both deadlines. The May 1, 1999 deadline falls very close to the reporting date for the 1999 Trustees Report.

Since the Trustees will necessarily conclude that a large financing gap remains in the Trust Funds, we may not want the commission's "solutions" to that challenge to be released at the same time. The August 1998 deadline seems too soon to permit the commission to conduct a thorough analysis of the problem. The timing issue interacts with a possible Social Security commission (see first bullet above).

I hope this update is helpful.

COMPARISON OF MEDICARE BABY BOOMER COMMISSION BILLS

BILL	Number of Members	Distribution of Members	Selection of Leadership	Start Date	End Date	Specific Considerations	Scored By	Outside Experts
Vays & Means	15	6 Senate (not more than 4 from one party) 6 House (not more than 4 from one party) 3 ex officio members (cabinet level officials)	Chair & vice-chair of different parties and appointed by different methods are selected by the commission at the first meeting.	Feb. 1998	May 1, 1999 Provision to set up a permanent Independent Commission on Medicare. *	- amount & sources of funds - other nations' programs - age eligibility changes - trends in employee-related health care (MSAs, etc.)	CBO	Advisory Panel of health care experts, consumers, providers. Studies by GAO and other agencies as necessary.
Commerce	15	Same as above	Same as above	Same	May 1, 1999	Same as above <u>plus</u> - needs of the chronically ill	CBO	Same
Both/Boynihan	15	Same as above	The Speaker of the House, in consultation with the Senate Majority Leader, chooses the chair.	Same	One year after passage of act	None given.	None given.	Comptroller General Studies by other executive and legislative agencies Library of Congress information

The English Amendment directs the Commission to study the feasibility and desirability of establishing an Independent Commission on Medicare that would make annual recommendations on how to best match the structure of the Medicare program to available funding for the program (including a default mechanism enforcing spending targets if Congress fails to approve such targets). The Commission will report back with its recommendations for this permanent Independent Commission one year after passage of the Act.

1997-SE-007325

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220



DRAFT - CLOSE HOLD

DRAFT - CLOSE HOLD

July 9, 1997

MEMORANDUM FOR: DEPUTY SECRETARY SUMMERS
SECRETARY RUBIN

FROM: JONATHAN GRUBER *JG*
Deputy Assistant Secretary (Economic Policy)

ALAN COHEN *AC*
Senior Advisor (Economics and Budget)

SUBJECT: Medicare and SS Commissions

There was a meeting yesterday at 5:00, chaired by Gene Sperling, to discuss the process going forward on Medicare and Social Security commissions. We attach a **very close hold** memo written by Peter Orszag at NEC which summarizes the meeting. We have commented in several places (in italics).

DRAFT - CLOSE HOLD

DRAFT - CLOSE HOLD

Alternative approaches to Social Security

July 9, 1997

Alternative 1. Include a commission in the budget legislation

Under this alternative, we would push for including a Social Security commission in the budget legislation. There are three principal arguments put forward for such a strategy:

1. We may have a short window of opportunity to engage in a bipartisan process, and that opportunity could be lost if we wait to analyze our options further.
2. Even if we fail in creating the commission, the effort clearly signals our commitment to Social Security reform. Since we want to place our initial emphasis on Social Security reform, sending such a signal makes sense both substantively and politically.
3. It dissipates some of the momentum away from a Medicare commission. In particular, it sustains Social Security reform by making it less likely that the prominent players would be attracted to the "only long-term entitlement game in town."

These arguments are weakened, however, by several factors.

1. We may be in a better bipartisan position immediately after signing a budget deal, at which time we could create a commission by executive order if desired.

-- Further, we could probably always create irresistible bipartisan pressure for Social Security reform by engaging the help of Bob Dole, Warren Rudman, Pete Peterson, and other luminaries.
2. There are other ways of signaling our commitment. For example, we could simply have the President give an important speech highlighting his commitment to Social Security reform.
3. We may endanger our chances of shaping the Medicare commission the way we want it by pushing for a Social Security commission. The differences in composition and reporting dates between the commissions may be too glaring, and therefore to obtain a "real" Social Security commission, we may be pressured to accept a "real" Medicare commission.
4. Even if everyone agreed that a Social Security commission were desirable, squabbling over its details -- membership, reporting deadline, responsibilities, etc. -- would further complicated our budget negotiations.
5. We don't need to worry about momentum behind Medicare reform. We have enough

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power to thwart any threats to move Medicare reform in a direction we oppose

NOTE: Alan Cohen is opposed to this alternative. He feels that we would unnecessarily complicate the budget process, and that we could still accomplish our goals outside of the budget window, as detailed below.

Alternative 2. Form a high-level Social Security commission following budget agreement

Under this alternative, we would engage in a relatively short public education effort to "prime the pump." Then we would appoint a high-level Social Security commission -- including the key players from the Hill -- and perhaps set up some sort of fast-track process to ensure that the commission's recommendations could be implemented.

The arguments in favor of this approach are:

1. It ensures bipartisan buy-in at an early stage, since the relevant players would all be present.
2. It minimizes the problems of "commission overkill" by making it clear that the commission is an action, not an advisory, one.
3. It may be the fastest route to implementation.

The problems are:

1. Raising the profile of the Social Security commission to this degree may prompt Hill leaders to raise the profile of the Medicare commission also.
2. Commissions are often unable to agree on recommendations. Even the Greenspan commission required back-door negotiations to reach closure on a package.
3. The strategy may not provide enough time for the public to digest the problem and the proposed solutions. A high-level policy-making commission is unlikely to be the best conduit for public education efforts.

It may be necessary to form some sort of CPI sub-commission to report to the policy-making commission, given the large outstanding questions surrounding the CPI. If the CPI group comprised technical experts, we need to decide whether it should include either BLS economists or members of the Boskin commission. If not, there aren't too many experts left.

Alternative 3. Develop policies outside high-level policy making commission

Under this approach, we would develop our own policies internally. There are several

sub-alternatives of this alternative:

- In order to signal the President's intentions to tackle Social Security reform, he could deliver a prominent speech on the topic in the near future.
- While the internal process was working, we would engage in an intensive public education effort.
- Two types of advisory commissions could prove beneficial in this process:
 1. One comprising prominent individuals -- such as Bob Dole, Bill Bradley, Pete Peterson, George Mitchell, or Warren Rudman -- To educate the public on the nature of the problem. This commission could hold public fora, publish issue briefs, and organize conferences. One possibility would be to have the Social Security Trustees appoint the panel.

-- To minimize the "commission overkill" problem following Gramlich commission, it may be preferable not to have the group issue any policy recommendations, and perhaps even to call it a "public education panel."

NOTE: Jon Gruber feels that this is an important point. We have already had one high level "advisory commission" that issued a report. We undercut this process if we then follow this with yet another commission that does basically the same thing. If we are going to have a commission here, it must differentiate itself in some important way from what came before.

-- Alternatively, the advisory commission could develop a set of policies that would then be handed off to some sort of policy implementation process. One problem with this approach is that it may be difficult to explain why we are creating another commission so soon after the Gramlich one.

2. A technical advisory panel comprising academics and outside specialists to support the internal process. This panel would be similar to the panel that advises CBO on its economic forecasts: it would bring together the most knowledgeable outside people, and allow us to draw upon their knowledge. The Social Security Trustees could appoint the panel.
- Under any of the scenarios, we would probably need some sort of "hand-off" strategy to facilitate implementation. The hand-off could be as simple as a joint statement by the President and Hill leaders, or it could involve more complicated processes.

This approach has many different sub-options, and it is therefore difficult to list costs and benefits for the approach as a whole. But the fundamental feature would involve forgoing a high-level commission and instead developing our own set of policies.

