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FOLDER TITLE:

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RESTRICTION CODES

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- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

File
**ADMINISTRATION OF THE
MEDICARE INCOME-RELATED PREMIUM.**

- **Income-related premium.** High-income Medicare beneficiaries would pay an income-related Medicare Part B premium. The income thresholds for the phase-in of this premium would be indexed to inflation and would begin at \$X,000 and be fully phased in at \$Y,000. (Note: For single beneficiaries, the Senate and Blue Dog's proposals begin at \$50,000, the 1995 Republican Budget began at \$60,000, and the 1994 health reform proposal began at \$90,000). The proposal assumes that the maximum payment is set at 75 percent of program costs to reduce the incentive for the healthiest and wealthiest beneficiaries to leave the program.

ADMINISTRATION

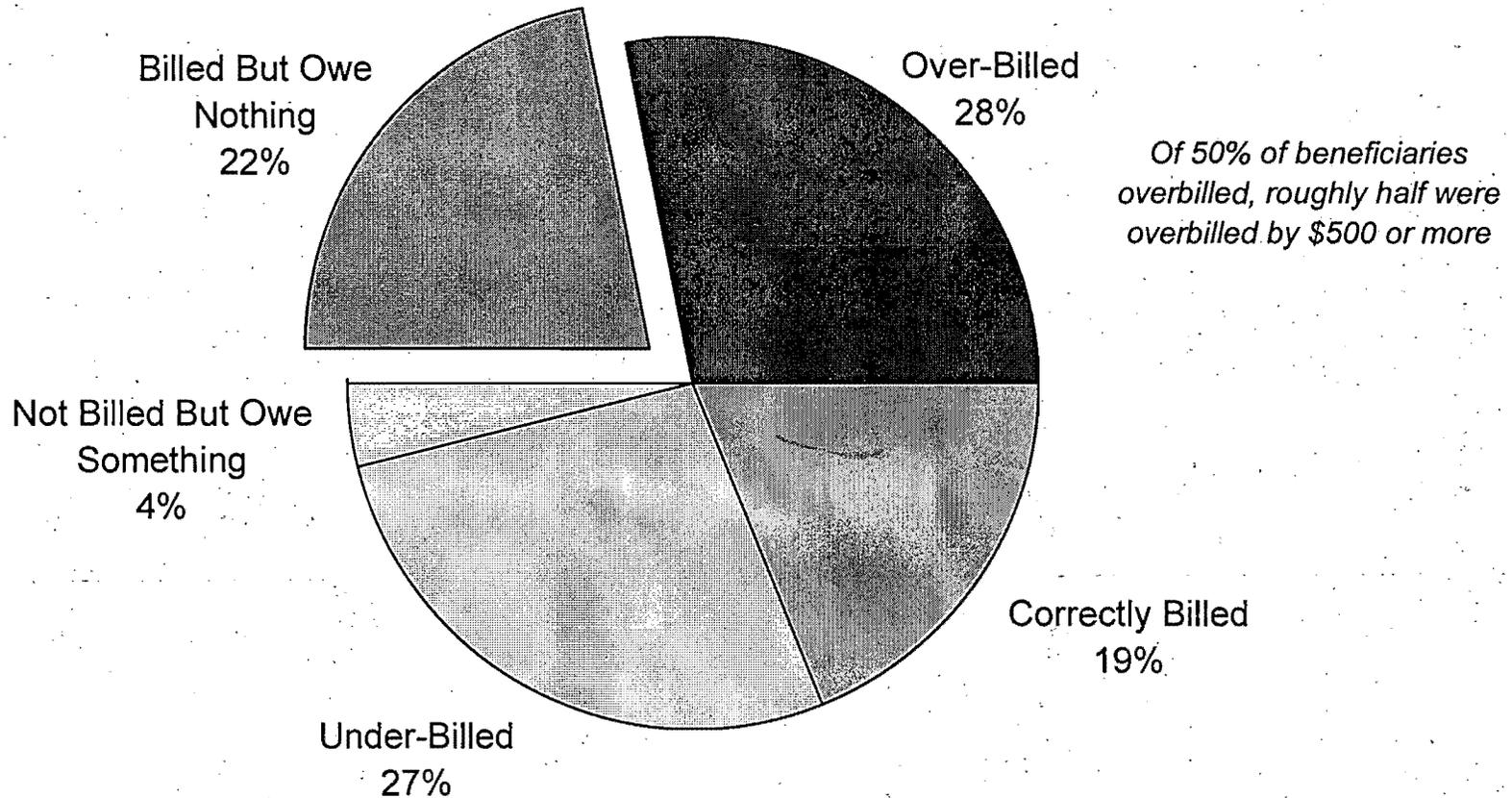
- **Simple process.** Designed to ensure that only the beneficiaries who qualify for the premium adjustment (less than 8 percent) fill out any form. Beneficiaries would determine whether they qualify for the premium adjustment by measuring modified adjusted gross income. If over the threshold, the beneficiary would be alerted about the availability of the "Medicare Premium Adjustment Form " in their annual tax instructions.
- **"Medicare Premium Adjustment Form".** This form would contain (1) instructions on how to calculate income and (2) a worksheet to figure out their premium adjustment. It would be available at post offices, the Internet and other places where government forms are typically available.
- **Payments to the Medicare Trust Fund.** Beneficiaries would return the form and any payment through a check made payable to the Medicare Trust Fund. The payments would be due on April 15th. The form and payment would be mailed back with their returns. The Treasury Department would make sure that the Medicare payments are directed to the Part A Trust Fund.

COMPARISON OF THE ADMINISTRATION OF THE HIGH-INCOME PREMIUM

PROVISION	SENATE BILL ADMINISTERED BY HHS*	SENATE BILL ADMINISTERED BY TREASURY*
Who Administers	Health & Human Services (HHS), Social Security Administration (SSA), & Treasury	Treasury
Savings	\$3.9 billion (assumes loss of over 50% of savings in the first 5 years)	\$8.9 billion (assumes traditional compliance rates)
Administrative Costs	\$30 to 50 million per year	\$5 to 10 million per year
How Eligible Beneficiaries Are Identified	HHS identifies beneficiaries by: (1) Getting income from the latest reviewed Treasury tax data, which is 2-3 years old (e.g., 1995 for 1998) (2) Sending notices to at least 3 million beneficiaries to ask if this past income is what they will receive in the next year and require them to respond in writing in 30 days Note: Sharing income data across agencies raises significant privacy concerns	Beneficiaries would fill out a separate "Medicare Premium Adjustment Form". They would report their income, reference a schedule, and send the payment with their tax returns.
How Premiums Are Collected	Assumes that extra premium is subtracted from monthly Social Security check after HHS sends to SSA their estimate of who gets how much taken out of their checks	See above
Reconciling Income	To ensure that the right amount of premium was assessed, Treasury would send the actual income from reviewed tax data to HHS. However, because this would be done retrospectively this would take 2-3 years (e.g., 2001 correction for 1998 mistake)	Since income is not projected but is the actual reported income, no reconciliation is required.

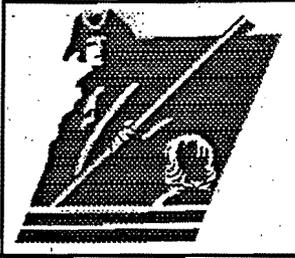
* This policy assumes the Senate policy which phases in 100% of the premium for beneficiaries with incomes between \$50,000 and \$100,000 for singles, \$75,000 and \$125,000 for couples. The Administration opposes the Senate's 100% phase out, administration through HHS/SSA, and lack of indexing of the income thresholds.

Incorrectly Billed Seniors in HHS-Administered High-Income Premium



Shows the proportion of elderly households whose income has changed from 3 years ago. This assumes that HHS would base its determination of premiums on 3-year old Treasury income data.

Source: Preliminary Treasury Department Estimates



FACING FACTS

The Truth about Entitlements and the Budget

A Fax Alert from The Concord Coalition

Volume III • Number 11

July 16, 1997

A PREMIUM HIKE IS NOT A TAX HIKE

The Senate's proposal to raise Medicare Part B premiums for affluent beneficiaries has hit a snag. As written, the measure would require the means test to be administered by IHHS. The White House insists that it would be simpler and more effective to have the IRS administer it. The White House is right. But the GOP leadership, worried an IRS-administered means test could be misconstrued as a tax hike, refuses to acquiesce.

This is a dispute without substance. A premium hike is not a tax hike, no matter what agency administers it. The White House should help allay GOP political concerns by stating publicly that it understands this fact. Congressional negotiators should make the sensible change the White House wants—and Congress and the President should pass this important measure into law.

Imaginary Tax Hikes

The tax hike issue has bedeviled the means-testing debate from day one. To avoid the semblance of raising taxes, the Senate Finance Committee initially concocted an awkward and unworkable plan to means-test deductibles, which aren't payable to the government. After critics assailed the plan, the full Senate adopted the current and much fairer plan to means-test premiums. The obvious way to administer the plan is to have IRS collect the money. Instead, the Senate would have HHS collect it. As Majority Leader Trent Lott explains, involving IRS in the means test "turns it into a tax."

No it doesn't. Part B premiums are not taxes. They are fees that beneficiaries pay to participate voluntarily in a highly subsidized insurance program. Currently, these fees cover only one-quarter of full Part B costs. The balance is paid for with a direct general revenue subsidy—the only genuine tax involved. That subsidy is projected to cost taxpayers \$383 billion over the next five years, 50 to 100 times more than the means-tested premium hike Congress is agonizing over.

The problem with having HHS collect the new means-tested premiums is that it possesses neither the data nor the infrastructure to do so. A whole new bu-

reaucracy would have to be set up to accomplish a task that the IRS could accomplish by adding a single line to the current 1040 form. Even when it's up and running, moreover, IHHS would probably be much less effective than IRS. In fact, the CBO projects it would only collect half as much in premiums over the next five years.

Apparently, some conservatives are more spooked by imaginary tax hikes than the prospect of creating a needless and cumbersome new federal bureaucracy.

