



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

INFORMATION

November 19, 1999

ASSISTANT SECRETARY

**MEMORANDUM FOR THE SECRETARY
DEPUTY SECRETARY EIZENSTAT**

FROM: David W. Wilcox *DW*
Assistant Secretary for Economic Policy

SUBJECT: A Breaux-Frist Proposal on Medicare Reform

Senators Breaux and Frist released a package of detailed Medicare reforms last week. It differs from the Breaux-Thomas plan primarily in that it would offer subsidized drug coverage to all Medicare beneficiaries. While the subsidy is smaller than the Administration proposed, the fact that it is universal bridges what we had thought might be the most intractable gap between us. That said, Breaux-Frist retains a number of other features of Breaux-Thomas that the Administration and core Democrats have opposed. In the interest of keeping alive some hope for broader Medicare reform in this Congress, we believe the Administration should refrain from criticizing the Breaux-Frist plan publicly – at least until it has had a chance to develop a strategy for next year's Medicare debate. The main features of Breaux-Frist are as follows:

- *Subsidized drug benefit for all Medicare beneficiaries.* Most beneficiaries would receive a 25 percent subsidy for drug coverage – about \$200 per year gross, but subject to income taxation. The Administration proposed a 50 percent subsidy, on the theory that a subsidy this large would be required to overcome adverse selection. It is not clear how much the smaller subsidy in Breaux-Frist would increase drug coverage. Also, the benefit in Breaux-Frist would be defined only in general terms, which would offer more flexibility in design but would raise further concerns about adverse selection and about whether the benefit would really represent a guarantee to seniors.
- *"Premium support" system of competition, overseen by a Medicare Board.* Breaux-Frist is identical to Breaux-Thomas here, with government contributions tied to the average cost of all plans and a Medicare Board established outside of HHS to manage the competition between traditional Medicare and private plans.
- *Soft cap on general revenue financing.* Breaux-Frist also retains the provision of Breaux-Thomas that would limit general revenues to 40 percent of total program costs – unless Congress votes to raise the limit. Proponents have argued that this would provide some added fiscal discipline, but concerns were raised that this approach would either be meaningless or could create pressure for unwise cuts in the face of a financing "crisis."
- *Deletion of some controversial Breaux-Thomas elements.* Breaux-Frist does not call for an increase in Medicare's eligibility age or for benefit rationalizations like a combined deductible for Parts A and B and co-payments on home health care – components of Breaux-Thomas that the Administration had opposed. It also drops the BBA "extenders" (which provided a large share of the savings in Breaux-Thomas and in our plan).



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The Deputy Secretary of the Treasury

December 20, 1999

NOTE FOR DAVID WILCOX

Assistant Secretary for Economic
Policy

FROM: STUART E. EIZENSTAT

SUBJECT: A Breauz-Frist Proposal on Medicare
Reform

This Breaux-Frist proposal seems like real forward movement. Shouldn't we try to get Chris J. and/or Gene Sperling to call a meeting to discuss our response? Let's discuss as soon as possible.

Attachment

cc: Karen Kornbluh
Carolyn Keene

Room 3326

622-1080



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

INFORMATION

November 19, 1999

DEC 1 12/12

ASSISTANT SECRETARY

MEMORANDUM FOR THE SECRETARY
DEPUTY SECRETARY EIZENSTAT

FROM: David W. Wilcox *DW*
Assistant Secretary for Economic Policy

SUBJECT: A Breaux-Frist Proposal on Medicare Reform

To: David Wilcox
Fr: *AE*

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EXECUTIVE SECRETARIAT



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

INFORMATION

December 13, 1999

ASSISTANT SECRETARY

**MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT**

FROM: Assistant Secretary Wilcox ^{DW}
Deputy Assistant Secretary Elmendorf ^{DE}

SUBJECT: The Medicare Drug Benefit Debate

In the last two months there have been two significant developments in the debate about a Medicare drug benefit. First, the White House has stepped up its criticism of the pharmaceutical industry, in the hope of forcing the industry to accept a universal drug benefit like the one that the Administration proposed. Second, Senators Breaux and Frist have put forward a Medicare reform plan that includes a universal drug benefit – instead of the low-income drug benefit proposed in Breaux-Thomas.

This memo: 1) reviews the merits of the drug industry's charge that our plan would cause seniors to lose their current employer drug coverage; 2) outlines the study of drug pricing requested by the President from HHS; 3) compares the Breaux-Frist drug proposal with our plan; and 4) presents our suggestions for how the Administration should proceed.

1. The Drug Industry's Criticisms of the Administration's Plan

The pharmaceutical industry has mounted a highly visible ad campaign against the Administration's proposed drug benefit. They have argued that our plan will: i) cause employers to drop existing drug coverage; ii) put big government in seniors' medicine cabinets; iii) stifle competition by having only one benefit manager in each region; and iv) lead to price controls. We focus on the first issue, which is the one they have emphasized publicly. (The second charge can be rebutted directly, the third might be addressed by allowing multiple managers in each region, and the fourth is more a question of political economy.)

The Administration's plan contains the following subsidies:

- Individuals who take the Medicare benefit would receive a 50 percent premium subsidy – so if the average cost of the benefit were \$600, they would pay \$300.
- Employers who provide coverage at least as good as the Medicare benefit would receive a reduced subsidy, equal to one-third of the total cost of the Medicare benefit (e.g., \$200).
- Employers who pay the Medicare premium on their retirees' behalf would receive the same 33 percent subsidy – so their premium payment would be \$400 in this example.

*These subsidies were designed so that – assuming a personal tax rate of 25 percent – employers that offer good drug benefits now would be **indifferent** between: a) continuing coverage; b) paying their retirees' new Medicare premiums and providing additional coverage themselves (“wrapping around Medicare”); and c) wrapping and giving retirees added compensation with which to pay the Medicare premiums themselves.*

The drug industry charges that our proposal would cause 6 to 9 million seniors to lose their current employer coverage. We believe that the PricewaterhouseCoopers (PWC) analysis underlying this charge is both inaccurate and misinterpreted:

- First, PWC mistakenly assumes that employers will have a financial incentive to drop existing coverage and wrap around Medicare. This mistake may have arisen because the Administration's public documents were not clear about the case in which employers pay the Medicare premium on their retirees' behalf.
- Second, the industry unfairly implies that beneficiaries would be worse off if their former employers wrapped around Medicare. In fact, they would receive the same overall drug coverage as today, and employers would likely go this route only if it cost less apart from the subsidies or had some non-financial advantages.

CBO and the HCFA actuaries concluded that 75 percent of retirees would continue to receive drug coverage from their employers (who will receive the Medicare subsidies). The remaining 3 million retirees would generally still be better off than under the current system, but making that case is more difficult:

- Most employers that will drop coverage now offer less generous insurance than our proposal. Their future retirees will receive better coverage and may pay less, on net, because they will receive government subsidies and presumably alternative compensation from their employers. Yet, the charge of “one size fits all” could be leveled here.
- Some employers may use the establishment of a Medicare “safety net” as an excuse to drop coverage that is more generous than our proposal. We would argue that future retirees will receive higher compensation in some other form, but this argument lacks political appeal and may not apply to current retirees. A more substantive concern is that those who would like more generous coverage than Medicare will find it difficult to buy a wrap-around policy on their own, because of adverse selection.

2. The HHS Drug Pricing Study

In an October speech, the President sharply criticized the drug industry's ads. He disavowed interest in “a big price control system” and argued that the increase in sales resulting from a universal drug benefit would more than offset the lower prices that Medicare's benefit managers might negotiate. As a result, the President argued, drug companies would be better off in the same way that doctors and hospitals gained from the establishment of Medicare itself.

The President also asked HHS to report (before the State of the Union address) on:

- price differences for the most common drugs for people with and without coverage;
- drug spending across age groups, as a share of income and total health spending; and
- trends in drug spending across age groups, as a share of income and total health spending.

Ideally, this report will reinforce the case for providing drug coverage to the elderly; combined with the difficulties of targeting a drug benefit at people who now lack coverage, it will help to show that the benefit should be universal. Nevertheless, we have two concerns about possible misinterpretations of the study's results:

- *Cost-Shifting?* Some might conclude that people without coverage are charged higher prices *because* people with coverage receive lower prices. (Indeed, this is the conclusion of drug pricing studies done for Representatives Waxman, Allen, and Sanders.) We think this inference is unwarranted and also not useful: both Medicaid and the Veteran's Administration now pay low prices, and attacking cost shifting could pin the blame for higher consumer prices on the government.
- *Best Available Price?* Others might conclude that Medicare should pay the lowest price charged to any other U.S. customer – the “best available price.” (The House Democrats have used their studies to make this point.) In the internal debate, Treasury argued that competitive bidding would yield appropriate discounts, and the actuaries said they would not score mandated discounts off a reference price any more generously than the competitive approach, because the reference price would simply adjust endogenously. We would also argue that such provisions tend to discourage price competition.

The White House pressed internally for a comparison of drug prices across countries, in an attempt to show that American seniors generally – and those without coverage particularly – are paying higher prices than necessary. In recent remarks, both the President and Vice President have emphasized international comparisons (to Canada in particular). However, Treasury and other agencies lobbied successfully to exclude these questions from the current study, for three reasons:

- Such comparisons may not be meaningful, since price differences across countries reflect not just supplier behavior but also exchange rates, demand differences, and differences in regulatory environments (such as patent protections and price control mechanisms).
- Reliable data could not be acquired to complete such a study in the time available.
- *Such comparisons do not help make the case for our proposed drug benefit, because we have not proposed any measures that would allow us to obtain drugs at foreign prices.* The comparisons to Canada are particularly problematic because they suggest that we are interested in adopting the strict system of drug price controls used there.

3. **The Breaux-Frist Plan**

Senators Breaux and Frist (BF) included a subsidized drug benefit for all Medicare beneficiaries in their recent reform plan. The proposed subsidies would be insufficient to achieve universal coverage, and the plan retains many elements of the Breaux-Thomas proposal that the Administration and core Democrats opposed. Nevertheless, the move to universal subsidies eliminates a key difference between our proposal and the leading alternative on an issue where compromise seemed unachievable.

BF would offer a 25 percent subsidy for drug coverage, which is much smaller than the 50 percent subsidy that the HCFA actuaries believe is necessary to make a drug benefit attractive to all seniors. (The subsidy is also subject to income taxation, which reduces its net value further for many seniors and would create a reporting burden for all enrollees.) There are also other differences from our proposal:

- *How is the Benefit Defined?* BF would require all drug plans to have an average cost across the elderly population that is about equal to the Administration's proposed benefit. However, BF would allow providers to meet that requirement through any combination of deductibles, coinsurance, and benefit caps they chose, in contrast to the specific parameters required under the Administration's proposal. The BF approach would allow drug plans to be tailored more closely to the needs of different seniors, but it would simultaneously create strong selection pressures and weaken price competition.
- *Is it a Package Deal?* To obtain BF drug coverage, seniors would also have to purchase unsubsidized insurance that would limit their out-of-pocket costs for basic Medicare (excluding drugs). In addition, beneficiaries choosing this "high option" package would apparently be barred from purchasing Medigap, which reduces beneficiary cost-sharing to zero or nominal amounts. While such catastrophic-only coverage would make these plans more attractive to healthy beneficiaries and thus reduce selection pressure on the drug benefits, it could make the drug benefit unappealing to many seniors.
- *How Many Benefit Managers are Allowed?* BF would allow any willing firm to provide the drug benefit to enrollees in traditional Medicare, in contrast to our proposal that would have one drug-benefit manager in each region. Allowing multiple managers in a region would require an extensive information campaign (especially because the elderly with cognitive limitations would not have a default option) and would result in some adverse selection, but there would be offsetting gains from providing more choices.

4. **How to Proceed**

We believe that the Administration should:

- rebut misleading claims about our proposed drug benefit directly and emphatically;
- play down criticism of drug pricing or pharmaceutical companies in general; and

- seek a compromise with Senator Breaux and others in Congress.

It is critical to counter any false claims about people losing their existing insurance coverage. For example, this fear was one reason why the last attempt to create a Medicare drug benefit (the Catastrophic Care Act of 1988) was quickly repealed. At the same time, it will be difficult to win the argument that the industry is price-gouging, and attempting to do so will likely make it more difficult to enact a meaningful drug benefit:

- Unlike the tobacco companies or HMOs, the drug companies are reasonably well regarded by the public. In addition, industry-bashing proved unsuccessful in the debate on the Health Security Act, and Medicare's history suggests that reforms do not take place without the acquiescence of affected provider groups.
- Attempts to shame the industry for charging too much are as likely to raise fears about price controls as to generate progress toward a drug benefit.



DEPARTMENT OF THE TREASURY

WASHINGTON, D.C. 20220

February 29, 2000

MEMORANDUM FOR SECRETARY SUMMERS DEPUTY SECRETARY EIZENSTAT

From: David Wilcox
Jon Talisman
Doug Elmendorf
Len Burman

Subject: **Income-Related Medicare Drug Premiums**

Chris Jennings is pressing for the interagency Medicare staff-level group to discuss the pros and cons of relating drug premiums to income. Chris's interest in this issue apparently arises from his conversations with people outside the Administration, but we do not know the details. One impetus may be the Breaux-Frist plan, which would tax drug premium subsidies.

As you recall, the Administration came close last summer to proposing that Medicare Part B premiums be related to income. That issue does not appear to be on the table now; instead, the focus is on income-relating the proposed new Part D premiums.

Treasury has been asked to prepare a short document to inform the interagency discussion. Obviously, the discussion below could form the basis for such a document. We would like your views on this subject before we distribute such a document.

Overview

- **Should subsidies be related to income?**

Income-relating drug subsidies would enable the government to focus its scarce resources on drug subsidies for seniors who can least afford to pay full price. Taking this approach might also increase the likelihood that Part B premiums would be tied to income in the future.

But for the revenue gain to be significant, a substantial number of seniors would have to face a reduced net subsidy. The HCFA actuaries have concluded that our proposed 50 percent subsidy is needed to ensure near-universal take-up, and that lower subsidies could lead to substantial adverse selection. If adverse selection is severe enough, some of the direct revenue gain could be offset by higher program costs per participant. Moreover, the approach would make the tax code more complex.

On balance, we recommend that the drug premium *not* be related to income.

- **If we income-relate subsidies, how is that best achieved?**

There are two related advantages to using the tax system. First, the tax system already collects information on income, eliminating the need for a new administrative structure. Second, the tax system would naturally make this year's subsidy dependent on this year's income, which is probably preferable to basing this year's subsidy on last year's income as might occur in a non-tax system.¹

Within the tax system, there are two ways to income-relate subsidies:

- Include subsidies in taxable income, or
- Subject subsidies to a separate recapture tax that increases with income.

If the Administration chooses to relate drug subsidies to income, we recommend that they be included in taxable income rather than taxed separately. Inclusion in income is much simpler than the alternative and would not create a separate implicit tax on the income of seniors. It also has the political advantage of a precedent in the Breaux-Frist proposal.

Background

The Administration has proposed a subsidized prescription drug benefit for all Medicare participants. The subsidy would be 50 percent for individuals who pay their own premiums for drug coverage through the new fee-for-service drug plan or a comparable managed care drug plan.² The subsidy would be 33 percent for employers who pay for comparable drug coverage for their retirees, either by providing it themselves or by paying premiums to Medicare. Individuals below 150 percent of poverty would receive additional subsidies; which would be income-related through a separate mechanism from those discussed below.

For comparison, the Breaux-Frist plan would offer a 25 percent subsidy for individuals and include it in taxable income. The plan provides additional subsidies for individuals below 150 percent of poverty, but it has no subsidies for employers.