TREASURY CLEARANCE SHEET

NO. _____

Date _____

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Jon Gruber

THROUGH: _____

SUBJECT: Medicare and SS Commissions

REVIEW OFFICES (Check when office clears)

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| <input type="checkbox"/> Domestic Finance | <input type="checkbox"/> ATF | <input type="checkbox"/> Scheduling |
| <input type="checkbox"/> Economic Policy | <input type="checkbox"/> Customs | <input type="checkbox"/> Public Affairs/Liaison |
| <input type="checkbox"/> Fiscal | <input type="checkbox"/> FLETC | <input type="checkbox"/> Tax Policy |
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| | <input type="checkbox"/> OCC | |

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S)				
Jon Gruber			Economic Policy	2-0563
Alan Cohen				2-0056
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer _____ Date _____ Executive Secretary _____ Date _____

1997-SE-006042



DEPARTMENT OF THE TREASURY
WASHINGTON
June 6, 1997

ASSISTANT SECRETARY

MEMORANDUM FOR: SECRETARY RUBIN
DEPUTY SECRETARY SUMMERS

FROM: JONATHAN GRUBER *JG*
Deputy Assistant Secretary (Economic Policy)

DON LUBICK *DL*
Assistant Secretary (Tax Policy)

SUBJECT: Medicare Medical Savings Accounts (MSAs)

Action Forcing Event

Yesterday the Ways and Means Subcommittee on Health marked up a bill that included a provision to allow for 500,000 Medicare beneficiaries to participate in Medicare Medical Savings Accounts (Medicare MSAs). The White House has agreed in principle to "a" demonstration for Medicare MSAs, but not the one marked up by the subcommittee. Last year during the final negotiation for MSAs for a segment of the under age 65 population, the Republicans forced the Administration into a "demonstration" that was really the introduction of a broad based permanent MSA program. We want to insure that the Medicare MSA proposal is limited to a demonstration project, rather than a phase-in of a permanent program.

Proposal

Under the proposal, Medicare beneficiaries would be allowed to opt into a Medicare MSA plan that would combine private health insurance (with a deductible) with an MSA. Medicare payments for each individual would be demographically adjusted. The difference between the Medicare payment and the premium would be deposited by Medicare into an MSA for an individual. Deductibles could not exceed \$6,000 (indexed). Unlike the traditional Medicare plan in which there is a 20 percent co-payment, once a deductible was reached, there would be no co-payments. Physicians and hospitals would be allowed to balance bill, that is, bill more than the amount permitted in the traditional Medicare plan. The program would run for at least four years, although participants would be able to keep their accounts after conclusion of the demonstration.

Issues

- MSAs are likely to cause problems of *adverse selection*, with healthier individuals being most likely to opt into the MSA option. Mechanisms for risk-adjusting Medicare payments are not very fine-tuned, with the result that these healthy individuals are likely to receive Medicare payments that exceed their true expected costs.
 - Under some proposals Medicare costs would rise, since an amount close to the average cost for all Medicare beneficiaries would be paid for healthy MSA participants, even though their underlying program costs are much lower than average. Previous discussion envisioned Medicare payments for this option at managed care levels, which have been proposed at 90% of average costs. Medicare annual incurred costs for the aged were \$5,200 in 1996. Using other data, half of all Medicare enrollees, including aged and others, had program payments of \$500 or less in 1994. (Program payments may slightly understate incurred costs.)
 - Under draft language, risk-adjustment methods would be worked out in the future. Economic research convincingly demonstrates that it is impossible to appropriately risk-adjust payments of this variety. As a result, payments will be too high regardless of the risk-adjustment methodology adopted
- MSAs would receive preferential tax treatment. Contributions would be tax-free, earnings on assets in the account would be tax-free, and withdrawals for medical expenses would be tax-free. Distributions used for nonmedical purposes would be taxable, and to the extent that nonmedical withdrawals reduce assets in the account to a level below 60 percent of the health insurance deductible amount, these withdrawals would be subject to additional tax of 50 percent.
 - Under the proposal, healthy Medicare MSA participants would be granted a source of tax-free savings that is not available to sicker Medicare beneficiaries, a perverse distributional outcome.
 - Medicare MSAs would be difficult to administer. Current law MSAs (for the under age 65 population) are difficult to administer because taxation depends on whether withdrawals are spent on medical or other purposes. Medicare MSAs would expand these current problems to the Medicare population. Furthermore, Medicare MSAs would be even more difficult to administer because the 50 percent additional tax would depend upon the amount of assets in the account, as well as, on the amount of the deductible.
- Last year's MSA demonstration (for the under age 65 population) did not include a serious evaluation component. Given the potential problems with Medicare MSAs, it is

critical to include a satisfactory evaluation into the agreement so that we can learn from this "demonstration".

- Although a higher deductible than under the traditional Medicare plan would increase cost consciousness with respect to covered expenditures in the short-term for some individuals, other features of the proposal could cause longer run increases in total health care spending.

-- MSAs reduce the after-tax price of medical care not covered by the traditional Medicare plan, including long-term care. As a result, beneficiaries may be encouraged to spend more on health care, including some long-term care items that may be difficult to distinguish from everyday needs.

-- Some individuals would buy policies that paid physicians and hospital higher payment rates than allowed under the traditional Medicare plan. Others might use MSA funds to pay for more expensive care. Either way, health care expenditure would be likely to grow as a result of this proposal.

-- Unlike current MSAs for the under age 65 population, it is our understanding that the MSA proposal for Medicare would not require policies to have a minimum deductible. If insurance companies were successful at attracting healthy individuals, they might be able to offer health insurance policies that have fairly low deductibles and pay for balance billing. In effect Medicare benefits could be expanded for healthy individuals who need it least.

Recommendation

Continue to oppose the principle of Medicare MSAs in general. In addition, advocate limiting the demonstration program as much as possible. The demonstration should not be designed in a way that limits the ability to have a serious research component. Treasury ought to take an active role in the final design, including, but not limited to, tax issues.

Agree Disagree Let's Discuss

cc: Scholz, Iwry, Judson, Weller, Dworin, Nunns, Conly, Duggan, Hunter



June 9, 1998

**MEMORANDUM FOR SECRETARY RUBIN
DEPUTY SECRETARY SUMMERS
ASSISTANT SECRETARY WILCOX****FROM: Jonathan Gruber** *JG*
Deputy Assistant Secretary (Economic Policy)**SUBJECT: Medicare Commission Update****Summary**

The Medicare Commission's recent meetings indicate it will have a very difficult time forging a consensus behind a set of reform proposals by its March 1999 deadline. This reflects not only the objective difficulties of choosing among controversial alternatives, but also the differing priorities of the panel members and the lack of any agreed analytic framework for determining what the implications of different options are. Like the recent Advisory Council on Social Security, though, this panel may still play an important role in defining "the problem" and generating a range of reform options (in this case, probably a very wide range). The Commission is now taking the first steps in the process, and as a result the Administration's internal efforts to provide analytic support to its Commission appointees are picking up steam. (A list of all 17 Commission members is attached.)

Background on Latest Commission Meeting

The full Commission convened for the third time on June 1-2 to have a preliminary discussion about the spectrum of Medicare issues — benefits, eligibility age, costs and administration, and financing mechanisms — and to hear from the sub-group that will be modeling the impact of proposed reforms. (Previous meetings were largely organizational or took testimony.) It was this sub-group's report on its baseline projections that generated articles about long-term Medicare costs exceeding the Administration's estimates.

Projections. The modeling group had settled on two sets of baseline projections which they thought both spanned the likely range of outcomes and highlighted the uncertainty about future growth in health care costs. One is the intermediate projection from the trustees' report, which assumes that the growth rate of Medicare spending per capita will slow down to the rate of GDP growth per capita by 2022. Their other baseline uses the same assumptions for all other variables, but does not project a slowdown in health care costs. Though the ultimate difference is only about 2% per year, the compounded effect means that Medicare spending in 2030 would amount to 6% of GDP under the trustees intermediate projections and 8% of GDP under the "No Slowdown" projection (compared to nearly 3% now).

