

Author: Sue Nelson at Budget  
Date: 3/12/99 7:09 PM  
Priority: Normal  
TO: Bruce King, randy devalk at Daschle-DC  
Subject: Medicine & Health Flash 3/12/99

*Chris*

FYI

Forward Header

Subject: Medicine & Health Flash 3/12/99  
Author: Katie Horton at Minority:Finance  
Date: 3/12/99 5:27 PM

This will come up at hrg. on thurs.

Forward Header

Subject: Medicine & Health Flash 3/12/99  
Author: medhealth@faulknergray.com at internet  
Date: 3/12/99 5:18 PM

MEDICINE & HEALTH FLASH  
MARCH 12, 1999  
5:15 P.M.

NEW CEO PROJECTIONS BELIE TRUST FUND FEARS

New baseline projections for Medicare released today by the Congressional Budget Office say that by the year 2005 the Medicare Hospital Insurance Trust Fund will have a positive balance of \$177.9 billion-about \$90 billion more than previous CBO projections for that year. CBO projections used by the National Bipartisan Commission on the Future of Medicare showed the trust fund with a deficit of \$49 billion in the year 2010. The new projections go only to the year 2009 but show in that year a positive balance of \$141.6 billion, which is larger than the current balance of \$127 billion. A Capitol Hill source familiar with the projections said that the new figures reflect assumptions about continuing economic growth yielding higher trust fund revenues from payroll taxes, as well as sharply reduced Medicare spending growth in the past two years.

The new numbers are bad news for legislators who have argued that the trust fund's deteriorating condition is evidence that Medicare needs fundamental reform. Others, though, warn that long term forecasting is unreliable and major policy changes shouldn't be based on such uncertain economic assumptions.

The Commission is next scheduled to meet at 5 p.m. in room 1100 of the Longworth House Office Building in Washington on Tuesday, March 16. Apparently the CBO news hadn't caught up to the Commission; its meeting notice states that "without reform, Medicare is projected to go bankrupt in the year 2008."

526-9167

March 30  
more years

| Year      | CBO<br>Off-budget | CBO<br>On-budget | Original<br>Medicare | Cumulative<br>Value of<br>Contributions<br>to Trust Fund |
|-----------|-------------------|------------------|----------------------|--|
| 2000      | 138               | -5               | 18                   | 19   |
| 2001      | 145               | 11               | 20                   | 41   |
| 2002      | 153               | 59               | 28                   | 73   |
| 2003      | 162               | 51               | 27                   | 105  |
| 2004      | 171               | 68               | 30                   | 143  |
| 2005      | 184               | 79               | 33                   | 187  |
| 2006      | 193               | 116              | 41                   | 241  |
| 2007      | 204               | 134              | 46                   | 304  |
| 2008      | 212               | 146              | 50                   | 375  |
| 2009      | 218               | 165              | 56                   | 456  |
| 2010      | 221               | 175              | 60                   | 548  |
| 2011      | 224               | 182              | 65                   | 649  |
| 2012      | 223               | 190              | 68                   | 761  |
| 2013      | 218               | 179              | 71                   | 883  |
| 2014      | 209               | 180              | 72                   | 1014   |
| 2000-2004 | 769               | 184              | 124                  |  |
| 2000-2009 | 1780              | 824              | 350                  |  |
| 2000-14   | 2875              | 1730             | 686                  |  |

*w/interest*

1014

## Lock 4: Medicare at 33 percent in a

| Year             | CBO<br>On-budget<br>Surplus | Lock 4<br>Medicare<br>(33%) | President<br>Medicare | % of<br>President's<br>Medicare |
|------------------|-----------------------------|-----------------------------|-----------------------|---------------------------------|
| 2000             | -4.6                        | 0                           | 18.3                  | 0%                              |
| 2001             | 10.7                        | 4                           | 20.3                  | 18%                             |
| 2002             | 59.0                        | 19                          | 28.1                  | 69%                             |
| 2003             | 51.1                        | 17                          | 26.9                  | 63%                             |
| 2004             | 67.5                        | 22                          | 30.4                  | 74%                             |
| <b>2000-2004</b> | <b>183.8</b>                | <b>62.4</b>                 | <b>124.0</b>          | <b>50%</b>                      |
| 2005             | 79.1                        | 26                          | 33.4                  | 78%                             |
| 2006             | 116.0                       | 38                          | 40.8                  | 94%                             |
| 2007             | 134.0                       | 44                          | 45.9                  | 96%                             |
| 2008             | 146.0                       | 48                          | 50.3                  | 96%                             |
| 2009             | 165.4                       | 54                          | 55.6                  | 98%                             |
| <b>2000-09</b>   | <b>824.2</b>                | <b>273.6</b>                | <b>350.0</b>          | <b>78%</b>                      |
| 2010             | 175.2                       | 58                          | 60.1                  | 96%                             |
| 2011             | 182.3                       | 60                          | 64.5                  | 93%                             |
| 2012             | 189.7                       | 63                          | 68.1                  | 92%                             |
| 2013             | 179.2                       | 59                          | 70.9                  | 83%                             |
| 2014             | 179.5                       | 59                          | 72.0                  | 83%                             |
| <b>2000-14</b>   | <b>1730.1</b>               | <b>572.6</b>                | <b>685.6</b>          | <b>84%</b>                      |

very preliminary - Also ask Sue whether her surplus #'s are calendar or fiscal year;  
 Tell her I've faxed her the CBO Baseline (I got it from B/P/11 V.5)

**ROUGH NEW BASELINE**

**CBO MEDICARE BASELINE / ADJUSTED FOR 1998 TRUSTEES' ASSUMPTIONS**

(Dollars in billions, calendar year, cash basis)

|      | INCOME            |          |             |           |                 | SPENDING     |                    |         | INCOME - SPENDING |         | ASSETS            |                 |
|------|-------------------|----------|-------------|-----------|-----------------|--------------|--------------------|---------|-------------------|---------|-------------------|-----------------|
|      | HI Payroll Taxes* | HI Other | HI Premiums | Additions | Interest Income | TOTAL INCOME | Current Spending** | Savings | New Spending      |         | Start of the Year | End of the Year |
| 2000 | 137               | 6        | 1           |           | 7               | \$152        | 143                |         | \$143             | \$9     | \$127             | \$137           |
| 2001 | 139               | 8        | 1           |           | 8               | \$157        | 148                |         | \$148             | \$9     | \$137             | \$146           |
| 2002 | 146               | 9        | 2           |           | 9               | \$166        | 153                |         | \$153             | \$12    | \$146             | \$158           |
| 2003 | 153               | 9        | 2           |           | 10              | \$173        | 163                |         | \$163             | \$10    | \$158             | \$168           |
| 2004 | 159               | 10       | 2           |           | 10              | \$181        | 175                |         | \$175             | \$7     | \$168             | \$174           |
| 2005 | 167               | 10       | 2           |           | 11              | \$190        | 188                |         | \$188             | \$3     | \$174             | \$177           |
| 2006 | 174               | 11       | 2           |           | 11              | \$199        | 197                |         | \$197             | \$1     | \$177             | \$178           |
| 2007 | 182               | 12       | 2           |           | 11              | \$207        | 214                |         | \$214             | (\$7)   | \$178             | \$171           |
| 2008 | 190               | 13       | 2           |           | 10              | \$215        | 230                |         | \$230             | (\$15)  | \$171             | \$156           |
| 2009 | 199               | 14       | 2           |           | 9               | \$224        | 247                |         | \$247             | (\$23)  | \$156             | \$133           |
| 2010 | 209               | 15       | 3           |           | 7               | \$234        | 264                |         | \$264             | (\$30)  | \$133             | \$103           |
| 2011 | 219               | 16       | 3           |           | 5               | \$243        | 282                |         | \$282             | (\$38)  | \$103             | \$64            |
| 2012 | 230               | 18       | 3           |           | 2               | \$253        | 302                |         | \$302             | (\$50)  | \$64              | \$15            |
| 2013 | 241               | 19       | 3           |           | (1)             | \$262        | 324                |         | \$324             | (\$62)  | \$15              | (\$48)          |
| 2014 | 253               | 21       | 3           |           | (5)             | \$271        | 348                |         | \$348             | (\$76)  | (\$48)            | (\$124)         |
| 2015 | 265               | 22       | 4           |           | (11)            | \$280        | 372                |         | \$372             | (\$92)  | (\$124)           | (\$216)         |
| 2016 | 277               | 24       | 4           |           | (17)            | \$288        | 398                |         | \$398             | (\$110) | (\$216)           | (\$326)         |
| 2017 | 290               | 26       | 4           |           | (24)            | \$296        | 427                |         | \$427             | (\$131) | (\$326)           | (\$457)         |
| 2018 | 303               | 29       | 4           |           | (33)            | \$303        | 458                |         | \$458             | (\$155) | (\$457)           | (\$612)         |
| 2019 | 317               | 31       | 5           |           | (44)            | \$309        | 492                |         | \$492             | (\$182) | (\$612)           | (\$794)         |
| 2020 | 332               | 34       | 5           |           | (56)            | \$315        | 528                |         | \$528             | (\$213) | (\$794)           | (\$1,007)       |
| 2021 | 347               | 37       | 5           |           | (70)            | \$319        | 567                |         | \$567             | (\$248) | (\$1,007)         | (\$1,255)       |
| 2022 | 362               | 40       | 5           |           | (86)            | \$322        | 596                |         | \$596             | (\$274) | (\$1,255)         | (\$1,529)       |
| 2023 | 379               | 43       | 6           |           | (104)           | \$324        | 625                |         | \$625             | (\$302) | (\$1,529)         | (\$1,830)       |
| 2024 | 395               | 47       | 6           |           | (124)           | \$325        | 657                |         | \$657             | (\$331) | (\$1,830)         | (\$2,162)       |
| 2025 | 413               | 51       | 7           |           | (145)           | \$326        | 689                |         | \$689             | (\$364) | (\$2,162)         | (\$2,526)       |
| 2026 | 432               | 55       | 7           |           | (169)           | \$325        | 724                |         | \$724             | (\$398) | (\$2,526)         | (\$2,924)       |
| 2027 | 451               | 60       | 8           |           | (195)           | \$324        | 760                |         | \$760             | (\$436) | (\$2,924)         | (\$3,360)       |
| 2028 | 471               | 65       | 8           |           | (223)           | \$322        | 798                |         | \$798             | (\$476) | (\$3,360)         | (\$3,836)       |
| 2029 | 492               | 71       | 9           |           | (254)           | \$318        | 838                |         | \$838             | (\$520) | (\$3,836)         | (\$4,356)       |
| 2030 | 514               | 77       | 9           |           | (287)           | \$313        | 880                |         | \$880             | (\$567) | (\$4,356)         | (\$4,923)       |

\* Adjusted to that total income equals CBO projected income (converted to calendar years); other numbers are Trustees' 1998

\*\* From CBO (converted to calendar years)