A Bigger Misunderstanding

All of this points to a bigger misunderstanding. If politicians are afraid the public will confuse a means test with a tax hike it's because many Americans believe what's being reduced is something they own and have somehow paid for. But they don't and they haven't. Again, the Part B premium does not come close to covering the Part B benefit. In any case, the benefit, and therefore the supposed "tax," is voluntary—that is, you can avoid any contact with any federal agency by refusing it. As for Part A, the Supreme Court has repeatedly ruled that in programs like Medicare (and Social Security) the payroll taxes government levies give participants no contractual claim to future benefits.

Let's face it: Medicare is a pay-as-you-go transfer. If our Uncle Bob or Fred gives us a less generous gift than expected, he hasn't taxed us. If Uncle Sam gives us a less generous benefit, he hasn't taxed us either.

The Public's Good Sense

Polls show that means-testing enjoys far more public support than any other approach to entitlement reform. This is a testament to the public's good sense: Americans understand that entitlement costs need to be controlled, but want to preserve a floor of protection.

Let's hope politicians show as much sense. Means-testing Medicare premiums would help correct the huge imbalance between the benefits being promised to tomorrow's elderly and the taxes tomorrow's workers will be able to pay. It would be tragic if Congress lets the opportunity slip away because of a misapplied scruple. ■

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The Concord Coalition, 1019 19th Street, NW, Suite 810, Washington, DC 20036 • Annual Subscription: \$25
phone: 202-467-6222 • fax: 202-467-6333 • <http://concordcoalition.org>

The Senate's Medicare High Income Premium Policy How It Would Work

Senate Policy. The Senate bill increases the Medicare Part B premium for high-income beneficiaries from 25 to 100 percent of Part B costs.

Single beneficiaries: Begins at \$50,000 with full payment at \$100,000
Couple: Begins at \$75,000 with full payment at \$125,000

Maximum Extra Premium in 2002

Single beneficiaries: About \$200 per month, \$2,400 per year
Couple: About \$400 per month, \$4,800 per year

This premium increase would be administered by Health and Human Services (HHS) or Social Security (SSA).

How It Would Work.

- Before the beginning of each year, the Treasury Department will send the latest available, reviewed tax information to HHS. For 1998, this would be 1995 income, for example.
- HHS will then send notices to beneficiaries who appear to be eligible to ask if this income from the older tax returns is accurate for the coming year. Beneficiaries will have 30 days to respond.
- After incorporating any mailed-in changes, HHS will send this income information to SSA, which will deduct any extra premium from Social Security checks (or HHS sets up its own collections and billing process)
- At the end of the year, HHS will use the Treasury tax information to check actual income against income used to assess the premium. For 1998, this actual income information will be available in the summer of 2000.
- HHS will increase or decrease the next year's premiums based on the previous year's error -- plus interest. If the beneficiary had died, the surviving spouse or estate will have to pay the premium owed. For a beneficiaries whose income was understated in 1998, an extra amount will be taken out of their 2001 Social Security check.

HIGH-INCOME MEDICARE PREMIUM

	2002		Annual Change from 25% Premium
	Monthly	Annual	
25% Premium *	\$66	\$792	
75% Premium	\$198	\$2,376	\$1,584
100% Premium**	\$264	\$3,168	\$2,376

* About the CBO-scored 25% premium under the House and Senate bills.

** What single beneficiaries with income above \$100,000 and couples with income above \$125,000 would pay under the Senate bill. Note: couples would pay twice as much if both are enrolled in Medicare.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

July 16, 1997

Memorandum to: Chris Jennings
Deputy Assistant to the President for Health Policy

From: Jonathan Gruber *JG*
Deputy Assistant Secretary of the Treasury (Economic Policy)

Re: Income Dynamics and Part B Premium Payments

As you know, the Senate proposal for administering the income-related Part B premium would have HCFA use IRS data to determine payment amounts. Individuals would be billed according to the income on their latest available tax return.

A key limitation of this approach is that tax returns are available only with a substantial lag, so that HCFA would use tax data that was three years old in determining premium payments. With the assistance of the Office of Tax Policy here at Treasury, we have computed the implications for income related Part B payments of using three year old tax data. Our findings are striking:

- We estimate that **twenty-two percent of households billed based on three year old tax data would in fact owe no income related premiums based on today's income.** Many individuals in the over-65 population have declining incomes, particularly upon retirement or death of a spouse. These individuals would be inappropriately billed by a system using previous tax data.
 - Although Part B enrollees are given an opportunity, under the legislation, to provide a revised estimate of income to HCFA, it is likely that many will fail to do so. Furthermore the process of entering and verifying revised data is likely to lead to additional errors.
- Moreover, of those receiving bills, **roughly one-half will be overbilled. One-half of this group will be overbilled by \$500 or more.**
- We also estimate that **four percent of households not billed based on three year old tax data would in fact owe income related premiums based on today's income.** Since the proposal calls for only billing those who are determined to owe premiums based on previous tax data, we would not send bills to this population whose income is increasing, and therefore should owe some income-related premium.
- We find that **total mis-payments of premiums would amount to over \$1.3 billion dollars.** This is comprised of approximately \$650 million in underpayments, and \$700 million in overpayments.

W. J. ...

-- This is a very sizeable amount: these mis-payments amount to roughly one-third of the total five year revenues that CBO estimates we could raise through HCFA-administered Part B premiums.

-- The fact that overpayments and underpayments are roughly equal in no way implies that these are "harmless" errors: the underpayments are likely to be substantially unmet, while the overpayments are likely to lead to sizeable complaints among the billed population.

to CBO ...

20/10/05

Medical Research Society



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Clara Challa

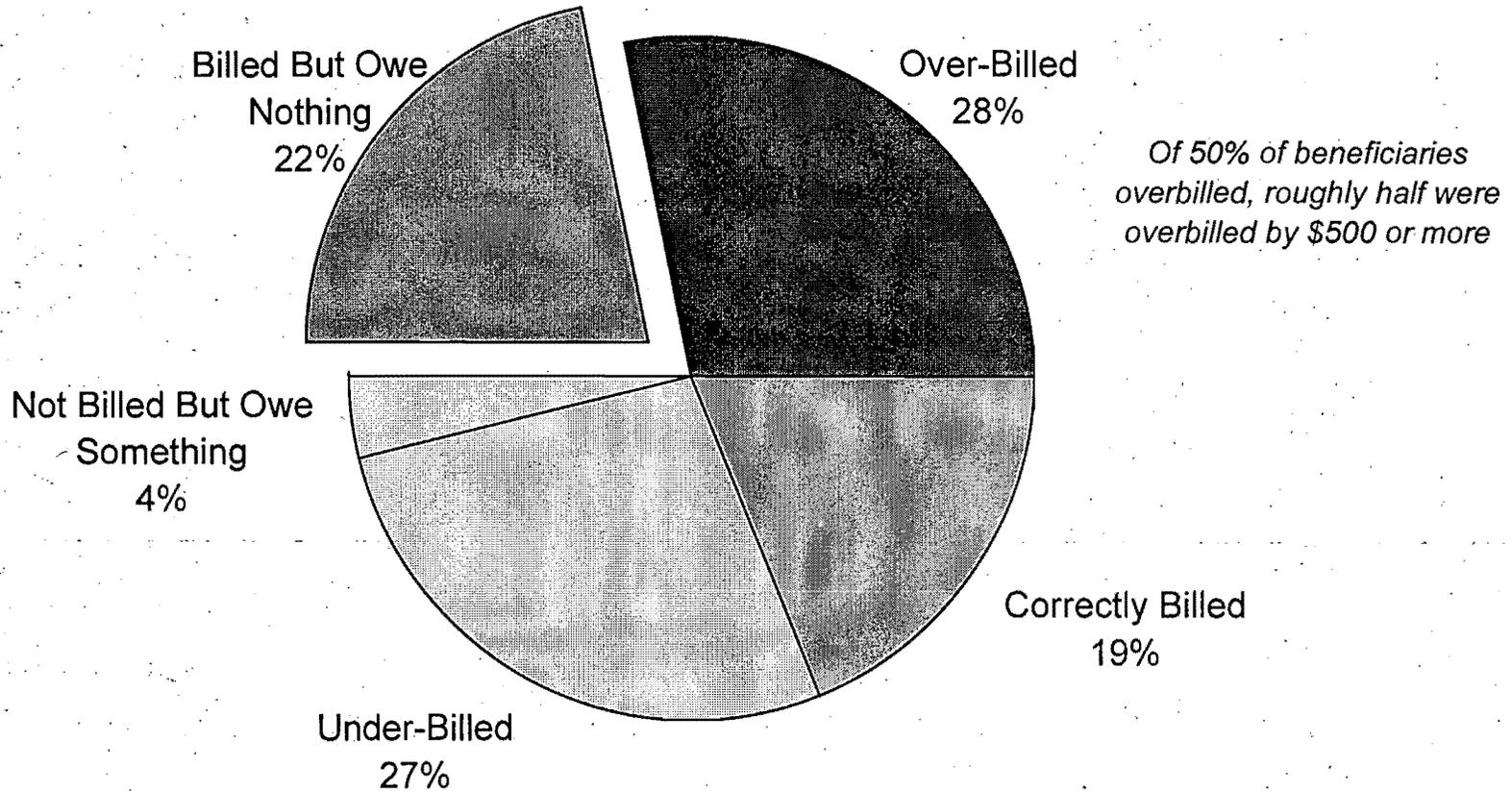
(CJ) File Income
"High Related Premium"

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How Premiums Are Collected	Assumes that extra premium is subtracted from monthly Social Security check after HHS sends to SSA their estimate of who gets how much taken out of their checks	See above
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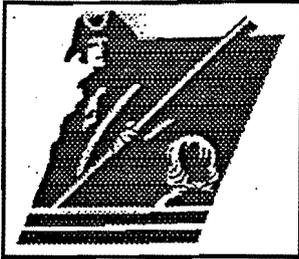
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-- This is a very sizeable amount: these mis-payments amount to roughly one-third of the total five year revenues that CBO estimates we could raise through HCFA-administered Part B premiums.