In the ensuing discussion, many panel members expressed skepticism that cost growth would abate; some even cited the admission in the trustees report that, relative to the intermediate projection, the odds of a more adverse outcome might exceed the odds of a more favorable one. It should also be noted, however, that the trustees report made this assumption for a reason — namely that continuing the historical growth trend would eventually yield a Medicare program “so large as a percent of GDP that it would be implausible given other demands on those resources.” This would suggest that cost constraints to keep Medicare spending down to about 6% of GDP — which the trustees report assumed, in effect — will ultimately be necessary. Having said all that, many Commission members indicated that their deliberations should not be dictated by such highly uncertain projections — former Medicare administrator Bruce Vladeck called them exercises in “comparative fantasy” — and that they must consider the adequacy of the Medicare benefits and the equity and efficiency of the program as well as its financial status. The modeling sub-group will also be conducting further analysis of how such things as future trends in retirement and productivity growth will affect these projections.

Benefits. A wide variety of views was expressed in this discussion, ranging from those who thought quality health care for seniors was a moral obligation that should be guaranteed despite its costs, to those who were much more concerned about the costs of these benefits. A number of members with differing perspectives showed an interest in adding coverage for prescription drugs and nursing home care to the benefit package, at least in some form. Some of the Administration appointees mentioned an approach (which is being reviewed internally) that would try to rationalize the structure of the current Medicare benefit package and use some of the resulting savings to increase its scope.

Costs and Administration. Panel members differed on whether managed care could — or should be expected to — continue to control rates of cost growth, either in Medicare or in the private sector. Some also noted the common view that reductions in fraud and abuse could solve the program’s financing problems, but pointed out that control measures often met with substantial resistance from those who find it more difficult to get services as a result. At about 2% of total program costs, Medicare’s administrative budget is much lower than a comparable private plan — but may be so low that it is unable to effectively monitor claims or educate beneficiaries about their increasingly complex enrollment options.

Eligibility. Discussion centered on the proposal passed in the Senate last year to raise the Medicare eligibility age gradually from 65 to 67. The Administration’s appointees and others stressed the problem this would create for those who lacked access to alternative insurance, and mentioned the proposal to let those just below 65 buy into the program at cost. Chairman Breaux thought the phase-in period would provide enough time for adjustments. In the discussion, the key role of future retirement trends as labor becomes more scarce was also stressed.

Financing. Panel members differed sharply about whether the projected future costs of Medicare noted above were manageable or not. The Administration’s appointees generally

argued that economic growth would make this burden potentially bearable, both for the economy as a whole and individual taxpayers, while others expressed the view that the resulting tax rates would be prohibitive. There was some agreement that Medicare should not be the funding source for medical residency programs or uncompensated care for the poor, but many also had concerns about finding an alternative and steady source of revenue for these endeavors.

Attachment



The National Bipartisan Commission on the Future of Medicare

List of Commission Members

Senator John Breaux
Chairman

Congressman Bill Thomas
Administrative Chairman

Mr. Bobby Jindal
Executive Director

Mr. Stuart H. Altman, Ph.D.
Sol C. Chaikin Professor of National Health
Policy, Brandeis University, Waltham, MA
Appointed by: President Bill Clinton

Mr. Samuel H. Howard
Chairman, Phoenix Healthcare Corporation,
Nashville, TN
Appointed by: Honorable Newt Gingrich

Honorable Michael Bilirakis
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Honorable J. Robert Kerrey
United States Senate
Appointed by: Honorable Thomas Daschle

Honorable John Breaux
United States Senate
*Appointed jointly by: President Bill Clinton,
Honorable Trent Lott, Honorable Thomas
Daschle, Honorable Newt Gingrich and
Honorable Richard Gephardt*

Honorable James A. McDermott
U.S. House of Representatives
Appointed by: Honorable Richard Gephardt

Honorable John Dingell
U.S. House of Representatives
Appointed by: Honorable Richard Gephardt

Honorable John D. Rockefeller, IV
United States Senate
Appointed by: Honorable Thomas Daschle

Honorable Bill Frist
United States Senate
Appointed by: Honorable Trent Lott

Ms. Deborah Steelman
Attorney, Washington, D.C.
Appointed by: Honorable Trent Lott

Honorable Greg Ganske
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Honorable Bill Thomas
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Ms. Illene Gordon
State Office Staffer, Honorable Trent Lott
Appointed by: Honorable Trent Lott

Ms. Laura D'Andrea Tyson, Ph.D.
Professor of Economics, University of
California at Berkeley
Appointed by: President Bill Clinton

Honorable Phil Gramm
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Appointed by: Honorable Trent Lott

Mr. Bruce Vladeck, Ph.D.
Professor of Health Policy, Mt. Sinai School
of Medicine, New York, N.Y.
Appointed by: President Bill Clinton

Mr. Anthony L. Watson
Chairman and CEO, Health Insurance Plan,
New York, N.Y.
Appointed by: President Bill Clinton

TREASURY CLEARANCE SHEET

NO. _____
Date 6/9/98

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Jonathan Gruber

THROUGH: _____

SUBJECT: Medicare Commission Update

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DEPARTMENT OF THE TREASURY

WASHINGTON

July 14, 1998

**MEMORANDUM FOR DEPUTY SECRETARY SUMMERS
ASSISTANT SECRETARY WILCOX**

FROM: Mark McClellan *MM*
Deputy Assistant Secretary (Economic Policy)

SUBJECT: Medicare Commission and Medicare Reform – Memo Summary

The attached memo reviews major policy issues in the Medicare program, the range of reforms that might be adopted to address them, and the current status of the Medicare Commission. Here I summarize the background, major reform proposals, and Treasury options for influencing the Medicare Commission process.

Background on Medicare Policy Issues

- More use of more costly medical technologies is the proximate cause of Medicare's rapid expenditure growth, averaging around 5% per year real. While some of the spending involves hospital and physician treatment for acute illnesses, much of the growth reflects increasing spending on supportive and long-term care. The value of much of Medicare spending for health is unclear.
- Though Medicare is financed in part by a payroll tax (Part A), an increasing share of Medicare expenditures are financed through general Federal revenues (Part B).
- A variety of Medicare reforms have been adopted, with goals of controlling program costs, improving the value of Medicare-financed services, and limiting beneficiary out-of-pocket payments. The reforms include some features of managed care and "managed competition" now used by many private employers. Expenditure growth has persisted.
- The problem of beneficiary heterogeneity and of adverse selection in health insurance plans is regarded as an important obstacle to the adoption of other key features of employer-provided insurance today. Average spending per beneficiary is high -- around \$6000 in 1998. Most elderly beneficiaries are relatively healthy, with far lower expected expenditures. However, Medicare also includes the long-term disabled and many elderly with serious and costly chronic illnesses.

Range of Reform Proposals

Benefit Reforms:

- *Reform defined-benefit Medicare.* Proposals include: continue to increase "bundling" of provider payments and reduce real payment levels; "rationalize" Medicare benefits by

integrating coverage for long-term care, prescription drugs, and copayments and deductibles now covered by Medigap; improve quality review mechanisms; reform the payments and contracting conditions for Medicare managed-care plans.

- *Switch to a premium-support (defined contribution) program.* Like many private employers and FEHBP, Medicare would make a contribution toward the premium of a set of approved health plan choices. Because of substantial beneficiary variation in expected health costs and ability to choose plans effectively, these proposals all include mechanisms such as risk adjustment to address concerns about cost and availability of adequate insurance coverage.

Financing Reforms:

- *Continue "pay as you go" financing.* Options include: increasing the share of general-revenue financing to avoid Trust Fund "insolvency" problems; and increasing beneficiary contributions (now at 25% of Part B costs), possibly in an income-related way.
- *Switch to a funded system:* The issues are similar to those in Social Security reform.

Reforms have also been proposed in other components of Medicare (special funding for teaching hospitals and hospitals treating "disproportionate shares" of low-income patients), and in Medicare eligibility (entitlement age, availability of buy-ins).

Treasury Options

Options include:

- Continue current role of largely passive observation of Medicare Commission activities. Commission may conclude with a little-noticed final report.
- Encourage the development of a clearer framework of alternatives for Medicare reform, so that the Commission report will increase public and legislative understanding of the issues and options facing the Medicare Program. Gramlich Commission model.
- Encourage the development of a particular Administration policy direction for long-term Medicare reform. Even if the Commission report is itself ineffective, its release would provide an opportunity to publicize Administration principles for Medicare reform, complementing initiatives such as reforming Social Security, enhancing the well-being of the disabled, and improving the availability and cost of health insurance.