Discussion

This memo describes the mechanics of the two tax approaches and then considers a number of issues that arise in the context of income-related premiums:

- taxing employer subsidies,
- fairness,
- take-up rates and adverse risk selection,
- government costs and beneficiary premiums, and
- administrability.

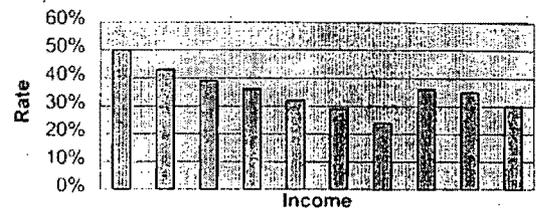
¹ Under this alternative, individuals who experience a decline in income would receive a subsidy that might be deemed too small. This could be a particular problem for senior citizens.

² Because the drug benefit is phased in over 7 years and then indexed to prices, this subsidy would start at roughly \$300 in 2003, grow to about \$600 in 2009, and rise further thereafter.

Including Subsidies in Taxable Income

- An argument in favor of inclusion is that the subsidy is a form of income to the recipient. Insofar as the progressive income tax reflects society's view of people's ability to pay tax, including subsidies in taxable income may be seen as a natural way to determine an individual's ability to pay for prescription drug coverage.
- However, the resulting net subsidies would not decrease smoothly with income because effective marginal tax rates for seniors do not rise steadily with income. Over the income range in which Social Security benefits are subject to tax, subsidy rates would fall sharply and then rise. Taxing a 50 percent subsidy would produce the schedule of effective subsidy rates shown in the chart, which may seem unfair.
- Moreover, taxable income may not be a good measure of ability to pay for the elderly. A working couple with \$50,000 in earnings but no pensions or savings may have fewer financial resources than a retired couple with \$30,000 in unearned income. Also, the retired couple may receive another \$20,000 in Social Security benefits that would not be taxed and thus would not be counted in taxable income.
- About 60 percent of all seniors face a Federal marginal income tax rate of 0, and they would still enjoy the full 50 percent subsidy.³ Roughly 20 percent of seniors would face a net subsidy rate below 40 percent, and about 40 percent would face a net subsidy rate below 43 percent. A few seniors would have effective subsidy rates below 25 percent.⁴
- This approach would not affect marginal tax rates for most seniors. Only those seniors whose income before the subsidy falls just below the threshold for a higher tax bracket would find their marginal tax rates increased from 0% to 15%, 15% to 28%, and so on.
- Including the subsidies in income would make some seniors now claimed as dependents on another taxpayer's return ineligible for that status. (About 1.5 million elderly people are claimed as dependents. Their gross income cannot exceed \$2,800.) The additional tax paid by the taxpayer formerly claiming the dependent would frequently exceed the amount of the subsidy. Creating an exception to avoid this problem would further complicate the tax code.

Effective Subsidy Rate When Subsidy is Taxed



³ In states that followed the Federal government in including these subsidies in taxable income, state tax rates would reduce the effective subsidy a little more.

⁴ These numbers are based on counts of all seniors; as we discuss below, these proposals could involve taxing employer subsidies or not, and in the latter case, the more relevant calculations would be based on marginal tax rates for individuals not covered by an employer plan.

Separate Recapture Tax

- A recapture tax would be phased in at a specified rate for incomes above a specified threshold.
- This approach would allow the most accurate targeting by income (subject to the above-mentioned caveat that income reported on tax returns may not accurately represent ability to pay for some seniors).
- However, creating a separate schedule for the recapture tax would be more complicated than simply including the subsidy in income.
- Relating subsidies through a recapture tax would raise marginal tax rates for beneficiaries in the phase-in income range (although not for those above it or below it). The average increment to marginal tax rates could be small because the drug subsidy is fairly small. For example, if the \$1,200 joint (\$600 single) subsidy phased out over a \$60,000 (\$30,000) income range, the average increase in marginal tax rates would be 2 percent ($\$1,200/\$60,000$). However, a wide phase in range would mean that the revenue collected would be small compared with the number of persons affected.

Taxing Employer Subsidies

- It is not clear how employer drug subsidies should be treated under this scheme.
- If individual subsidies are taxed and employer subsidies are not, some people without employer coverage might complain that they were being disadvantaged.
- At the same time, if retired employees currently receiving employer-provided drug benefits were required to include the new employer subsidy in taxable income, they would be taxed without receiving any new benefits. Because they are retired, their employers could not pass on their new subsidies in the form of higher wage compensation, and are unlikely to pass them on in the form of higher pension payments.
- The mechanics of taxing employer subsidies at the individual level would add an extra complication as well.
- One way to restore the plan's existing relationship between employer and employee subsidies would be to further reduce the employer subsidy relative to the individual subsidy, but to exclude individuals receiving drug benefits from employers from taxation.

Fairness

- One argument for income-related premiums is that the government should focus its scarce resources for drug subsidies on seniors who can least afford to pay full price.

- A counter-argument is that Part B premiums do not vary with income, and treating Part D premiums differently could appear inconsistent. Some people or groups (such as labor unions) may also be concerned that taxing this health benefit would set a precedent for taxing other health benefits. And some people might even view this new “tax” as somehow analogous to the very unpopular catastrophic health insurance law of 1988.

Take-Up Rates and Adverse Risk Selection

- Individuals would have a one-time election to join the prescription drug program during the first year of the program, during the first year of Medicare eligibility, or when employer-provided benefits cease due to retirement, death of a spouse, or employer dropping of coverage for all retirees. The one-time election would reduce adverse selection compared with a program that allowed choice every year. Individuals who are currently healthy may opt for the program to ensure that they can participate in later years when their health may decline.
- Because the actuaries have argued that a 50 percent subsidy is needed to ensure near-universal take-up, they may conclude that reducing effective subsidies in our plan would induce adverse selection. (Because the Breaux-Frist subsidy is only half as large as the Administration’s, that plan would have a serious adverse selection problem even in the absence of their proposal to tax subsidies.)
- Healthy high-income seniors would be less likely to purchase drug coverage if subsidies are income-related, but how *much* less likely is unclear. (Under proposals such as Breaux-Frist that do not specify the drug benefit, the availability of certain options – such as catastrophic-only – could also influence people’s decisions.) More generally, it is unclear whether ensuring the enrollment of high-income seniors might require a larger or smaller effective subsidy than is required for lower-income seniors:
 - Because these beneficiaries have higher income, they may feel less need than lower-income beneficiaries to buy insurance against moderate drug expenses.
 - On the other hand, high-income beneficiaries have higher Medicare spending than low-income beneficiaries, and they are likely to live longer. They may be able to take a longer view than low-income beneficiaries and pay premiums beginning at age 65 rather than face unpredictable future expenses. They may also want to ensure that they can afford the new wave of expensive drugs developed over time. All of these factors imply that high-income beneficiaries may expect to receive greater benefits from drug coverage than low-income beneficiaries, which would encourage their purchase of insurance.

Government Costs and Beneficiary Premiums

- Reducing the effective drug subsidy for higher-income beneficiaries would have several effects on government spending:

- The government would save money on everyone in that group who would still buy coverage (the difference between the official 50 percent subsidy and the effective subsidy). The average subsidy rate would fall to about 44 percent if subsidies were included in taxable income, suggesting that the government would save \$15 to \$20 billion over ten years before accounting for the following effects.⁵
- The government would save the subsidy dollars that would be paid on behalf of those who drop coverage.
- But the loss of healthier-than-average beneficiaries because of adverse selection would raise average spending by those in the risk pool, and the government would lose money by paying higher subsidies to those people.
- Only the third of these effects would matter for beneficiary premiums, which would therefore be higher. However, part or all of the savings could be used to increase the pre-tax subsidy rate in an attempt to hold beneficiaries at lower tax rates harmless.
- If drug subsidies were taxed separately, then the share of seniors who faced a notably lower effective subsidy could be designed to be fairly small. This suggests that all of the effects described in the previous bullets could be small – the direct government savings, the change in average spending by the insured population, and the change in premiums, but the added complexity to the tax system would remain.

Administrability

- Proponents of taxing drug subsidies argue that the relevant information could be reported on 1099 forms that are already sent to all Social Security recipients. And since drug premiums would generally be deducted from Social Security benefit checks, the additional work involved in reporting the subsidy on the 1099 might be small. However, the precise mechanics would need to be developed by SSA and the IRS.
- Beneficiaries would need to include subsidy information in computing their tax liabilities. Some current non-filers would have to file tax returns because the subsidies would increase their taxable income above the filing threshold.
- Both proposals would complicate the tax system. In addition, creating a separate recapture tax could set an unfortunate precedent for other complicated new taxes.

⁵ This saving includes increases in Social Security revenue owing to an increase in the number of individuals exceeding the thresholds for taxation of Social Security benefits.

TR TO LHS (READING)
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April 7, 2000

**MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT**

FROM: Assistant Secretary Wilcox
Acting Assistant Secretary Thomas
Deputy Assistant Secretary Elmendorf

SUBJECT: Latest Developments in the Medicare Drug Benefit Debate

This memo reviews and analyzes key developments in the drug benefit debate over the past month. It covers: 1) the Graham-Conrad drug proposal; 2) new proposals from House Republicans; 3) developments in the Senate Finance Committee; 4) the views of House Democrats; 5) HCFA scoring of single versus multiple benefit managers; 6) some facts about the out-year costs of a catastrophic drug benefit; and 7) the HHS drug pricing study.

1. The Graham-Conrad Proposal

Their Plan. The drug benefit proposal that Senators Graham and Conrad are developing is broadly similar to the Administration's drug plan, but differs on some key details.

Similarities:

- Defined benefit with a 50 percent premium subsidy for most seniors and more help for those with low income (so take-up would be assumed to be universal).
- Begins in 2003 with a one-time enrollment option.
- HCFA provides oversight (no Medicare Board).

Differences:

- Multiple PBMs allowed in each region (compared with one in our plan).
- \$250 deductible (compared with no deductible in our plan).
- Catastrophic coverage in the form of a \$3,000 stop-loss limit, which would start in 2003 (compared with an unspecified benefit beginning in 2006 in our budget).
- More rational benefit structure in between, with a declining co-payment rate and no "donut" in the middle where seniors pay full price.
- Income-related drug benefit premium that would be administered through the tax code (starting at \$75,000 for singles and \$125,000 for joint returns, the premium subsidy would phase down gradually from 50 to 25 percent).

Our Views. This proposal avoids some of the disadvantages of the Administration's plan but is substantially more expensive as a result – about \$50 billion higher over 10 years, according to HCFA's preliminary estimates. In large part, this discrepancy arises because Graham-Conrad does not phase the benefit in – either by ratcheting up the initial coverage level over time, or by

delaying the stop-loss protection. At the same time, we understand that their goal was to produce a plan which costs about the same as ours over 10 years, so the Administration has made suggestions to Graham's staff about how to reduce costs (e.g., by including our employer subsidy plan and by indexing the catastrophic threshold to the drug CPI instead of general inflation). It is worth noting that Graham's office favors using multiple PBMs but would accept a single PBM per region if the cost savings were significant – so the scoring of these alternatives by the HCFA actuaries (discussed below) will be particularly important.

2. House Republican Plans

In the House, jurisdiction over Medicare is shared between the Commerce and Ways and Means Committees, and Speaker Hastert has appointed a joint committee to develop a consensus plan – but for now the two Committees are proceeding on their own.

House Commerce Plan. Republicans on the House Commerce Committee, led by Chairman Bliley, have begun circulating a draft of their own drug benefit proposal.

- Somewhat surprisingly, the House Commerce plan rejects a proposal to finance the benefit through block grants to states – which was put forward by sub-committee chair Michael Bilirakis. Instead, all seniors in traditional Medicare would be eligible to purchase individual drug policies from any willing private insurer (akin to Medigap).
- As expected, their proposal provides explicit premium subsidies only for lower-income seniors. The new wrinkle is that the government would cover costs for those with more than \$5,000 in drug spending – which would lower premiums for everyone, regardless of income. The plan does not specify an administrative structure or financing mechanism for this re-insurance pool, and we have not seen an overall cost estimate.

House Ways and Means. Particularly in its reliance on private insurers, the Commerce drug plan is similar to one that Congressman Thomas of Ways and Means is reportedly developing. He indicated recently that his plan might not be ready until June, and that his proposal will link the drug benefit to other program reforms.

Administration Reaction. At a recent internal meeting, this Commerce proposal was described as rejecting one bad approach (state block grants) in favor of a worse one.

- The Administration's main concern, of course, is that offering sizeable subsidies only to the lowest-income seniors would still leave millions uninsured or underinsured.
- Chip Kahn, head of the Health Insurance Association of America (HIAA), has testified that insurers would not want to offer drugs-only policies to individuals – a point the Administration has highlighted. (The insurers are concerned that these policies would attract only the sickest seniors and thus would be costly to offer – even as state insurance regulations would prevent premiums from keeping pace with costs while requiring the policies to be renewed in perpetuity.)

- Rather than rely on the troubled individual-insurance market, the Administration has argued for letting the government pool risks through Medicare while the private sector manages the benefit – exploiting the comparative advantage of each sector, in effect.

We tend to agree with these arguments, but believe further thought should be given to the favorable effects that the proposal might have – by attracting healthy low-income seniors, and offering subsidized catastrophic protection – on the risk pool, incentives to offer such policies, and take-up rates.

3. Developments in the Senate Finance Committee

Senator Moynihan has formally introduced the Administration's legislative language, but there are a number of signs that serious progress in this committee may be slow in coming:

- We understand that Majority Leader Lott has told Chairman Roth to make sure he has support from Committee Republicans before he starts working with Senator Moynihan or other Democrats on a bipartisan proposal. In turn, contact between the Committee's majority and minority staffs has atrophied, and the bipartisan meetings with Administration staff have ceased. What is more, Chairman Roth will be away for one month following surgery, starting next week.
- The recent Senate Finance hearings on the drug benefit laid bare the substantive disputes underlying these procedural problems. As Senator Snowe put it, there is a consensus that Medicare should have *a* drug benefit, but no consensus one what *the* drug benefit should be. Views continue to differ strongly about whether subsidies should be universal or limited to those seniors with low income, and also about whether and how the addition of the drug benefit should be linked to overall Medicare reform.
- Of particular note, Senator Breaux expressed interest in an approach similar to the House Commerce plan described above, linked to some elements of reform (such as a Medicare Board and/or a cap on general revenue financing on Medicare); neither he nor Senator Frist seems to be pushing for the kind of universal subsidy contained in the Breaux-Frist plan. Meanwhile, Senator Kennedy recently announced that the improvements in Trust Fund solvency mean the drug benefit can be added without other reforms.

4. Views of House Democrats

Their Views. Recent meetings with the staffers for key House Democrats revealed the following:

- They want to examine other models for obtaining discounts on drugs – such as the Medicaid rebate program, the Allen bill, or simply having HCFA buy all of the drugs (“just like other Medicare benefits”). (The Kennedy-Stark drug bill allowed for multiple PBMs but also required HHS to certify it was getting the best price for each drug.)
- They claimed that organized labor opposes our proposal to subsidize employers “simply for fulfilling their contractual obligations.” (Our understanding was that the unions did

not advocate this approach but did not oppose it either, and they would be well positioned to benefit from the added resources that our proposal would put on the bargaining table.)

Our Reaction. Clearly the positions of the House Democrats raise concerns on both economic and political grounds.