-- The fact that overpayments and underpayments are roughly equal in no way implies that these are "harmless" errors: the underpayments are likely to be substantially unmet, while the overpayments are likely to lead to sizeable complaints among the billed population.

DECISIONS ABOUT TREASURY-ADMINISTERED MEDICARE INCOME-RELATED PREMIUM

- **Separate form versus income-tax form:**
Using a separate form is the most important way to distinguish the premium from an income tax. It could be called the "Medicare Premium Adjustment Form" or whatever is decided upon. However, the disadvantage of this is that beneficiaries may be less likely to report their income correctly and pay the premium in a timely, efficient way if it is not on the same form as income taxes.

Separate forms also lead to higher administrative costs since extra forms would have to be processed and reviewed. A separate review process will be needed since the premium amount is below current thresholds for active collections.

If separate:

- **When and how is the form mailed:**
 - **Sent with the tax forms or separately**
While a separate mailing is more costly, it may lessen the perceived link to the income tax.
- **When and how is the form and premium payment returned:**
 - **Sent to IRS or "Medicare"**
It is possible that beneficiaries make the check out to the "Medicare Trust Fund" and mail it to a PO box distinct from where they send their taxes. This would reinforce the fact that the money is not going to general revenues. However, some beneficiaries may be confused by the separate mailings, especially if both income tax and the premium assessment are due on the same day (below).
 - **April 15th return or some other date**
The advantage of requiring the Medicare form and check to be returned by April 15th is that beneficiaries may be more likely to calculate their income once, correctly, for both forms, thus lessening the error rate.
- **How are errors corrected:**
 - **Refund adjustments or separate billing**
Downwardly or upwardly adjusting the tax refunds is the most effective way of correcting errors, but explicitly connects the premium with taxes.



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

JUL 11 1997

MEMORANDUM FOR THE PRESIDENT

As you know, the Senate has proposed a number of changes that would affect Medicare beneficiaries, including the introduction of an income-related Part B premium starting at \$50,000 for single beneficiaries and \$75,000 for couples. In our letter to the Conferees, the Administration made clear that while we do not oppose income-relating the Medicare premium in principle, we have a number of concerns about the proposal as currently structured. I wanted to raise to your attention the two aspects of the proposal that I think raise the most significant problems. (I have discussed my concerns with Secretary Rubin).

First, if the Administration agrees to an income-related premium, I believe we should strongly oppose the Senate provision for HHS to administer the collections process. The Administration has consistently taken the position that any such premium should be collected by the Treasury Department, where it could be managed simply and efficiently as part of the filing of a beneficiary's tax return. (As you may recall, this is how we proposed to collect the income-related premium in the Health Security Act; we adhered to this position in the balanced budget negotiations). Part I of this memorandum sets forth in more detail the reasons why administration of an income-related premium by HHS would be impractical, expensive, and more burdensome to beneficiaries. Administration by HHS runs serious risks of alienating several million senior citizens.

Second, I am concerned that the Senate proposal has the potential to cause a substantial percentage of the highest income beneficiaries to opt out of Medicare Part B altogether, because it phases out the premium subsidy entirely at the top end of the income scale. Part II of the memorandum explains why it is very important that we not agree to an income-related premium that includes this feature.

I. Concerns about Administrability of Income-Related Premium by HHS

Administration of an income-related premium by HHS would be a formidable undertaking. HHS does not now have access to information on beneficiary income. In addition to serious concerns about the privacy of income information, requiring HHS to collect an income-related premium would mean establishment of a large and expensive bureaucracy at HHS, a task for which the Department has no expertise or comparative advantage. We estimate that such a bureaucracy, which would duplicate functions performed by Treasury, would require more than 300 new

Federal employees and cost more than \$30 million per year (not counting start-up costs), and run counter to Administration and Congressional goals of downsizing the Federal government.

Furthermore, the inefficiencies inherent in the Senate proposal for HHS to collect the income-related premium have led both CBO and HCFA actuaries to estimate that less than half of the revenue theoretically obtainable would be achieved. We believe that CBO would estimate that the income-related premium in the Senate bill would raise about \$8-\$9 billion over five years if the collections were handled by Treasury, compared to only the \$4 billion that CBO has estimated if the premium were administered by HHS.

A. What HHS Would Have to Do to Administer Income-Related Premium

The Senate bill would require HHS to undertake a complicated series of steps.

- (1) The Senate bill requires Treasury to provide HHS with income information on Medicare beneficiaries since HHS does not have such information. Collecting and reconciling information about beneficiary incomes would be an entirely new function for HHS, one that some beneficiaries may not find appropriate, given the sensitivity of such information.
- (2) The income information provided by Treasury would be three years old. Treasury would send HHS 1995 tax return information, the latest available information, in order to give HHS sufficient time to develop and send to beneficiaries an initial determination (i.e., a preliminary estimate which would need to be reconciled after the actual tax filing for the year) of their 1998 income and an initial determination of their 1998 income-related premium liability, and give the beneficiary an opportunity refute the HHS estimate.

Use of income data three years old is problematic. It would be inherently confusing. Past income is not a good indicator of a Medicare beneficiary's future income. For example, income for beneficiaries who were working in 1995 but later retired would result in an overstatement of estimated 1998 income for the beneficiary. Similarly, if a beneficiary had a capital gain in 1995, that gain would be included in the beneficiary's 1995 income used to project 1998 income.

In contrast, if Treasury were administering the income-related premium, they would not have to use three year-old data. Rather, because the income-related premium would be collected as part of the filing of the beneficiary's tax return, it would be based on actual income information for the relevant year.

HHS would have to respond to the many letters from beneficiaries or Congressional Offices who might be concerned with the general notion of a governmental agency estimating their income for a year and why they had to supply income data to two different governmental agencies.

- (3) The Senate bill requires that HHS send the beneficiary an estimate of their income by September 1 of the year before the year for which the income-related premium applied and that the beneficiary be given thirty days to refute the estimate. If the beneficiary refutes the HHS estimate, the Senate bill provides that the beneficiary's estimate would hold. If the beneficiary does not challenge the HHS estimate, the Senate bill specifies that the HHS estimate would hold.
- (4) While the Senate bill does not specify how the income-related premiums would actually be collected, they could be collected either by HHS direct billing, or SSA deductions from the Social Security check (for the bulk of beneficiaries).

In the case of exclusive HHS direct billing, HHS would have to send quarterly bills to about 3 million beneficiaries in 1998. For those beneficiaries who did not make timely payment, additional efforts at collection would need to be undertaken.

Alternatively, the beneficiary-specific income-related premium liability could be sent to SSA before the beginning of a year and SSA could deduct the amount from the beneficiary's Social Security check. This method could be used for 85 percent of beneficiaries; the remainder would need to be direct-billed by HHS.

- (5) If high-income beneficiaries did not make premium payments, they would be terminated from Medicare Part B coverage. Challenges to terminations could consume additional HHS resources. Termination may also involve correspondence with beneficiaries and Congressional offices.
- (6) Since the initial premium payments for a year would be based on the "initial determination" of income and since "actual" income and the actual income-related premium liability for the year may be different from the estimated amounts, the Senate bill requires that there be a reconciliation after the year. The Senate bill requires Treasury to send HHS income information after the beneficiary filed their tax returns for the year. Using actual income, HHS would determine the actual premium liability for the year.

For income-related premium liabilities for 1998, the reconciliation would occur in 2001. This could be confusing to beneficiaries since the reconciliation would involve resurrecting their actual information from a tax return three years earlier and generate additional correspondence.

- (7) After HHS reconciled estimated and actual income and income-related premium liabilities, underpayments would have to be collected from beneficiaries and overpayments would have to be refunded. If a beneficiary had died, collections would have to be made from, and refunds made to, the surviving spouse or estate. Special efforts may be needed to recoup underpayments from heirs where estates had already disbursed assets.

- (8) The paperwork burden for HHS administration of an income-related premium is staggering. New forms would have to be developed to send income estimates to beneficiaries, receive their responses and reconcile estimated and actual income. Twelve million bills would need to be sent if HHS did exclusive billing for income-related premiums. Additional correspondence would be involved for delinquent collections. Up to 3 million letters might be sent to handle overpayments and underpayments for a year. Special paperwork might be needed to recoup underpayments from surviving spouses or estates.

B. Comparison with Administration by Treasury

In contrast, an income-related premium could be calculated through the income tax return, in a manner similar to the way that the tax on Social Security benefits is currently determined. One line would be added to the 1040 tax form representing the amount owed for income-related premium. Determination of the income-related premium owed would be calculated on a worksheet in the 1040 instructions in the same manner that individuals calculate the amount of their Social Security benefit subject to income taxation. If the individual pays estimated taxes, the income-related premium liability could be included as part of the individual's periodic filing. There would be some increase in Treasury's administrative costs to run this program, but we believe those costs are relatively small.

C. Potential Costs of Administration by HHS

In an era of ever more constrained funding for program administration, requiring HHS (and SSA) to take on these administrative functions would be impossible without a more than \$30 million annual increase in administrative funding (and \$20 million in start-up costs) and more than 300 new Federal employees. These estimates of administrative costs do not take into account the need to deal with inquiries or complaints from Congressional offices, or the IRS itself (which will continue to be identified as the source of final income data). In the absence of additional resources, processing those inquiries would detract from the capacity of those organizations to provide other services. Nor do those estimates reflect the additional costs to beneficiaries who believe -- rightly or wrongly -- that there are errors in the information on which their filings are based. Just as other taxpayers incur considerable expenses for accountants, lawyers, and so forth, so for the first time would thousands of Medicare beneficiaries.

II. Concerns about the Maximum Beneficiary Contribution in Senate Proposal

The Administration's Health Security Act proposed that beneficiaries pay a maximum contribution of 75 percent at or above the top income level. In other words, there would be a 25 percent subsidy for the highest income beneficiaries.