OPTION 2. President's Budget

**CBO MEDICARE BASELINE / ADJUSTED FOR 1998 TRUSTEES' ASSUMPTIONS**

(Dollars in billions, calendar year, cash basis)

|      | INCOME                  |          |                |           |                    | TOTAL<br>INCOME | SPENDING             |         |                 | INCOME -<br>SPENDING | ASSETS               |                    |
|------|-------------------------|----------|----------------|-----------|--------------------|-----------------|----------------------|---------|-----------------|----------------------|----------------------|--------------------|
|      | HI<br>Payroll<br>Taxes* | HI Other | HI<br>Premiums | Additions | Interest<br>Income |                 | Current<br>Spending* | Savings | New<br>Spending |                      | Start of the<br>Year | End of the<br>Year |
| 2000 | 137                     | 6        | 1              | 18        | 8                  | \$171           | 143                  |         | \$143           | \$28                 | \$127                | \$155              |
| 2001 | 139                     | 8        | 1              | 20        | 10                 | \$179           | 148                  |         | \$148           | \$31                 | \$155                | \$187              |
| 2002 | 146                     | 9        | 2              | 28        | 12                 | \$197           | 153                  |         | \$153           | \$44                 | \$187                | \$230              |
| 2003 | 153                     | 9        | 2              | 27        | 15                 | \$205           | 163                  |         | \$163           | \$42                 | \$230                | \$272              |
| 2004 | 159                     | 10       | 2              | 30        | 18                 | \$219           | 175                  |         | \$175           | \$44                 | \$272                | \$317              |
| 2005 | 167                     | 10       | 2              | 33        | 21                 | \$234           | 188                  |         | \$188           | \$46                 | \$317                | \$363              |
| 2006 | 174                     | 11       | 2              | 41        | 24                 | \$253           | 197                  |         | \$197           | \$55                 | \$363                | \$418              |
| 2007 | 182                     | 12       | 2              | 46        | 28                 | \$270           | 214                  |         | \$214           | \$56                 | \$418                | \$473              |
| 2008 | 190                     | 13       | 2              | 50        | 31                 | \$287           | 230                  |         | \$230           | \$56                 | \$473                | \$530              |
| 2009 | 199                     | 14       | 2              | 56        | 35                 | \$305           | 247                  |         | \$247           | \$58                 | \$530                | \$588              |
| 2010 | 209                     | 15       | 3              | 60        | 38                 | \$325           | 264                  |         | \$264           | \$61                 | \$588                | \$649              |
| 2011 | 219                     | 16       | 3              | 65        | 42                 | \$345           | 282                  |         | \$282           | \$63                 | \$649                | \$712              |
| 2012 | 230                     | 18       | 3              | 68        | 46                 | \$365           | 302                  |         | \$302           | \$62                 | \$712                | \$774              |
| 2013 | 241                     | 19       | 3              | 71        | 50                 | \$384           | 324                  |         | \$324           | \$59                 | \$774                | \$834              |
| 2014 | 253                     | 21       | 3              | 72        | 53                 | \$402           | 348                  |         | \$348           | \$54                 | \$834                | \$888              |
| 2015 | 265                     | 22       | 4              | 0         | 54                 | \$345           | 372                  |         | \$372           | (\$28)               | \$888                | \$861              |
| 2016 | 277                     | 24       | 4              | 0         | 52                 | \$357           | 398                  |         | \$398           | (\$41)               | \$861                | \$819              |
| 2017 | 290                     | 26       | 4              | 0         | 49                 | \$369           | 427                  |         | \$427           | (\$58)               | \$819                | \$762              |
| 2018 | 303                     | 29       | 4              | 0         | 45                 | \$381           | 458                  |         | \$458           | (\$77)               | \$762                | \$685              |
| 2019 | 317                     | 31       | 5              | 0         | 39                 | \$392           | 492                  |         | \$492           | (\$99)               | \$685                | \$586              |
| 2020 | 332                     | 34       | 5              | 0         | 32                 | \$403           | 528                  |         | \$528           | (\$125)              | \$586                | \$461              |
| 2021 | 347                     | 37       | 5              | 0         | 24                 | \$413           | 567                  |         | \$567           | (\$155)              | \$461                | \$306              |
| 2022 | 362                     | 40       | 5              | 0         | 14                 | \$421           | 596                  |         | \$596           | (\$174)              | \$306                | \$132              |
| 2023 | 379                     | 43       | 6              | 0         | 2                  | \$430           | 625                  |         | \$625           | (\$195)              | \$132                | (\$63)             |
| 2024 | 395                     | 47       | 6              | 0         | (11)               | \$438           | 657                  |         | \$657           | (\$218)              | (\$63)               | (\$281)            |
| 2025 | 413                     | 51       | 7              | 0         | (25)               | \$446           | 689                  |         | \$689           | (\$243)              | (\$281)              | (\$525)            |
| 2026 | 432                     | 55       | 7              | 0         | (41)               | \$453           | 724                  |         | \$724           | (\$271)              | (\$525)              | (\$795)            |
| 2027 | 451                     | 60       | 8              | 0         | (59)               | \$460           | 760                  |         | \$760           | (\$300)              | (\$795)              | (\$1,095)          |
| 2028 | 471                     | 65       | 8              | 0         | (78)               | \$466           | 798                  |         | \$798           | (\$332)              | (\$1,095)            | (\$1,427)          |
| 2029 | 492                     | 71       | 9              | 0         | (100)              | \$472           | 838                  |         | \$838           | (\$366)              | (\$1,427)            | (\$1,793)          |
| 2030 | 514                     | 77       | 9              | 0         | (124)              | \$477           | 880                  |         | \$880           | (\$403)              | (\$1,793)            | (\$2,196)          |

2014

\* Adjusted to that total income equals CBO projected income (converted to calendar years); other numbers are Trustees' 1998

\*\* From CBO (converted to calendar years)

OPTION 3. 33% of CBO On-Budget

CBO MEDICARE BASELINE / ADJUSTED FOR 1998 TRUSTEES' ASSUMPTIONS

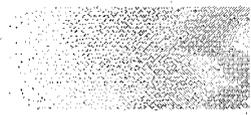
(Dollars in billions, calendar year, cash basis)

|      | INCOME                  |          |                    |           |                    | TOTAL<br>INCOME | SPENDING             |         |                 | INCOME -<br>SPENDING | ASSETS               |                    |
|------|-------------------------|----------|--------------------|-----------|--------------------|-----------------|----------------------|---------|-----------------|----------------------|----------------------|--------------------|
|      | HI<br>Payroll<br>Taxes* | HI Other | HI<br>Premium<br>s | Additions | Interest<br>Income |                 | Current<br>Spending* | Savings | New<br>Spending |                      | Start of the<br>Year | End of the<br>Year |
| 2000 | 137                     | 6        | 1                  | 0         | 7                  | \$152           | 143                  |         | \$143           | \$9                  | \$127                | \$137              |
| 2001 | 139                     | 8        | 1                  | 4         | 8                  | \$161           | 148                  |         | \$148           | \$13                 | \$137                | \$149              |
| 2002 | 146                     | 9        | 2                  | 19        | 10                 | \$186           | 153                  |         | \$153           | \$33                 | \$149                | \$182              |
| 2003 | 153                     | 9        | 2                  | 17        | 12                 | \$192           | 163                  |         | \$163           | \$28                 | \$182                | \$210              |
| 2004 | 159                     | 10       | 2                  | 22        | 14                 | \$207           | 175                  |         | \$175           | \$32                 | \$210                | \$243              |
| 2005 | 167                     | 10       | 2                  | 26        | 16                 | \$221           | 188                  |         | \$188           | \$34                 | \$243                | \$276              |
| 2006 | 174                     | 11       | 2                  | 38        | 19                 | \$244           | 197                  |         | \$197           | \$47                 | \$276                | \$323              |
| 2007 | 182                     | 12       | 2                  | 44        | 22                 | \$262           | 214                  |         | \$214           | \$48                 | \$323                | \$371              |
| 2008 | 190                     | 13       | 2                  | 48        | 24                 | \$278           | 230                  |         | \$230           | \$48                 | \$371                | \$419              |
| 2009 | 199                     | 14       | 2                  | 55        | 27                 | \$297           | 247                  |         | \$247           | \$50                 | \$419                | \$469              |
| 2010 | 209                     | 15       | 3                  | 58        | 31                 | \$315           | 264                  |         | \$264           | \$51                 | \$469                | \$520              |
| 2011 | 219                     | 16       | 3                  | 60        | 34                 | \$332           | 282                  |         | \$282           | \$50                 | \$520                | \$570              |
| 2012 | 230                     | 18       | 3                  | 63        | 37                 | \$350           | 302                  |         | \$302           | \$47                 | \$570                | \$618              |
| 2013 | 241                     | 19       | 3                  | 59        | 39                 | \$362           | 324                  |         | \$324           | \$37                 | \$618                | \$655              |
| 2014 | 253                     | 21       | 3                  | 59        | 42                 | \$377           | 348                  |         | \$348           | \$30                 | \$655                | \$685              |
| 2015 | 265                     | 22       | 4                  | 0         | 41                 | \$332           | 372                  |         | \$372           | (\$41)               | \$685                | \$644              |
| 2016 | 277                     | 24       | 4                  | 0         | 38                 | \$343           | 398                  |         | \$398           | (\$55)               | \$644                | \$589              |
| 2017 | 290                     | 26       | 4                  | 0         | 34                 | \$355           | 427                  |         | \$427           | (\$72)               | \$589                | \$517              |
| 2018 | 303                     | 29       | 4                  | 0         | 29                 | \$365           | 458                  |         | \$458           | (\$93)               | \$517                | \$425              |
| 2019 | 317                     | 31       | 5                  | 0         | 23                 | \$376           | 492                  |         | \$492           | (\$116)              | \$425                | \$309              |
| 2020 | 332                     | 34       | 5                  | 0         | 15                 | \$385           | 528                  |         | \$528           | (\$142)              | \$309                | \$166              |
| 2021 | 347                     | 37       | 5                  | 0         | -5                 | \$394           | 567                  |         | \$567           | (\$173)              | \$166                | (\$7)              |
| 2022 | 362                     | 40       | 5                  | 0         | (6)                | \$401           | 596                  |         | \$596           | (\$194)              | (\$7)                | (\$201)            |
| 2023 | 379                     | 43       | 6                  | 0         | (19)               | \$409           | 625                  |         | \$625           | (\$217)              | (\$201)              | (\$418)            |
| 2024 | 395                     | 47       | 6                  | 0         | (33)               | \$415           | 657                  |         | \$657           | (\$241)              | (\$418)              | (\$659)            |
| 2025 | 413                     | 51       | 7                  | 0         | (49)               | \$422           | 689                  |         | \$689           | (\$268)              | (\$659)              | (\$927)            |
| 2026 | 432                     | 55       | 7                  | 0         | (67)               | \$428           | 724                  |         | \$724           | (\$296)              | (\$927)              | (\$1,223)          |
| 2027 | 451                     | 60       | 8                  | 0         | (86)               | \$433           | 760                  |         | \$760           | (\$327)              | (\$1,223)            | (\$1,550)          |
| 2028 | 471                     | 65       | 8                  | 0         | (107)              | \$437           | 798                  |         | \$798           | (\$361)              | (\$1,550)            | (\$1,911)          |
| 2029 | 492                     | 71       | 9                  | 0         | (131)              | \$441           | 838                  |         | \$838           | (\$397)              | (\$1,911)            | (\$2,308)          |
| 2030 | 514                     | 77       | 9                  | 0         | (156)              | \$444           | 880                  |         | \$880           | (\$436)              | (\$2,308)            | (\$2,744)          |

\* Adjusted to that total income equals CBO projected income (converted to calendar years); other numbers are Trustees' 1998

\*\* From CBO (converted to calendar years)

Crippen's testimony  
not posted yet on web or  
available thru  
Lexis Nexis.  
Will continue to look.