- As an economic matter, we believe that the HCFA actuaries will conclude that the Medicaid rebate model would not cost less than a PBM-based approach (since the reference price from which the rebate is calculated would simply adjust endogenously). To the extent that House Democrats seek deeper discounts out of concern over drug industry profit levels, we will press the case that this is not an appropriate basis for policy.
- As a political matter, it is hard to see how the drug industry or Republicans would be able to support anything to the left of multiple PBMs. We will continue to encourage our colleagues in the Administration to avoid making comments that would complicate the process of accepting multiple PBMs down the road.

5. Single vs. Multiple PBMs in a Region

- After going back and forth for a while, the HCFA actuaries have apparently concluded that allowing multiple PBMs to compete for beneficiaries in each region would result in higher costs than our single-PBM proposal. We thought they might reach this conclusion based on selection effects alone – since letting seniors choose the best deal for themselves is likely to shift some costs to the government.
- The new development is that the actuaries now believe allowing multiple PBMs will lead to smaller price discounts. They have not yet said *how much* it would raise costs to use multiple PBMs, however.
- We disagree with their conclusion about price discounts. The key factor in obtaining discounts is probably a PBM's national market share, including people under age 65, and this is not likely to be affected greatly by how many PBMs can operate in each region (especially since, to foster future competition, we would probably not allow the same PBM to be the sole contractor in every region).
- It is unclear whether we should dispute their conclusion. In part this is because they rarely respond to such pressure – indeed, they have helpfully resisted suggestions from others to provide favorable scoring for mandatory discounts. Moreover, the rest of the Administration's health team seems to share the actuaries' views.
- It is possible that CBO will reach a conclusion more consistent with our views. We have heard them argue, however, that a single PBM may be in a stronger position to extract concessions from pharmacies. It is not clear to us that this matters much, given the Administration's position that any pharmacy can participate as long as it has the requisite computer system and accepts the dispensing fee set by the PBM. Even if larger PBMs are able to make lower dispensing fees stick, this is an argument that competition for

seniors will eventually lead to a dominant PBM in each region – but it doesn't mean that such competition for seniors should be precluded.

6. Costs of a Catastrophic Drug Benefit

Facts. The catastrophic drug benefit proposed by the Administration has fairly modest costs over the first 10 years (\$35 billion), but it would be extremely expensive in the very long run.

- The cost grows about 16 percent per year, and therefore doubles about every 5 years. By comparison, our basic benefit grows “only” 7 percent per year. The difference arises because the share of total drug spending that falls above individuals’ stop-loss amount increases very quickly. (These estimated growth rates may slow eventually, because the actuaries predict that Medicare spending per person slows to the growth of real wages by 2025.)
- As shown in the table below, the drug benefit is much more expensive in the second ten years than in the first ten years, in part because both the basic benefit and the catastrophic protection are being phased in during 2001-10.

	Basic Benefit	Basic plus Catastrophic
Costs in 2001-05	\$22 B	\$22 B
Costs in 2001-10	\$160 B	\$195 B
Costs in 2011-20	\$434 B	\$737 B
Costs in 2011-20 / Costs in 2001-10	2.7	3.8

- The Administration’s February budget included no funding for the catastrophic drug benefit after 2010. If we proposed a specific catastrophic benefit in the Mid-Session Review – instead of a “reserve” – we would need to incorporate its long-term cost in our projections. With no other change in proposed policies, funding the catastrophic drug benefit would require an increase of over \$300 billion in the baseline on-budget surplus for that year, as shown below. Depending on the additional resources forthcoming in the MSR, this might or might not be a difficult hurdle to surpass.

	Basic Benefit	Basic plus Catastrophic
Cost of Benefit Payments in 2030	\$106 B	\$320 B
Share of GDP	0.3 %	0.9%
Total Medicare Share of GDP	4.4 %	5.0%
Cost Including Interest on Prior Spending	\$250 B	\$585 B

Recommendations. To help control the costs of the catastrophic drug benefit, we would suggest the following measures:

- *Start Small.* When the MSR comes out, there will likely be pressure to make the catastrophic benefit more generous. We urge that spending be kept to \$35 billion for the years 2006-2010 – since out-year costs will grow even more sharply otherwise – and that any added resources be used to start the catastrophic coverage sooner, so as to provide better

insurance. The main critique we have heard of our catastrophic proposal is not that it is too meager but that it starts too late. This approach would also help reduce the ratio of out-year costs to in-year costs.

- *Maintain Co-Payments.* The catastrophic benefit need not pay 100 percent of the cost of each prescription immediately; a more cost-effective approach to providing insurance would maintain some co-payments (e.g., 10-20%) over an initial range, until a higher point of true “stop-loss” was reached. In a fee-for-service program where care is not managed, co-pays are a particularly important means of ensuring that the health benefits of expensive drug therapies warrant their costs.
- *Index to Drug Expenditures.* The options currently being considered index the limit on out-of-pocket spending by seniors to either the CPI or the drug CPI. If this amount was indexed instead to the growth rate of total drug expenditures per person, then it would cover roughly the same share of drug expenditures each year (the approach that was used in the 1988 Catastrophic Coverage Act). To prevent the “donut” between the basic and catastrophic benefits from growing larger over time, the cap on the basic benefit would have to be indexed in the same way – as was done in the estimates that use the drug CPI – but this would still keep a larger share of the drug spending distribution in a range where seniors face co-payments. Initial cost estimates indicate that using the drug CPI instead of the CPI reduces the 30-year costs to Medicare by 10-15 percent, so switching from the CPI to drug expenditure growth per capita would have even larger effects.

Clearly the proposals to maintain co-payments and index the benefit more rapidly will be controversial, but they also should help sell the proposal to critics – since they can be described as sharing a portion of the costs and risks between the fisc and individuals.

7. HHS Drug Pricing Study

The HHS study of drug pricing, which the President requested last fall, will be released on Monday.

- The study was designed to focus on the extent of drug coverage among seniors and on drug price differences for those with and without coverage – which should help the Administration make the case for a universal benefit through which seniors would get appropriate, privately negotiated discounts.
- At the same time, recent revisions draw attention to the difficulties involved in determining the true prices at which drugs are sold in the private market – which is a problem for implementing the current Medicaid rebate provisions, but also implicitly reveals the limits of price control regimes.
- Per your guidance, the mandate for the proposed follow-up conference will be expanded to include the benefits of using market-based purchasing mechanisms and the importance of maintaining strong incentives for innovation.

April 22, 2000

MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT

FROM: Assistant Secretary Wilcox
Deputy Assistant Secretary Elmendorf

SUBJECT: **Taking Medicare Off-Budget**

The main purpose of this memo is to address various objections to taking Medicare out of the budget that were raised at the last NEC principals' meeting. It also provides an updated statement of the advantages of such a move.

1. Possible downsides of taking Medicare out of the budget

- Charge: Taking Medicare out of the budget would increase "Stockman risk" – the risk that non-Medicare discretionary spending would get squeezed in the event of a downturn in the economy.
 - *Rebuttal:* Taking Medicare out of the budget would *reduce* Stockman risk rather than increasing it.
 - Consider the following example (based on recent receipts levels) in which Medicare receipts decline by 3% and other on-budget receipts decline by 5% (recognizing that Medicare receipts are probably less cyclical than average on-budget receipts). With Medicare in the budget, achieving budget balance in hard times would require a \$96 billion cut in spending – and that cut would almost certainly not include any Medicare reductions. With Medicare out of the budget, budget balance could be achieved with a \$91 billion cut in spending. The difference of \$5 billion is small, but the point is that it goes in the *right* direction, contrary to the charge we heard at the NEC meeting.
 - This rebuttal hinges on two critical assumptions:
 - First, that leaving Medicare in the budget would probably not allow a substantially higher level of discretionary spending to be built into the baseline. (If this assumption were violated, any cutting in the event of a future economic downturn would at least start from a higher base if we left Medicare in the budget.)
 - Second, that leaving Medicare in the budget would probably not increase the willingness of the Congress to leave some resources uncommitted. (If leaving Medicare in the budget somehow "fooled" Congress into creating a

rainy-day fund that it otherwise would not have created, then leaving Medicare in the budget would be the lower-risk way to go.)

- We believe that the budget process in which we are currently engaged will probably fully commit available resources (i.e., leave nothing in a rainy-day fund) regardless of whether Medicare is left in the budget. Moreover, we believe that the “extra” resources that would be available if we leave Medicare in the budget would more likely flow into a tax cut than into additional spending. If these views are correct, then those who fear Stockman risk should support taking Medicare out of the budget.
- *Charge:* Taking Medicare out of the budget might create a slippery slope toward taking other trust funds off-budget
 - *Rebuttal:* There are important distinctions between Social Security and Medicare, on the one hand, and the other programs that might be candidates for being taken out of the budget.
 - Social Security and Medicare require people to make contributions while working in order to receive benefits while retired. There is nothing wrong with the view that each beneficiary is “just getting back what they paid into the system.” Indeed, we should encourage that belief as a means of reinforcing the current move toward more thorough pre-funding of these two programs.
 - The other trust funds that bear the closest functional resemblance to the Social Security and Medicare Trust Funds are the ones associated with the civilian and military retirement programs. A refusal to take these programs out of the budget could be defended on the grounds that the liability they pose is not closely related to the retirement of the babyboom generation, and that addressing the babyboom phenomenon should be our first priority.
- *Charge:* Taking Medicare Part A out of the budget but leaving Part B in the budget would be “messy” or create technical problems
 - *Rebuttal:* Medicare Parts A and B are financed in a completely different manner now, so there would be no conceptual difficulty in taking Part A out of the budget while leaving Part B within the on-budget account.
 - Part A is financed out of a dedicated payroll tax, equal to 2.9 percent of taxable payroll. By contrast, three-fourths of the resources for Part B comes from general revenue, and the remainder comes from beneficiary premiums.

- If there was a felt need to treat Parts A and B in the same way, one could “move Part B off-budget” along with Part A, but continue to keep track of “Part B” expenditures, and finance them in the same way as under current law. This would be essentially identical in budget impact to taking only Part A off-budget.
- *Charge:* A proliferation of off-budget accounts could make it easier for some future Congress and Administration less committed to the cause of fiscal responsibility to “re-unify” the budget.
- *Rebuttal:* The ability to reunify the budget could be the ultimate protection against “Stockman risk” (see below).

2. Advantages to taking Medicare out of the budget

- Taking Medicare out of the budget could help soak up “excess” on-budget surpluses
 - Taking Medicare out of the budget may be the only available unilateral means of taking on-budget resources off the table.
 - Once accepted, this commitment would be difficult to reverse. Therefore, it could be the only effective block we have against irresponsible tax cuts that *future* Administrations may seek to enact. (As usual, actions that take resources off the table for tax cuts also take them off for future spending.)
- Taking Medicare out of the budget would help ensure that HI Trust Fund accumulations reflect true pre-funding
 - Taking Medicare out of the budget would ensure that *baseline* Medicare surpluses are used to pay down debt. (Under present law, an improvement in the baseline Medicare surplus can simultaneously benefit the trust fund and provide resources for other programs, all the while leaving the budget in balance.)
 - Taking Medicare out of the budget would also preclude double-counting any proceeds of “real reforms.” Thus, savings from structural Medicare reform could not be spent on other purposes while also extending Medicare solvency.
- Taking Medicare out of the budget would help legitimize general revenue transfers
 - It would allow us to revert to standard accounting practices. Thus, on the new definition, the reported on-budget surplus would equal the actual on-budget surplus.

- Ensconcing the transfers in traditional accounting would raise the probability that the transfers themselves would, in fact, be used to pay down debt.
- Taking Medicare out of the budget would reverse the current practice of allowing interest on transfers to be double-counted. As a result, incremental trust fund assets in 2015 would equal the additional reduction in public debt by that same year.

From: David W. Wilcox
To: DOM3.DOPO5.WATCHOFFICE, DOM3.DOPO5.MATERAC, DOM3.D...
Date: 4/24/00 7:15am
Subject: document for Summers and Eizenstat

Dear Watch Office:

Would you please print out and fax the attached document to Secretary Summers and Deputy Secretary Eizenstat immediately. Thank you.

Larry and Stu:

The attached document address various objections to taking Medicare out of the budget that were raised at last week's NEC budget meeting.

David Wilcox and Doug Elmendorf

CC: doug

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*Please
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4/24/00

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<i>NCC</i>	<i>cc</i>	<i>to</i>	<i>A. Cohen</i>
			<i>NCI/PA/TK/TRA</i>
			<i>SS</i>
			<i>TS</i>
			<i>CK</i>
			<i>CMP/PM</i>
			<i>HM</i>
			<i>KK</i>
			<i>Marsha/Reane</i>



May 16, 2000

MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT

FROM: Assistant Secretary Wilcox *DW*
Deputy Assistant Secretary Elmendorf *DE*

SUBJECT: House Republicans' Medicare Prescription Drug Plan

Last month, the House Republicans released an outline of their Medicare drug plan, which proposes a voluntary drug benefit that would be offered by private insurers. The Republicans are awaiting cost estimates from CBO before announcing the plan's details, and the current lack of specificity is one aspect of the Administration's criticism of the proposal. Based on the information available at this point, the Administration has important concerns about the structure of the benefit and subsidies, and about the financing and oversight of the program – the two topics that we explore in this memo.

Despite these problems, constructive engagement with the Republicans probably offers the best chance of achieving a drug benefit this year. Republican rhetoric was very accommodating toward the Administration, and public reaction to the proposal was less negative than many had expected. In particular, the AARP stated that "this proposal has merit and should be explored carefully," and the Health Insurance Association of America – which has consistently opposed drugs-only insurance – said "this proposal is different from others we have seen, so we want to study it before we take a definitive position."

1. **Structure of the Benefit and Subsidies**

- Under the Republican proposal, seniors would receive subsidies for buying drug coverage from any private insurer that offered it.
 - Full subsidies would be given to seniors with income below 135 percent of poverty, who represent about 40 percent of all Medicare beneficiaries and about 45 percent of those lacking drug coverage.
 - Medicare would also cover most of the costs for all seniors with very high drug expenditures. Details remain sketchy, but we understand that the goal of this reinsurance mechanism is to relieve 25 percent of insurers' total costs.
- This structure can be described as "Medigap plus subsidies," in reference to existing Medigap policies that cover drugs. The analogy is not comforting: Medigap policies experience terrible adverse selection, pushing the price of such coverage close to the amount of drug purchases covered. Moreover, Medigap policies are capped at a fairly

small amount of drug spending, and insurers rarely bargain with drug companies to achieve price discounts. As a result, only 10 percent of Medicare beneficiaries currently receive drug coverage through Medigap.

- One of the Administration's key concerns is that the proposed subsidies would not make drug coverage sufficiently attractive to millions of seniors who are uninsured or underinsured today – and thus would not meet our central goal of universal take-up.
 - The full subsidy for low-income seniors and the apparent 25-percent subsidy through the reinsurance scheme would improve the risk pool compared with the current Medigap market. However, the HCFA actuaries assume that a universal 50 percent subsidy would be needed to avoid an adverse risk spiral, so this proposal seems inadequate.
 - Still, we are encouraged, as we were earlier with the Breaux-Frist proposal, that the debate appears to be about the **level** of a universal subsidy, not its **existence**.
- Another central concern is that insurers may not be willing to offer such policies.
 - As we noted above, the insurance industry has strongly opposed drugs-only insurance proposals in the past. Insurers fear that – as in Medigap today – they would be caught between high costs, on the one hand, and insurance regulations, on the other. It is unclear whether the reinsurance mechanism and low-income subsidy ameliorates this problem sufficiently.
 - There would be no mechanism for guaranteeing that every senior would have a policy available to him or her. More generally, this proposal is more of a “voucher” arrangement than a direct addition to the Medicare benefit, which seems an important distinction to both sides.
- The Administration also objects that the benefit is not specified and would presumably vary across insurers. Moreover, the government would apparently contract with any willing provider of insurance. These features would worsen the adverse selection spiral and make it difficult for seniors to make sensible choices among drug plans.
- Lastly, the Administration is concerned that insurers might not achieve discounts on drug prices. At the same time, some Medigap insurers negotiate with drug companies today, and the larger scale of activity under this proposal might encourage others to do so. Thus, a favorable spin on this proposal is “multiple, subsidized PBMs offering price discounts and flexible benefit design.”