There is an important rationale for this policy. If the entire subsidy is removed, the younger and

healthier persons among highest income beneficiaries would have strong incentives to drop out of Part B coverage. On average, Medicare spending for high-income beneficiaries is about 15 percent lower than for all beneficiaries. Since their average expenses would be considerably less than their Part B premium contributions, they could probably purchase a Part B benefit package privately, at less cost than a Medicare premium equal to 100 percent of the average cost for all aged beneficiaries. If a significant number of high-income beneficiaries dropped out, it would raise costs for those who remain. HCFA actuaries assume that about 30 percent of high-income beneficiaries would drop out if the income-related premium were set equal to 100 percent of average program costs. This would increase the Part B premium for every other beneficiary. The Administration believes that the maximum beneficiary contribution at the highest incomes should be 75 percent.

Conclusion

For all of these reasons, I strongly believe we should support an income-related premium only if it is administered through Treasury. I also believe that if this provision remains in the bill, the maximum beneficiary contribution should be 75 percent.



Donna E. Shalala

cc: Robert Rubin
Secretary, Department of Treasury

John Callahan
Acting Commissioner, Social Security Administration

of \$100,000 for singles (\$150,000 for couples). Income includes adjusted gross income plus other items such as tax-exempt interest. This income is already reported to the Internal Revenue Service for purposes of determining the taxability of Social Security benefits.

Medicare enrollees will declare during the Medicare open enrollment period whether their estimated income for the upcoming year will exceed the income thresholds. If enrollees are unsure of their income for the upcoming year, they may use their modified income reported on the previous year's Federal income tax return. The Secretary of Health and Human Services will notify the Social Security Administration of the amount of premium to deduct from each enrollee's Social Security check based upon the beneficiary's declaration of income. The amount of the Medicare Part B premium payment will be reconciled with actual income in conjunction with the annual income tax filing process. A separate form, to be filed with the Secretary, will be included in enrollees' Federal income tax return forms package. Underpayments and overpayments will be handled directly through the Secretary of Health and Human Services. The Secretary and the Internal Revenue Service (IRS) will share certain tax return information to permit verification of declared income with actual income reported to the IRS.

Effective Date

This provision will be effective for calendar years beginning on or after January 1, 1997.

Chapter 4—Provisions Relating to Parts A and B

SUBCHAPTER A—GENERAL PROVISIONS RELATING TO PARTS A AND B

SECONDARY PAYER PROVISIONS

(Sec. 7055)

Present Law

(a) Generally, Medicare is the "primary payer," that is, Medicare pays medical claims first, with an individual's private or other public insurance only responsible for claims not covered by Medicare. For certain Medicare beneficiaries, however, the beneficiary's employer's health insurance plan pays medical bills first (so-called "primary payer"), with Medicare paying for any gaps in coverage within Medicare's coverage limits (Medicare is the "secondary payer"). Medicare is the secondary payer to certain employer group health plans for: (1) aged beneficiaries (age 65 and over); (2) disabled beneficiaries, and (3) beneficiaries with end-stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Medicare secondary payer provision regarding aged beneficiaries is permanent law. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the law making Medicare the secondary payer for disabled and ESRD beneficiaries through October 1, 1998.

MEMORANDUM

TO: Gene S. and John H.
FROM: Chris J. and Jeanne L.
RE: **CBO ESTIMATES OF SAVINGS FOR HIGH-INCOME PREMIUM**
DATE: July 15, 1997

Today, we received confirmation from CBO that the savings from an income-related premium are much lower when administered by HHS versus Treasury. The attached shows the same policy administered by the two different Departments:

	<u>5-Year Savings</u>	<u>10-Year Savings</u>
HHS Administration	\$3.9 billion	\$19.6 billion
Treasury Administration	\$8.9 billion	\$31.9 billion

The offset to the savings under the HHS administration is larger in the early years since HHS will take time learning how to implement it. However, even in the tenth year, the savings are 30 percent lower than if administered by Treasury.

Please call with questions.



DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

July 18, 1997

MEMORANDUM FOR: Chris Jennings
Jeanne Lambrew
Josh Gottbaum

FROM: Jonathan Gruber *JG*
Ken Krupsky
Chris Rizek

SUBJECT: Medicare Part B recapture -- non-1040 options

Enclosed are our preliminary thoughts on collecting Medicare Part B premium recapture amounts using the IRS but not on the 1040 form. The IRS has not completed its review of these alternatives yet.

One important issue to which you should be alerted: If assessed separately, outside of the 1040 assessment, a tax in the \$1000 to \$3000 range would fall below the IRS's thresholds for devoting active collection resources (revenue officer time, lien and levies, etc.). The only routine collection activity for such small assessments is refund offset. So there would be virtually NO SEPARATE "ENFORCEMENT" of this tax. This is another strong argument for keeping this as part of the 1040 income tax system. We leave it to you as to whether to make this point explicit in our memo or not.

July 18, 1997

Medicare Part B premium recapture -- Non-income tax options

This proposal would permit the IRS to collect the Medicare Part B premium recapture -- retaining an effective linkage to participants' income and allowing the enforcement and collection powers of the IRS to be made available -- but would have the IRS do so outside of the Form 1040 and income tax system. *Caveat: If the IRS is to collect the premium recapture, that amount must be treated as a "tax" for purposes of the Internal Revenue Code's enforcement provisions.*

Under this proposal, the IRS would provide taxpayers with a separate "Part B Premium Recapture" form. Taxpayers who participate in Part B would complete the form using data taken from their Form 1040 (adjusted gross income and desired "modifications"). The premium recapture amount would be returned and payable separately from the income tax. It would be assessed and (if underpaid) collected by the IRS like any other tax. Traditional pre- and post-payment remedies for contesting disputed amounts (deficiency proceedings or refund claim proceedings) could be adapted to this tax.

In addition to the tax consequences of collecting the premium recapture amount, an additional sanction could be considered for persons who are liable for the premium but who fail to pay. Such non-payers could ultimately be disenrolled or barred from participation in Medicare Part B.

Variations on this proposal

1. Include the "Part B Premium Recapture" form with the Form 1040 package that the IRS provides to taxpayers in January of each year. Require covered Part B participants to submit the form in the same envelope with their income tax return for the preceding year, *i.e.* by April 15.
2. Provide the "Part B Premium Recapture" form at an entirely different time of year (*e.g.*, July 1) and require the form and payment to be submitted separately (*e.g.*, September 15).

Advantages of this proposal:

- The information on the Part B form, including the adjustments to AGI, can be verified by cross-reference to the taxpayers' income tax form. This will help in achieving a relatively high level of compliance and minimize the discrepancies between the forms. (Higher compliance could probably be obtained under variation 1, because taxpayers will have the information readily available and can obtain assistance completing the forms at the same time they complete their income tax returns. By contrast, under variation 2, more taxpayers will require assistance and more errors or discrepancies will arise.)
- Treating the premium recapture like any other tax will enable the IRS to adapt existing systems (for form processing and data entry, assessment, examination, and collection) easily. (Nonetheless, the cost to the IRS is approximately twice the cost of a Form 1040 system, or

roughly \$10 million.)

- It might be possible for IRS to target the taxpayers who need to be provided the separate forms (e.g., by using HHS/SSA information), so that the forms need not be mailed to all of the nearly 120 million U.S. individual taxpayers. (It would probably still be necessary to provide the Part B forms to all 38 million participants, however.)
- It would be relatively simple to identify those high-income Part B participants who have failed to pay their premium recapture amounts, for purposes of making continued eligibility determinations.

Disadvantages of this proposal:

- All of the information needed for determining the premium recapture is on the income tax form. It makes little sense to require taxpayers to fill out separate forms and make separate payments outside of the income tax system, particularly if they are processed at different locations or are due at different times in the year (variation 2). Likewise, it makes little sense for the IRS to duplicate its processing of the same information. This simply multiplies the paperwork burden on both taxpayers and the Government.
- Compliance is likely to be impeded by minor obstacles, especially under variation 2. For instance, if taxpayers are required to send the premium recapture form and payment to a different location than the income tax return, there will inevitably be some level of mix-ups. If the premium recapture is due at a different time from the income tax return, those taxpayers who have not kept copies of their returns will need to obtain them or duplicate the information.
- Assessments of the premium recapture are likely to be relatively small in dollar amount (e.g., approximately \$1,300 per taxpayer), and thus administration costs will be higher per dollar collected than for the income tax. In particular, such assessed amounts might fall below the thresholds used by the IRS in determining allocation of collection resources and undertaking collection activities. Additional appropriations might be necessary to achieve the same level of compliance as under the income tax.
- Applying deficiency procedures could result in clogging the Tax Court with many small-dollar cases.
- Compared to a system in which the premium recapture amount is included in estimated income tax payments, this proposal will result in the Government's loss of some "float" on the estimated payments.

Cost of this proposal:

Approximately \$10 million in direct costs; lost time value of estimated payments not yet determined.

**THE WHITE HOUSE
WASHINGTON**

MEMORANDUM

TO: DISTRIBUTION
FROM: Chris Jennings
RE: MEDICARE HIGH-INCOME PREMIUM
DATE: July 11, 1997

Attached are several pages describing:

- A side-by-side comparison of the approaches;
- A list of major concerns with the Senate proposal;
- How the Senate-passed income-related premium works; and
- How such a policy would work if administered by Treasury.

Please call with questions.