Attachment



DEPARTMENT OF THE TREASURY
WASHINGTON

July 14, 1998

MEMORANDUM FOR DEPUTY SECRETARY SUMMERS
ASSISTANT SECRETARY WILCOX

FROM: Mark McClellan *MM*
Deputy Assistant Secretary (Economic Policy)

SUBJECT: Medicare Commission and Medicare Reform

Action-Forcing Nonevent

The Bipartisan Commission on the Future of Medicare, charged with developing a plan to assure the long-term financial stability and quality of health insurance for the U.S. elderly and disabled, is in the fifth month of its one-year charge. There is increasing concern that the Commission will not make clear recommendations for reforming the program, or even outline clear steps that would lead to recommendations in the future, let alone forge a bipartisan consensus on how the program should be reformed. So far, Treasury has been an observer in this process. This memo reviews the current status of the program, reform options, the status of the Commission, and options for Treasury to influence the Commission and the Medicare reform process.

Memo Outline

- I. Background for Medicare Reform
- II. Medicare Reform Possibilities
- III. Current Commission-Related Activities
- IV. Treasury Options

I. Background

With OASDI, Medicare forms the core of social insurance for the U.S. elderly and long-term disabled. Many experts argue that Medicare needs substantial reform, principally because the program's expected expenditure growth is regarded as "unsustainable," and because its current structure is thought to lead to inefficient program spending. Similar issues motivate proposals for Social Security reform, but Medicare differs for the following reasons.

More use of more costly medical technologies, not demographic change, is the principal source of Medicare's rapid expenditure growth. Population aging, with the retirement of Baby Boomers, is expected to lead to real growth in Medicare expenditures of close to 2% per year beginning around 2010, just as for Social Security. But over the previous two decades, when demographic pressures have been relatively modest, Medicare real expenditure growth has averaged around 5% per year, with no recent slowdown like that experienced in private health insurance.

All payments for particular Medicare-covered services are strictly regulated, and generally have been reduced over time. Use of more quantities of services per beneficiary is thus

the source of expenditure growth: beneficiaries are receiving more medical treatments, and more intensive medical treatment. Studies have documented that the vast majority of these increases in reported services represent real changes in the use of medical care, and not changes in the reporting of services by providers, other "gaming" of the billing system, or fraud.

As a result, **Medicare expenditure growth is much more rapid than Social Security expenditure growth.** Current-year expenditures, around \$230 billion or \$6000 per beneficiary, are only about 60% as high as Social Security expenditures. But Trustee forecasts of Medicare expenditures, which use assumptions about growth in expenditures per beneficiary in "out" years that are substantially lower than those experienced throughout the program's history, predict that Medicare spending per beneficiary will surpass Social Security spending per beneficiary by 2015, and that the program will account for over 6% of GDP by 2025. Projections that extrapolate past expenditure growth conclude that the GDP share may be as high as 10%. (The attached table provides the two sets of cost projections being used by the Commission; one essentially uses all of the Trustees' intermediate assumptions, while the other — labeled "No Slowdown" — assumes that Medicare expenditure growth will continue at current rates. The Trustees' report assumed a slowdown because the alternative was a Medicare program too large as a share of GDP.)

Medicare also differs from Social Security in the extent to which growth in program outlays motivates policy action due to concerns about "Trust Fund insolvency." **An increasing share of Medicare expenditures is being financed through general Federal revenues.** Only Part A of Medicare is financed by the Medicare payroll tax (a total rate of 2.9% on all earnings, with no cap). Most (75%) of Part B is financed by general revenues, and the remainder is financed by monthly beneficiary premiums (now \$43.80/month). Recent shifts of more benefits to Part B has helped defer projected insolvency to 2008.

In addition to more spending for intensive medical treatments, much Medicare expenditure growth is the result of increased spending on supportive care and long-term care. Most of Medicare's expenses are for hospital and physician treatment. But much of Medicare's spending growth involves non-acute services, including treatment by skilled nursing facilities, home health services, and hospices. In part, these services have substituted for intensive care in hospitals. But expenditures on non-acute services have grown far more rapidly than can be explained by substitution alone, and so also reflect Medicare's provision of new treatments or treatments previously covered by Medicaid or private sources. Even with the rapid growth in expenditures, Medicare still covers only a small portion of the total long-term care and supportive care than is provided by Medicaid, private spending, and in-kind assistance from family members.

The effect of much Medicare spending on health is unclear. Social Security benefits are direct dollar transfers, and so their value to beneficiaries is relatively easy to assess. The effect on beneficiary well-being of the health care financed by Medicare is much more difficult to quantify. Clearly, the health of the elderly has improved substantially during the 33 years of Medicare: life expectancy at 65 has increased by about one month per year, and many studies have concluded that quality of life (as reflected in functional capabilities and time spent living

independently) has improved substantially. Although changes in medical treatment undoubtedly have contributed to these health improvements, little is known about the contributions of most of the treatment changes. Many economists suspect that the average value of technological change in Medicare is high. But considerable evidence also suggests that many changes in treatment are worth less to beneficiaries than their true cost.

Many Medicare reforms have already been adopted, yet concerns about expenditure growth and the efficiency of Medicare spending persist. The attempt discussed above to move some treatments to less acute settings has been one avenue of reform. Other reforms can be lumped into two categories, both within the largely fee-for-service structure of “traditional” Medicare insurance:

- *Reductions in provider payments.* Medicare sets the provider reimbursement amount for each service it covers, so that reducing the amount paid for specific services can reduce program spending and growth. For example, the Balanced Budget Act achieved the bulk of its projected Medicare savings by modest reductions in payments and in the growth rate of payments (e.g., updating by CPI-1% percent rather than by CPI). These price reductions do not regulate the quantity of services provided; this is why increases in quantities of services comprise the principal source of expenditure growth.
- *Greater bundling of payments.* Payment reforms are increasingly bundling payments for sets of services together. For example, Medicare adopted the Prospective Payment System for acute-care hospitals in 1984, in which hospitals receive an essentially fixed payment per admission based on a patient’s diagnosis and treatment received. Analogous reforms for outpatient hospital visits and for nonacute hospital admissions were recently adopted. Because providers no longer receive greater reimbursement for performing more services (lab tests, days in the hospital, etc.) within these bundled “sets,” the reforms reduce incentives to provide more services within each bundle. However, they have weaker effects on incentives to provide more costly bundles or combinations of bundles -- for example, treating a heart attack patient with a surgical procedure rather than with less costly drugs, or transferring a stroke patient to a nonacute hospital for rehabilitation after a shorter admission to an acute hospital.

Medicare has not adopted many of the managed-care and plan choice reforms that characterize other health insurance plans today. Most Americans insured privately and by Medicaid now enroll in managed care plans. Instead of relying on demand-side financial incentives (co-payments and deductibles), these plans limit use of medical services despite providing near-“first dollar” coverage by discouraging use through other means. For example, they require primary-care doctors and not patients initiate referrals to specialists, they limit the availability of doctors in the plan, they provide even more “high-powered” financial incentives to physicians and hospitals than are used by Medicare (such as capitation payments per plan member per month for all services provided), and they conduct “utilization review” to discourage providers from using costly services. Traditional Medicare does not rely on such managed-care methods other than some utilization review, and much Medicare utilization review is focused on increasing the use of appropriate services, and the other reforms in its traditional insurance

program.