2. **Financing and Oversight**

- The Republicans have set aside \$40 billion over 5 years “to strengthen Medicare and offer prescription drug coverage to every beneficiary.”

- This amount may not be sufficient to finance the Republicans' proposal, especially because \$20 billion may actually be devoted to more BBA give-backs.
- Out-year financing is uncertain and would be threatened by a large tax cut.
- The Republicans propose that the new drug program be overseen by a Medicare Board. This Board would be separate from HCFA, but – according to some email rumors – “not necessarily” outside of HHS. If true, this would represent a small step in the Administration's direction.
- It is unclear to us whether the proposal would involve a new solvency test for Medicare analogous to the combined Part A/Part B solvency test of the Breaux-Thomas and Breaux-Frist proposals.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

INFORMATION

June 14, 2000

MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT

FROM: Assistant Secretary Wilcox ^{DW}
Deputy Assistant Secretary Elmendorf ^{DE}

SUBJECT: **House Republicans Release Medicare Prescription Drug Plan**

House Republicans have released a more detailed description of their Medicare drug plan, and are expected to introduce legislative language later this week. They hope to bring the legislation to the House floor before the July Fourth recess.

1. **The Big News**

- The Republicans envision seniors buying drug policies directly from private insurers. The Administration has argued that insurers would not offer such “drugs-only” policies (as the insurers themselves have warned), so this approach would not ensure universal access to drug coverage. To counter this charge, **the Republicans now say that the government would provide coverage if private insurers do not.** Said Bill Thomas, “The federal government, under our bill, will be the insurer of last resort. Our plan does not leave seniors out in the cold if private insurers don’t participate. Private insurers can do a great job. But we should never leave it totally to the private sector.”
- **The Administration has expressed its openness toward the idea of competition with a government-sponsored plan, while repeating its criticism of other aspects of the Republican proposal.** The President said today: “If the proposal ... gives all seniors the ability to choose an affordable, defined, fee-for-service drug benefit under Medicare, even if it’s just one of several options, that could certainly serve as a foundation for a bipartisan agreement on this issue.” The key words here are “affordable” – which requires a larger subsidy than the Republicans have proposed – and “defined” – which requires greater specificity in benefit design than the Republicans have proposed.

2. **Structure of the Drug Benefit and Subsidies**

- Under the House Republican proposal, seniors could purchase a qualified drug coverage policy from any private insurance company that offered it. While a benchmark policy would be defined, insurers could vary the deductible and co-payment rate so long as their policy retained the same “stop-loss” amount (the maximum amount of out-of-pocket drug spending in one year) and remained just as generous overall.

- Seniors would receive direct and indirect subsidies of at least 25 to 30 percent when they buy a qualified drug coverage plan.
 - Those with income below 135 percent of poverty – who represent about 40 percent of all Medicare beneficiaries and about 45 percent of those lacking drug coverage – would pay no premium for the cheapest qualified plan available in their area, and would pay only a nominal amount for each prescription.
 - Those with incomes between 135 and 150 percent of poverty would receive direct premium assistance on a sliding scale, and would also face low co-payments.
 - Medicare would also cover most of the costs for any senior with very high drug expenditures. The stated goal is to relieve 25 to 30 percent of insurers' total costs. If the insurance market were competitive, so that these savings were passed on to seniors in the form of lower premiums, this reinsurance mechanism would yield a 25 to 30 percent subsidy for all seniors.
- Expected premiums under this proposal are unclear (and would vary across insurers, as discussed below).

2. Administration Concerns about the Proposed Drug Benefit

- One key Administration concern is that the proposed subsidies are not large enough to ensure universal take-up.
 - The Administration has publicly stated that the indirect subsidies for middle-income and high-income seniors reflect a “flawed trickle-down theory” and might not be passed on to seniors through lower premiums. (We commented internally that the pass-through of the indirect subsidies seemed likely to us, but to no avail.)
 - Even if the indirect subsidies are passed along, the 25 to 30 percent subsidy rate is well below the 50 percent threshold that the HCFA actuaries deem necessary to avoid an adverse risk spiral. It is true (but not publicly acknowledged) that the full subsidy for low-income seniors and the small indirect subsidy for other seniors would improve the risk pool relative to the current, unsubsidized Medigap market. This would make meaningful drug coverage more attractive than today, but not so much that it would be attractive to all seniors.
 - Still, we are encouraged, as we were earlier with the Breaux-Frist proposal, that the debate appears to be about the level of a universal subsidy, not its **existence**. (We also understand that Breaux and Frist are developing a revised version of their plan that would combine direct premium subsidies for all with indirect subsidies through reinsurance and thus yield total subsidies closer to 50 percent.)
- Another Administration concern is that the flexibility in benefit design would reduce effective competition, and would raise program costs due to adverse selection.

- Many health experts believe that standardization in benefit design is important for achieving effective price and quality competition. Variability in benefits can make it difficult for seniors to make sensible choices among drug plans. This is especially important if the number of alternative providers (and thus benefit designs) could be quite large.
- Variability in benefit design could also induce selection across plans. The required uniformity of the stop-loss reduces this risk (by limiting the opportunity to design coverage that is more attractive to healthy seniors and less attractive to sicker ones) but does not eliminate it.
- The benchmark policy might not be too different from the Administration's revised proposal. The Republicans have reportedly chosen a \$200-\$250 deductible, a 50% co-payment rate up to a cap of about \$2000 of drug spending, and a 100% co-payment rate up to a \$5000-\$6000 stop-loss. Our revised proposal would have no deductible, a 50% co-payment rate up to \$2500 of drug spending when phased in, and a 100% co-payment rate up to a \$4000 stop-loss.
- Another fundamental Administration concern is that insurers may not be willing to offer "drug-only" policies.
 - The insurance industry opposes drugs-only insurance proposals. Insurers fear that – as in Medigap today – they would be caught between high costs, on the one hand, and insurance regulations, on the other. It is unclear to us whether the reinsurance mechanism and low-income subsidy ameliorates this problem sufficiently. The head of the Health Insurance Association of America said yesterday that "not only would such plans have to clear insurmountable financial, regulatory, and administrative hurdles simply to get to market, but the likelihood that the people most likely to purchase this coverage will be the people anticipating the highest drug claims would make drug-only coverage virtually impossible for insurers to offer to seniors at an affordable premium."
 - The House Republican plan asserts that beneficiaries would have a choice of at least two private drug plans, at least one of which would be available to fee-for-service patients (i.e., seniors not participating in Medicare managed care). If the options did not materialize, the government would negotiate with private insurers, presumably by offering greater incentives of some sort. If these negotiations failed, the government would contract with a benefit manager to provide the coverage.
 - Partisan differences may be narrowing here – although the precise nature of the government fallback is a critical issue, as seen in the President's remarks. Moreover, many would argue that this fallback would be the likely result in practice, so there is no point in starting with the insurer-based approach.

- The Administration is also concerned that atomized insurers might not achieve discounts on drug prices.
 - This concern seems misguided to us. Some Medigap insurers negotiate with drug companies today, and the larger scale of activity under this proposal might encourage others to do so.

3. Other Elements of the House Republican Plan

Medicare Management

- Unlike earlier proposals to establish a quasi-independent agency to run Medicare, the House Republican plan would set up a new Medicare Oversight and Management Administration (MOMA) that would be part of HHS and would administer both the drug benefit and Medicare+Choice (the Medicare managed care program). The traditional fee-for-service program would still be run by HCFA, while MOMA would oversee the competition between it and private health plans. (Other elements of the proposal would increase payments to managed care plans.)
- The House Republicans would also set up a Medicare Policy Board within MOMA to advise and make recommendations on topics that “could include” beneficiary education, enrollment, and competitive bidding. This board would submit reports to the President and Congress, and would have seven members appointed by the President and the Congress. This proposal was modeled explicitly on the IRS Oversight Board, and differs substantially from previous proposals to establish a “Medicare Board.”

Program Solvency

- The House Republican plan requires the Medicare Trustees to report “the total amounts obligated from the General Fund to Medicare” and the share of program finances derived from general revenues. Congressional committees of jurisdiction would be required to hold hearings on the report.
- This proposal reflects the legitimate concern that Part A solvency is a misleading measure of Medicare’s financial health, and that little consideration is given to Medicare Part B’s draw on general revenues. It is a far cry from the Breaux-Frist “hard cap” on general revenue contributions to Medicare – which the Administration vehemently opposed as undermining the entitlement to Medicare benefits.

Support for Drug R&D

- Earlier this week, the Republican plan included a requirement that USTR negotiate with the G-8 countries and NAFTA signatories “to eliminate price controls and unfair trade practices” with the goal of ensuring that “other countries pay their fair share of the pharmaceutical research.” If these negotiations did not succeed, USTR would be allowed

to recommend to Congress measures to eliminate the disparity “under Section 301 of the Fair Trade Act of 1974.”

- USTR folks believe that they would have virtually no prospect of successfully negotiating on this issue. First, it does not involve intellectual property rights, for which our international suasion has a firmer basis in law and international agreements. Second, the United States government does not pay market prices in all of its transactions with drug companies.
- The latest version of the Republican plan replaces this provision with a requirement that USTR report on whether the efforts to impose price controls overseas constitute unfair trade practices and, if so, to deliver recommendation for addressing the problem.

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May 18, 2000

MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT

FROM: Assistant Secretary Wilcox ^{DW}
Deputy Assistant Secretary Elmendorf ^{DE}

SUBJECT: Medicare Drug Benefit Options for the Mid-Session Review

Action-Forcing Event

Friday's meeting of the budget principals will consider options for Medicare and health coverage for the Mid-Session Review. The options fall into three categories:

- improvements in the proposed prescription drug benefit, which we discuss in this memo;
- new Medicare provider "give-backs" and cuts in our proposed future savings, which we discuss in the attached memo sent to you earlier in the week and in a separate memo sent to you today; and
- expansion of the "FamilyCare" health insurance proposal for low-income children and parents, which we discuss in another separate memo sent to you today.

We feel especially strongly that – to maintain fiscal discipline – Treasury should argue against raising the overall drug premium subsidy above 50 percent.

New Drug Options

The Medicare team has developed a set of alternative drug benefits, which will be presented to you on Friday. Over 10 years, they are expected to cost \$55-90 billion more than the basic benefit in the February budget, and \$20-55 billion more than the benefit including the catastrophic drug benefit reserve. The major moving pieces are as follows:

- *Effective Date.* The options move this up from 2003 to 2002, which adds at least \$30 billion to the 10-year cost. It is unclear whether a drug benefit can be implemented that quickly, but all Congressional proposals envision starting in 2002, so it is politically untenable for the Administration not to follow suit.
- *Catastrophic Coverage Threshold.* Most options start catastrophic coverage at \$4,000 in out-of-pocket expenditures (or \$8,000 worth of drugs used, given a 50 percent coinsurance rate). The options may differ in whether seniors would pay

nothing for drugs above this threshold (“stop-loss” protection) or would continue to face nominal coinsurance (e.g., 10 percent).

- *Premium Subsidy.* At the deputies level, this issue is often framed as what portion of the gross costs of the catastrophic protection will be passed on to premiums (with options ranging from zero to 50 percent). While that may be one useful metric, it is important to consider the overall subsidy rate as well – because no one will be able to purchase the benefits separately. Although we do not have precise numbers, we believe that covering 50 percent of the base benefit and all of the catastrophic benefit would raise the total subsidy to over 60 percent.
- *The Donut.* Some of the options will have a gap between the cap on the basic benefit and the level of spending at which catastrophic protection begins. Under such a structure, seniors would pay 50 percent of the price of their prescriptions until they hit the cap, then 100 percent of the price until they hit the catastrophic threshold, and then 0 or 10 percent thereafter. This is sometimes described as a “donut.” Under other options, there will be no hole in the donut, so that seniors would pay 50 percent of drug prices up to the catastrophic threshold.
- *The Index Factor.* Most of the options we have considered index the benefit caps and catastrophic thresholds to the drug CPI. Another possibility is to index these amounts to average drug spending by Medicare beneficiaries.

As a technical note, the options presented will have “Net Budget” cost that is higher than the “Net Medicare” cost. The difference is the additional federal spending on Medicaid. This arises because: 1) Medicaid will cover all or part of the drug premiums and cost-sharing for many low-income seniors, and 2) the existence of a drug benefit will induce more seniors to sign up for the assistance that Medicaid already offers toward the costs of existing Medicare benefits. Part of the additional Medicaid spending would be borne by the states and is not included in the tables you will see.

Treasury Views on Fiscal Discipline

Despite the improvement in the budget outlook, we believe the Administration should be cautious about proposing a benefit whose cost greatly exceeds our previous estimates.

We are now on track to propose a benefit whose net cost over 10 years would be five times the net cost of last year’s proposal:

- When the benefit was first announced last summer, the government’s cost was estimated at about \$120 billion over 10 years, with \$70 billion of savings, for a net cost of \$50 billion.
- In the February budget, the gross cost escalated to \$160 billion, owing primarily to revisions to the actuaries’ calculations; proposed savings fell to \$60 billion, so

the net cost was \$100 billion. (Including the catastrophic drug reserve raised the gross and net costs to \$195 billion and \$135 billion respectively.)

- We are now considering benefits with a gross cost of \$250 billion; we are also considering reducing our savings to \$27 billion (from \$62 billion in the budget) and offering give-backs of \$25 billion. This would put net savings at zero and the net cost of the benefit at \$250 billion.
- There are legitimate arguments and strong constituencies for these changes. Moreover, some of the latest increase would come from phasing in the program more rapidly, which would give a clearer picture of the ultimate cost. Still, we are concerned that the combined impact of these changes will be to highlight the scale of the new entitlement being proposed, and thereby to generate public resistance and negative reaction from the elite media.

The catastrophic benefit could double in cost every 5 years, making it a more expensive addition to the proposal than 10-year budget numbers suggest:

- Preliminary estimates of possible catastrophic benefits show their cost rising at 15 percent per year, much more rapidly than the cost of the Administration's basic benefit. This difference is most prominent when drug spending is not used as the index – so the share of total drug spending that falls above the catastrophic threshold rises more quickly than the share below the basic benefit cap.

To maintain fiscal discipline, we recommend:

- *Begin the full benefit immediately rather than phasing it in, in order to give a clearer picture of the long-run costs.*
 - There has been some discussion of starting the catastrophic coverage in 2003, rather than 2002, both to reduce the 10-year costs and to mirror the Daschle drug bill. We see this as a rather transparent gimmick.
- *Index the thresholds to average drug spending, rather than the drug CPI, in order to limit the long-term explosion of costs.*
 - This approach would keep the share of total drug spending that is covered by the catastrophic benefit roughly constant over time. It would avoid future debates (like those that occur for Social Security) about whether the CPI measures price increases correctly. And, it would mean that the initial threshold could be lower for the same 10-year cost.
 - However, this approach would also allow the out-of-pocket burden on seniors to rise more rapidly over time.