COMPARISON OF THE ADMINISTRATION OF THE HIGH-INCOME PREMIUM

PROVISION	SENATE BILL ADMINISTERED BY HHS*	SENATE BILL ADMINISTERED BY TREASURY*
Who Administers	Health & Human Services (HHS), Social Security Administration (SSA), & Treasury	Treasury
Savings	\$3.9 billion (assumes loss of over 50% of savings in the first 5 years)	\$8 to 9 billion (assumes traditional compliance rates)
Administrative Costs	\$30 to 50 million per year	\$5 to 10 million per year
How Eligible Beneficiaries Are Identified	HHS identifies beneficiaries by: (1) Getting income from the latest reviewed Treasury tax data, which is 2-3 years old (e.g., 1995 for 1998) (2) Sending notices to at least 3 million beneficiaries to ask if this past income is what they will receive in the next year and require them to respond in writing in 30 days Note: Sharing income data across agencies raises significant privacy concerns	Beneficiaries report their income, reference a schedule, and add the extra premium to the bottom line of their tax return
How Premiums Are Collected	Assumes that extra premium is subtracted from monthly Social Security check after HHS sends to SSA their estimate of who gets how much taken out of their checks	See above
Reconciling Income	To ensure that the right amount of premium was assessed, Treasury would send the actual income from reviewed tax data to HHS. However, because this would be done retrospectively this would take 2-3 years (e.g., 2001 correction for 1998 mistake)	Since income is not projected but is the actual reported income, no reconciliation is required.

* This policy assumes the Senate policy which phases in 100% of the premium for beneficiaries with incomes between \$50,000 and \$100,000 for singles, \$75,000 and \$125,000 for couples. The Administration opposed the Senate's 100% phase out, administration through HHS/SSA, and lack of indexing of the income thresholds.

The Senate's Medicare High Income Premium Policy Concerns

- **Duplicates bureaucracy.** Today, the Treasury Department is the only Federal agency that has the income information needed to collect a high-income premium. HHS or SSA would either have to collect their own income information, like a second tax return, or borrow the Treasury income information. In either case, a large, new bureaucracy, with hundreds of new workers, would be needed to duplicate the Treasury structure. This could cost \$30 to \$50 million per year — many times more than it would cost if administered through Treasury.
- **Errors likely.** HHS cannot easily identify who should be paying the extra premium. It would base its identification of these people on 3-year old income information received from the Treasury. One in four seniors who are above the income thresholds fall below them three years later, mostly because they have been working but have since retired. Others may have died or have spouses that have died, changing the amount that they owe. Beneficiaries have a 30-day window to mail in any corrections, but this may be too short of a time period and could be difficult to understand or process for some seniors.
- **Collections difficult.** Collecting this extra premium is not as simple as reducing beneficiaries' Social Security checks. Three agencies — HHS, SSA, and Treasury — would have to coordinate information to ensure that the right premium is collected. This not only raises major privacy concerns, but is inefficient. The right amount of the premium won't be known for years, since it takes time for Treasury to review tax returns, HHS to match the actual income with that used to determine the premium, and SSA to collect any over- or underestimate. Recouping the extra premium years later creates bureaucratic challenges — HHS would need practices like a collections agency — as well as hardship for beneficiaries. Since most beneficiaries' incomes will decline as they age, beneficiaries will be paying no extra premium when they can afford it and more when they can afford it less.
- **Major loss of revenue.** A consequence of this administrative complexity is the loss of the premium revenue from the policy. Cost estimators at CBO and OMB assume that more than half of the potential revenue will be lost due to problems in administration. In contrast, only a small percent will be lost if administered by the Treasury, which already has most of the administrative structures in place.
- **Loss of healthier, wealthier beneficiaries.** Totally phasing out the premium could cause long-run problems for Medicare. Faced with a large, extra premium, the healthiest beneficiaries have a strong incentive to leave Medicare. It is likely that an insurance market will develop that can offer Part B services at a lower price — especially since Medicare spends, on average, 15 percent less for high-income beneficiaries than for all beneficiaries. HHS Actuaries assume that about half a million healthy, wealthier beneficiaries would leave Medicare if the premium rose to 100 percent. The loss of these beneficiaries not only means less premium revenue but could raise the cost of Medicare for those who remain.

The Senate's Medicare High Income Premium Policy How It Would Work

Senate Policy. The Senate bill increases the Medicare Part B premium for high-income beneficiaries from 25 to 100 percent of Part B costs.

Single beneficiaries: Begins at \$50,000 with full payment at \$100,000
Couple: Begins at \$75,000 with full payment at \$125,000

Maximum Extra Premium in 2002

Single beneficiaries: About \$200 per month, \$2,400 per year
Couple: About \$400 per month, \$4,800 per year

This premium increase would be administered by Health and Human Services (HHS) or Social Security (SSA).

How It Would Work.

- Before the beginning of each year, the Treasury Department will send the latest available, reviewed tax information to HHS. For 1998, this would be 1995 income, for example.
- HHS will then send notices to beneficiaries who appear to be eligible to ask if this income from the older tax returns is accurate for the coming year. Beneficiaries will have 30 days to respond.
- After incorporating any mailed-in changes, HHS will send this income information to SSA, which will deduct any extra premium from Social Security checks (or HHS sets up its own collections and billing process)
- At the end of the year, HHS will use the Treasury tax information to check actual income against income used to assess the premium. For 1998, this actual income information will be available in the summer of 2000.
- HHS will increase or decrease the next year's premiums based on the previous year's error – plus interest. If the beneficiary had died, the surviving spouse or estate will have to pay the premium owed. For a beneficiaries whose income was understated in 1998, an extra amount will be taken out of their 2001 Social Security check.

Treasury Department-Administered Medicare High Income Premium How It Would Work

Policy. Like the Senate bill, this policy would increase the Medicare Part B premium for high-income beneficiaries. It differs from the Senate approach since beneficiaries pay at most 75 percent of the premium and the income thresholds are indexed to inflation.

Single beneficiaries: Begins at \$50,000 with full payment at \$100,000
Couple: Begins at \$75,000 with full payment at \$125,000
Indexed to inflation for years after 1998

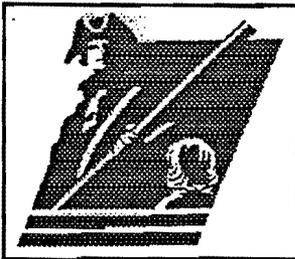
Maximum Extra Premium in 2002

Single beneficiaries: About \$130 per month, \$1,600 per year
Couple: About \$260 per month, \$3,200 per year

This premium increase would be administered by the Treasury Department.

How It Would Work.

- The extra premium will be collected through the tax system. Most eligible beneficiaries will fill out an extra line on their annual tax returns. This will be done by comparing income (modified adjusted gross income) with a premium schedule that will be included in the tax instructions.
- Beneficiaries who pay quarterly taxes will take the premium into account when calculating their withholding and / or quarterly estimated tax payments.
- The income information will be checked through the usual Treasury review process.
- The revenue from the extra premium will be transferred periodically to the Medicare trust fund.



FACING FACTS

The Truth about Entitlements and the Budget

A Fax Alert from The Concord Coalition

Volume III • Number 11

July 16, 1997

A PREMIUM HIKE IS NOT A TAX HIKE

The Senate's proposal to raise Medicare Part B premiums for affluent beneficiaries has hit a snag. As written, the measure would require the means test to be administered by HHS. The White House insists that it would be simpler and more effective to have the IRS administer it. The White House is right. But the GOP leadership, worried an IRS-administered means test could be misconstrued as a tax hike, refuses to acquiesce.

This is a dispute without substance. A premium hike is not a tax hike, no matter what agency administers it. The White House should help allay GOP political concerns by stating publicly that it understands this fact. Congressional negotiators should make the sensible change the White House wants—and Congress and the President should pass this important measure into law.

Imaginary Tax Hikes

The tax hike issue has bedeviled the means-testing debate from day one. To avoid the semblance of raising taxes, the Senate Finance Committee initially concocted an awkward and unworkable plan to means-test deductibles, which aren't payable to the government. After critics assailed the plan, the full Senate adopted the current and much fairer plan to means-test premiums. The obvious way to administer the plan is to have IRS collect the money. Instead, the Senate would have HHS collect it. As Majority Leader Trent Lott explains, involving IRS in the means test "turns it into a tax."

No it doesn't. Part B premiums are not taxes. They are fees that beneficiaries pay to participate voluntarily in a highly subsidized insurance program. Currently, these fees cover only one-quarter of full Part B costs. The balance is paid for with a direct general revenue subsidy—the only genuine tax involved. That subsidy is projected to cost taxpayers \$383 billion over the next five years, 50 to 100 times more than the means-tested premium hike Congress is agonizing over.

The problem with having HHS collect the new means-tested premiums is that it possesses neither the data nor the infrastructure to do so. A whole new bu-

reaucracy would have to be set up to accomplish a task that the IRS could accomplish by adding a single line to the current 1040 form. Even when it's up and running, moreover, HHS would probably be much less effective than IRS. In fact, the CBO projects it would only collect half as much in premiums over the next five years.

Apparently, some conservatives are more spooked by imaginary tax hikes than the prospect of creating a needless and cumbersome new federal bureaucracy.

A Bigger Misunderstanding

All of this points to a bigger misunderstanding. If politicians are afraid the public will confuse a means test with a tax hike it's because many Americans believe what's being reduced is something they own and have somehow paid for. But they don't and they haven't. Again, the Part B premium does not come close to covering the Part B benefit. In any case, the benefit, and therefore the supposed "tax," is voluntary—that is, you can avoid any contact with any federal agency by refusing it. As for Part A, the Supreme Court has repeatedly ruled that in programs like Medicare (and Social Security) the payroll taxes government levies give participants no contractual claim to future benefits.

Let's face it: Medicare is a pay-as-you-go transfer. If our Uncle Bob or Fred gives us a less generous gift than expected, he hasn't taxed us. If Uncle Sam gives us a less generous benefit, he hasn't taxed us either.

The Public's Good Sense

Polls show that means-testing enjoys far more public support than any other approach to entitlement reform. This is a testament to the public's good sense: Americans understand that entitlement costs need to be controlled, but want to preserve a floor of protection.