Medicare does allow beneficiaries to enroll in approved managed-care plans. But the beneficiary incentives to join these plans are very different from those in the private sector. As a result, increased managed-care growth in Medicare's current system is unlikely to slow expenditure growth. The available alternatives are now being expanded by the Medicare+Choice provisions of the Balanced Budget Act. But enrollment in a managed care plan is not required, and the financial incentives for beneficiaries to select a lower-cost alternative to "traditional" Medicare are much weaker than in the private sector or FEHBP. In particular, when a beneficiary chooses a Medicare managed-care plan, Medicare pays the plan a fixed amount per month based on the average cost of beneficiaries in traditional Medicare residing in the same county. Plans are allowed to charge beneficiaries a monthly premium beyond this payment, but most do not do so. Instead, they may try to attract beneficiaries by offering additional benefits – particularly benefits like preventive care services that are valued by relatively healthy, low-cost beneficiaries. Thus, because plans have only limited opportunities to attract beneficiaries by cutting prices and because relatively healthy beneficiaries have joined, managed care has probably increased costs in Medicare.

Why not extend an FEHBP-like program to Medicare? Undoubtedly there are important political reasons for the failure of such reforms to be adopted so far in Medicare. But there are important policy reasons as well. **Medicare includes a much more heterogeneous population than that covered through employment-related insurance or the FEHBP.** Beneficiaries range from 75 year-olds who are perfectly healthy to those who are cognitively impaired, incapable of activities of daily living, and afflicted with illnesses that require frequent, costly treatment. Among the beneficiaries entitled to Medicare through disability, beneficiaries range from those with illnesses that lead to relatively low medical expenditures (e.g., chronic back pain or mental illness) to those that are dependent on intensive medical treatments for survival (e.g., patients with end-stage renal disease who require dialysis). These features of the Medicare program suggest that many beneficiaries might not be able to choose plans effectively, or may need more assistance in making informed plan choices than employees require.

The problem of adverse selection may create serious obstacles to an FEHBP-like program for Medicare. Large private employers and FEHBP make relatively fixed contributions toward a range of alternative plan choices that meet certain benefit requirements. Employees are largely responsible for paying the differential cost of more expensive plans, and are able to keep any savings from choosing less costly plans. Such financial incentives in plan choice have reduced expenditure growth in private health plans, as many employees have opted for less costly coverage with more managed-care restrictions on use of medical services. But several investigators have documented adverse effects of this "managed competition" system of plan choice on the price and availability of relatively generous plans that would be preferred by employees with greater demands for health services.

The "death spiral" observed for generous plans in managed competition settings is an illustration of the adverse selection problem. Relatively healthy employees, who place relatively low value on the benefits in the more generous plans, opt for less generous, less costly coverage

when they are responsible for the additional cost. As a result, the average cost of the relatively sick employees who opt for the generous plan increases, driving up the premium and the additional payments by the employees remaining in the generous plan. In turn, this causes the healthiest of the remaining employees to opt for a less costly choice, further increasing the premium in the generous plan, and so on. As a result, the generous coverage that many individuals would desire may become unavailable, or available only at a very high price.

Because Medicare has a relatively large share of beneficiaries with serious chronic illnesses and low incomes, the adverse selection problems of managed competition are likely to be greater than those experienced by FEHBP or private employers. There is considerable debate about how much greater any resulting problems of higher costs of or less “access” to generous insurance would be. In addition, even if such a modified FEHBP-like program could be implemented, it is not clear that this step alone would limit Medicare’s long-term spending growth. Many studies have demonstrated that managed care can achieve important one-time savings, for example through reducing payment rates to providers and eliminating some services thought to be duplicative or wasteful. But it is unclear whether these one-time savings could have long-term effects on the changes in medical care that account for spending growth. Current Administrative and Congressional initiatives aimed at limiting these cost-reducing practices by managed care plans suggest that managed care may be reaching the limits of its abilities to constrain health care use. The recent resumption of expenditure growth in employer plans and FEHBP supports this view.

II. Range of Possible Reform Proposals

The Commission has discussed a broad array of reform proposals but has not moved toward adopting any of them. Given the Commission’s diversity of beliefs about reform and the need for 11 out of 17 members to approve any recommendation, it seems unlikely that it ever will. The following review summarizes the range of possible Medicare reforms, and the current work of the Commission’s three major task forces.

1) Benefit Reforms

a) Reform “Traditional” Defined-Benefit (DB) Medicare

Supporters of this view advocate continuing the basic defined-benefit structure of Medicare; that is, enrollees would retain the option of choosing “traditional” fee-for-service Medicare insurance at no additional out-of-pocket cost. But an enormous range of reform proposals exist within this general option, including the following:

- *Continue reducing/bundling Medicare provider payments:* Some proposals advocate continuation of current policies of reducing prices or price growth for particular services (e.g., by extending the price reductions in the Balanced Budget Act), and “bundling” more prices.
- *“Rationalize” Medicare benefits:* Most beneficiaries currently have supplemental

insurance policies (Medigap or Medicaid) that cover the substantial co-pays and deductibles in Medicare, and sometimes provide prescription drug coverage. This proposal envisions revising Medicare benefits so that such policies would be incorporated into Medicare (and Medigap might be prohibited); at the same time, the demand-side incentives and payments could be rationalized, and Medicare benefits might be expanded (e.g., to include some drug coverage). Unfortunately, most of these proposals appear to be cost-increasing.

- *Improve quality assurance:* These proposals would expand “utilization review” programs, reporting requirements, and other Medicare activities relating to encouraging high-quality care for beneficiaries. The proposals focus on managed-care plans in Medicare, but similar reforms would be adopted for “traditional” Medicare. Many of these changes can be adopted within current legislation; the President’s recent (6/22) announcement of a set of initiatives on quality of care in Medicare illustrates this. These reforms are likely to increase program costs.
- *Reform the “+Choice” components of Medicare+Choice:* Many proposals would affect the managed-care and other plan choices that will soon be available in Medicare as a result of the Balanced Budget Act. Various proposals advocate more regulation of managed care plans (e.g., requiring disclosure of information on provider payment contracts, requirements for coverage of certain benefits), further reductions in payment, and better risk adjustment of payments to managed-care plans. The key difference between these proposals and the defined-contribution reforms described below is that they do not provide strong beneficiary incentives to leave traditional Medicare. For example, if managed-care plan payments are reduced, plans will probably respond by reducing benefit generosity. Beneficiaries will respond by staying in traditional Medicare. In contrast, if beneficiaries had to pay the difference in “premiums” between the managed-care plans and traditional Medicare, they may select the managed-care plan anyway, especially if they placed low value on freedom of provider choice, few managed-care utilization restrictions, etc.

Supporters of these relatively incremental reforms emphasize the popularity of the current program, and the likely difficulty in choosing plans and obtaining health care services that frail, low-income, chronically ill, or otherwise disadvantaged beneficiaries would face if more fundamental reforms were adopted.

b) Switch to a “Premium Support” (Defined Contribution) Program

These more fundamental reforms all involve the adoption of something like the FEHBP system. This system has many of the key features advocated by the architects of health insurance reforms in large private companies:

- *“Managed” health plan choices:* Government benefit experts would manage key features of the plan choice process for Medicare beneficiaries, to improve competition among plans and to assure that beneficiaries received certain benefits. Management

would include specifications of “minimum” benefit packages, and restrictions on the diversity of benefits that would be allowed. Restrictions on the exact structure of benefits beyond the minimum package are intended to make it easier for beneficiaries to select plans effectively, since plans can potentially vary in a bewildering number of relatively unimportant ways. Benefit experts might also impose additional requirements on plans, such as standards for releasing information on quality. “Traditional” Medicare and a medical savings account plan might be among the plan choice options.

- *Defined Medicare contribution toward beneficiary plan choice:* The Medicare program would make a “fixed” contribution toward the premium of any of the approved plans. The “fixed” contribution could vary based on beneficiary characteristics that are not easily changed in response to the payment incentives (e.g., age, sex, and other “risk adjustments”) The level of the contribution could be pegged to the least expensive plan, the average plan, or another rule. The key feature is that the “marginal” payment for the cost differences between plans is borne by the *beneficiary* and not Medicare. To implement this system fully, beneficiaries who enroll in a plan with a lower premium than the contributed amount would need to keep the difference.