- We have pressed the estimators to report 30-year costs as well as 10-year costs (probably as shares of GDP, because nominal figures are very misleading at that horizon). Of course, longer-term estimates are even more uncertain, but they capture an important implication of the policy choices.
- *Limit subsidies to 50 percent (for the basic and catastrophic benefits combined), because we do not think that higher subsidies are necessary.*
 - Under our current proposal, the government would pay 50 percent of the cost of the drug benefit. Therefore, the increase in estimated government costs since last summer has been mirrored by an increase in estimated premiums (although not proportionally, for technical reasons). We originally talked about premiums of \$24 per month in 2003, but could now be looking at about \$45 per month.
 - The health group has discussed the government paying for 100 percent of the cost of the catastrophic benefit. This reflects concerns about premium levels expressed by Congressional Democrats, and would also make the proposal more comparable to the House Republicans' plan – since they have the fisc pick up 100 percent of costs above some (unspecified) level.
 - One reason to worry about higher premiums is that they might discourage participation. Low participation would not meet the Administration's goal of a universal benefit, and it would heighten the risk of adverse selection that could raise costs for the government and other beneficiaries.
However:
 - The increase in estimated premiums since last summer corresponds primarily to higher observed drug spending and an improvement in the generosity of the proposed benefit. Both of these factors should encourage participation. That is, the benefit is still a very good deal *relative to buying drugs without insurance*.
 - The actuaries have consistently assumed that a 50 percent subsidy would be sufficient to achieve near-universal participation.
 - Increasing the overall subsidy rate now would make it more difficult to reach a bipartisan agreement on a drug benefit, since the Breaux-Frist and Republican plans call for only a 25 percent subsidy.
 - As a historical matter, the subsidy for Part B (non-hospital costs) started at 50 percent in 1965 but had increased to 75 percent by 1980. It seems most prudent, then, to start with the lowest subsidy rate that will achieve our policy objective of full take-up.

Treasury View on Optimal Insurance Structure

With the extra resources that will be available, we believe that the Administration should propose a sensible insurance structure. This means that co-payments should decline as an individual's drug spending rises – but not necessarily to zero.

- Our original benefit provided “front-loaded” coverage, in which individuals paid only half of the first dollar spent on drugs, but paid all of the costs above the cap. This approach was dictated by the combination of a tighter budget constraint and the desire to offer a Medicare benefit that would be attractive to all seniors.
- Current options represent more sensible insurance, with co-payments that decline from 100 percent (up to the amount of the deductible) to 50 percent for a wide range of spending, and then fall further to 0 or 10 percent above the catastrophic threshold.
- Options that include a donut hole may appear attractive on cost grounds but are difficult to defend on policy grounds.
- It is less clear on policy grounds whether the catastrophic threshold should be a stop-loss limit or small co-payments should continue above that level.
- Co-payments reduce government costs and premiums while doing little to reduce the insurance value of the benefit. Co-payments also help ensure that the benefits of the drugs warrant their costs, and they discourage abuse in a fee-for-service system. Moreover, co-payments may be particularly helpful with CBO scoring for technical reasons.
- At the same time, there are rhetorical and policy arguments for offering seniors a true cap on their liability – so that the policy does look like good insurance.



June 23, 2000

**MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT**

FROM: Assistant Secretary Wilcox DW
Deputy Assistant Secretary Elmendorf DE

SUBJECT: The Debate About Choice in the Medicare Drug Benefit

A key difference between the Administration's proposal and the Republican proposal is how much choice seniors would have. This memo analyzes the two primary dimensions of drug benefit choice: 1) whether to have competing entities offer drug coverage, and 2) whether to standardize the drug benefits that are offered. We conclude that choice would be feasible only if seniors had a limited number of options and if payments to drug plans were risk-adjusted.

1. Single Pharmacy Benefit Manager in Traditional Medicare vs. Multiple PBMs

Arguments for Having a Single Benefit Manager in Each Region (as in the Administration Plan)

- PBMs would compete for the regional contracts, providing sufficient incentive to control costs, maintain quality, and adopt innovative services.
- Seniors will continue to choose between traditional Medicare and an HMO, and different PBMs will become one element of that choice. Allowing a further choice among separate drug plans would:
 - be difficult for the elderly, many of whom have cognitive impairments, and
 - generate wasteful "Coke vs. Pepsi" advertising (especially because a standardized drug benefit would provide little grounds for choice anyway).
- Choice among plans that adopt different drug "formularies" (lists of preferred drugs) could generate severe risk selection, which would raise program costs and degrade the ultimate benefit. (We return to this issue in the next section on benefit variation.)
- A single PBM in each region could yield larger price discounts by pooling the purchasing power of seniors more effectively – which explains the drug industry's opposition.
- This approach is followed by all private health plans.

Arguments for Having Multiple Benefit Managers in Each Region (as in the Republican Plan)

- Letting seniors choose PBMs directly would foster more effective competition than letting a government agency choose:
 - The government might be reluctant to switch PBMs, especially because it would involve a switch in formularies that would change the prices of most drugs.
 - This approach would allow the program to evolve more gradually in response to seniors' choices.
- Traditional Medicare is expected to enroll the vast majority of seniors for the foreseeable future, and about one fourth of beneficiaries have no HMO option at all. Thus, providing choice to seniors requires multiple PBMs within fee-for-service.
 - Different formularies, pharmacy networks, and service programs would provide a real basis for competition.
- Multiple PBMs are needed to maintain an "arm's length" relationship between the government and benefit managers, and thus to avoid the slippery slope to price controls.
- Price discounts probably depend more on a PBM's *national* market share, including people under age 65, than its share of the Medicare market in a given region. Economies of scale within Medicare would naturally lead to a greater concentration of purchasing power – and concerns arise about the total share of Medicare coverage going to one PBM arise about equally under either system.

2. Standardized Benefit vs. Benefit Variation

The Administration has specified the parameters of its proposed Medicare drug benefit – the deductible, co-payment, initial benefit cap, and stop-loss point (the maximum amount of out-of-pocket drug spending in one year). The Republican proposal would allow providers to specify their own parameters as long as their policies had the same actuarial value (cost for the average Medicare beneficiary) and the same stop-loss.

One basic argument in favor of a standardized drug benefit is that Medicare is a defined benefit program, and it offers all seniors the same premium nationwide. Allowing benefits to vary would yield differing premiums in different parts of the country, and would be a slippery slope toward vouchers. At the same time, Medicare benefits are less standardized than meets the eye – the amount of care received varies greatly nationwide, even though all pay the same premium, and this is a major complaint for those in low-service areas.

Other arguments about standardizing the benefit fall into two categories: selection effects and information costs.

A. *Selection Effects*

Arguments for Standardizing the Drug Benefit

- Adverse selection would raise program costs, as people sorted themselves into plans that were better for them and therefore more expensive for the government. This problem is especially acute because people could switch between plans annually.
- To encourage competition on efficiency and quality, and not on who enrolls, payments to drug plans would need to be risk-adjusted:
 - Ensuring adequate risk adjustment would be very difficult. It might be aided by the chronic nature of drug use among seniors (which may reduce the amount of private information) and by the existence of diagnosis histories for seniors in traditional Medicare. On the other hand, HCFA's inability so far to include outpatient history in their managed care risk adjustment is not encouraging.
 - Risk adjustment would probably be complemented by some degree of reinsurance or retrospective reimbursement, which would mute the incentive for efficiency.
- If risk adjustment and reinsurance are not effective, selection pressures could generate a single benefit design *de facto* – one that is more attractive to healthier people and thus provides less in the way of insurance. If any statutory minima will simply become maxima over time, then there would be little cost of defining the benefit in advance.

Arguments for Allowing the Drug Benefit to Vary

- Allowing seniors to choose drug policies that best fit their preferences toward risk would make them better off. Critics of a standardized benefit thus complain about it being a “one size fits all” approach.
- To the extent that seniors choose drug policies that best fit their expected future drug spending, choice cannot make everyone better off. This selection would raise government costs (as noted above), and returning to the same cost would require a less generous average benefit. In the end, some people would be better off and some worse off than with a standardized benefit with the same total cost to the government.
- Risk adjustment would be a critical part of the competition we envisage between traditional Medicare and managed care, so let's not get cold feet about it.

B. *Information Costs*

Arguments for Standardizing the Drug Benefit

- A standardized benefit permits “apples-to-apples” comparisons on price and quality.

- While HMOs in Medicare can currently offer added benefits, our competition plan proposes substantial standardization.
- Medigap benefits were standardized to enhance competition; previously, the bewildering variety of policies led to ineffective competition and some fraud.
- Since seniors must make a one-time enrollment decision when they first become eligible, benefit variation makes it more difficult know whether to sign up.
- Benefit variation makes it more difficult for doctors to know what their patients' coverage is, and thus what therapy to recommend on the margin.

Arguments for Allowing the Drug Benefit to Vary

- Benefit design could emerge from seniors' choices rather than a government decision.
- Drug benefits will automatically adjust over time in response to changing circumstances, avoiding the inertia and switching costs of revamping a standardized benefit.
- A significant number of health plan choices is feasible:
 - Although enrollees in FEHBP choose their health plan and drug benefit as a package, this program has worked effectively with a large number of choices.
 - Even with standardization, Medigap has 10 different plans, so seniors can choose the benefits they prefer while insurers compete on price.

3. Balancing the Costs and Benefits of More Choice

We believe that giving choices to seniors would make sense only if the number of options were limited and payments to drug plans were risk-adjusted. The net gains from choice are smaller for benefit flexibility than for multiple PBMs – a view that, coincidentally, seems consistent with the priorities of both the drug industry and core Democrats.

Number of PBMs

- The number of competing PBMs could be limited (perhaps 3 to 5 per region) to reduce complexity while still gaining most of the benefits of choice. This approach would parallel health plan choices at many employers, and as experience with the program develops, the number of PBMs could be expanded or contracted as necessary.
- This approach would still require the government to make some decisions about which PBMs can participate, but the pressures and concerns would be much less than in a winner-take-all bidding system.

Benefit Design

- The Republican drug plan specifies the stop-loss amount that all policies must offer. This approach limits selection pressures, but it is not sufficient. Variation in benefit design below the (rather high) stop-loss amount would probably still generate significant adverse selection.
- Further limits on benefit flexibility would help to reduce selection.
 - One option is the Medigap model, where the government would specify a set of benefits that could be offered.
 - Another option is to subject PBMs' proposed benefits to government approval, as in the Republican proposal to exclude drug plans that "are designed to encourage adverse selection." Enforcing this standard seems difficult at best.
- In the end, a robust risk adjustment mechanism would also be needed, both to ensure that selection pressures do not erode the insurance value of the drug benefit over time, and to encourage competition on price and quality instead of enrollment.
 - The Republican reinsurance mechanism functions as a form of retrospective risk adjustment, but it is limited to the highest-cost cases.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

INFORMATION

November 16, 2000

**MEMORANDUM FOR SECRETARY SUMMERS
DEPUTY SECRETARY EIZENSTAT**

FROM: Assistant Secretary Wilcox ^{DW}
Deputy Assistant Secretary Elmendorf ^{DE}

SUBJECT: Long-Term Medicare Cost Growth

The Medicare Technical Advisory Panel has just agreed to recommend that, in the long run, "real, age-adjusted, per beneficiary expenditures for both SMI and HI should be assumed . . . to grow at a rate 1 percentage point above real per capita GDP growth."

If this assumption were adopted by the Trustees, the projected long-run annual growth rate of Medicare spending would be increased by about 1.2 percentage points in HI (Hospital Insurance) and 1 percentage point in SMI (Supplementary Medical Insurance, mostly doctors' visits). The change would increase HI's 75-year actuarial imbalance substantially, but by itself would probably have less effect on the projected exhaustion date of the HI trust fund since its primary impact on the cost estimates occurs after 2025. The change would also reduce projected budget surpluses in the very long run by raising estimated spending for both HI and SMI.

The Technical Panel consists of three economists (David Cutler of Harvard, Michael Chernew of Michigan, and Len Nichols of the Urban Institute) and three actuaries. While they are now in the process of drafting the Panel's final report, they may not finish their work before the next Trustees' meeting. However, Secretary Shalala is expected to provide the Trustees with a brief summary of their key findings. This memo analyzes the Panel's recommendation on the long-term growth rate of Medicare costs.

Current Practice

The intermediate estimates presented in the Trustees' Reports currently assume that:

- In SMI, costs per age-adjusted beneficiary will ultimately increase at the same rate as GDP per capita.
- In HI, costs per unit of medical care service (e.g., per hospital admission) will ultimately increase at the same rate as average hourly earnings.

These growth rates are reached after 25 years and hold for the rest of the 75-year projection period. The primary rationale for these assumptions is stated clearly in the SMI Report: "Assuming a continuation of the historical trend [in Medicare's cost growth] for another 75 years

would result in an SMI program so large as a percent of GDP that it would be implausible given other demands on those resources." The Trustees Reports are supposed to assume that current Medicare policy will be maintained, so the argument is essentially that some natural checks on Medicare cost growth (or health cost growth more generally) will emerge. In 1991, the last panel to examine the Medicare assumptions found that this approach to long-term cost growth was "not unreasonable" but should be "adjusted, if necessary, as further experience develops."

Proposed Change

For SMI, the Technical Panel's draft recommendation would not change the "base" used for calculating long-run cost growth, but would simply add 1 percentage point to that base.

For HI, the Technical Panel's draft recommendation would add 1 percentage point to the base **after** changing the current base in two ways: first, by using GDP per capita rather than average hourly earnings; and second, by using the growth rate per age-adjusted beneficiary rather than the growth rate per unit of service.

- *GDP per Capita vs. Average Hourly Earnings.* Growth rates of these two variables differ because of projected changes in labor force participation, wages as a share of compensation, the relationship of different price indexes, and other factors. On net, the last Trustees Reports showed GDP per capita increasing faster than average hourly earnings by 0.1 percentage points in 2030 and 0.2 percentage points in 2075 (with the difference due to a changing growth rate in the number of workers per capita).
- *Cost per Age-Adjusted Beneficiary vs. Cost per Unit of Service.* We understand that this change would not alter the projection because HCFA assumes that units of HI services per age-adjusted beneficiary will be constant after 25 years. This may seem surprising, but the major units of service in HI are hospital *admissions* or *days* in a skilled nursing facility, so factors that increase the intensity of treatment during an admission show up as increases in the cost per unit of service.

The following table shows the overall effect of the Technical Panel's draft recommendation on real cost growth per age-adjusted beneficiary in 2075:

GROWTH-RATE ASSUMPTIONS	HI	SMI
Cost per Unit of Service (= Avg. Hourly Earnings)	1.1	
+ Units per Beneficiary	0.0	
= Current Real Growth Rate per Beneficiary	1.1	1.3
+ Switch to Real GDP per Capita	0.2	
+ Increment Above Real GDP per Capita	1.0	1.0
= Proposed Real Growth Rate per Beneficiary	2.3	2.3

Historical Experience and Current Projections

The following table shows that the annual rates of real Medicare cost growth per beneficiary have consistently exceeded real GDP growth per capita by more than one percentage point:

	<i>HI</i>	<i>SMI</i>	Combined Medicare	GDP per Capita	Difference
1970-1980	5.1%	5.5%	5.2%	1.5%	3.7%
1980-1990	3.2%	7.5%	4.7%	1.7%	3.0%
1990-2000	2.9%	3.4%	3.1%	1.6%	1.5%
1970-2000	3.7%	5.5%	4.3%	1.6%	2.7%

For further illustration, the figures on the last page show the difference between the 5-year average growth rates of Medicare spending per beneficiary and GDP per capita.¹

- The top figure shows this difference separately for HI and SMI, based on the 2000 Trustees Report. Cost growth is projected to match the growth in GDP per capita much more closely in the future than it has in the past.
- The bottom figure shows this difference for HI and SMI together from the 2000 Trustees Report, and compares it to the same difference from the 1995 Trustees Report. The substantial convergence of the lines by 2005 is quite striking when one considers that the 1995 Report predicted an HI trust fund exhaustion date of 2002 and had Medicare spending nearly 9 percent of GDP by 2070, compared with the current projections of 2025 and 5 percent.