Let's hope politicians show as much sense. Means-testing Medicare premiums would help correct the huge imbalance between the benefits being promised to tomorrow's elderly and the taxes tomorrow's workers will be able to pay. It would be tragic if Congress lets the opportunity slip away because of a misapplied scruple. ■

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The Concord Coalition, 1019 19th Street, NW, Suite 810, Washington, DC 20036 • Annual Subscription: \$25
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HIGH-INCOME MEDICARE PREMIUM

	2002		Annual Change from 25% Premium
	Monthly	Annual	
25% Premium *	\$66	\$792	
75% Premium	\$198	\$2,376	\$1,584
100% Premium**	\$264	\$3,168	\$2,376

* About the CBO-scored 25% premium under the House and Senate bills.

** What single beneficiaries with income above \$100,000 and couples with income above \$125,000 would pay under the Senate bill. Note: couples would pay twice as much if both are enrolled in Medicare.



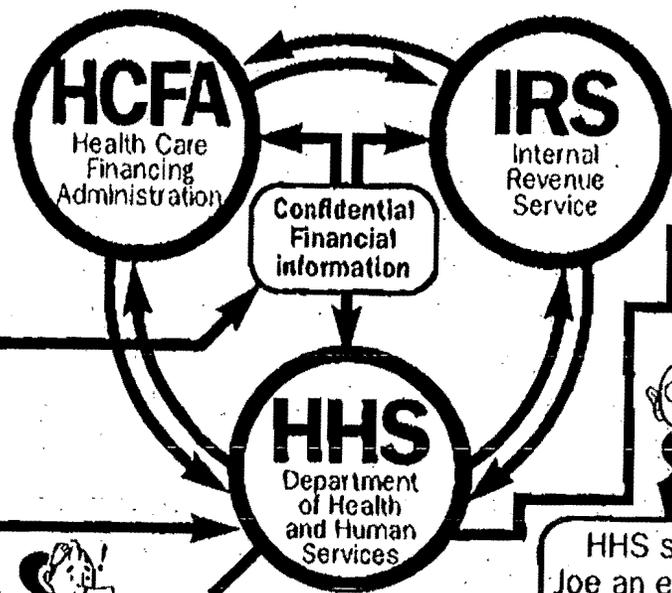
Joe Payer and millions of other Medicare recipients file their 1997 federal tax forms by April 15, 1998.*

HHS (which runs Medicare), HCFA and the IRS exchange confidential financial information on these individuals.

What information??

- Taxpayer Identity Information
- Adjusted Gross Income (AGI)
- Amounts Excluded From AGI
- Filing Status
- Tax Exempt Interest Income
- Foreign Income

* The Senate bill asks beneficiaries to start paying this new premium in 1998. Since most people believe this is impossible, this chart shows how complicated it would be even if...



HHS, HCFA and/or the IRS calculate 1999 estimated income level for Joe, using 1997 tax return.

Q: What if Joe's income or situation changes within the 3-year period from the government's estimates to actual payment?
 A: Follow the arrows....

HHS sends Joe an estimate of his 1999 income by Sept. 1, 1998.

Joe agrees with estimate.

Social Security adjusts Joe's monthly benefit check, subtracting higher Medicare premium.

Joe disagrees with estimate. (What if the government is wrong?)

Joe sends letter to HHS within 30 days.

HCFA trusts Joe, revises estimate.

HCFA disputes.

Joe overpaid.

Joe's error.

Joe's premium for the year 2000 is adjusted downward.

Joe pays increase in premium plus penalty in the year 2000.

Joe's additional premium is deducted from his Social Security check every month.

At an unspecified future point, HCFA rules...

Joe didn't pay enough.

Gov't error. Oops... sorry! Premium increased in the year 2000.

And if you're married it gets even more complicated!

COMPROMISE ON TREASURY-ADMINISTERED MEDICARE INCOME-RELATED PREMIUM

- **Income-related premium.** High-income Medicare beneficiaries would pay an income-related Medicare Part B premium. The income thresholds for the phase-in of this premium would be indexed to inflation and would begin at \$X,000 and be fully phased in at \$Y,000. (Note: For single beneficiaries, the Senate and Blue Dog's proposals begin at \$50,000, the 1995 Republican Budget began at \$60,000, and the 1994 health reform proposal began at \$90,000). The proposal assumes that the maximum payment is set at 75 percent of program costs to reduce the incentive for the healthiest and wealthiest beneficiaries to leave the program.

ADMINISTRATION

- **Treasury-run process for premium adjustment.** The Treasury Department, which is set up to collect income information and payments, would administer the premium adjustment.
- **"Medicare Premium Adjustment Form".** Near the end of the year, all elderly Americans would receive this form in the mail. Instructions attached to the form would tell beneficiaries how to calculate their income (same as on their income tax form) and how to use the enclosed worksheet to figure out their premium adjustment. This would be sent to the Treasury Department with the tax form.
- **Payments to the Medicare Trust Fund.** Beneficiaries would return the form and any payment through a check made payable to the Medicare Trust Fund. The payments would be due on April 15th so that beneficiaries can calculate their incomes once for both purposes and the mailed with their returns. The Treasury Department would make sure that the Medicare payments are directed to the Part A Trust Fund.
- **Combined review and corrections process.** Any overpayment or underpayment of the premium would be corrected through the tax refund process so that beneficiaries only have to deal with the Treasury once (not twice through a separate billing or refund process).

Income-Related Part B Premium Administration

- Seniors with adjusted gross income, as calculated on their tax forms, over \$50,000 for an individual or \$75,000 for a couple would submit a Medicare Premium Adjustment Form. This form would be an additional tax-like form, either included in the income tax instructions or -- like many additional schedules -- available from the IRS. It would include income tables to enable beneficiaries to calculate their additional premium.
- Beneficiaries would submit their premium adjustment forms to HHS with a check, payable to the Medicare Trust Fund, for their additional premium liability. These payments would be due on April 15, so that beneficiaries only need to calculate their incomes once.
- Treasury and HHS would reconcile and audit reported income with premium payments. Overpayments and underpayments could be reconciled through a "premium refund" or additional premium charge run by Treasury in conjunction with tax refunds.

Draft

ADMINISTRATION OF THE MEDICARE INCOME-RELATED PREMIUM

- **Income-related premium.** High-income Medicare beneficiaries would pay an income-related Medicare Part B premium. The income thresholds for the phase-in of this premium would be indexed to inflation and would begin at \$X,000 and be fully phased in at \$Y,000. (Note: For single beneficiaries, the Senate and Blue Dog's proposals begin at \$50,000, the 1995 Republican Budget began at \$60,000, and the 1994 health reform proposal began at \$90,000). The proposal assumes that the maximum payment is set at 75 percent of program costs to reduce the incentive for the healthiest and wealthiest beneficiaries to leave the program.

ADMINISTRATION

- **Simple process.** Designed to ensure that only the beneficiaries who qualify for the premium adjustment (less than 8 percent) fill out any form. Beneficiaries would determine whether they qualify for the premium adjustment by measuring modified adjusted gross income. If over the threshold, the beneficiary would be alerted about the availability of the "Medicare Premium Adjustment Form" in their annual tax instructions.
- **"Medicare Premium Adjustment Form".** This form would contain (1) instructions on how to calculate income and (2) a worksheet to figure out their premium adjustment. It would be available at post offices, the Internet and other places where government forms are typically available.
- **Payments to the Medicare Trust Fund.** Beneficiaries would return the form and any payment through a check made payable to the Medicare Trust Fund. The payments would be due on April 15th. The form and payment would be mailed back with their returns. The Treasury Department would make sure that the Medicare payments are directed to the Part A Trust Fund.
- **Combined review and corrections process.** Any overpayment or underpayment of the premium would be corrected through the tax refund process, like over- and under-payment of Social Security FICA, so that beneficiaries only have to deal with the Treasury once (not twice through a separate billing or refund process):

Draft

800

COMPROMISE ON TREASURY-ADMINISTERED MEDICARE INCOME-RELATED PREMIUM

- **Income-related premium.** High-income Medicare beneficiaries would pay an income-related Medicare Part B premium. The income thresholds for the phase-in of this premium would be indexed to inflation and would begin at \$X,000 and be fully phased in at \$Y,000. (Note: For single beneficiaries, the Senate and Blue Dog's proposals begin at \$50,000, the 1995 Republican Budget began at \$60,000, and the 1994 health reform proposal began at \$90,000). The proposal assumes that the maximum payment is set at 75 percent of program costs to reduce the incentive for the healthiest and wealthiest beneficiaries to leave the program.

ADMINISTRATION

- **Treasury-run process for premium adjustment.** The Treasury Department, which is set up to collect income information and payments, would administer the premium adjustment.
- **"Medicare Premium Adjustment Form".** Near the end of the year, all elderly Americans would receive this form in the mail. Instructions attached to the form would tell beneficiaries how to calculate their income (same as on their income tax form) and how to use the enclosed worksheet to figure out their premium adjustment. This would be sent to the Treasury Department with the tax form.
- **Payments to the Medicare Trust Fund.** Beneficiaries would return the form and any payment through a check made payable to the Medicare Trust Fund. The payments would be due on April 15th so that beneficiaries can calculate their incomes once for both purposes and the mailed with their returns. The Treasury Department would make sure that the Medicare payments are directed to the Part A Trust Fund.
- **Combined review and corrections process.** Any overpayment or underpayment of the premium would be corrected through the tax refund process so that beneficiaries only have to deal with the Treasury once (not twice through a separate billing or refund process).

2. **Fee-for-service premium difference.** Premium support encourages efficiency by having beneficiaries pay different premiums based on their choice of plans. The range of premiums and amount that people would pay for fee-for-service Medicare depend on the policy design. Under the Breaux plan, a beneficiary choosing an average cost plan would pay 12.3 percent of the premium (slightly more than current law). A beneficiary choosing fee-for-service would pay about 14 percent of the premium. Without fee-for-service reforms, this is about 18 to 30 percent above current law (10 to 20 percent more with fee-for-service reforms).

Issues:

- Beneficiaries would pay higher premiums for fee-for-service, even in areas without plan choices. Similarly, beneficiaries whose private plan options do not suit their health care needs (e.g., people with rare diseases or cognitive impairment) would pay more.