The defined-contribution (DC) idea in Medicare is similar to DC ideas proposed elsewhere (e.g., funded individual accounts for Social Security, vouchers for school choice, and bidding by financial institutions to finance guaranteed student loans). The key difference is that health insurance for Medicare beneficiaries is a much more heterogeneous product. Beneficiaries differ enormously in their expected health care utilization, with predicted annual expenditures ranging from <\$2000 for healthy young beneficiaries to over \$80,000 for beneficiaries with kidney failure and other high-use chronic illnesses. Plans thus have enormous opportunities to attract profitable beneficiaries not by providing more efficient care but rather by designing plans to select the favorable risks. Medicare also includes many low-income beneficiaries, who would be particularly likely to select less generous plans under this choice system.

Several methods, all imperfect, have been proposed to address this problem.

- *“Risk adjust” Medicare contributions based on beneficiary characteristics:* Medicare’s contribution to a beneficiary’s plan choice might be adjusted based on the age, sex, and health characteristics of the beneficiary. Those expected to have greater demands for medical care would be given larger contributions toward their plan choice. Unfortunately, it is not feasible to capture many important aspects of disease severity that might be expected to lead to differences in expected medical costs.
- *Relate Medicare contributions to past expenditures:* Medicare contributions toward plan choice might be adjusted in proportion to a beneficiary’s previous expenditures, or plans might be given additional payments for their highest-cost members. But such adjustments are like fee-for-service insurance: they weaken the incentives of plans and beneficiaries to limit costs.
- *Restrict plan choices to protect “high-cost” beneficiaries:* For example, health plans might be required to offer more and less generous plans with a more or less extensive set

of required benefits, and the allowable difference in premiums between the plans could be capped. Such reforms would create incentives to skirt the required benefits (a plan might meet a requirement of offering specialized care for oncology by hiring a single oncologist for its entire membership, thereby limiting access to her and skirting the intent of the requirement).

Most supporters of DC Medicare favor one or more of these reforms, and argue that the “DC” label would consequently be both misleading and bad politics. “Premium support” is one example of a label that attempts to convey more effectively how DC Medicare would work.

All of these proposals for mitigating the adverse selection problem in “DC Medicare” could amount to enormous explicit redistributions of Federal funds. For example, deciding whether or not “heart failure” or “presence of 2+ functional impairments” should be included as a risk-adjuster may sound like an esoteric health policy question. But in defined-contribution Medicare, it would amount to additional Federal transfers of \$3,000-\$10,000 or much more per year to individuals with these conditions, for the purchase of health insurance or potentially other uses. In contrast, if a risk adjuster for a particular type of Medicare beneficiary is not included, then the switch from DB to DC Medicare might result in their bearing substantially higher health care costs.

Other proposals would take steps to reduce the opportunities for selection to occur. One such proposal is to use a longer lock-in periods for plan choices. For example, beneficiaries might only have “open enrollment” periods every two years. Currently, semiannual plan switching is allowed. Because it is harder to predict medical spending for longer time periods, the problem of risk selection would be diminished. But beneficiaries would also have less opportunity to leave a plan they did not like. None of these proposed methods for protecting high-cost beneficiaries have yet been tested in a population like Medicare’s.

All these reforms might be implemented on a limited, “demonstration” basis. HHS views existing legislation as giving it the authority to evaluate DC-like reforms on a demonstration basis. Last year, for example, HHS sought to implement a system of Medicare choice in Denver in which choices would be “managed,” but the other key defined-contribution feature -- beneficiary responsibility for differences in plan payments -- was to be adopted in only a limited way.¹ The Denver demonstration was ultimately suspended, due to opposition both from beneficiary groups and from health plans -- apparently because of concerns about burdensome reporting requirements, possibly because of concerns about increased competition resulting from standardization of benefits. Whether current legislation would permit a true

¹Plans submitted bids to provide at least a minimum package of health insurance benefits specified by HCFA/HHS. HCFA would then use a weighted average of the middle bids to set premiums for all Denver plans. Plans could then walk away or offer to contract with all willing beneficiaries at this price (there was limited risk adjustment). These features are much like “managed competition” in private health insurance. However, beneficiaries could continue in “traditional” Medicare at no additional cost.

defined-contribution "demonstration" is unclear.

2) Financing and Eligibility Reforms

a) Continue "Pay As You Go" Financing

With the Medicare Part A Trust Fund projected to become insolvent in 2008, Medicare might seem to be facing a financing crisis that prevents this option from being a long-term solution. But a key difference from Social Security is that Medicare is not financed exclusively by a dedicated payroll tax. Thus it is more straightforward politically to ease the pressure on funding from the dedicated payroll tax through incremental reforms that increase program funding from the two other principal sources:

- *Increase general-revenue funding:* Because Part B funding is from general revenues, increasing the share of Medicare benefits reduces Medicare Trust Fund expenditures but has no effect on the unified Federal budget. In 1997, the Balanced Budget Act transferred home health spending from Part A to Part B, thereby delaying the projected insolvency of the Medicare Trust Fund for about 8 years. Total projected Federal outlays were unaffected, so no offsets were required. Other Part A benefits, such as hospice care, rehabilitation care, or even some acute hospital care, could also be switched to general-revenue financing.
- *Increase beneficiary contributions:* Proposals include an across-the-board increase in "premium" payments by current beneficiaries (for example, by increasing the Part B monthly premium to cover a larger share of Part B costs), or the adoption of income-related premiums. Income-related premiums have been motivated by the fact that wealthier Medicare beneficiaries tend to use more program benefits.

b) Switch to "Funded" Medicare: Individual Health Accounts

The pre-funding idea for Medicare is equivalent to the individual-account idea for Social Security: required contributions as a percentage of earnings during an individual's working life would be invested in equities or bonds. When the individual reaches Medicare eligibility age, the account could be used for approved medical expenditures. The same issues arise as in the Social Security case (uncertainty in returns, transition problems, progressivity and redistributive issues, etc.), plus additional issues. Most pre-funding proposals, for example that by Senator Gramm, envision its use in purchasing from among a set of alternative plans in a "defined contribution" framework -- that is, the beneficiary bears the incremental cost differences across plan premiums. The individual account might be used as a medical savings account. Either way, supplemental government contributions based on beneficiary characteristics (e.g., presence of a nonfatal but costly chronic illness) or actual expenses (e.g., exhaustion of the individual account) would probably be necessary, because even lifetime expenditures are predictably skewed. Thus, issues with individual accounts are similar to those discussed previously for DC Medicare.

If substantial government redistribution of individual account income is required, **government rather than individual equity investment of Medicare funds might be a more effective mechanism.** The proceeds of such investments would be used to finance "premium support" in DC Medicare. Government investment of Trust Funds could also be used to finance benefits in DB Medicare.

c) Reform Other Components of Medicare

A substantial part of Medicare hospital expenditures, over \$15B per year, involves supplemental Disproportionate Share (DSH) payments to hospitals with large shares of low-income and public patients, and supplemental Indirect Medical Education (IME) payments to teaching hospitals. These expenditures are within Medicare Part A because they are paid largely as a proportional add-on to reimbursement for hospital discharges. Both programs have been reformed recently, and some proposals advocate either eliminating them entirely, or removing them from Medicare and replacing them with Federal programs designed to accomplish the same policy aims, outside of Medicare's hospital reimbursement.

d) Change Program Eligibility

Some proposals advocate increasing the age of Medicare entitlement, for example to match the impending increases in Social Security. Such increases would obviously reduce expected program expenditures. The Commission is also considering the Administration's proposal earlier this year to allow Medicare "buy-in" at younger ages, with buy-in premiums designed to cover the expected cost of the expansion.

III. Current Status of Commission-Related Activities

This section thus discusses briefly the current status of Commission deliberations and its interactions with the Administration, to provide some political and procedural context for Treasury's options.