One difficulty with comparing historical cost growth to projected cost growth is that past data include the effects of changes in law, while projections are supposed to reflect current law. Having said that, it is unclear whether purging legislative changes from past data would raise or lower the cost growth rates, because those changes have both expanded benefits (e.g., home health visits, HMO options) and reduced provider payment rates.

The Case for Medicare Cost Growth Exceeding GDP Growth by 1 Percent Per Year

The Technical Panel's draft report makes the following case for its recommendation, which David Cutler described as probably the consensus view of outside economists:

- Health care costs have outpaced GDP for a long time, driven largely by advances in medical technology. Based on studies by Newhouse, Cutler, and others, the Panel agreed that 50 to 70 percent of past growth in real per capita costs could be attributed to technological change. Other key factors include the spread of insurance, income growth, and relative price inflation.

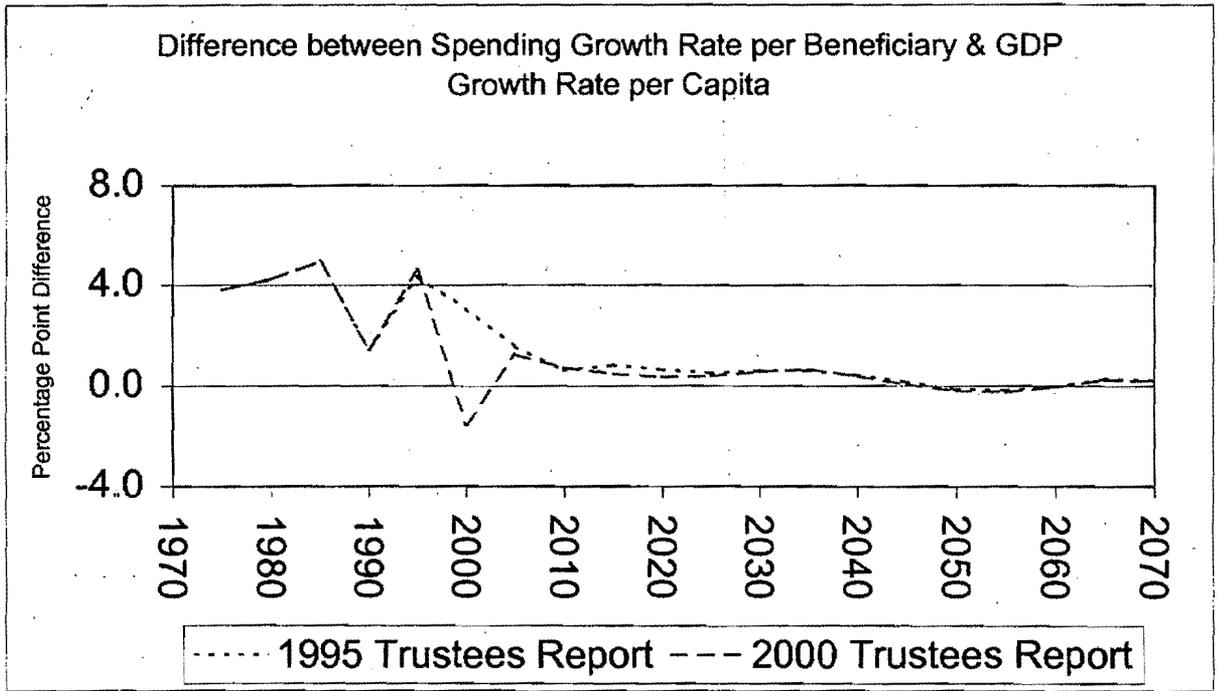
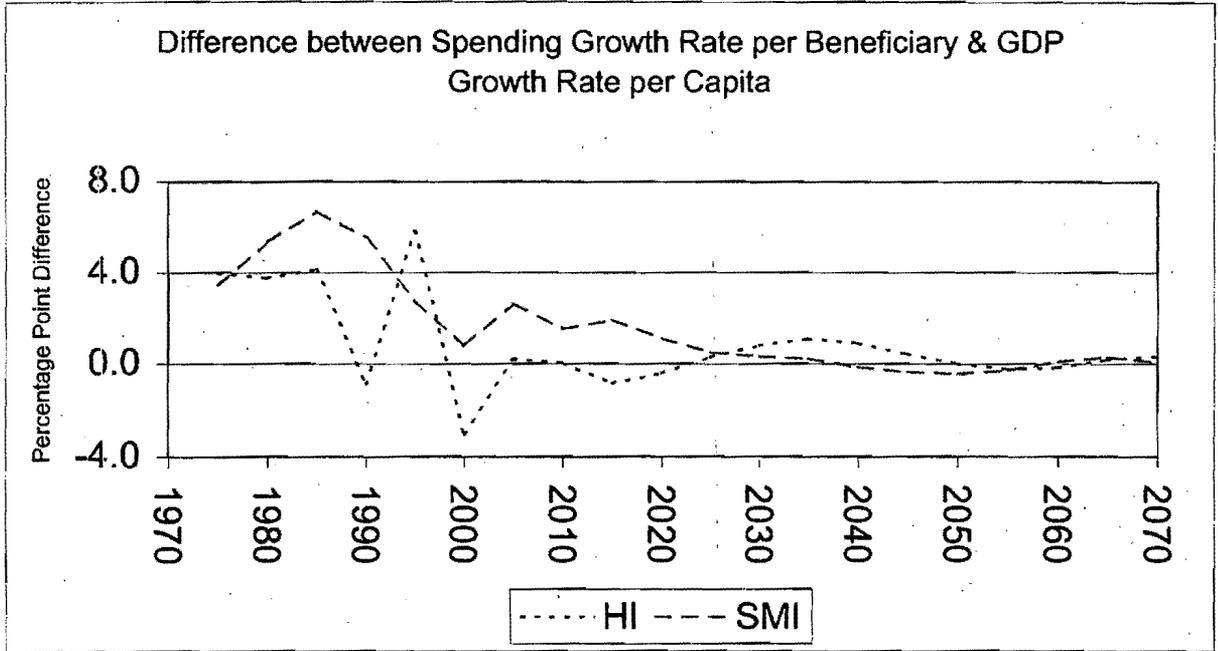
¹ This difference is not constant after 2025 because we cannot adjust for the changing age distribution of enrollees.

- Although the future of medical technology is quite uncertain, the best guess is that it will develop and spread in the future in about the same way that it has in the past. For the postwar era as a whole, and for sub-periods therein, real health spending per capita has grown more than 4 percent per year. Attributing a little more than half of this growth to technological change and subtracting past rates of real GDP growth per capita yields a projected growth differential from technology alone of about one percentage point.
- Health care costs can grow somewhat faster than GDP for the next 75 years while still permitting real increases in other consumer expenditures (so the “natural checks” argument currently used is not persuasive). For example, ignoring demographic effects, the Panel estimated that annual growth rates of 1.2 percent for real GDP and 2.2 percent for real health expenditures could raise health spending as high as 30 percent of GDP in 2075 while still allowing annual growth in non-health spending of nearly 1 percent. The Panel viewed these figures as “not implausible or unsustainable.”

The Technical Panel’s draft report also discusses the following sources of uncertainty:

- The broader adoption of prospective payments systems in Medicare, and increased enrollment in managed care plans (which may limit technological diffusion modestly), could reduce cost growth relative to historical rates.
- The nature and type of technological innovations could change – although it is unclear whether cost growth would accelerate or decelerate as a result (e.g., less invasive procedures could be less costly per unit but could be used much more widely).
- To the extent that health care is a luxury good, rising real income would continue to boost health spending relative to the economy as a whole, over and above the effects attributed to technology.
- Cost growth in HI and SMI could diverge. Although the two programs have experienced different growth rates in the past, the Panel concluded that it had no strong belief “about whether development and diffusion of new medical technology would differentially affect the trust funds.”

A related issue that was not a focus of the Panel’s discussion is the impact on costs of the changing age distribution of Medicare beneficiaries. Our understanding is that HCFA currently assumes the intensity of medical care for a beneficiary of a given age will not change over time. CBO has recently shifted to a more optimistic view of future medical spending: that 80-year-olds will be healthier and thus less expensive. (In its most recent projections of long-run budgetary trends, CBO has also adopted the assumption that age-adjusted cost growth per Medicare enrollee will exceed wage growth by 1.1 percentage points from 2025 on – which is very close to the Technical Panel’s recommendation.) Research by David Cutler and Louise Sheiner leans in CBO’s direction, but does not go as far. On the other hand, Mark McClellan recently found that improvements in longevity are associated with gains in health status, but do not generate declining treatment intensity and actually induce more intensive treatment for the very old (such as joint replacements and bypass surgery).



ADMINISTRATION HISTORY APPENDIX
CHAPTER ONE: FISCAL DISCIPLINE

SHUTDOWN

95-147416



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

CLOSE HOLD

ASSISTANT SECRETARY

June 23, 1995

MEMORANDUM FOR BOB RUBIN
FRANK NEWMAN
LARRY SUMMERS
LAURA TYSON
JOE STIGLITZ

FROM: Alicia Munnell *AM*
SUBJECT: Economic Effects of a Budget/Debt Trainwreck

Attached is a memorandum from Treasury and CEA regarding the likelihood and potential economic impact of a trainwreck if budget and appropriation bills are not approved by the beginning of the fiscal year or gridlock develops over raising the debt ceiling.

The main conclusions are:

- i. A budget train wreck from lack of agreement on appropriations bills could lead to a short government shutdown.
- ii. If a trainwreck on the appropriation bills shut down the government for one week, the direct macroeconomic impact would be small -- roughly -0.1 percent lower GDP for two quarters.
- iii. If financial markets lost confidence because of a trainwreck and interest rates rose significantly, the impact could be significantly larger -- as much as -0.5 percent lower GDP for four quarters.
- iv. A debt ceiling trainwreck almost certainly would not lead to default and is unlikely to lead to a government shutdown, in and of itself. Various means are available for postponing when the debt ceiling binds.

Attachment

CLOSE HOLD

ECONOMIC IMPLICATIONS OF A BUDGET/DEBT TRAINWRECK

June 21, 1995

Office of the Assistant Secretary for Economic Policy, U.S. Treasury
Council of Economic Advisers

1. This memo examines the economic implications and likelihood of a "trainwreck" this fall if budget and appropriation bills are not approved by the beginning of the new fiscal year or if there is a gridlock on raising the debt ceiling. The main points of this analysis are:
 - i. A budget trainwreck from lack of agreement on appropriations bills could lead to a short government shutdown.
 - ii. A debt ceiling trainwreck almost certainly would not lead to default and is unlikely to lead to a government shutdown, in and of itself. Various means are available for postponing when the debt ceiling binds.
 - iii. If a trainwreck on the appropriation bills shut down the government for 1 week, the direct macroeconomic impact would be small, shaving only about 0.1 percentage point off fourth-quarter growth in real GDP at an annual rate.
 - iv. If financial markets lost confidence because of a trainwreck and interest rates rose significantly, the impact could be substantially larger. In a truly worst case scenario in which long-bond rates rose 50 basis points and stayed at that higher level, growth in real GDP at an annual rate could be held down by 0.5 percentage point in the fourth quarter of this year and next few quarters. If the interest rate jump were temporary, the impact on GDP growth would be much smaller.

2. WHAT IS A TRAINWRECK?

There are two trainwreck scenarios; under certain circumstances, both scenarios could be merged into one larger budget/debt controversy.

The Budget Trainwreck. This scenario comes into play if the President and Congress fail to reach agreement on appropriation bills by October 1. If there is no Continuing Resolution, the government could be forced to shut down. In the 1990 budget crisis, the government shut down for a weekend. Correctly predicting the politics of Continuing Resolutions is difficult, but Congress is behind on the budget process and this could easily spill over into October.

The Debt Limit Trainwreck. This scenario comes into play if Congress fails to approve an increase in the debt limit or if Congress puts so many extra baggage cars on the debt limit train that the President vetoes the bill and Congress does not send up a new clean bill. The current debt limit is \$4.9 trillion and estimates suggest that the debt limit train could crash in early fall, perhaps a little after the budget train.

A debt ceiling trainwreck almost certainly would not lead to default and is unlikely to lead to a government shutdown, in and of itself. In the past, temporary increases in the debt limit have been approved (like a Continuing Resolution) and various trust funds have been tapped to avert default and shutdown.

3. ECONOMIC IMPACT OF A TRAINWRECK

Suppose a trainwreck on appropriations forces the government to shut down. Everyone consulted agreed that a 2-week shutdown is way beyond any reasonable upper limit for what could happen. For this exercise, the calculation is done for a 1-week shutdown, which can be grossed up easily by the pessimists.

The following are likely effects of a 1-week shutdown.

- i. The ultimate level of most government spending would not be affected by a shutdown although the timing of the spending might be affected.
- ii. A possible exception is the federal payroll. If government workers are sent home, it is possible that they would not be paid for those days; however, many government employees are essential and would work even if there were a shutdown.

Total federal civilian payroll was about \$90 billion in 1995.¹ Suppose 25 percent of

¹This figure excludes postal workers. Including postal workers would boost the payroll number up to about \$120 in 1995.

civilian employees continue working and are ultimately paid. Then a 1-week shutdown would reduce nominal federal spending on compensation by \$1.3 billion ($=\$90 \times 0.75/52$).

With an impact multiplier of 1.5, this would reduce nominal GDP by \$1.9 billion. *In terms of real GDP, growth in the fourth quarter would be held down by only about 0.1 percentage point at an annual rate.* The economic impact on the Washington, DC area would be larger. (See the attached table for dynamic macroeconomic effects.)

- iii. A trainwreck could create turbulence in financial markets, perhaps reflecting uncertainty about future bond auctions and refundings or concern about the budget-balance resolve of the government. In either case, a runup in interest rates could result, reversing part of the 150 basis point decline in the 10-year bond rate over the past six months.

As a worst case scenario, suppose there is a massive train wreck and rates shot up 50 basis points and remained at that elevated level. Then, apply the rule-of-thumb that a 10 basis point rise in long rates lowers real GDP by \$5 billion. And, assume that the impact on the level of real GDP builds over one year. *In this truly worst case scenario, the interest rate runup would hold down real GDP growth by almost 0.5 percentage point in the fourth quarter of this year and the following few quarters.* (See attached table for dynamic effects.) If the runup in interest rates was temporary rather than permanent, the impact would be much smaller and shorter lived.

In this worst case scenario, the dollar would be subject to two opposing influences. Higher interest rates would put upward pressure on the dollar, while a loss in confidence in U.S. fiscal policy could pull the dollar downward.

- iv. Consumers and businesses might also lose confidence in the economy, although this influence is difficult to quantify and depends on other economic developments.