Options:

- Target lower fee-for-service premium: Beneficiaries without private plan options (or other selected groups of beneficiaries) would get a discount on their fee-for service premium. This is the most targeted approach, but would create situations where beneficiaries living in adjacent towns pay different premiums for the same coverage. Also, it would be difficult to determine which beneficiaries get the discount (e.g., what if there was only 1 plan with limited capacity; would ESRD, people with certain diseases be excluded).
- Adjust fee-for-service premium nationwide:
 - Set the 12 percent premium not at the weighted average, but at the FFS premium. This means that all plans whose premium is at or below the FFS premium would receive a marginally increasing government subsidy; plans with premium above FFS would charge beneficiaries 100 percent of the difference. This has the advantage of assuring beneficiaries that they would pay no more than they pay today (like 25 percent Part B premium). It is not clear whether / how much savings would accrue.
 - Cap the fee-for-service premium at a percent above the national average: Restrict the fee-for-service premium for so that it never exceeds a certain percent (e.g., it cannot be more than 2 percentage points above the national average rate). This option only provides beneficiaries choosing the FFS plan -- not those choosing similar cost plans above the weighted average -- with premium protection. However, it could possibly affect the competitive incentives.

- 3. Geographic adjustment of private plan payments.** Under the Breaux plan, the beneficiary's premium is based on a comparison of the plan's bid for services in a particular area and the national average. The government's payment would be partially geographically adjusted (in an attempt to reduce variation in Medicare payments). This approximates what is happening under Medicare+Choice today.

Issues:

- Beneficiaries would likely to pay for some geographic variation. Under current law, the amount that a plan gets paid does not vary with their actual costs; what varies is how much beneficiaries pay for coverage or get in extra benefits. Under the proposal, plans could set their premiums higher or lower, and get paid more or less, depending on the relationship of the plan to the national average. Thus, since the government is only paying part of the geographic cost variation, the plan is likely to over- or under-bid their premiums to make up for the partial geographic adjustment. This would mean that beneficiaries would pick up the amount of their costs not assumed by the government.
- Fully geographically adjusting the government payment is different than current law. This could have the effect of changing the distribution of enrollment in plans (probably more people in high-cost areas, fewer in low-cost areas.) However, it lessens the risk that beneficiaries face differences in the FFS and private plan premiums that are not reflective of real price differences.

Options:

- Use current partial adjustment: Consistent with current law and the Breaux plan, but could have unintended results.
 - Use full geographic adjustment. Inconsistent with current law, but would help insulate beneficiaries from geographic costs in private plans.
 - Regional model: The premium support model under consideration maintains one, national fee-for-service premium which is determined by taking into account managed care enrollment in all areas of the country. Alternatively, the fee-for-service and private plan payments could be set locally rather than nationally. In rural areas, this insulates the fee-for-service premium from what is happening in other areas of the country. However, this means that the fee-for-service premium would vary from place to place.
- 4. Transition issues:** When is the soonest that premium support could be phased in? How would it be best to phase it in (e.g., regionally, for certain beneficiary groups, expanded). Demonstrations first?

JDD Talking Points for Call to Laura D'Andrea Tyson

[Note: We believe that Dr. Tyson still likes the idea of premium support. She feels that restructuring Medicare is necessary because without reform, the life of the program is limited. Also, she is an economist and the argument that premium support would be a more efficient system appeals to her.]

- I have enjoyed working with you throughout the tenure of the Medicare Commission. You have been an important voice in calling for a reform package that improves the Medicare program for seniors and people with disabilities
- I realize that you want to restructure Medicare in order to ensure the solvency of the program for the next generation of seniors. I want reform as well, because I know it is necessary in order to preserve this vital program. However, I'm concerned because Senator Breaux's premium support proposal is not the right kind of reform.
- For months, I was open-minded about proposals for reform that were brought before the Commission. I listened attentively to arguments in favor of a premium support system. I did all the right things to try and cooperate with Senator Breaux in working toward a proposal that we could all support.
- At the last Commission meeting, I realized that this process is fatally flawed. Senator Breaux has consistently and repeatedly ignored the Democratic principles we all agreed on. He has ignored numerous requests for more details about his premium support plan.
- I am very skeptical about any plan that Senator Breaux proposes, or any subsequent modifications to that plan. I have no reason to believe that his plan will incorporate our Democratic principles, or that his plan will reflect any of the comments and concerns we brought before him at Commission meetings.
- *Gramm*
You were at the last Commission meeting when Senator Gramm revealed that he wants the Commission to complete its work in time for Senator Breaux's proposal to be included in the Republican budget. The Republican's don't care about saving Medicare--they care about financing their tax cut. As a result, we have before us a proposal is being used to benefit wealthy taxpayers, not to protect seniors and the Medicare program.
- I have cared about this program for 40 years. I have to do the right thing for current and future seniors. I can't vote for Breaux's premium support plan, because I still don't know the details, or whether it will save any money. In my years in Congress, I have learned that details are what matter, because the details determine how any policy will affect people. I don't know how this plan will affect low-income seniors, seniors with chronic illnesses, people with disabilities, and seniors in my district.
- I know you want to do the right thing as well, but you cannot give Breaux and his supporters cover for this flawed and incomplete plan.

- I promise that if we get through the Commission process, I am committed to working with you to do the right thing. The end of the Commission does not mean the end of discussions of Medicare reform. I promise that I will work with you to develop a reform proposal that protects people as well as the program.

WHY DEFINED BENEFITS IS IMPORTANT

Improves Competition

- **Reischauer and Aaron's premium support creating the idea of premium support:** "A standard benefit package and standardized cost-sharing regimes are important, at least initially, because they will reduce risk segmentation among plans and help participants to compare the cost and quality of different plans. Numerous benefit packages and cost-sharing arrangements would make comparisons difficult. Furthermore, higher-income, younger, and healthier participants would be attracted to plans with limited benefits and high cost sharing, which would place a greater burden on the yet-to-be-developed mechanism for making risk adjustment payments to the different plans." *Health Affairs*, Winter 1995.
- **Enthoven's original managed competition article:** In the article that originally described the idea of managed competition, standardization of benefits was a central concept: "Standardization should deter product differentiation, facilitate price comparisons, and counter market segmentation. There are powerful reasons for as much standardization as possible within each sponsored group. The first is to facilitate value-for-money comparisons and to focus comparison on price and quality. The second is to combat market segmentation -- the division of the market into groups of subscribers who make choices based on what each plan covers (such as mental health or vision care) rather than on price. The third is to reassure people that it is financially safe to switch plans for a lower price with the knowledge that the lower-priced plans did not realize savings by creating hidden gaps in coverage." *Health Affairs*, Supplement 1993.
- **CBO's assessment of managed competition:** "If managed competition proposals did not require that benefits and coinsurance rules be standardized, savings in health care spending would be smaller than otherwise for three reasons.

First, differences in coverage among plans could continue to cause premiums to vary. That would make difference among premiums more difficult to interpret and would lead consumers to give less weight to them when choosing among plans.

Second, insurers would have greater opportunities than otherwise to design their plans in such a way as to pursue favorable selection -- a phenomenon for which risk adjustments would offer only an imperfect remedy. This course of events would exacerbate a further source of premium differences among plans and would also diminish the pressure on insurers to compete by developing more cost effective ways to deliver care.

Third, failing to standardize covered benefits and to eliminate balance-billing could decrease the differences in premiums that would otherwise arise between traditional indemnity insurers and health maintenance organizations. This would tend to protect the market share of indemnity insurers that did not adopt cost-effective forms of managed care and so would reduce the savings in overall use of resource." CBO. *Managed Competition and Its Potential to Reduce Health Spending*. May 1993

Medicare Beneficiaries Are Less Able to Make Informed Choices

RURAL

- About 11 million beneficiaries -- nearly 30 percent of all Medicare beneficiaries -- do not have access to a private plan in Medicare.
- Only 24 percent of beneficiaries in rural areas will have access to a managed care plan in 1999.

REVISED COMMISSION PROPOSAL: February 16, 1999

PREMIUM SUPPORT

- **Types of plans:** Under this plan, there would be private managed care plans and Medicare fee-for service, but HCFA would also be required to organize a privately-run fee-for-service plan. Medicare fee-for-service would not operate in areas where HCFA had provided for a privately-run fee-for-service plan.
- **Benefits:**
 - **Standard option.** All plans would offer "standard option": those benefit items currently covered "to an extent comparable to the government-run plan" (probably some amount, duration and scope flexibility).
 - **High option plan.** Private managed care and private fee-for-service plans would have to offer a "high option" plan that includes prescription drugs and any other benefit at the Board's approval. There would be no high-option plan in Medicare fee-for-service -- only in the private fee-for-service option.
 - **Cost sharing rationalization:** This would include:
 - Combined Part A and B deductible of \$380 (indexed to inflation) and a 10 percent copayment for home health (not clear whether it reduces preventive cost sharing).
 - Medigap reform: All plans would be required to offer prescription drugs, and a new drug-only plan would be approved. Medigap could not cover the deductible or coinsurance in private plans.
- **Government payments:** The government would pay a percent of the plan's premium up to a cap. This payment schedule is based on the "national weighted average" of the plan's standard option premiums only. Specifically, all plans, including Medicare fee-for-service, would submit their premiums for the standard option benefits, as well as their estimated enrollment. A national average would be calculated from this information. Using this national average, a government payment schedule would be set so that government pays:
 - 100 percent of the premium for plans below 85 percent of the national average;
 - A percent between 100 and 88 percent for plans with premiums between 85 percent and 100 percent of the national average; and
 - 88 percent of the national average for plans with premiums above the national average.

While the schedule of government payments is based on premiums for the standard option, it appears that the government will pay for high option benefits if the premium for the high option plan is below the national average.

The government payment would be partially adjusted for geographic variation (75 percent of the variation). This partial geographic adjuster could have the effect of underpaying plans in high cost areas, and thus reducing the number of plans in those areas.