Mindy E. Myers  
03/12/99 08:01:25 PM

Record Type: Record  
To: Devorah R. Adler/OPD/EOP  
cc:  
Subject: Walker Testimony

DAVID ABERNATHY  
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LAURA TYSON  
5105242551 km

Document 2 of 2.

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MARCH 10, 1999, WEDNESDAY

~~XXXXXXXXXXXXXXXXXXXX~~ NO# for  
TOMY  
WATSON -  
SONY

SECTION: IN THE NEWS

LENGTH: 8125 words

HEADLINE: PREPARED STATEMENT OF  
DAVID M. WALKER  
COMPTROLLER GENERAL OF THE UNITED STATES  
UNITED STATES GENERAL ACCOUNTING OFFICE  
BEFORE THE SENATE COMMITTEE ON FINANCE  
SUBJECT - MEDICARE AND BUDGET SURPLUSES  
GAO'S PERSPECTIVE ON THE PRESIDENT'S PROPOSAL  
AND THE NEED FOR REFORM

BODY:

Mr. Chairman and Members of the Committee:  
It is a pleasure to be here today to discuss the President's recent proposal for addressing Medicare and use of the projected budget surpluses over the next 15 years. As you know, I testified last month on the implications of the President's surplus proposals for Social Security. Today, I will briefly reprise our views on the overall fiscal consequences of the proposal, discuss what it does and does not do for the Medicare program, and examine the importance of and difficulty in making fundamental changes to this complex program.  
Regarding the President's proposal:  
It would significantly reduce debt held by the public from current levels, thereby also reducing net interest costs, raising national savings, and contributing to future economic growth. This element of the President's proposal would have positive short and long-term effects on the economy. It provides a grant (or in the President's word a gift) of a new set of Treasury securities for the Medicare Hospital Insurance (HI) program which would extend the life of the HI trust fund from 2008 to 2020. It is important to note, however, that these new Treasury securities would constitute a new unearned claim on general funds for the HI program-a marked break with the payroll taxbased



for using the surpluses over the next 15 years. The proposal's effects on Medicare are part of a broader initiative to save a major share of the surplus to reduce the debt held by the public and thereby enhance future economic capacity for the nation.

The President proposes to use a significant portion of the total projected unified budget surpluses over the next 15 years to reduce debt held by the public. He also proposes to take some related steps to address the financing problems facing both the Medicare and Social Security programs. His approach to this, however, is extremely complex and confusing.

Specifically, the President proposes to allocate about two-thirds of the projected surplus over the next 15 years to reduce publicly held debt. This portion of his proposal would increase our future economic capacity. At the same time, the President proposes to transfer a like amount to the Social Security and Medicare trust funds in the form of nonmarketable Treasury securities. In effect, the President's proposal would trade debt held by the public for debt held by the Social Security and Medicare trust funds. The administration has defended this approach as a way of assuring both a reduction in debt held by the public and as securing a "first claim" for both Social Security and Medicare on what they call the "debt-reduction dividend" to pay future benefits for those two programs. The HI Program would receive nearly \$700 billion in additional Treasury securities - representing nearly 15 percent of total surpluses over the 15 years.<sup>1</sup> This transfer is projected to extend the life of the HI trust fund from 2008 to 2020.

The President's proposal has raised important questions about how the federal government can promote long term economic security by using today's surplus resources to "save for the future." In the federal unified budget, the only way to save for the future is to run a unified budget surplus or purchase a financial asset. When there is a cash surplus it is used to reduce debt held by the public. Therefore, to the extent that there is an actual cash surplus, debt held by the public falls. This is exactly what happened in fiscal year 1998 when the debt held by the public was reduced by \$51 billion.

In the federal budget, trust funds are not vehicles to park "real" savings for the future. They are simply budget accounts used to record receipts and expenditures earmarked for specific purposes. A private trust fund can set aside money for the future by increasing its assets. State governments similarly can "park" surplus resources in "real" pension funds and other trust funds which are routinely invested in "assets" (e.g., readily marketable securities) outside the government. However, under current law, when a trust fund like HI ran a surplus of payroll tax revenues over benefit payments, the excess was invested in Treasury securities and used to meet current cash needs of the government. These securities are an asset to the trust fund, but they are a claim on the Treasury. When a trust fund runs a cash deficit, like HI has been doing since 1992, it redeems these securities to pay benefit costs exceeding current payroll tax receipts.<sup>2</sup> Medicare will be able to do this until 2008 under current law when its trust fund securities will be exhausted. However, in order to redeem these securities, the government as a whole must come up with the cash by either increasing taxes, reducing spending or raising borrowing from the public above the baseline.

Increasing the balances of Treasury securities owned by HI trust funds alone would increase the formal claim that the trust funds have on future general revenues since the trust fund's securities constitute a legal claim against the Treasury. However, increasing the HI trust fund balances alone, without underlying reform, does nothing to make the program more sustainable. From a macro perspective, the critical question is not how much a trust fund has in assets, but whether the government as a whole has the economic capacity to finance the trust funds' claims to pay benefits now and in the future. From a micro perspective, trust funds can provide a vital signaling function for policy makers about underlying fiscal imbalances in covered programs. However, extending a trust fund's paper solvency without reforms to make the underlying program more sustainable can, in effect, obscure the warning signals that trust fund balances provide.

#### Government Financing

The President's proposals would enhance the nation's future economic capacity by significantly reducing debt held by the public from the current level of 44 percent of Gross Domestic Product to 7 percent over the 15-year period. The President notes that this would be the lowest level since 1917. Nearly two-thirds of the projected unified budget surplus would be used to reduce debt held by the

Lockhart  
proposal

public. Because the surplus is also to be used for other governmental activities, the amount of debt reduction achieved would be less than the baseline (i.e. a situation in which none of the surplus was used), but nonetheless the outcome would confer significant short and long-term benefits to the budget and the economy.

Our previous work on the long-term effects of federal fiscal policy has shown the substantial benefits of debt reduction.<sup>3</sup> One of these is lowering the burden of interest payments in the budget. Today net interest represents the third-largest "program" in the budget, after Social Security and Defense. Interest payments, of course, are a function of both the amount of debt on which interest is charged and the interest rate. At any given interest rate, reducing publicly held debt reduces net interest payments within the budget. For example, CBO estimates that the difference between spending the surplus and saving the surplus is \$123 billion in annual interest payments for debt held by the public by 2009--or almost \$500 billion cumulatively between now and then. Compared to spending the entire surplus, the President's proposal would also substantially reduce projected interest payments. Lower interest payments lead to larger surpluses; these in turn lead to lower debt which leads to lower interest payments and so on: the miracle of compound interest produces a "virtuous circle." The result would be to provide increased budgetary flexibility for future decisionmakers who will be faced with enormous and growing spending pressures from the aging population.

For the economy, lowering debt levels increases national saving and frees up resources for private investment. This in turn leads to increased productivity and stronger economic growth over the long term. Over the last several years, we and CBO have both simulated the long-term economic results from various fiscal policy paths. These projections consistently show that reducing debt held by the public increases national income over the next 50 years, thereby making it easier for the nation to meet future needs and commitments. Our latest simulations done for the Senate Budget Committee, as shown in figure 1, illustrate that any path saving all or a significant share of the surplus in the near term would produce demonstrable gains in per capita GDP over the long run.<sup>4</sup> This higher GDP in turn would increase the nation's economic capacity to handle all its commitments in the future.

#### Figure 1: GDP Per Capita Under Alternate Fiscal Policy Simulations

While reducing debt held by the public appears to be a centerpiece of the President's proposal--and has significant benefits--as I noted above, the transfer of a portion of the unified surpluses to the () trust fund is a separate issue. The transfer is not technically necessary: whenever revenue exceeds outlays and the cash needs of the Treasury, debt held by the public falls.

The President's proposal appears to be premised on the belief that the only way to sustain surpluses is to tie them to Social Security and Medicare. He has merged two separate questions: (1) how much of the surplus should be devoted to reducing debt held by the public and (2) how should the nation finance these two programs in the future. The President has proposed to save the surplus by, in effect, hiding it in the Social Security and () trust funds. The additional nonmarketable Treasury securities transferred to the Social Security and Medicare trust funds are recorded as a subtraction from the unified budget surplus - a new budgetary concept. Accordingly, the surplus disappears under this novel scoring approach since these transfers approximate the surplus the President is proposing to save by reducing publicly held debt.<sup>5</sup>

Let me turn now to the question of how the President's proposal would affect Medicare financing. Impact on Medicare Financing

The mechanics of the proposed transfer of surpluses to the Medicare program are, like the transfers to Social Security, complex and difficult to follow. In form they are similar, but the effects on Medicare would be somewhat different. Unlike Social Security, Medicare's HI program has been experiencing a cash flow deficit since 1992 - current payroll taxes and other revenues have been insufficient to cover benefit payments and program expenses. Accordingly, Medicare has been drawing on its special Treasury securities acquired during the years when the program generated a cash surplus along with interest on those accumulated balances. In effect, these general fund payments can be viewed as repaying the loan of cash that the trust fund provided the rest of government when the Medicare program was in surplus. In FY1999, the HI program will run a cash deficit of \$8 billion. As noted earlier, in order to redeem these securities, the government must either raise taxes, cut spending, or increase borrowing from the public. In essence, Medicare has already crossed the point where it is a net claimant on the Treasury - a threshold that Social Security is not

currently expected to reach until 2013. Stated differently, the bleeding of the HI trust fund has already started based on the program's annual cash flow deficits.

The current financing flows for the HI program are depicted in figure 2 below. As the figure shows, to help pay benefits in fiscal year 1999, the HI trust fund receives an \$8 billion general fund payment for interest it earned on its treasury securities from its past cash surpluses. The HI fund also receives \$5 billion for a portion of the income taxes paid on Social Security benefits.

Figure 2: Medicare Flows under Current Law Under the President's proposal, the above scenario would continue. However, as shown in figure 3, at the point where total tax receipts are allocated to pay for government activities, a new financing step would be added to "transfer" a portion of the projected unified budget surpluses to the Medicare HI trust fund. The Treasury would do this by issuing a new set of securities for the HI Trust Fund. Unlike the current securities owed the trust fund, these new securities are not supported by payroll tax surpluses in the program - rather they represent what amounts to a grant or gift. However, it is important to remember that these new securities equal a portion of the excess cash that would be used to reduce the debt held by the public. The Administration argues that the new securities are, in effect, supported by the enhanced economic resources gained by reducing publicly held debt. Nonetheless, we should remember that under the current law baseline--i.e., with no changes in tax or spending policy--this would happen without crediting additional securities to either the Social Security or Medicare trust funds.