IMPACT ON GDP OF A TRAIN WRECK
(changes relative to baseline)

	95:4	96:1	96:2	96:3	96:4
<u>Government Shutdown¹</u>					
Billion \$	-1.9	-0.3	-0.3	0.3	0.3
Billion 1987 \$	-1.2	-0.2	-0.2	0.2	0.2
Real GDP growth, % pts. annual rate	-0.1	-0.1	0.0	0.0	0.0
<u>Financial Market Uncertainty²</u>					
Interest rate reaction, basis points (10-yr)	50.0	50.0	50.0	50.0	50.0
Billion 1987 \$, \$5 billion per 10 basis pts	-6.3	-12.6	-18.9	-25.2	-25.2
Real GDP Growth, % pts., annual rate	-0.5	-0.5	-0.5	-0.5	0.0
Memo:					
Real GDP, Admin Baseline	5535.0	5569.0	5604.0	5638.0	5673.0
% change, ar	2.8	2.5	2.5	2.5	2.5

¹The federal payroll scenario assumes that 75 percent of civilian federal payroll is cut for one week yielding a nominal reduction of \$1.3 billion ($\$1.3 = \$90 \times 0.75 / 52$). With an impact multiplier of 1.5, this yields the \$1.9 billion reduction in nominal GDP for the fourth quarter. Applying a compensation deflator of about 1.6 generates the \$1.2 reduction in real GDP in the fourth quarter, which shaves 0.1 percentage point off real growth at an annual rate.

²The financial uncertainty scenario assumes that interest rates are pushed up 50 basis points in the fourth quarter of 1995 and remain at this elevated level. Each 10 basis points is assumed to reduce real GDP by \$5 billion with the effect building over four quarters for a total shortfall of \$25 billion on the level of real GDP.

TREASURY CLEARANCE SHEET

NO. 95-147416
Date _____

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

FROM: Alicia H. Munnell

THROUGH: _____

SUBJECT: Economic Effects of a Budget/Debt Trainwreck

REVIEW OFFICES (Check when office clears)

- | | | |
|--------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Under Secretary for Finance | <input type="checkbox"/> Enforcement | <input type="checkbox"/> Policy Management |
| <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 |
| <input type="checkbox"/> FMS | <input type="checkbox"/> Secret Service | <input type="checkbox"/> Treasurer |
| <input type="checkbox"/> Public Debt | <input type="checkbox"/> General Counsel | <input type="checkbox"/> E & P |
| <input type="checkbox"/> Under Secretary for International Affairs | <input type="checkbox"/> Inspector General | <input type="checkbox"/> Mint |
| <input type="checkbox"/> International Affairs | <input type="checkbox"/> IRS | <input type="checkbox"/> Savings Bonds |
| | <input type="checkbox"/> Legislative Affairs | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Management | |
| | <input type="checkbox"/> OCC | |

NAME (Please Type)	INITIAL	DATE	OFFICE	TEL. NO.
INITIATOR(S) Alicia H. Munnell			Economic Policy	622-2200
REVIEWERS				

SPECIAL INSTRUCTIONS

Review Officer

Date

Executive Secretary

Date

95-148580



DEPARTMENT OF THE TREASURY
WASHINGTON

July 31, 1995

ASSISTANT SECRETARY

MEMORANDUM FOR SECRETARY RUBIN

FROM:

George Muñoz *George Muñoz*
Assistant Secretary for Management & CFO

Edward S. Knight *Edward S. Knight*
General Counsel

SUBJECT:

Contingency/Shutdown Plans

Last week, our Office of Management issued guidance requesting bureaus to update and submit their contingency plans in the event of a shutdown of government operations due to a lapse in funding. When a shutdown arises, each agency head must implement a plan which specifies the actions to be taken in the event of a shutdown. Bureaus, as a result of prior shutdowns, have contingency plans in place, but they need to be reviewed and updated as necessary.

There have been times when the Federal Government has been faced with the lapse of appropriations. The Anti-Deficiency Act (31 U.S.C. 1341 - 1342) generally prohibits government officials from incurring obligations in excess of appropriations, or employing others to perform "personal services exceeding that authorized by law, except for emergencies involving the safety of human life or the protection of property." The possibility of a lapse in appropriations for FY 1996 has become apparent. Recently, the President has threatened to veto some appropriation bills, which could lead to a funding lapse if a Continuing Resolution is not enacted.

Whenever an expiration of appropriations becomes a possibility, the Department, the Office of Management and Budget, and the Office of Personnel Management provide instructions to the Bureaus. These instructions differ with each occurrence, depending on the specific circumstances of the lapse. From a broader perspective, the Office of Management and Budget is the primary adviser to the President concerning the broad policy issues and procedures associated with a shutdown. Prior shutdowns have typically lasted for no more than a day or two. However, the result is always a disruption of operations and a loss of productivity.

When there is a lapse in the operating funds for an agency, the agency must immediately restrict its operations in accord with the Anti-Deficiency Act. However, the Act recognizes that the agency cannot immediately dismiss all its employees, because such an action could

result in danger to life or loss or damage to property. There may also be activities in a agency which must continue because they support other mandated operations in another agency or activity, which must be continued. Opinions of the Attorney General have authorized continuation of those agency functions which satisfy any of the following circumstances:

- Functions related to the orderly shutdown of the agency;
- Functions reasonably necessary for the protection of human life or the protection of property; and
- Functions which are authorized by necessary implication because of a significant connection with other operations which must be continued according to law.

Based on current bureau plans, the attachment provides a summary status of bureaus' functions during a shutdown.

Attachment

STATUS OF TREASURY FUNCTIONS UNDER A SHUTDOWN
DUE TO ABSENCE OF APPROPRIATIONS

Treasury-wide

Maintain: Staff necessary to protect government facilities and property.

Internal Revenue Service

Shutdown: Taxpayer Service - Responding to taxpayer questions on tax law and the status of their accounts.

Examination of Returns - Auditing individual and corporate tax returns for compliance with tax law.

Processing tax returns which do not include remittances of taxes owed.

Maintain: Processing tax returns which include remittances.

Computer operations necessary to prevent the loss of data in process.

Secret Service

Maintain: All operations.

Federal Law Enforcement Training Center

Shutdown: All training operations.

Alcohol, Tobacco and Firearms

Shutdown: Compliance audits and inspections of alcohol and tobacco manufacturers, wholesalers and retailers.

Maintain: Law enforcement operations, including tracing of firearms and explosives.

U.S. Customs Service

- Shutdown: Classification/appraisal of imports and collection of Customs duties.
- Maintain: Cargo inspection and passenger processing.
- Law enforcement operations, including drug interdiction.

Financial Management Service

- Shutdown: Non-essential Headquarters administrative support staff (e.g., personnel and program management).
- Maintain: Payment of government obligations and claims, and government-wide accounting functions.

Bureau of the Public Debt

- Shutdown: Non-essential Headquarters administrative support staff (e.g., personnel and program management).
- Maintain: Activities in support of the issuance, servicing, and retirement of savings securities and marketable securities.

U.S. Mint

- Shutdown: All activities in support of domestic coinage production and distribution.
- Maintain: All reimbursable activities (numismatic and commemorative coinage).

Comptroller of the Currency, Office of Thrift Supervision and the Bureau of Engraving and Printing

- Maintain: All operations continue, since these organizations are funded through non-appropriated sources of funds.

96-154226



DEPARTMENT OF THE TREASURY
WASHINGTON

ASSISTANT SECRETARY
(MANAGEMENT)
AND
CHIEF FINANCIAL OFFICER

December 5, 1995

NOTE FOR SECRETARY ROBERT RUBIN

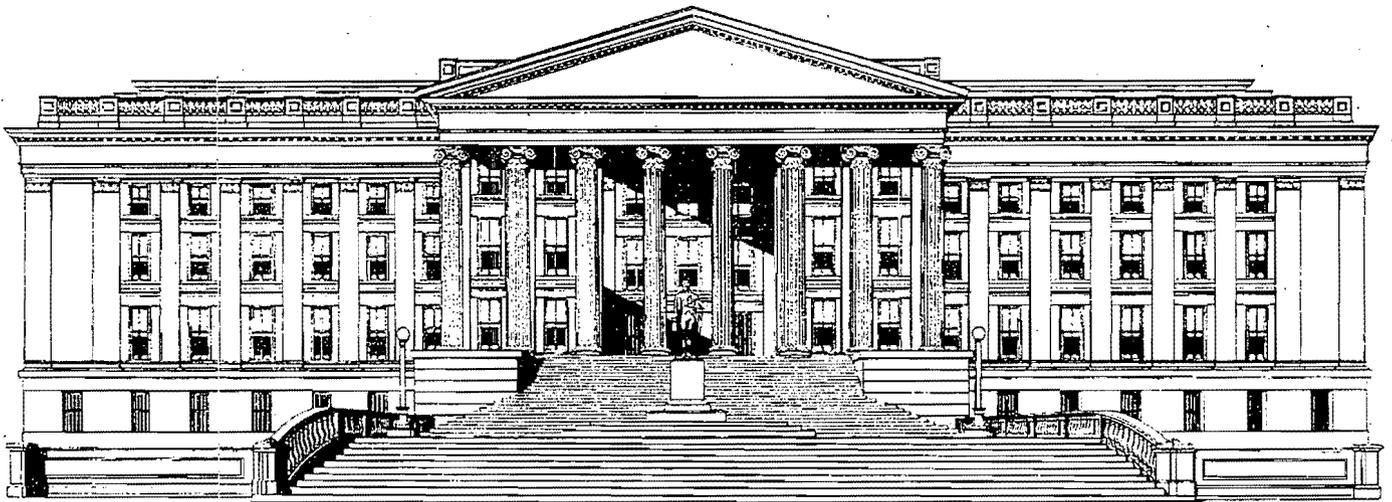
SUBJECT: Report on Treasury Shutdown

I will be testifying on your behalf on Treasury's activities during the partial government shutdown. In addition to my testimony, we have prepared the attached compilation of documents that track our shutdown planning, implementation and reactivation.


George Muñoz

Attachment

REPORT ON **SHUTDOWN '95**



Department of the Treasury
Office of Management & CFO

Outline of Documentation

EXECUTIVE SUMMARY

I. EVENTS PRIOR TO SHUTDOWN

- A. *Shutdown Guidelines and Policies*
- B. *Background Materials Supporting Departmental Plans, Procedures, and Policies*
- C. *Bureau Shutdown Plans (Separate Volume)*

II. OPERATIONS DURING SHUTDOWN

- A. *Treasury Shutdown Activities*
 - 1. *November 13, 1995*
 - 2. *November 14, 1995*
 - 3. *November 15, 1995*
 - 4. *November 16, 1995*
 - 5. *November 17, 1995*
- B. *Bureau Operations during Shutdown*
 - 1. *Departmental Offices (Separate Volume)*
 - a. *Personnel*
 - b. *Procurement*
 - c. *Travel*
 - d. *Other Administrative Services*
 - 2. *Other Bureaus (Separate Volumes)*

III. POST- SHUTDOWN

- A. *Policy and Guidance*
- B. *Impact on Mission and Employees*
- C. *Costs*

Executive Summary

The Department of the Treasury leadership recognized the serious threat of a government shutdown due to a lack of appropriations and began planning for that possibility early in the year. We emphasized thorough planning to ensure an orderly close down of operations, eliminate any deleterious effect, minimize the long-term impact and ensure strict compliance with law and regulation.

On November 14th 113,400 or 74% of Treasury's 154,000 employees, were furloughed. Employees remaining on duty were responsible for activities which had funding from other sources or which were necessary to protect life and property, carry out constitutional duties or support programs with appropriations. Work which continued to be performed during the shutdown included criminal investigations and law enforcement, collection of taxes and revenue, the payment of government obligations, issuance of Social Security checks, Secret Service protection, the inspection of cargo, processing of airline passengers, air and marine interdiction, management of the public debt and the production of coins, currency and stamps.

Policy and guidance from the Office of Management and Budget (OMB), the Office of Personnel Management (OPM), and the Attorney General (AG) were followed explicitly. The Department accepts full responsibility for their interpretation and application to the Treasury mission. An initial analysis of the impact of the shutdown in Treasury indicates a cost estimated at approximately \$400,000 to develop and implement shutdown plans and over \$400 million in lost revenue through the lack of tax enforcement actions during the five and a half furlough days. Additional information is being gathered on the impact/cost of items such as lost discounts, payment penalties, the effect of stop work orders on contractual performance, customer service, employee morale and programmatic delays.

In June, 1995 extant Treasury, OMB, OPM and AG shutdown guidance were reviewed and updated. On July 17, 1995, the Assistant Secretary for Management and Chief Financial Officer directed Treasury bureaus to develop equitable and comprehensive shutdown plans which complied with all applicable guidance, addressed both short and long term shutdown scenarios, and fully documented all decisions.

The plans address three areas: 1) preparation - identify excepted activities which will be continued; 2) implementation - notify employees and close down non-excepted activities; and, 3) reactivation - notify employees and resume full operations. The plans were continually reviewed and refined between August and November to resolve concerns. Managing a shutdown is a dynamic process; some activities which were initially suspended may need to be resumed in the event that the shutdown lasts longer than a week.

Shutdown teams were named in September; a listing of the senior Treasury shutdown officials in each organization is attached. Hotlines were established in the Department and Bureaus to provide up-to-date information on the shutdown, the status of Treasury appropriations and guidance to furloughed employees.

Secretary Rubin was frequently briefed on the contingency planning effort. The Treasury shutdown plan was approved and submitted to OMB in September. The Secretary held Town Hall meetings with Treasury employees to offer his perspective on the overall budget process, Treasury appropriations and the debt ceiling. Secretary Rubin also conveyed his appreciation for the level of attention and care with which Treasury staff addressed planning for a possible shutdown in the face of the critical functions which Treasury provides.

On November 14th OMB directed agencies to shutdown. Using the network of shutdown officials, Treasury suspended the majority of its operations. Furlough notices were given to employees, stop work orders were sent to contractors, travel and training were suspended and most offices were closed to the public. Customers, both external and internal, were notified of the effect of the government shutdown and when applicable, the steps that Treasury would take to ameliorate the effect of the shutdown.

Throughout the shutdown period, November 14 - 19, the Treasury Shutdown Review Team met regularly to monitor events, review requests and rethink decisions when necessary. At a minimum, daily conference calls were held with the bureau shutdown coordinators to provide updated information on events affecting Treasury and respond to bureau questions and concerns. Daily shutdown reports were compiled and plans were initiated for the archiving of shutdown materials to ensure a complete record of events.

This report and several additional volumes of material document Shutdown '95 in the Department of the Treasury. We are pleased to report that the shutdown was handled smoothly and effectively. We attribute this accomplishment to comprehensive pre-planning, open communications among the shutdown coordinators, the dedication of Treasury employees and the strong leadership of the Treasury Shutdown Review Team.

ADMINISTRATION HISTORY APPENDIX
CHAPTER ONE: FISCAL DISCIPLINE

*SMALL
BUSINESS JOB
PROTECTION
ACT*

1996-SE-005328



ASSISTANT SECRETARY

DEPARTMENT OF THE TREASURY
WASHINGTON

June 17, 1996

MEMORANDUM FOR SECRETARY ROBERT E. RUBIN
DEPUTY SECRETARY LARRY SUMMERS

FROM: DONALD C. LUBICK *DL*
ACTING ASSISTANT SECRETARY (TAX POLICY)

SUBJECT: SENATE FINANCE COMMITTEE ACTION ON
SMALL BUSINESS JOB PROTECTION ACT OF 1996

On June 12, 1996, the Senate Finance Committee agreed by unanimous voice vote to report out an amended tax title to the minimum-wage legislation, H.R. 3448, the Small Business Job Protection Act of 1996. It contains a gross tax cut of about \$15 billion and will add about \$7.7 billion to the deficit (1996-2002) as compared to the President's budget. The \$7.7 billion dollar figure represents the excess of pay-fors also contained in our budget over tax cuts also contained in our budget (treating Section 936 proposal as not being a pay-for in our budget). Of course, we support many of the provisions that were not in our budget (e.g., extension of expiring provisions, S Corporation reform, prepaid tuition clarification).¹

The bill includes (i) tax initiatives with the general theme of labor and small business; (ii) expiring tax provisions; (iii) a variety of revenue offsets; (iv) a variety of special-interest provisions and member items; and (v) technical corrections. Many of these proposals were derived from the vetoed Balanced Budget Act (BBA). The bill was voted out on a bipartisan basis, notwithstanding a variety of objectionable provisions. The members agreed in advance not to offer any amendments, although amendments will probably resurface during the Senate floor debate.