- **Beneficiary payments:** Beneficiaries would pay the difference between the plan's premiums and the government contribution.
 - **Low-income beneficiaries:** Current Medicaid protections would be expanded with a Federal matching rate of 100 percent. Beneficiaries with income below 135 percent of poverty would not have to pay premiums for plans available to them up to the cost of the Medicare fee-for-service plan, the standard option private fee-for-service plan, or the lowest-cost standard option plan available to them. Beneficiaries with income between 135 and 200 percent of poverty would receive premium assistance on a sliding scale.

Prescription drug coverage: Beneficiaries with income below 135 percent of poverty would receive a subsidy for drug coverage in a high option private managed care or private fee-for-service plan.

- **High-income beneficiaries:** Does not include a proposal for income-related premium.

MEDICARE FEE-FOR-SERVICE

- **Modernization:** This proposal would include a list of policies to give Medicare the same tools that the private sector uses to manage costs.
- **Balanced Budget Act Extenders:** The proposal includes a somewhat modified set of extenders, with the caveat that this does not "imply a literal extension of the listed provisions....serves only as a concrete example."

RAISING THE AGE ELIGIBILITY FOR MEDICARE

- **Conforms Medicare eligibility age to that of Social Security**
- **Allows certain beneficiaries with delayed eligibility to participate in Medicare.** For the purpose of the estimate, waives 2-year waiting period for people on disability insurance.

GRADUATE MEDICAL EDUCATION

- **Carves out direct medical education:** Removes from Medicare financing; funds those activities "elsewhere in the budget."
- **Reduces indirect medical education payments by 20 percent**

FINANCING

- **No proposals**

DRAFT: MEDICARE REFORM PLANS, February 18, 1999

COMPONENT	BREAUX'S PLAN	ALTERNATIVE (<i>changes in italics</i>)
Administration	Board that: Decides service areas Negotiates benefits, premiums Sets standards Provides information	Board that: Decides service areas Negotiates benefits, premiums Sets standards Provides information <i>Runs private fee-for-service plan</i>
Benefits	Basic: Includes core benefits Total package at least equal to FFS Drugs: <u>Private plans</u> : May design and offer a drug and other benefits and receive gov't subsidy if total premium is below national average <u>FFS</u> : No benefit [placeholder] Cost Sharing: <u>Private plans</u> : No Standards <u>FFS</u> : \$350 combined deductible 10% for home health , no hosp limits	Basic: <i>Appears to be equal to current benefits, with limited flexibility</i> Drugs: <i>Private managed care and fee-for-service plans: Must offer an unspecified drug benefit</i> <i>Medigap: Must offer drugs</i> <i>Medicare FFS: No benefit</i> Cost Sharing: <u>Private plans</u> : No Standards <u>FFS</u> : \$350 combined deductible 10% for home health , no hosp limits
Government Contribution	Fixed percent of the premium (<u>including</u> extra benefits) up to a dollar limit (fixed percent of the national average premium)	Fixed percent of the premium (<u>excluding</u> extra benefits) up to a dollar limit (fixed percent of the national average premium)
Beneficiary Contribution	In general: <u>FFS</u> : Difference between the national average Medicare spending and the gov't contribution <u>Private plans</u> : Difference plan premium and gov't contribution Low-income: Unspecified High-income: Phases from 12 to 27% of premium for benes with income b/w 300-500%	In general: <u>FFS</u> : Difference between the regional average Medicare spending and the gov't contribution <u>Private plans</u> : Difference between plan premium and gov't contribution Low-income: <i>No premium below 135% of poverty</i> <i>Sliding scale premium to 200%</i> <i>No premium for drug benefit in private plans below 135%</i> High-income: <i>None</i>
Fee-For-Service Reforms	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO	Enhanced demonstration authority Flexible purchasing authority Competitive bidding authority Negotiating authority Selective contraction authority Ability to make FFS a PPO <i>Some BBA extenders</i>
Age Eligibility Increase	Raise to conform with Social Security Allow some type of Medicare buy-in	Raise to conform with Social Security <i>Waive waiting period disability recipients</i>
Graduate Med. Education	Move direct medical education out of Medicare; Consider removing IME, DSH	Move direct medical education out of Medicare; <i>Cut IME by 20%</i>
Financing	No specific options	No specific options

PREMIUM SUPPORT (For Background Only)

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

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.
- **Total premium:** Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.
- **Government payment:** The government contribution toward that premium would be limited (e.g., a percent of the premium up to a cap and/or as a flat dollar amount).
- **Beneficiary payment:** Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.
- **Savings:** Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

COMMISSION PREMIUM SUPPORT MODEL

- **Beneficiary payment:** This amount depends on the relationship between the plan's premium and the national average premium. (Note: would be geographically adjusted)
 - Below average plans: 12 percent of the premium
 - Above average plans: 12 percent of the national average plus every dollar that the premium is above the national average.
- **Government payment:** 88 percent of the premium up to 88 percent of the national average.
- **Issues With Commission Model:**
 - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.
 - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. This also means that this model will not reduce Medicare costs.

POLICY PROS AND CONS OF PREMIUM SUPPORT

PROS

- **Would likely reduce Medicare costs through competition.** Premium support encourages beneficiaries to choose lower cost health plans by giving them a financial incentive to do so. Depending on how premium support is structured, efficient plans can attract beneficiaries by offering lower premiums or additional benefits. As beneficiaries move to lower-cost plans, the national average Medicare spending is reduced (or doesn't grow as fast as it would have), thus reducing Federal Medicare costs over time.
- **Better aligns Medicare with private health insurance.** Today, Congress and the President must make explicit changes to Medicare reimbursement levels to control program costs. While over time the growth in Medicare has roughly matched private health insurance growth, cost control is cumbersome and subject to significant political constraints. Under premium support, Medicare spending is more dependent on the ability of private plans to achieve efficiency, which should more closely align the growth of future government Medicare spending with the overall level of efficiency achieved by private health insurers.
- **Gives beneficiaries more choices.** Today, beneficiaries enroll in managed care plans because, in some areas, those plans can offer extra, free benefits. Under this proposal, beneficiaries can lower their Medicare premiums by enrolling in low-cost plans and, under some proposals, also get some extra benefits. Premium support also has the potential to attract more private plans to participate in Medicare or extend their market area, since they would have new flexibility to use financial incentives to attract beneficiaries.

CONS

- **Premium for traditional Medicare will likely be higher than private plan options.** Since the government's contribution to the traditional Medicare would be based on the premium support program, the Medicare fee-for-service premium can be expected to be higher than that of private plans -- especially if it is not allowed to use the same management tools as private plans. This could put people who do not want to enroll in private plans or who don't have the option (e.g., in rural areas) at a financial disadvantage. It could also create confusion and anxiety for beneficiaries -- and may not be worth it if the savings from premium support are small.
- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under premium support, a greater share of the efficiency savings accrue to the government, reducing the amount that can be provided as additional benefits.
- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- rather enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, premium support could have the unintended effects of creating higher premiums for people who are sick and low-income.

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

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

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SENT to GS

DRAFT: PREMIUM SUPPORT

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

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.
- **Total premium:** Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.
- **Government payment:** The government contribution toward that premium would be limited (e.g., a percent of the premium and/or as a flat dollar amount).
- **Beneficiary payment:** Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.
- **Savings:** Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

FRS?

PROS

- **Reduces Medicare costs through competition.** Premium support encourages beneficiaries to choose lower cost health plans by giving them a financial incentive to do so. Plans that can offer lower premiums can give some of those savings to the beneficiary in the form of a reduced premium or extra benefits. As beneficiaries move to lower cost plans, the national average Medicare spending is reduced (or doesn't grow as fast as it would have), thus reducing Federal Medicare costs over time.
- **Encourages more private plans to participate in Medicare.** Today, managed care plans usually only enroll Medicare beneficiaries in areas where the payment rate is high. Premium support typically allows plan to use lower premiums or extra benefits more aggressively to attract beneficiaries. Thus, more plans would probably participate in Medicare, offering beneficiaries more choice.

CONS

- **Medicare fee-for-service premium would differ -- and likely ~~be~~ higher -- than private plans.** Under most models, fee-for-service is included in competition, so that its premium will be higher or lower depending on its costs relative to some average. Since private plans have greater ability to selectively contract with providers, negotiate, etc., it is likely that Medicare fee-for-service premiums will be higher. This could put people who do not want to enroll in private plans at a financial disadvantage.
- **Beneficiaries in areas with no private plans could simply face higher premiums.** If the national fee-for-service premium turns out to be higher than average because of enrollment in private plans in urban areas, beneficiaries in rural areas could have to pay higher premiums for fee-for-service -- and probably would not have many, if any, private plan options.

COMMISSION PREMIUM SUPPORT MODEL

- **Government payment:** This amount depends on the relationship between the plan's premium and the national average premium, which is based on each plan's premium.
 - Plan whose premium is below 90 percent of the national average: 90% of the premium
 - Plan whose premium is between 90 and 100 percent of the national average: Decreasing percent down to 88 percent of the national average.
 - Above average plans: 88 percent of the national average.
- **Beneficiary payment:** Difference between the plan premium and the government payment.
- **Issues:**
 - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.
 - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. Thus, the national average would not be lowered as a result of competition, thus lessening the efficiency of this model.
- **Alternative:** To address the inefficiency in the original model, the Commission is considering setting the national average based on premiums for the standard, basic benefits only, rather than the premiums for whatever benefits package that the plan chooses. Plans could still receive higher payments for their extra benefits, but the payment rate and limit on the government payment would not be affected by these higher premiums since it is pegged to premiums for the standard benefits..

On the face of it, this change appears to make the model more efficient. It is likely that all private plans would provide supplemental benefits up to the national average cap, but since the national average does not take the cost of those supplemental benefits into account, it could conceivably still be lower over time as plans compete on their premiums for the standard benefits.

However, private plans would not have an incentive to compete on the basis of the standard benefits since that competition would lower the national average and thus lower their ability to get subsidies for the supplemental benefits.