Figure 3: Medicare Flows under President's Proposal The financial consequences of this transfer are depicted in figure 4 below. This graph first shows that by providing the additional Treasury securities, the solvency of the Hospital Insurance Trust Fund would be extended from 2008 to 2020. However, the figure also shows that the President's proposal does nothing to alter the imbalance between the program's tax receipts and benefit payments. It has been in cash deficit since 1992 and remains in a cash deficit even with the new Treasury securities. Thus, the President proposes to provide additional claims on the Treasury, not additional cash to pay benefits. *W/OP*

Figure 4: Medicare Hospital Insurance Trust Fund Financial Outlook under President's proposal Notwithstanding the fact that no real cash is exchanged, the transfer of additional securities to Medicare is a discretionary act with major economic consequences for the future financing of the HI program. As with Social Security, this proposal represents a fundamental shift in the way the HI program is financed. It moves it away from payroll financing toward a formal commitment of future general fund resources for the program for the future. The general fund obligation would begin far earlier than for Social Security. Specifically, the HI Trust Fund would begin drawing on the general fund to redeem these new securities in 2008 - well before the full reduction in publicly held debt and associated benefits to the general fund will have been realized under the President's plan. In addition, this is 24 years before the Social Security Trust Fund would begin drawing on the additional Treasury securities that the President is proposing to grant to that program.

The transfer would constitute an explicit general fund subsidy for the HI program - a subsidy whose magnitude is unprecedented for this program. This is true because the newly transferred securities would be in addition to any buildup of historical payroll tax surpluses. Securities held by the trust fund have always represented the value of the loan of its surpluses to the Treasury - annual cash flows in excess of benefits and expenses, plus interest. Under the President's proposal, the value of securities held by the HI trust fund would exceed that supported by earlier payroll tax surpluses and constitute a new and unearned claim on the general fund for the future. In effect, the proposal would shift the financing of the HI Trust Fund to look more like that for the Part B Supplemental Medical Insurance (SMI) Trust Fund. The SMI portion of Medicare obtains 75 percent of its revenues from a general fund subsidy, with the remainder supported by beneficiaries' premiums.

This is a major change in the underlying theoretical design of the HI program. Whether you believe it is a major change in reality depends on what you assume about the likely future use of general revenues under the current circumstances. For example, current projections are that the HI Fund will exhaust its securities to pay the full promised benefits in 2008. If you believe that this shortfall would--when the time came be made up with general fund moneys, then the shift embedded in the President's proposal merely makes that explicit. If, however, you believe that there would be changes in the benefit or tax structure of the fund instead, then the President's proposal represents a very big

change. In this case, less of the long term shortfall would be addressed through future changes in the ( ) program itself and more would be financed through higher taxes or spending cuts elsewhere in the federal budget as a whole. Thus, the question of bringing significant general revenues into the financing of the HI program is a question that deserves full and open debate. The debate should not be overshadowed by the accounting complexity and budgetary confusion of the President's proposal.

In our view, the proposal carries some significant risks that should be carefully considered by the Congress. One risk is that the transfers to both the Medicare and Social Security trust funds would be made regardless of whether the expected budget surpluses are actually realized. The amounts to be transferred apparently would be written into law as either a fixed dollar amount or as a percent of taxable payroll rather than as a percent of the actual unified surplus in any given year. These transfers would have a claim on the general fund even if the actual surplus fell below the amount specified for the transfers. However, it is important to emphasize that any proposal to allocate surpluses is vulnerable to the risk that those projected surpluses may not materialize. Proposals making permanent changes to use the surplus over a long period of time are especially vulnerable to this risk. The history of budget forecasts should remind us not to be complacent about the certainty of these large projected surpluses. In its most recent outlook book, CBO compared the actual deficits or surpluses for 1988-1998 with the first projection it produced five years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says its errors averaged about 13% of actual outlays. Such a shift in 2004 would mean a surplus \$250 billion higher or lower; in 2009 the swing would be about \$300 billion. Accordingly, we should consider carefully any permanent commitments that are dependent on the realization of a long-term forecast.

#### The Compelling Need for Fundamental Program Reform

A more significant risk of the President's proposal is that by appearing to extend financial stability for Medicare, it could very well undercut the incentives to engage in meaningful and fundamental reform of the HI program - reforms which are vital to making the HI program sustainable over the long term. Unlike Social Security, the HI program is already in a negative cash flow position--payroll taxes support 89 percent of spending now and will cover less than one-half 75 years from now. Even in the short term, the HI program's annual outlays grow by several times the rate of general inflation. Although its growth has slowed in recent years, it remains one of the most volatile and uncontrollable programs in the federal budget. According to CBO, the growth of Medicare--both HI and SMI-- will increase its share of the economy by nearly a full percentage point over the next 10 years, from 2.5 percent to 3.3 percent of GDP in 2009. By contrast, the share devoted to Social Security is projected to remain relatively flat during this period rising from 4.4 percent of GDP in 1999 to 4.7 percent in 2009. Over the long term, the program's growth rates are more daunting. Absent any changes, the combined Medicare program (i.e., HI and SMI) is projected to more than double its share of the economy by 2050 - from 2.7 percent now to 6.8 percent based on the Medicare Trustees' most recent best-estimated assumptions. When coupled with Medicaid, federal health care costs will grow to nearly 10 percent of GDP by 2050, as depicted in figure 5. The progressive absorption of a greater share of the nation's resources for health is, like Social Security, a reflection of the rising share of elderly in the population. However, health care growth rates also reflect the escalating cost growth of health care at rates well exceeding general rates of inflation. Increases in the number and quality of health services fueled by the explosive growth of medical technology has spurred much of this extraordinary cost growth in health care. Consequently, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

Figure 5: Medicare and Medicaid as a Share of GDP

The President's proposal to strengthen the HI program is more perceived than real. Specifically, while the H/Trust Fund will appear to have more resources as a result of the President's proposal, in reality nothing about the program has really changed.

The proposal does not represent program reform, but rather a supplemental means to finance the current program. Stated differently, the reform proposed has more form than substance.

What is most alarming is that the President's proposal could induce a sense of false complacency about the financial health of the HI program. The impending insolvency of the HI program sends

important signals to policymakers that the program needs to be made more affordable through benefit changes, revenue increases or both. The 2008 date has become an important cue to policymakers that could provide the impetus needed to make the hard choices necessary to promote the solvency and sustainability of the HI program for the long term. Extending the life of the HI Trust Fund without substantive program reform could be a recipe for delay and denial that could increase the ultimate fiscal and social cost of HI program reform. At a minimum, the President's proposal is likely to create a public misperception that something meaningful is being done to reform the Medicare program. Changes to the HI program should be made sooner rather than later. The longer meaningful action is delayed, the more severe such actions will have to be in the future. As the fastest growing sector of the federal budget, early action to reduce Medicare's costs will have compounding fiscal benefits. Even if the rate of growth is not changed, reducing the base level of spending can produce outyear dividends for the program's finances. Moreover, acting now would allow changes to benefits and health care delivery systems to be phased in gradually so that stakeholders and participants would have time to adjust their saving or retirement goals accordingly.

When viewed together with Social Security, the financial burden of Medicare on the future economy takes on daunting proportions. As figure 6 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers. This does not even include the financing challenges of the SMI program. Figure 6. Social Security and Medicare's HI Program as a Percent of Taxable Payroll

There is another reason to take early action to reform both Social Security and Medicare costs.

*diminished*  
Reducing the future costs of these programs is vital to reclaiming our future capacity as a nation to address other important needs in the public sector. To move into the future without changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming no financing or benefit changes, our long-term model (and that of CBO) shows a world in 2050 in which Social Security, Medicare, and Medicaid absorb a much greater share of the federal budget. (See figure 7.) Budgetary flexibility declines drastically and there is increasingly less room for programs for national defense, the young, infrastructure, and law -- enforcement--i.e., essentially no discretionary programs at all. Eventually, again assuming no program or financing changes, Social Security, health and interest take nearly all the revenue the federal government takes in by 2050. This is true even if we assume that the entire unified budget surplus is saved and these continued surpluses reduce interest from current levels. As shown in figure 8, the picture below is even more dramatic if we assume the entire unified budget surplus is used. In that scenario lower GDP and higher interest payments lead to a world in which revenues cover only Social Security, health and interest in 2030. And in 2050 revenues do not even cover Social Security and federal health expenditures alone! Although views about the role of government differ, it seems unlikely that many would advocate a government devoted solely to sending Social Security checks and health care reimbursements to the elderly.

Figure 7: Composition of Spending as a Share of GDP Under "Save the Unified Surplus" Simulation

Figure 8: Composition of Spending as a Share of GDP Under "No Unified Surplus" Simulation

Mounting Pressures on Medicare Spending Pose Challenges for Long-term Program Viability

It is clear that real and substantive reform of Medicare is essential to achieving the long-term solvency and sustainability of the program itself--it is not a question of whether, but when and how. However, multiple factors complicate and magnify the challenges involved in achieving such fundamental program reform.

Substantial growth in Medicare spending will continue to be fueled by demographic and technological change. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom. For example, today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of Medicare beneficiaries. So, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Compounding the cost pressures of serving a larger and needier Medicare population are the costs associated with the scientific breakthroughs for treating medical conditions and functional limitations.

Technological and treatment advances have resulted in more services being provided to more beneficiaries. These services can restore health, reduce pain, increase functioning, and extend lives. Medical miracles abound, such as medications that reduce the permanent damage resulting from heart attacks, hip replacements that improve the health and quality of life for many, and therapy regimens that promote recovery from what previously would have been debilitating strokes. The frequency and intensity of some high-tech services, however, may be of limited clinical value or fail to improve the quality of beneficiaries' lives.

These technological advances feed the public's expectations that more health care is better. Some expect virtually unlimited services to treat any condition. However, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted, because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. The demographic spiral will increase health care needs over the foreseeable future, while technological changes have begun expanding health care demand. But of this demand, how much are "needs" and how much are "wants"? The distinction is blurred by the effect of scientific advances making available new treatments--which may not be universally applicable or necessarily effective while individuals continue to be insulated from the full costs of care. At the same time, financial incentives to expand service use fail to be held in check by reasonable assessments of what society can afford.

While these financial questions loom, pressure is mounting to update Medicare's outdated benefit design. However, doing so carries with it the potential to exacerbate Medicare's spending trajectory. Consider the case of prescription drug coverage. In 1965, when the program was first established, outpatient prescription drugs were not nearly as important a component of health care as they are now. Used appropriately, pharmaceuticals can cure diseases, improve quality of life, and substitute for more expensive services. Most private insurance options and Medicaid programs recognize these advantages by including pharmaceutical coverage in their benefit packages. Many seek to similarly modernize Medicare's benefits. However, this desired expansion comes at a time when pharmaceutical companies are increasingly marketing their products directly to consumers--raising the spectre that wants will grow well beyond actual needs. Thus, the question of whether to include prescription drugs in Medicare's benefit package illustrates the importance of affordability counterweights to moderate notions of health care wants.