The Commission. **While the Commission and its task forces are now meeting regularly, many observers are concerned that its work to date seems to lack a clear sense of direction.** Some have blamed the makeup of the Commission for this alleged problem: the viewpoints are exceedingly diverse, many have very strong priors, and few seem to be investing in "building bridges." (A list of the 17 members is attached.) Others blame the Commission staff. They argue that the director has little prior Medicare or Federal experience, and more generally the Commission's limited staff has not been able to help members frame an effective approach for considering reform proposals. The two problems may be related: the members have emphasized that they do not want to be driven by staff in addressing the difficult analytic and political issues of Medicare reform. The Commission has not laid out a meaningful timetable for completing analyses and developing reform proposals in order to meet its March 1999 deadline. The Commission's work is proceeding through three major task forces: Reform (for "incremental" program reforms), Restructuring (for "major" program reforms), and Modeling (for evaluating the likely consequences of program reforms). Separate subgroups may

also be established to handle distinct issues like funding for graduate medical education.

The Administration's Appointees. The Administration's appointees are Laura Tyson, Bruce Vladeck (former HCFA Administrator), Stuart Altman (an academic health economist), and Tony Watson (CEO of a large HMO in New York). **They are viewed within the Administration as a relatively strong group of appointees that can have a disproportionate effect on the course of the Commission's deliberations.** At the same time, they have their own views on reform and are not bound to Administration goals. Thus, while there have been a series of inter-agency discussions with them to try to coordinate efforts, their approach so far has been largely to ask the Administration for background analyses and papers but not to seek policy guidance. To date, they have been more supportive of reforms within the structure of traditional Medicare, and they seem willing to accept that long-term revenue increases may be required. As the prospect that the Commission is headed for obscurity is increasing, however, their interest in more extensive input from the Administration on developing reform options may increase. In part to explore such issues, a "mini-retreat" involving the Administration appointees may occur later this month, before the next full Commission meeting in August.

Internal Administration Work. **The Administration's role so far has primarily been to provide background papers and actuarial analyses requested by the Commission, its staff, or our appointees.** Most of these are being done by HCFA; some background papers have also been prepared by HHS. Only one limited independent study process is proceeding, addressing options for adding benefits that Medicare does not now provide (prescription drugs and nursing home care). Senior staff at HHS, who largely favor incremental reforms in traditional Medicare, are also not optimistic about the Commission's prospects for reaching a meaningful conclusion. DPC and NEC efforts have primarily been focused on other health policy issues, and so have had only peripheral involvement with the Commission or its Administration appointees. White House health policy leaders have, however, expressed interest in exploring a more active Administration role.

IV. Treasury Options

With little political or legislative consensus in sight, and only limited political and public awareness of the most salient issues for Medicare reform, a distinct possibility is that the Commission will issue a report that has little impact on the challenging political process toward long-term Medicare reform. Treasury options for influencing this process include:

Continue current role of largely passive observation. This "wait and see" approach, in which we may comment or play a more active role on particular issues, is most consistent with Treasury's role in the process to date. The most likely outcome will be a little-noticed final report.

Encourage the development of a better legislative and public understanding of Medicare issues, and the development of a clearer framework of options for Medicare reform. A model for the desired result of this initiative is the Gramlich Commission. That commission struggled with an issue about which there was little political will or consensus for reform, and

laid out a set of three clear alternatives for the future of Social Security. These alternatives have provided the foundation for serious and specific public debate about Social Security reform. In this option, Treasury would seek to play a catalytic role in moving the Medicare Commission in the same direction. We would begin by outlining the major alternatives possible for the future of Medicare, through discussions with the other administration agencies and Commission staff and members. The eventual goal would be to identify several clear reform options, to guide future debate or possibly to serve as templates for HCFA demonstration projects.

There are several important contrasts between the Medicare Commission and the Gramlich Commission that illustrate the difficulties of this approach. In contrast to the largely academic Gramlich Commission, a majority of Medicare Commission are political leaders with a diverse range of views on Medicare and private citizens who are also less facile with Medicare policy issues. In addition, the Commission staff is probably less technically capable of translating Commission policy concepts into specific, workable reform options. These may be reasons for the slow pace of Commission activity to date, and suggest that developing a consensus even on a set of options may be difficult. Weaknesses in the Commission staff could provide the Administration with an opportunity to exert greater influence by supporting serious analysis of alternative reforms, but this could also create tensions with the Commission and particularly its co-chairs.

Encourage the development of a particular administration policy direction for long-term Medicare reform. The absence of any clear direction in the Commission's activities, and the relative strength of the Administration's appointees, suggests that any particular direction of reform supported by the Administration would have a relatively open field. In this option, Treasury would assist other administration agencies and Commission members in the development of key principles for Medicare reform. Even if these principles are not translated into a specific reform proposal, publicizing them through the Commission could still have a substantial impact on long-term public debate of Medicare reform. In addition, elucidation of these principles through the public platform of the Medicare Commission might provide opportunities for supporting other administration goals involving health care and the elderly, e.g. Social Security reform and expansions of health insurance for low-income Americans.

The obstacles to this approach include the fact that the Administration has not yet identified clear principles for Medicare reform. The Administration's appointees mostly support reforms within the "traditional" Medicare defined-benefit framework, but it is unclear whether there is any consensus beyond that. In addition, current public understanding and consensus about the future of Medicare is limited, and even general principles might divert public attention from other pressing administration initiatives.

Attachments

Summary Table 1.

Two Baseline Scenarios for Medicare Spending
(by selected calendar year)

DRAFT

01-Jun

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
No Slowdown in Growth of Medicare Spending	1	1	1	2	2	2	3	3	4	4	6	7	8
Trustees Intermediate	1	1	1	2	2	2	3	3	4	4	5	6	6
Medicare Spending as a Percent of Payroll ¹													
No Slowdown in Growth of Medicare Spending	1	2	3	4	4	5	6	6	8	9	11	14	17
Trustees Intermediate	1	2	3	4	4	5	6	6	8	9	10	12	13
Medicare Spending as a Percent of the Federal Budget (Discretionary Spending Balances the Budget) ²													
No Slowdown in Growth of Medicare Spending	3	4	6	7	8	11	13	16	19	23	28	33	37
Trustees Intermediate	3	4	6	7	8	11	13	16	19	22	25	28	30
Medicare Spending as a Percent of the Federal Budget (Revenues Balance the Budget) ³													
No Slowdown in Growth of Medicare Spending	3	4	6	7	8	11	13	16	19	22	26	30	33
Trustees Intermediate	3	4	6	7	8	11	13	16	19	22	24	26	28
Medicare Spending in Trillions of Dollars													
No Slowdown in Growth of Medicare Spending	0.007	0.015	0.036	0.070	0.108	0.180	0.247	0.363	0.537	0.817	1.258	1.949	2.972
Trustees Intermediate	0.007	0.015	0.036	0.070	0.108	0.180	0.247	0.363	0.536	0.801	1.148	1.611	2.212
Average Annual Growth in Spending from Previous Year Shown													
No Slowdown in Growth of Medicare Spending		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.2	8.7	9.0	9.2	8.8
Trustees Intermediate		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.1	8.4	7.5	7.0	6.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
No Slowdown in Growth of Medicare Spending		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.4	6.4	6.4	6.4	6.4
Trustees Intermediate		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.3	6.0	4.9	4.3	4.2

Source: Medicare Commission Staff.

Notes: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare

spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax. By 2003, when the transfer of much of Medicare's spending for home-health services from Part A to Part B is complete, Part A will account for roughly half of Medicare spending.
2. Assumes a roughly balanced federal budget. Discretionary spending frozen, 2009-2030 under No Slowdown scenario; discretionary spending grows by 1 percent a year less than inflation after 2008 under Trustees Intermediate scenario.
3. Assumes a roughly balanced federal budget. Revenue increase of 1 percent of GDP in 2010 and an additional 2 percent in 2025 under No Slowdown scenario; revenue increase of 1 percent of GDP in 2010 under Trustees Intermediate scenario.