¹ On June 12, 1996, the Finance Committee also ordered reported H.R. 3286, "The Adoption Promotion and Stability Act." It provides for a \$5000 adoption tax credit, similar to the legislation that has already passed the House and which the Administration supported. (Differences in the Finance Committee version of the adoption tax credit include increasing the credit to \$6000 for special-needs adoptions and sunsetting the credit for non-special needs adoptions after December 31, 2000.) The two pay-fors in this legislation -- reform of the income-forecast method of accounting and repealing the special bad-debt deduction for thrift institutions -- are also included in the President's FY 1997 budget. Thus, this legislation -- which is on a separate track from the minimum-wage legislation -- adds about an additional \$1.7 billion to the deficit, relative to the President's budget.

We will be required to prepare a Statement of Administrative Policy (SAP) shortly and should meet to discuss what our positions should be. In addition to the general budgetary concerns and our views as to some of the specific provisions, we should discuss whether we should take any specific action on spousal IRAs, the expiring provisions -- particularly Section 127 educational assistance (the Labor Department would like us to do more on the small business credit) and the R&D credit (we may have to take a position on the gap) -- and the FSC/software issue, which has not been addressed in this bill.

Here is a listing of the provisions. The ones that merit the most discussion are highlighted.

Tax Cuts

- **Small-business expensing --** Like the House bill, the Finance bill increases the amount of tangible depreciable property that small businesses can expense from \$17,500 to \$25,000 by the year 2003. The President's budget contains a similar proposal, except that it would have been fully phased in by 2002.
- **Spousal IRAs --** We prefer our IRA expansion proposal, which will be more cost-effective and does not include spousal IRAs. The Administration has taken no official position on this provision, though the Secretary expressed mild concern at a 1995 hearing about the distributional impact and the revenue cost. Still, it is hard to get in the way of this one.
- **Pension Simplification --** The Administration supports many of the pension simplification provisions of the bill which are the same as in the President's proposal and similar to the House-passed bill. The Administration prefers its pension package because it does more to encourage retirement savings by middle- and lower-wage workers, such as providing more meaningful employer contributions under the simplified small business plan. The bill allows owners to benefit themselves at a lesser cost of providing benefits to the rank and file. The Administration is also concerned about the bill's three-year waiver of the excise tax on very large distributions.
- **Employment tax status of fishing crews --** The Administration has not opposed this provision, which liberalizes the current exemption for fishing crews of less than 10 members. Unlike the House bill, it does not provide specific retroactive relief, and also does not include the House revenue offset (a new reporting requirement for cash sales of fish in excess of \$600). This provision is important to Democratic Members of the Massachusetts delegation, including Reps. Barney Frank and Richard Neal.
- **Liberalize involuntary conversion rules for tax deferral through replacement of property damaged as a result of Presidentially declared disasters --** The Administration is concerned that this provision, which allows gain to be deferred regardless of whether there is any connection between pre-disaster activities and post-disaster

activities, is an inappropriate departure from long-standing tax-policy principles. Although the provision applies to all Presidentially declared disasters after December 31, 1994, it has been promoted as a benefit for Oklahoma City bombing victims. A better approach would be the principal residence provision included in OBRA 93 that simply allowed more time for the rollover.

- Liberalize treatment of leasehold improvements -- The Administration does not oppose this provision, which was included in the BBA.
- Liberalize requirements for private-activity tax-exempt bonds for first-time farmers -- The Administration does not oppose these modifications, which include increasing the maximum size limit of land eligible for the bonds and relaxing related-party rules.
- Liberalize safe-harbor provisions for worker classifications as independent contractors -- We oppose most of the provisions and fear that the result may encourage shifting of workers to independent contractor status, with adverse effects not only on tax compliance, but availability of social protection reserved for employees (workers' compensation, overtime, unemployment insurance, etc.).
- Subchapter S simplification proposals -- The Administration has supported most of these simplification items, which are important to small business. We oppose two late additions to the package: one that would allow ESOPs to be S corporation shareholders and another to allow S corporations to be banks.
- State Prepaid Tuition Plans -- A provision which we support and on which we have assisted. It would solve our prepaid tuition problems.

Extension of Expired Provisions

- Targeted Jobs Tax Credit -- As in the BBA and the House bill, the credit is renamed the Work Opportunity Tax Credit and modified, including a reduction in the credit rate from 40 percent to 35 percent. The Administration generally has not opposed such a provision in the BBA. Treasury staff have developed a consensus package of recommendations for refinements to the Work Opportunity Tax Credit.
- Employer-Provided Educational Assistance (Section 127) -- The \$5,250 exclusion for employer-provided educational assistance, which expired after December 31, 1994, is reinstated retroactively and extended until December 31, 1996. Unlike the House bill, the Finance bill would maintain the incentive for post-graduate education. We strongly support permanent extension of section 127. Senator Moynihan does too, although he seems unwilling to make a fuss about it. The Administration has also announced its support for a 10% tax credit for educational assistance provided under section 127 plans for small businesses with

gross receipts of \$10 million or less. It has not generated much interest on the Hill. The Labor Department thinks we should have done more.

- **R&E credit --** The credit, which expired June 30, 1995, is reinstated prospectively only, through June 30, 1997, and is modified in certain respects. The Administration strongly supports the R&E credit, and would prefer a permanent extension. The gap issue is a sensitive one.
- **Orphan drug credit --** The credit, which expired December 31, 1994, is reinstated prospectively only, through June 30, 1997. The Administration supports this credit.
- **Contributions of appreciated stock to private foundations --** This provision, which expired December 31, 1994, would be reinstated, prospectively only, through June 30, 1997. The Administration supports this incentive.
- **Section 29 nonconventional fuels credit --** An additional year would be provided during which qualifying biomass and coal facilities could be placed in service and receive the credit. The Administration has opposed this extension as being no longer warranted.

Revenue Offsets

- **Repeal of Puerto Rico and possessions tax credit (section 936) --**The Finance Committee bill makes two modifications to the House bill. First, it extends permanently the grandfather of the economic-activity credit, although with a one-third reduction in the wages element of the credit after the House's 10-year grandfather period. This provides a more generous grandfather for the existing companies that contribute toward real economic activity in Puerto Rico, but provides no incentive for new or expanded investment in Puerto Rico after 1995. Second, the Senate bill extends the QPSII termination date by six months, until July 1, 1996. This addresses the retroactive taxation objection, but fails to provide a reasonable transition period for the Puerto Rican banking system. We cannot support this provision on account of these two defects and the lack of a spending element.
- **Repeal of the 50% interest exclusion for financial institution loans to ESOPs --** The Administration has not taken an official public position on this provision, which was included in the BBA, but is generally opposed to the repeal of this interest exclusion, which is the only ESOP tax incentive that requires majority ownership. The Labor Department strongly opposes the repeal.
- **Disallow exclusion of punitive damages received on account of personal injury or sickness --** The Finance provision is much narrower than the House bill, which would disallow the section 104(a)(2) exclusion for nonphysical damages, such as emotional

distress or discrimination. The Administration has never taken an official public position on the proposal, although we do not have a problem with it. Case law will likely reach this result in any event.

- Repeal interest allocation exception for certain nonfinancial corporations -- This proposal is also contained in the President's FY 1997 budget.
- Reinstatement of airport and airway trust fund excise taxes through December 31, 1996 -- The Administration's FY 1997 budget proposed extending the taxes through September 30, 2006. The Finance bill also includes new exemptions for air ambulances and helicopters used in energy development. We oppose these new exemptions.
- Expatriation tax proposal -- The Administration supports this version.
- Modify basis adjustment rules under section 1033 relating to involuntary conversions -
- The proposal was also contained in the President's FY 1997 budget.
- Repeal exemption for withholding on gambling winnings from bingo and keno where proceeds exceed \$5000 -- The proposal was also contained in the President's FY 1997 budget.
- Treatment of certain insurance on retired lives -- We do not oppose this provision, which achieves greater conformity between annual statements and tax treatment of assets held in a segregated account.

Other Special-Interest Provisions

- Provide 15-year depreciation for gas station/convenience stores -- The Administration has opposed this special-interest giveaway to retailers and food service establishments that sell gasoline.
- FICA tip credit changes -- As in the House bill, the provision would apply the existing income-tax credit to taxes paid on tips not timely reported and extend the credit to tips received by individuals delivering food and beverages. The Administration has opposed these special-interest provisions that reward taxpayers who failed to comply with the law.
- Treatment of dues paid to agricultural or horticultural organizations -- As in the House bill, the proposal would exempt from unrelated business taxable income (UBTI) dues payments of up to \$100 that an agricultural or horticultural organization receives from its associate members. The Administration has not supported this

special-interest provision. In addition, we have already provided some measure of administrative relief.

- Treatment of newspaper carriers and distributors as independent contractors -- In the veto message to the BBA, this provision was identified as a special-interest provision benefitting certain newspaper companies.
- Tax relief for fishing vessels and canneries that provide meals to employees -- We do not support this provision, which singles out one industry for special treatment.
- Lower the rate of tax on certain hard ciders -- The Administration testified in opposition to this proposal last summer, on grounds that such a change should be made only in the context of a general review of alcoholic beverage excise tax rates.
- Liberalize tax treatment of certain length-of-service for volunteer public safety workers -- In 1995, the Administration testified in opposition to this type of targeted relief.
- Suspend imposition of diesel fuel on motorboats -- The Administration opposes this provision.
- Treatment of Financial Asset Securitization Investment Trusts (FASITs) -- We have not supported this provision, which would facilitate the securitization of debt obligations such as credit card receivables, home equity loans and auto loans. It may create significant revenue loss outside the budget window; in addition, there are unresolved technical issues.
- Phase out luxury tax -- The Administration opposed this provision in the BBA, and proposed a permanent extension in its FY1997 budget.
- Election to avoid tax-exempt bond penalties for local furnishers of electricity and gas -- This special-interest provision was included in the BBA and is supported by Chairman Roth on behalf of a Delaware-based gas utility.
- Tax-free contributions in aid of construction (CIACs) -- The bill restores the pre-1986 treatment of CIACs for water utilities, paid for by stretching out the depreciation period for these utilities. We do not oppose the provision.
- Exempt Alaska from diesel-dyeing requirement while Alaska is exempt from similar dyeing requirements under the Clean Air Act -- The Administration testified in support of this change in 1995.

- Common paymaster provision -- We do not oppose this provision, which provides relief from FICA taxes for medical practice plans related to State university medical schools by treating the university and the practice plan as a single employer.
- Exempt imported recycled halons from the excise tax on ozone-depleting chemicals -- The Administration supports this provision with modifications.
- Exempt chemicals used in metered-dose inhalers from the excise tax on ozone-depleting chemicals -- The Administration testified in opposition to this proposal last summer, on grounds that these chemicals already enjoy a substantial advantage over other ozone-depleting chemicals.
- Authorize tax-exempt bonds for purchase of Alaska Power Authority -- The President's budget also contains this provision.
- Allow for tax-free conversion of common trust funds to mutual funds -- This provision was included in the list of special-interest provisions in the President's veto message of the BBA. On policy grounds, however, we do not oppose it.

Technical Corrections

Most of the technical corrections were developed on a consensus basis over the past several years and are unobjectionable. The Finance bill keeps several new special-interest provisions that were first introduced in Chairman Archer's mark of the House bill, however, that were not developed on a consensus basis and that appear to benefit special interests and are not really technical corrections (thus abusing the process since technical corrections do not have to be paid for).

Items In House-Passed Bill but Omitted from Finance Bill

- Repeal provision to tax excess passive assets for controlled foreign subsidiaries (section 956A) -- The Administration strongly opposes the repeal of this provision, which Treasury proposed and Congress enacted in 1993. This opposition was mentioned in the President's veto message of the BBA.
- Provide that certain charitable risk pools would qualify as charitable organizations under section 501(c)(3)
- Extension of FUTA exemption for alien agricultural workers

- Apply look-through rule for purposes of characterizing certain subpart F insurance income as UBTI
- Repeal advance refunds of diesel fuel tax for diesel cars and light trucks

Office of Tax Policy
June 17, 1996

Attachment

cc: Linda Robertson, Assistant Secretary (Legislative Affairs)

Analysis of Senate Small Business Job Protection Act of 1996
 Net Deficit Impact Relative to President's FY 1997 Budget
 JCT Estimates

	Fiscal Years										1996-2002	1996-2005
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005		
	(\$'s in millions)											
Tax Cuts												
Tax Cuts Similar to President's FY 1997 Budget:												
Increase in section 179 expensing limitations	--	-66	-175	-256	-327	-759	-935	-1029	-977	-928	-2518	-5452
Pension Simplification	--	34	-106	-129	-373	-558	-615	-674	-708	-757	-1747	-3875
Subtotal	--	-32	-281	-385	-700	-1317	-1550	-1703	-1685	-1685	-4265	-9327
Other Tax Cuts												
Small Business Provisions	-25	-69	-89	-101	-109	-115	-117	-120	-130	-112	-625	-987
Provisions Relating to S Corporations	--	-32	-73	-92	-106	-115	-125	-136	-147	-157	-543	-983
Expiring Provisions	-366	-1736	-651	-368	-249	-142	-57	-36	-37	-38	-3569	-3680
Miscellaneous Tax Cuts	--	-25	-21	-21	-15	-13	-13	-14	-14	-14	-108	-150
Subtotal	-391	-1862	-834	-582	-479	-385	-312	-306	-328	-321	-4845	-5800
Total Tax Cuts	-391	-1894	-1115	-967	-1179	-1702	-1862	-2009	-2013	-2006	-9110	-15127
Revenue Offsets												
Revenue Offsets Similar to Presidents FY 1997 Budget												
Section 936	190	595	540	530	475	500	685	1075	1295	1555	3515	7440
Eliminate interest allocation exception for certain nonfinancial												
Reinstate Airport and Airway Trust Fund taxes	393	1530	--	--	--	--	--	--	--	--	1923	1923
Revision of expatriation tax rules	15	37	63	97	139	181	216	247	275	298	748	1568
Subtotal	598	2162	603	627	614	681	901	1322	1570	1853	6186	10931
Modify basis adjustment rules under section 1033	--	1	5	9	14	20	29	37	46	56	78	217
Gambling withholding	3	12	6	6	6	7	7	7	7	8	47	69
Total Offsets in President's Budget	601	2175	614	642	634	708	937	1366	1623	1917	6311	11217

Other Revenue Offsets

Revenue Offsets	35	125	128	149	467	599	623	574	604	660	2126	3964
Treatment of certain insurance on retired lives	-	2	1	-2	5	2	--	10	-5	2	8	15
Total Revenue Offsets	636	2302	743	789	1106	1309	1560	1950	2222	2579	8445	15196
Net Senate Bill	245	408	-372	-178	-73	-393	-302	-59	209	573	-665	69
Net Effect on Deficit (= excess of revenue offsets from budget over tax cuts from budget) (positive amount = addition to deficit)	636	2270	462	404	406	-8	10	247	537	894	4180	5869

Net to PER
 Net to LS
 Net to J3U
 to 1/15/06
 Please
 LOY
 EN
 J. Gotbaum
 SD
 NB
 A. Cohen