#### BBA Reforms Overshadowed by Magnitude of the Problem

The kinds of reforms needed to put Medicare on a more sustainable footing for the future will require hard choices. Real changes in providers' incomes and services to beneficiaries will undoubtedly be necessary. Substantive reform, not simple financing shifts among funds within the budget--which have been all too frequent in the past as a way to delay the inevitable day of reckoning--will be required to address this daunting problem.

Let's not kid ourselves--this will not be easy. The Balanced Budget Act of 1997 (BBA) illustrates how challenging reforms can be for this program. BBA contains what are probably the most significant changes to Medicare since its inception more than 30 years ago, yet it was never intended to substitute for long-term reform.

The changes will extend the HI trust fund's solvency to 2008 before the baby boomers even begin to draw on the program. The changes will also result in an estimated \$385 billion in lower program expenditures over a 10-year period through a combination of savings from constrained provider fees, increased beneficiary payments, and structural reforms. To make even these incremental changes to Medicare required substantial effort on the part of the Congress.

Effective implementation of the Act has proved daunting to the Health Care Financing Administration (HCFA), as we have recently reported.<sup>7</sup> Moreover, to the extent that these changes have produced new winners and losers among health care providers, pressures to undo the related changes are growing. For example: Introduction of prospective payment for certain Medicare services:

Prospective payment systems will alter how reimbursements are made to skilled nursing facilities, home health agencies, hospital outpatient departments, and rehabilitation facilities. Rather than paying

largely whatever costs providers incur, the objective is to fix rates, giving providers incentives to deliver care and services more efficiently. Our work in this area shows that weaknesses in the design and implementation details could substantially erode the expected savings. Furthermore, over the past year, the Congress has faced intense industry pressure to revisit certain BBA provisions that constrain payments to particular groups of providers.

**Creation of Medicare + Choice:** The BBA established this new program to encourage the expansion of managed care. It represents a first step toward the restructuring of Medicare from two perspectives. The first addresses cost growth through increased reliance on private sector expertise and resources to control costs. The Medicare + Choice provisions addressing health plan and beneficiary participation reflect in part the expectation that increased managed care enrollment will help slow Medicare spending. To date, Medicare managed care has failed to meet that promise and, owing to payment methodology flaws, has actually cost the government more than if enrolled beneficiaries had remained in traditional fee-for-service Medicare. The BBA attempts to correct this problem by mandating several adjustments to Medicare's payments to managed care plans. These are adjustments which industry representatives have sought to delay and which they claim will lead to less rather than greater plan participation in Medicare + Choice.<sup>8</sup>

The second perspective touches on beneficiary expectations. In principle, managed care can reshape consumer behavior. The intent of Medicare + Choice is to provide beneficiaries a greater menu of plan choices that offer additional benefits, like prescription drugs, not covered in traditional Medicare. Simultaneously, however, plans will attempt to manage care, thus resulting in beneficiaries facing limits on both traditional and additional services. In this way, Medicare + Choice would demonstrate that resources are constrained and that expanding choice must involve trade-offs. The BBA illustrates the temptation to proceed down the slippery slope of federal treasury funding rather than sticking with the more difficult task of attempting meaningful program or financing reforms. The act calls for reallocating a portion of home health spending from the HI program to the SMI program. This is essentially an accounting exercise that moves obligations from the HI trust fund account to SMI. While this reallocation could position policy makers to develop additional structural reforms for this benefit, the movement of home health payments from (I) to SMI alone generates little net savings. Similarly, 1993 legislation increased the taxable portion of Social Security benefits and, for all practical purposes, shifted this additional revenue to the HI trust fund. These two shifts illustrate a pattern of taking from Peter to pay Paul.

The lessons learned so far from the BBA experience are twofold. First, passing the legislation is a bold first step, but remaining resolute and effectively implementing the provisions constitute an equally challenging second step. Second, relative to the reforms necessary to align Medicare spending with the nation's priorities for all spending, BBA's changes may represent only a minor excision when major surgery is required to assure the HI program's solvency. The BBA did result in reduced costs and cut the long-term actuarial imbalance significantly. Nonetheless, the HI and SMI programs together, are still projected to grow by nearly a full percentage point of GDP over the next 10 years. The pressures that continue to drive health care spending upward are exacerbated by the undefined boundaries between what the nation and individuals want, need, and can afford.

#### Conclusions

Budget surpluses provide a valuable opportunity to capture significant long-term gains to both improve the nation's capacity to address the looming fiscal challenges arising from demographic change and aid in the transition to a more sustainable Medicare program. The President's proposal should prompt a discussion about the importance of the trust fund concept in disciplining spending for Medicare. The President's proposal is both wide-ranging and complex, and it behooves us to clarify the consequences for both our national economy and the Medicare program.

A substantial share of projected budget surpluses over the next 15 years would be used to reduce publicly held debt, providing demonstrable gains for our economic capacity to afford our future commitments. Saving a good portion of today's surpluses can help future generations of workers better afford the billowing costs of these commitments, but we must also reform the programs themselves to make these commitments more affordable and sustainable over the long term.

The transfer of surplus resources to the HI trust fund, which the administration argues is necessary to lock in surpluses for the future, would nonetheless constitute a major shift in financing for the

Medicare program. However, it would not constitute real Medicare reform because it does not modify the program's underlying commitments for the future. Moreover, the proposed transfer may very well make it more difficult for the public to understand and support the hard choices necessary for the program's future viability.

While meaningful reform is urgently needed, it will require reshaping the nation's perspective on health care consumption and draw clearer distinctions between needs, wants, and affordability.

Complicating this effort is the nation's strong commitment to maintaining and even enhancing the quality of and access to services. Further, we have a history of technological development, which may in some cases make health care delivery more efficient or effective, but sometimes has driven spending up without contributing significantly to the quality or length of life.

Irrespective of whether the President's proposal is enacted or not, the Medicare program is in need of fundamental reform to assure its solvency and sustainability over the long term. There will be many proposals to modify Medicare and to implement fundamental change. I would suggest the following five criteria for evaluating these proposals.

-- Affordability: Changes should ensure that the Medicare program consumes a reasonable share of our productive resources and that it does not unduly encroach on other necessary public programs or private sector activities. Retaining the self-financing feature of the HI trust fund will help instill the necessary fiscal discipline that I fear could be eroded through general fund subsidies for the program. Shifting excess expenditures from one sector of the budget to another or transferring the burden to different payers or future generations should not be construed as actions that will make the trust fund solvent or future program commitments sustainable. Rather, there needs to be a fundamental rethinking of the incentives in the current program that promote increased intensity and utilization of services without sufficient consideration of their costs. Proposals that involve early action on modifications to the program to take advantage of the compounding fiscal dividends of savings that are achieved sooner should be preferred.

-- Equity: Reforms should not impose a disproportionate burden on particular groups of beneficiaries or providers. It may be that correcting the distortions created by our current system requires substantial reductions in utilization by certain groups of beneficiaries or of certain types of services. Graduated implementation could make the burden of such shifts less onerous.

-- Adequacy: Beneficiaries should have appropriate access to health care services, regardless of their individual ability to pay. Further, the tradition of technology development, which has contributed greatly to health and health care in this country, needs to be maintained in a manner that supports cost-effective and clinically meaningful innovations that enhance the quality and length of life.

-- Feasibility: Reforming an entitlement defined in specified benefits rather than dollar terms must involve changing the behavior of beneficiaries and providers. A proposal must contain the correct array of incentives to achieve necessary behavioral change.

It must also involve mechanisms that an entity like HCFA can implement and monitor. There must also be provisions for a safety valve to recalibrate aspects when the intermediate goals are not achieved.

-- Acceptance: Beneficiaries, taxpayers, and providers must reach a consensus on any major changes to ensure their long-term viability. The path for getting there must begin with steps that will make program costs, which today are barely opaque, much more transparent to the public. Sufficient beneficiary and provider education to the realities of the tradeoffs involved may facilitate their acceptance. Further, a phased approach could help ease any disruptions in services or incomes while garnering public approval.

Applying such criteria will require a detailed understanding of the possible outcomes and issues associated with the various elements of proposals. We will be happy to work to provide the data, information, and analysis needed to help policymakers evaluate the relative merits of various proposals and move toward agreement on much needed Medicare reforms.

The time has come for meaningful Medicare reform. Delay will only serve to make the necessary changes more painful down the road. We must be straight with the American people, achieving the goal of saving Medicare will require real options and tough decisions to increase program revenues and/or decrease program expenses. There is no "free lunch."

We have an historic opportunity to deal with the temporary surpluses available today and how we do so could position us better to deal with the future. We also have an obligation to execute our fiduciary responsibilities regarding the nation's fiscal health. This involves demonstrating prudent management of the projected unified surpluses. At the same time, we cannot let the comfort afforded by these temporary surpluses lull us into complacency. Instead, we must capitalize on this opportunity to engage in serious entitlement reform.

We at GAO stand ready to help the Congress as you develop effective, equitable, and affordable solutions for Medicare reform. Working together, we can make a positive and lasting difference for our country and the American people. FOOTNOTES:

1 With the additional interest these new securities would earn, total assets held by the HI trust fund would go up by over \$1 trillion.

2 This may mean either using interest or the principal itself to cover the difference.

3 Budget Issues: Analysis of Long-Term Fiscal Outlook (GAO/AIMD/OCE- 98-19, October 22, 1997).

4 The "On-budget balance" path assumes that any surplus in the non Social Security part of the budget is "spent" on either a tax cut or spending increases or some combination but assumes the current law path for the Social Security trust fund. Thus the surplus in the Social Security trust fund remains untouched until it disappears in 2013 after which the unified budget runs a deficit equal to the SSTF deficit. The "Save the Surplus" path assumes no changes in current policies and that budget surpluses through 2024 are used to reduce debt held by the public. The "No Surplus" path assumes that permanent increases in discretionary spending and tax cuts deplete the surpluses but keep the budget in balance through 2009. Thereafter, deficits re-emerge as spending pressures grow.

5 The President also proposes to use about 13 percent of these surpluses to purchase stocks for Social Security.

6 Our "No Surplus" simulation is not a forecast but rather an illustration of the implications of taking fiscal actions that eliminate projected surpluses and the fiscal pressures posed by the aging of the baby boom generation. This simulation shows ever-increasing deficits that result in declining investment, a diminishing capital stock, and a collapsing economy. In reality these economic consequences would inevitably force policy changes to avert such a catastrophic outcome.

7 HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21 Century (GAO/T-HEHS-99-58, Feb. 11, 1999).

8 See Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO-HEHS-99-72, Feb. 25, 1999).

END

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# The Breaux-Thomas Proposal:

What Will It Mean For Medicare  
Beneficiaries?

A Families USA Analysis  
of Ten Important Questions

*As of March 12, 1999*

## Introduction

In this document, Families USA analyzes the impact of the Breaux-Thomas Medicare reform proposal on the 39 million elderly and disabled people served by the Medicare program. We raise ten key questions and provide answers based on what we currently know from the documents issued by the Medicare Commission and from its deliberations.

This analysis will be revised when the Medicare Commission completes its work.