The National Bipartisan Commission on the Future of Medicare

List of Commission Members

Senator John Breaux
Chairman

Congressman Bill Thomas
Administrative Chairman

Mr. Bobby Jindal
Executive Director

Mr. Stuart H. Altman, Ph.D.
Sol C. Chaikin Professor of National Health
Policy, Brandeis University, Waltham, MA
Appointed by: President Bill Clinton

Mr. Samuel H. Howard
Chairman, Phoenix Healthcare Corporation,
Nashville, TN
Appointed by: Honorable Newt Gingrich

Honorable Michael Bilirakis
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Honorable J. Robert Kerrey
United States Senate
Appointed by: Honorable Thomas Daschle

Honorable John Breaux
United States Senate
*Appointed jointly by: President Bill Clinton,
Honorable Trent Lott, Honorable Thomas
Daschle, Honorable Newt Gingrich and
Honorable Richard Gephardt*

Honorable James A. McDermott
U.S. House of Representatives
Appointed by: Honorable Richard Gephardt

Honorable John D. Rockefeller, IV
United States Senate
Appointed by: Honorable Thomas Daschle

Honorable John Dingell
U.S. House of Representatives
Appointed by: Honorable Richard Gephardt

Ms. Deborah Steelman
Attorney, Washington, D.C.
Appointed by: Honorable Trent Lott

Honorable Bill Frist
United States Senate
Appointed by: Honorable Trent Lott

Honorable Bill Thomas
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Honorable Greg Ganske
U.S. House of Representatives
Appointed by: Honorable Newt Gingrich

Ms. Laura D'Andrea Tyson, Ph.D.
Professor of Economics, University of
California at Berkeley
Appointed by: President Bill Clinton

Ms. Illene Gordon
State Office Staffer, Honorable Trent Lott
Appointed by: Honorable Trent Lott

Mr. Bruce Vladeck, Ph.D.
Professor of Health Policy, Mt. Sinai School
of Medicine, New York, N.Y.
Appointed by: President Bill Clinton

Honorable Phil Gramm
United States Senate
Appointed by: Honorable Trent Lott

Mr. Anthony L. Watson
Chairman and CEO, Health Insurance Plan,
New York, N.Y.
Appointed by: President Bill Clinton

TREASURY CLEARANCE SHEET

NO. _____
Date 7/14/98

MEMORANDUM FOR: SECRETARY DEPUTY SECRETARY EXECUTIVE SECRETARY
 ACTION BRIEFING INFORMATION LEGISLATION
 PRESS RELEASE PUBLICATION REGULATION SPEECH
 TESTIMONY OTHER _____

FROM: Mark McClellan
 THROUGH: _____
 SUBJECT: Medicare Commission and Medicare Reform - Memo Summary

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Mark McClellan	<i>MM</i>	7/14/98	Deputy Assistant Secretary	622-0563
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer _____ Date _____ Executive Secretary _____ Date _____



DEPARTMENT OF THE TREASURY
WASHINGTON

January 8, 1999

MEMORANDUM FOR DEPUTY SECRETARY SUMMERS

FROM: Mark McClellan *MM*
Deputy Assistant Secretary
for Economic Policy

SUBJECT: Options for Dedicating Part of the Surplus to Medicare

The attached memo reviews two options for dedicating part of the surplus to Medicare in our Social Security reform proposal. We endorse the basic proposal, but including Medicare in the Social Security debate raises some complex policy and political issues that have not been much discussed. For this reason we prefer Option 2, which seeks to put some bounds on the Medicare debate from the time we raise it. We have reviewed our concerns with Chris Jennings, who does not necessarily agree with all of our conclusions but does agree the issues merit a Principals' review.

Recommendation

That we send the attached memo to Gene Sperling, either formally or informally, and that you encourage some Principals-level discussion of the "Medicare strategy" in Social Security reform.

_____ Agree _____ Disagree _____ Let's Discuss

Attachment

Dedicating Part of the Budget Surplus to Medicare

This memo describes two options for presenting the Medicare piece of the Social Security reform package: the current version of the proposal, which signals Administration commitment to Medicare reform but not to any particular reforms (Option 1); and an alternative version, that seeks to focus the Medicare debate in this session of Congress on relatively uncontroversial, short-term reforms (Option 2).

As you know, recent Social Security reform proposals would dedicate a portion of the expected unified surpluses through 2020 to the Medicare Part A Trust Fund (which mainly finances hospital benefits in Medicare). Based on the most recent OMB budget forecasts, allocating 18% of the surplus will extend Part A Trust Fund solvency from 2008 to around 2020.

Pros: Unexpected and significant initiative to protect Medicare, and to preserve a substantial part of the surplus from tax cuts.

Cons: (1) Open to criticism of "double-counting." (2) Could also be criticized as a relatively small step toward solving the enormous long-term Medicare financing problem. Because the rest of the unified surplus would be allocated to other purposes, it might even make it more difficult to implement reforms in the future to make the program solvent through the Baby Boom. (3) Claims of solvency through 2020 may be difficult to sustain, because the budget forecasts assume that the Medicare spending growth rate will slow toward the GDP growth rate beginning around 2013.

The cons do not outweigh the benefits of the proposal, but they are likely to create pressure to add details on Medicare reform to the proposal after it is introduced. The two options differ in how they try to limit and direct this pressure.

Options

Option 1: Propose to reserve a portion of the surplus, as a step toward achieving long-term Medicare reform.

This approach may pave the way for much Congressional attention to long-term Medicare reform this year. It is likely that the Commission's report will recommend the adoption of a "premium support" structure with a range of "procompetitive" reforms modeled on developments in private insurance. Senator Breaux, Co-Chair of the Medicare Commission, has already signaled his intent to introduce legislation based on the Commission's report. It is unlikely that the Administration and many Democrats would support this proposal, at least until many difficult issues are addressed. Republican leaders, including Thomas and Archer, are on record as opposing the commitment of any additional revenues to Medicare, at least until major reforms to increase efficiency and control costs in the program are adopted. Opposing such proposals for long-term reforms would require debating their weaknesses and developing alternatives. To the extent that this legislative debate remains linked to Social Security, it could complicate and bog down the Social Security reform process.

Option 2: Propose to reserve a portion of the surplus and to adopt reforms now to shore up the Medicare program for the next decade.

In addition to dedicating part of the surplus, the Administration could propose over the next month a credible set of short-term reforms to "modernize" Medicare -- as a way to see the program through the next 5 to 10 years and as a positive step toward effective long-term reform. These reforms (such as selective contracting based on cost and quality, and preferred provider arrangements) would consist mostly of initiatives included in recent Administration budget proposals, would have minimal budgetary cost, and would provide HCFA with the authority to emulate some of the more successful recent innovations in private health insurance. They are also relatively uncontroversial within the Administration, though not completely uncontroversial. Providers have opposed some of them, and HCFA has only received legislative authority to adopt many reforms on a local demonstration basis. Medicare Commission proposals that could be easily appended to the current Medicare system, such as a limited prescription drug benefit, might be added. Such reforms do not represent a long-term Medicare solution. But they do provide a credible path toward the very difficult problem of long-term Medicare reform, thereby shifting the Medicare reform debate in this Congress to relatively simpler issues. The Administration would not be dragged into debates on major long-term issues such as "premium support" Medicare, except to argue that extensive further deliberation and study will be needed to assure that such reforms protect beneficiaries from high medical costs or poor access to care. In the long run, it would be possible to include modernized traditional Medicare as one option in a premium support system. But that issue could be deferred until after 2000, and after Social Security has been fixed.

One risk of Option 2 is that it might alienate Medicare Commissioners, as it suggests a direction for Medicare reform on the eve of the Commission's report. This concern could be addressed by avoiding specificity now (e.g., State of Union would urge only that this Congress not delay action on short-term reforms with broad support) and perhaps by meeting with key Commission members. Option 2 may actually lead to a more favorable Commission report. Many on the Commission would favor modernizing and rationalizing the traditional Medicare program in the short term, while aiming for adoption of premium support in another decade, giving enough time to work out the major kinks. However, some Commission Republicans and staff members apparently are trying to downplay the formulation of a credible proposal to modernize traditional Medicare, because premium support would look better next to the current "antiquated" Medicare program. This Administration proposal would likely be supported by Democratic members and Administration appointees to the Commission, and would give a needed boost to the inclusion of a serious proposal to modernize the current program in the report.