## Executive Summary

### **1. Will Medicare beneficiaries still be guaranteed the same benefits they have today?**

*No.* Under the Breaux-Thomas proposal, there are no guarantees that beneficiaries will have the same benefits that they receive today. Each health plan will have significant latitude, within specified categories of benefits (such as in-patient hospital care or home health care) to determine the scope, duration, caps, and cost-sharing for different services. As a result, private health plans and insurance companies will have the right to design their benefit packages so that there are limitations on services provided (such as caps on hospital or home health care days), and beneficiaries may be required to pay significant amounts in copayments for those services. In addition, cost pressures will cause benefits to erode over time unless they are guaranteed by law.

### **2. Are beneficiaries likely to pay more than they do now?**

*Yes.* The Breaux-Thomas proposal allows plans to impose greater cost-sharing requirements on beneficiaries. This can significantly increase the overall Medicare-related costs faced by beneficiaries compared to what they pay under current law. Also, the lack of sufficient savings and revenues in the proposal makes it likely that, as health costs increase over time, the government will reduce its subsidization of premiums, shifting these costs to beneficiaries. In addition, private insurance plans will pass on to beneficiaries new costs for marketing, enrollment, administration, and profits.

### **3. Do the structural changes being proposed ensure Medicare's long-term financial stability?**

*No.* The Congressional Budget Office stated that it could not determine how the Breaux-Thomas proposal would affect costs. HCFA actuaries said that restructuring the program to a premium support model would achieve relatively small savings. Hence, the Breaux-Thomas proposal will result in significant structural changes, with potentially large unintended consequences, but will not ensure the program's long-term stability.

### **4. One in five Medicare beneficiaries is eligible for financial assistance to cover some of their Medicare costs. Will they still be able to receive this help?**

*Not Clear.* The Breaux-Thomas proposal states that low-income protections will be the same as under the current system. But many crucial questions remain unanswered. Will premium subsidies be provided to beneficiaries up to 135 percent of poverty? Will these low-income beneficiaries receive subsidies for their deductibles and copayments as well? As premiums and cost-sharing increase, will there be a corresponding increase in the eligibility criteria for such assistance? How will cost-sharing assistance be determined when each plan establishes varying copayment levels? What will be done to provide assistance to the more than 5 million low-income beneficiaries who now are eligible for such help but don't receive it?

**5. Will Medicare beneficiaries be guaranteed that the plan they signed up for will have the same benefits and doctors from year to year?**

No. Under the Breaux-Thomas proposal, private health plans will be able to modify the benefit and cost-sharing features being offered each year. Plans will also be able to modify the list of physicians in their networks. Thus, plans will be able to undertake so-called “bait-and-switch” practices—luring people into plans based on attractive benefit and network features, and subsequently offering less favorable plan features. The Breaux-Thomas proposal is silent on the issue of what protections will be available to beneficiaries if they become dissatisfied with their HMOs and want to return to traditional Medicare or if their HMOs pull out of the market.

**6. Will health insurance companies be able to discourage sicker or older seniors or people with significant disabilities from joining their plans?**

Yes. The Breaux-Thomas proposal gives general authority to a Medicare Board to “protect against adverse selection,” but the proposal contains no specific steps to carry out this charge and does little to define the authority of the Board. Since the Board is being created partially because Commission members oppose HCFA’s more regulatory approach, there is reason to fear that the Board may be less inclined to intervene effectively against health plans’ “cherry picking.” Under the Breaux-Thomas proposal, plans will have a greater ability to design benefit packages attractive to younger and healthier beneficiaries that are inadequate for sicker beneficiaries. For example, a plan may offer fitness classes but limit home health services. This will enhance risk selection and segregate Medicare beneficiaries into some plans serving the young and healthy and other plans for the old and frail.

**7. Will beneficiaries have the same consumer protections they now have?**

*Not Clear.* The Breaux-Thomas proposal provides no assurance that the same consumer protections that exist in the current program will be in place and, if they exist, how they might be enforced.

**8. Will the many beneficiaries who depend on traditional Medicare be guaranteed that it will remain viable and affordable?**

No. The Breaux-Thomas proposal makes traditional Medicare compete with private plans. It allows private sector plans to offer benefits that are attractive only to younger, healthier beneficiaries and to limit benefits needed by those in poor health. Traditional Medicare will then be the choice of older and sicker beneficiaries, making its premium increasingly expensive. At some point the premium for traditional Medicare may become so expensive that enrollment declines and the program becomes unsustainable.

**9. Will all Medicare beneficiaries have a prescription drug benefit?**

*Not Clear.* The Breaux-Thomas proposal identifies prescription drugs as an “open issue” that still requires resolution.

**10. Will more older people become uninsured?**

Yes. The Breaux-Thomas proposal gradually increases the eligibility age for Medicare from 65 to 67 years of age. As a result, many 65- to 67-year-olds would become uninsured. Research indicates that as many as 1.4 million people will be left without any insurance or will be seriously underinsured. Over time, more people will lose coverage as employers continue to drop retiree health coverage.

## Analysis

### 1. Will Medicare beneficiaries still be guaranteed the same benefits they have today?

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Today, Medicare beneficiaries are guaranteed a specific set of benefits. The scope of these benefits, their duration, and the cost-sharing requirements related to them are all specifically defined in law. These benefits include hospital care; skilled nursing care; home health care; hospice care; physician services; inpatient and outpatient medical and surgical care; physical, occupational, and speech therapy; and diagnostic and laboratory services. Out-patient prescription drugs are not included, and most experts acknowledge that this gap needs to be filled.

Not only are specific benefits promised, but beneficiaries can rely upon actually receiving those benefits. Data from the 1995 Medicare Current Beneficiary Survey indicate that only 4 percent of Medicare beneficiaries reported trouble getting care.<sup>1</sup>

The Breaux-Thomas proposal does not provide a clear guarantee of benefits. Commission documents describe a requirement that health plans provide the same *categories* of benefits offered in traditional Medicare; however, health plans could vary the scope, duration, and cost-sharing requirements of benefits in each category.<sup>2</sup> The failure to provide a statutory guarantee of precisely defined benefits would leave beneficiaries vulnerable to erosion in the value of benefits over time as health care costs increase. For example, health plans could reduce reimbursable hospital days or place a dollar limit on specialty care. At the same time, cost-sharing amounts are likely to rise. (See Question #2.)

Under the Breaux-Thomas proposal, the precise design of benefit packages would lie within the purview of a new Medicare Board vested with the authority to negotiate premiums and approve benefit packages. Medicare would be modeled after the Federal Employees Health Benefits Plan (FEHBP). One can look to the Office of Personnel Management (OPM), which performs the same tasks ascribed to the Medicare Board, for insight on benefits. Although OPM has a policy of minimizing variation in FEHBP benefit packages, a great deal of variation is still permitted. FEHBP plans vary in actuarial value by as much as 31 percent—an indication of significant differences in the type, scope, and duration of benefits.<sup>3</sup>

Although the Breaux-Thomas plan models Medicare after FEHBP, details of the proposal are vague enough that a host of important questions remain unanswered. Will *all* plans provide a broad array of benefits, including hospital, physician, outpatient, laboratory, skilled nursing care,

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home care, and prescription drugs? Will these benefit categories be prescribed in law? How much can plans limit the duration of important benefits such as home care or hospital days? How much authority or statutory obligation will the Medicare Board have to limit variation in the value of benefit packages and enforce its goals for benefit design? Will traditional Medicare continue to have a statutorily mandated package of benefits defined in scope, duration, and cost-sharing requirements, or will traditional Medicare negotiate benefits with the Medicare Board like other health plans?

## **2. Are beneficiaries likely to pay more than they do now?**

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Under the current Medicare system, the amount beneficiaries pay in premiums and cost-sharing (copayments and deductibles) for the Medicare benefit package is limited by law.<sup>4</sup> For physician and other Part B services, Medicare beneficiaries pay a premium of \$546 a year and copayments of 20 percent of physician services after meeting a \$100 deductible. For hospital services, beneficiaries pay a deductible of \$768 for each episode of hospitalization, no copayment for days 1-60 in the hospital, \$192 daily for days 61-90, and \$384 daily for days 91-150. No copayment is required for home care. Currently, beneficiaries pay an average of one fifth of their incomes in out-of-pocket costs.<sup>5</sup>

Under the Breaux-Thomas proposal, there is reason to expect that, over time, beneficiaries in both traditional Medicare and the new private plans will pay more in real dollars for premiums, cost-sharing, or both than they would pay for the same benefits they have today. This is because the proposal is likely to result in cost-shifting to beneficiaries.

The Breaux-Thomas proposal attempts to save money by forcing health plans to compete with each other for Medicare's business. The proposal is based on the theory that a system of competing health plans will be more efficient than the current Medicare system. While experts debate whether savings can be achieved from competition and, if so, how much, there is general agreement that any savings from competition alone will not be enough to sustain the program through the huge influx of baby boom retirees. (See Question #3.)

Unless additional revenues are provided for the Medicare program to supplement any savings realized through competition, there will inevitably be a shortfall in funding. Under Breaux-Thomas, there are a number of ways the government can address this shortfall: it can reduce benefits (see Question #1); it can increase cost-sharing; and it can ratchet down its contribution to the costs of Medicare premiums. All of these mechanisms shift costs on to beneficiaries.

**Increased Cost-sharing in the Premium Support Model:** Because the proposal allows the benefit package to vary, the Medicare Board could allow health plans to increase cost-sharing requirements on beneficiaries (or reduce benefits). When health plans submit bids each year, the Board has the power to approve benefit packages, including co-payments and deductibles (as well as dollar and time limits on benefits). Allowing health plans to increase cost-sharing (or curtail the scope and duration of benefits) shifts the burden of increasing costs onto beneficiaries.

**Increased Cost-sharing in Traditional Medicare:** In the Breaux-Thomas proposal, cost-sharing would rise in traditional Medicare for the majority of beneficiaries in a given year. For the traditional Medicare fee-for-service plan, the proposal calls for a combined deductible of \$350, which would replace the existing Part B deductible of \$100 and the hospital deductible of \$768. The combination of the two deductibles into one means that most beneficiaries—the 80 percent who are not hospitalized in a given year—will have higher out-of-pocket costs. They will pay \$250 more than they pay today. The proposal also imposes new copayments of 10 percent for home care visits and in-patient hospital care. A provision in the proposal to restrict Medigap first-dollar coverage of cost-sharing would limit the options seniors have to protect themselves against growing out-of-pocket expenses.

**Decreased Government Contribution:** Under the Breaux-Thomas proposal, health plans submit bids to the Medicare Board, and the Board calculates the average premium. This average becomes the “benchmark” premium. (The traditional fee-for-service plan, like private plans, would submit a premium bid.)

The federal government would pay an average of about 88 percent of the benchmark premium toward the cost of the health plan chosen by each beneficiary. Beneficiaries would pay the remaining amount—about 12 percent. (This 12 percent beneficiary contribution was based on the amount of Medicare’s per capita expenditure that beneficiaries are scheduled to pay in Part B premiums after the Balanced Budget Act is fully implemented in 2002.) The actual contribution by any individual beneficiary would be determined by a formula based on the benchmark premium (see below).

The government could reduce its contribution by adjusting the underlying formula. This could be done in three ways: 1) directly decrease the percentage of the benchmark premium that the government contributes for each beneficiary; 2) lower the benchmark premium upon which the government contribution is based; or 3) change the incentives in the formula to encourage enrollees to choose low-cost plans.

1) *Directly decrease percentage:* The first method is easy to understand. Instead of contributing an average of 88 percent of the beneficiary premium, the government could lower its average contribution to 75 percent or 60 percent. Cost-containment that is this direct and transparent would be politically difficult, however.

2) *Lower the benchmark:* A more subtle approach is to lower the percentile of the benchmark premium on which the government contribution is based. For example, instead of using the average premium (at the 50<sup>th</sup> percentile of all premiums) to determine the federal contribution, the government could use a benchmark premium that falls at the 25<sup>th</sup> percentile or even the lowest cost plan in a region. As a result, beneficiaries would have to pay more to stay in a given plan.<sup>6</sup>

3) *Change the incentives:* An even subtler way of shifting costs to the beneficiary is to create incentives in the formula so that beneficiaries themselves drive down that contribution by choosing lower-cost plans. If more people choose lower-cost plans, then the benchmark premium is likely to decline and bring down the government contribution with it, as described above.

Commission documents describe a formula that encourages beneficiaries to choose lower-cost plans: for plans with premiums below 85 percent of the benchmark, beneficiaries would pay nothing. For plans with premiums above 85 percent of the benchmark but below 100 percent, beneficiaries would pay 75 percent of the additional costs. For plans with premiums above 100 percent of the benchmark, beneficiaries would pay the full portion of any additional amount.<sup>7</sup>

Because most beneficiaries are likely to remain in the traditional fee-for-service plan at the outset, at first the benchmark premium will be close to or the same as the traditional plan. However, if more seniors move out of the traditional plan as intended by the reform proposal, the benchmark premium will change to reflect the cost of the plans they choose. This is because the benchmark is not a simple average but a weighted average, meaning it is influenced by the number of people in each plan.

Beneficiaries are likely to choose plans that do not cost them anything—those at 85 percent of the benchmark. This is especially true because the government will only pay 25 percent of the added cost of plans between 85 and 100 percent of the benchmark and nothing beyond that. People choosing plans with such low premiums will either receive lesser coverage, pay more in cost-sharing, or both.

As the declining benchmark drives down the government contribution to premiums, people who want to keep the same level of benefits will have to pay more out-of-pocket. Unlike private plans, traditional Medicare will be unable to reduce benefits to stay competitive and will become increasingly expensive. Beneficiaries who live in areas served only by traditional Medicare will have no choice but to pay more out-of-pocket.

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### **3: Do the structural changes being proposed ensure Medicare's long term financial stability?**

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The purpose of the Medicare Commission was to develop ways to ensure the future financial stability of Medicare. The Balanced Budget Act (BBA) charged the Commission with analyzing solutions "that will ensure both the financial integrity of the Medicare program and the provision of appropriate benefits under such program."<sup>8</sup>

The Breaux-Thomas proposal to transform Medicare into a market-based model will have many unpredictable and unintended consequences and yet will not generate significant savings. Over the past two-and-a-half decades, public and private sector health costs have increased at similar rates: between 1970 and 1996, average annual spending growth per enrollee was 10.8 percent for Medicare and 11.3 percent for private insurance.<sup>9</sup> And future per capita growth in Medicare spending is projected to be lower than growth in the private sector for the next several years, partly because of measures in the BBA that reduce excess payments to providers.<sup>10</sup> In examining the financial impact of the Breaux-Thomas proposal, HCFA's Office of the Actuary found that long-term savings from the BBA measures and from premium support were similar: extending the BBA provisions saves \$12.2 billion in the year 2009 and premium support saves \$11.4 billion that year.<sup>11</sup>

Given current policy, Medicare will experience a long-term shortfall that market forces under the Breaux-Thomas proposal will hardly affect. That shortfall will not be due to Medicare's inability to control per capita costs, but will result largely from growth in the number of beneficiaries. In the absence of other savings or increased revenues to restore Medicare's financial balance, the Breaux-Thomas proposal will shift costs to beneficiaries. The plan's design provides convenient tools for the government to limit its costs. As discussed in Questions #1 and #2, the government can reduce its contribution to premiums and allow plans to increase cost-sharing or reduce benefits. All result in higher costs for beneficiaries.

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**4. One in five Medicare beneficiaries is eligible for financial assistance to cover some of their Medicare costs. Will they still be able to receive this help?**

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A number of Medicare “buy-in” programs now exist to help low-income beneficiaries. Under the Qualified Medicare Beneficiary (QMB) program, beneficiaries with incomes up to 100 percent of the federal poverty level are entitled to full coverage of their Medicare premiums, deductibles, and co-payments, paid for by the Medicaid program. Under the Specified Low-Income Beneficiary (SLMB) program, those with incomes between 100-120 percent of poverty are entitled to Medicaid coverage of their Medicare Part B premiums (but not their cost-sharing). And, under the Qualified Individual-1 (QI-1) program, those with incomes between 120-135 percent of poverty are eligible for—but not entitled to—Medicaid coverage of their Part B premiums from a pool of limited funding available on a first-come, first-served basis.

While the buy-in program has helped millions of seniors afford health care, it has serious administrative flaws that prevent millions more from receiving benefits to which they are entitled. Currently, nearly 10 million beneficiaries are eligible for assistance under QMB/SLMB/QI-1, but fewer than 5 million of them receive this assistance.<sup>12</sup>

The Breaux-Thomas proposal would continue the current buy-in program—a program that has been ineffective in reaching those who need the benefits. The current system is hindered by a division of administrative responsibility among several federal regulatory bodies and between federal and state governments. Funding is divided between the federal and state governments, creating a disincentive for the states to help make the program work. An extremely cumbersome application process intimidates many eligible beneficiaries. The Breaux-Thomas proposal does not make clear how these problems would be solved.

The proposal is vague about how the buy-in program would be implemented in a premium support model. The proposal does not explicitly define who would be eligible under the premium support program. Unless people at or below 135 percent of poverty are included, as under the current QMB/SLMB/QI-1 programs, these low-income beneficiaries would be forced to pay a potentially unaffordable premium.

Another concern is how the Breaux-Thomas proposal would cover cost-sharing requirements for low-income people. Since the Commission’s proposal allows health plans to determine scope, duration, and dollar caps for plan benefits, it is unclear how the cost-sharing protections would be structured. Would it be determined on a plan-by-plan basis, with different cost-sharing protections for enrollees in different plans? Who would decide about the size of the protections—the Medicare Board, health plans, HCFA, the states, or some other entity? Without details about this structure, it’s hard to determine whether low-income beneficiaries will receive the protections needed to keep Medicare affordable.

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**5. Will Medicare beneficiaries be guaranteed that the plan they sign up for will have the same benefits and doctors from year to year?**

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A goal of the Breaux-Thomas plan is to shift increasing numbers of beneficiaries into managed care plans. As described in Question #1, beneficiaries in traditional Medicare enjoy the security of legislatively guaranteed benefits that are consistent from year to year. An act of Congress is required to change the benefit package. Even though there are gaps in benefits, the constancy of benefits enables beneficiaries to arrange for supplemental coverage. Additionally, virtually all physicians accept Medicare patients, and most accept Medicare's payment rate without billing additional amounts to beneficiaries. Thus, beneficiaries have virtual certainty that they will be able to maintain relationships with their doctors over the years.

Beneficiaries in HMOs, however, have less certainty. They cannot be sure that their plans will remain in the Medicare program, that benefits will stay the same in scope or duration, or that the same panel of doctors will be available in a given plan from year to year. For example, diabetics who rely on a set number of home care visits or a certain amount of dietetic counseling and physical therapy will be at risk if their health plans are permitted to reduce benefits in these areas. Patients can suffer disruption in care if their doctors are dropped from health plans or leave due to intrusions into patient care. Involuntary change of physicians is especially disconcerting to patients undergoing long-term treatment, as is the case with much of the Medicare population.

Beneficiaries are especially hard hit when health plans leave the market altogether. Nearly 100 plans recently pulled out of Medicare+Choice or dropped counties from their coverage areas, affecting 450,000 Medicare+Choice beneficiaries—about seven percent of Medicare+Choice enrollees. These beneficiaries were forced to find another health plan in their area that provided the benefits they required—or they could return to traditional Medicare and search for a supplemental policy that provided those benefits. About 50,000 of the beneficiaries who were dropped live in areas with no other HMOs. Currently, insurers are required to issue 4 of the 10 standard Medigap plans to beneficiaries whose HMOs leave the market. Unfortunately, none of these plans offers prescription drugs. The law also permits beneficiaries to return to Medigap plans in which they were enrolled within the previous year.

Under the Breaux-Thomas proposal, the ability of beneficiaries to rely on consistent availability of plans, benefits, and physicians is likely to decline. If plan oversight decreases from the current level, the potential for unscrupulous plans to engage in subtle bait-and-switch marketing tactics would increase. Plans could offer more desirable benefits at first, and decrease or change these in subsequent years. The Breaux-Thomas proposal's creation of a Medicare Board to supplant HCFA is rooted in an anti-regulatory environment and is, in part, a response to critics of HCFA's regulatory efforts. The proposal does not describe what the Board's membership

will be or how it will hold plans accountable. The proposal also does not describe the Board's regulatory powers and enforcement mechanisms. Thus, there is no assurance that the Board will be an effective overseer. In addition, the proposal fails to address access to Medigap coverage for beneficiaries who leave HMOs either due to dissatisfaction or plan termination.

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**6. Will health insurance companies be able to discourage sicker or older seniors or people with significant disabilities from joining their plans?**

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Several factors allow health plans to discriminate against sicker people who incur high costs. These include the ability to vary benefits packages, and lax oversight by regulators. In addition, the technology for risk-adjusting premiums is in its infancy, and therefore is of little help, so far, in minimizing "cherry picking."

Currently, Medicare HMOs are limited in how they can use benefit design to select better risks because they must provide Medicare's defined benefit package. HCFA exercises some regulatory oversight by approving health plans' marketing materials for consistency and comprehensibility. And a risk adjustment system to improve the accuracy of payment rates to HMOs is being phased into Medicare+Choice.

Despite these restrictions, Medicare HMOs today are able to avoid high-risk beneficiaries to some degree. A significant body of research shows that the beneficiary population enrolled in Medicare HMOs is healthier—and therefore less expensive—than the Medicare population as a whole. For example, a study by the Physician Payment Review Commission (now the Medical Payment Advisory Commission, MedPAC) found that beneficiaries enrolling in HMOs had lower-than-average costs while beneficiaries disenrolling from HMOs had higher-than-average costs.<sup>13</sup> MedPAC estimated that HMOs were being overpaid about \$2 billion annually, given the relative low health risks (10-12 percent below average) of their enrollees.<sup>14</sup> The Congressional Budget Office and Mathematica Policy Research also conducted studies showing that HMOs were overpaid because their populations were healthier than other Medicare beneficiaries. If HMOs are able to avoid risk in a program requiring standardized benefits, it seems clear there will be an increase when flexibility in the benefit package is introduced under the Breaux-Thomas proposal.

The Breaux-Thomas proposal offers few details about how risk selection will be prevented. The proposal gives general authority to the Medicare Board to "protect against adverse selection" but contains no specific steps to carry out this charge. If the proposal does not require a precisely defined benefits package, health plans would have increased ability to use benefit design to target healthier beneficiaries and discourage enrollment by those who are sicker and costlier. For example, health plans might offer plenty of fitness classes while limiting home health care. The extent of benefit-driven risk selection will also depend on the authority and

willingness of the proposed Medicare Board to limit benefit variation among plans. The Breaux-Thomas proposal calls on the Board to do this but does not specify how it will hold plans accountable.

Also unclear is what authority and resources the Medicare Board will have to oversee the marketing behavior of health plans. Throughout Commission deliberations, Commission members and witnesses expressed a strong desire to curtail HCFA's regulatory oversight, an indication that the Board's oversight authority may be circumscribed.

The Breaux-Thomas premium support proposal depends on risk-adjusted reimbursement to health plans, but the ability of risk adjusters to accurately predict health plan costs and to pay plans enough (but not too much) is uncertain at best. Furthermore, implementing effective risk adjustment will be difficult in the face of industry opposition. The industry charges that the data collection required for good measurement of health status—a critical variable in risk adjustment—will be burdensome and that any overall reduction in payments would be unfair. While the Breaux-Thomas proposal calls for using health status as a risk adjuster, it does not specify how to measure it. Moreover, the proposal states that health status adjusters should avoid “unwarranted administrative burdens that could affect varying types of plans’ ability or willingness to offer coverage,” undermining the likelihood of effective risk adjustment.<sup>15</sup>

## **7. Will beneficiaries have the same consumer protections they now have?**

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Currently, Medicare+Choice beneficiaries are covered by a number of consumer protections that help to ensure that they receive the benefits to which they are entitled. These protections include the following:

- Medicare has adopted the “prudent layperson” standard for emergency care, and beneficiaries are protected against cost-sharing when they appropriately seek care from non-plan providers. In addition, health plans must respond to requests for pre-approval of out-of-plan post-stabilization care within an hour of the emergency.
- Medicare specifically prohibits discrimination on the basis of medical conditions, genetic information, and evidence of insurability. Additionally, it prohibits termination of coverage for those who develop end-stage renal disease.
- Women are entitled to use the services of a qualified women's health specialist for routine and preventive care, without seeking prior authorization from a primary care physician. Individuals with complex medical conditions are entitled to an assessment of their condition within 90 days of their enrollment in the plan.

- Health plans that terminate their contracts with Medicare must notify enrollees at least 30 days before the termination is effective, and plans must distribute to enrollees information about alternative plans and Medigap services in their area.
- Beneficiaries in Medicare+Choice plans have the right to full disclosure of health plan policies on benefits, cost-sharing, available providers, and methods used to reimburse providers. Physicians must be able to tell patients about all available treatment options without any consequences or restrictions.
- Medicare plans must abide by a detailed internal appeals system for payments and denials, and a grievance system. Appeals for denial of service must be resolved in 60 days and expedited for urgent health matters. Each beneficiary is entitled to appeal through the Center for Health Dispute Resolution and, depending on the cost of the claim, to judicial review.

The Breaux-Thomas proposal fails to itemize any protections for Medicare beneficiaries. It creates a new Medicare Board, which would replace HCFA in administering the premium support system. The proposal states, "The board will have the authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries." The proposal also states, "It [the proposal] would allow for a blend of existing government protections and market-based competition." The lack of specificity about consumer protections in the proposal raises doubts about whether consumers will retain their current protections and whether any such protections will be adequately enforced. The answers depend on how the Medicare Board interprets its duties, how it hold plans accountable, and what powers of enforcement the Board has at its disposal.

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**8. Will the many beneficiaries who depend on traditional Medicare be guaranteed that it will remain viable and affordable?**

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About five out of six Medicare beneficiaries rely on the traditional program, and the Congressional Budget Office projects that half of beneficiaries will continue to rely on the program by 2030.<sup>16</sup> Beneficiaries in the traditional program enjoy unfettered access to virtually any physician. Those who are chronically ill, in particular, tend to choose traditional Medicare over HMOs. (See Question #6.) Thus, traditional Medicare functions as a safe haven for those beneficiaries who need more complex care or who worry that HMOs will inappropriately skimp on care. And the traditional program is financed independently of Medicare HMOs.

The Breaux-Thomas proposal would require traditional Medicare to submit a premium bid and compete with private plans. A recent version of the Breaux-Thomas proposal states, "The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries."<sup>17</sup> The viability of the traditional Medicare plan will depend on a number of factors, including the degree of risk selection among all plans and the flexibility given to HCFA to manage the fee-for-service plan to enable it to compete effectively.

Benefit design is one way in which health plans attempt to select better risks. If traditional Medicare offers more of the type and level of benefits needed by sicker beneficiaries than private plans do—home health care, for example—then it is likely to attract sicker and more expensive beneficiaries, making its premium increasingly expensive. At some point, the premium would become so expensive that enrollment would decline and traditional Medicare could no longer stay in operation. For example, one of the models recently developed by the Urban Institute projected that, under a premium support system, out-of-pocket costs in the traditional Medicare plan could rise to nearly 40 percent of income in 2025<sup>18</sup> — double what they now pay.

In addition, while the Breaux-Thomas proposal calls for premiums to be risk-adjusted so that plans with sicker enrollees are paid more, risk adjustment is an undeveloped science. (See Question #6.)

The ability of traditional Medicare to compete with private plans will also depend on the management flexibility Congress is willing to give HCFA. Currently, HCFA's administrative authority is tightly scripted by Congress. To purchase almost any service—from physician and hospital services to home care or laboratory services—HCFA is required to contract with any licensed provider. Beneficiaries and physicians may choose among any of these providers. HCFA is not permitted to harness its purchasing power to select contractors who agree to lower prices. Together, these contractors constitute a strong political constituency, and Congress has been unwilling to change the law so that HCFA can selectively contract. Courts have generally upheld the due process rights of contractors whom HCFA has refused.<sup>19</sup>

The Breaux-Thomas proposal would give HCFA these types of management tools: "enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements." Such changes may enhance efficiency and achieve savings.

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**9. Will all Medicare beneficiaries have a prescription drug benefit?**

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While a Medicare prescription drug benefit would be expensive, drug therapy is an integral part of modern health care and drug coverage is essential to the credibility of any Medicare reform proposal. Outpatient drugs alone consume an increasing portion of total health expenditures—6 percent now and rising to 8 percent by 2007. The elderly make up 12 percent of the entire population, but they use one-third of all medications, and three out of four Medicare beneficiaries regularly use more than one prescription drug.<sup>20</sup> While Medicare beneficiaries suffer disproportionately from chronic conditions that require drug therapy, beneficiaries have less prescription drug insurance than the employed population. Today, beneficiaries pay out of their pockets for more than half of all prescription drug expenditures.

The Breaux-Thomas proposal identifies prescription drugs as an “open issue” that still requires resolution.

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**10. Will more older people become uninsured?**

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Today, Americans age 65 and above are eligible for Medicare benefits. Because of Medicare, virtually all elderly Americans have health coverage, while 43 million non-elderly Americans lack coverage. In fact, the number of non-elderly people without coverage has risen steadily over decades, and the trend is expected to continue despite a prosperous economy.

The Breaux-Thomas proposal recommends raising the eligibility age to 67. The issue has a life of its own beyond the Medicare Commission, however. In 1997, the Senate Finance Committee voted to raise the age from 65 to 67.

Raising the eligibility age will cause more people to lose insurance coverage. Up to 1.7 million people ages 65 and 66 could be left uninsured or seriously underinsured.<sup>21</sup> A large number of 65-66 year-olds would be left without coverage because of their decreased access to both employer-sponsored and individual coverage. After the age of 50, the percent of workers who are offered employer-sponsored coverage declines. While 82.9 percent of individuals ages 25-34 are offered coverage through their employers, only 74.2 percent of individuals ages 60-64 are offered coverage.<sup>22</sup>

Employers have reduced retiree coverage steadily over the past decade, and the trend is expected to continue. A recent survey of large employers (those with more than 500 workers) found that 40 percent offered retiree health benefits in 1993 but only 31 percent did so in 1997.<sup>23</sup> In addition, premiums for retiree insurance are rising dramatically. These developments are part of a general diminution of employer-sponsored health coverage in the face of rising

costs. Because retirees do not make a current contribution to firm productivity, their health benefits are more vulnerable to curtailment than those of current employees. For all these reasons, the trend toward reduced retiree coverage is expected to continue.

Newly ineligible 65- to 66-year-olds would have to fend for themselves in procuring health coverage in the individual insurance marketplace, where coverage and costs are based on individual health status. Many of these seniors would be rejected outright by insurers or charged extremely high premiums they could not afford. Even if these seniors were permitted to buy into Medicare, low-income individuals would need subsidies to afford the premium.

Raising the Medicare eligibility age would achieve some limited savings. However, these savings would be offset by the increased costs incurred by seniors who delay health care until they are eligible for Medicare. In sum, the savings achieved by increasing the eligibility age come at a steep price.

## ENDNOTES

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<sup>1</sup> Physician Payment Review Commission (PPRC, now the Medical Payment Review Commission, or MedPAC), an advisory board to Congress, *1997 Annual Report to Congress*, p. 304.

<sup>2</sup> National Bipartisan Commission on the Future of Medicare, "Draft Working Document," Jan. 22, 1999. In a later document issued by the Commission ("Premium Support Estimate from the HCFA Actuary," Feb. 23, 1999), two alternatives are presented and scored by HCFA—one allowing the 10 percent variation in benefits and one with no benefit variation.

<sup>3</sup> Mark Merlis, "Medicare Restructuring: The FEHBP Model," prepared for the Henry J. Kaiser Family Foundation. (Washington, DC: Institute for Health Policy Solutions, February 1999), p. 16. In calculating the value of FEHB plans, the author uses information from the Center for the Study of Services published in *Checkbook's Guide to 1998 Health Insurance Plans for Federal Employees*.) OPM claims that differences in FEHB plan actuarial values are as little as 10 percent, according to the author.

<sup>4</sup> Beneficiaries in HMOs may pay less in cost-sharing for the same benefits.

<sup>5</sup> Marilyn Moon, Crystal Kuntz, and Laurie Pounder, "Protecting Low-Income Medicare Beneficiaries" (New York: The Commonwealth Fund, 1966). Moon's estimate of Medicare out-of-pocket spending is 21 percent for all non-institutionalized beneficiaries, and the AARP/Lewin estimate is 19 percent. The Moon estimate projects from the National Medical Expenditure Survey of 1987 and includes home care, while the AARP projection uses data from the 1993 Medicare Current Beneficiary Survey and excludes home care.

<sup>6</sup> Say the average cost plan is \$1000, and a beneficiary chooses a plan that costs the same amount. With a benchmark pegged to the average premium (and assuming a 12 percent government contribution), the beneficiary will receive \$880 towards the \$1,000 premium. Let's say the government changes the benchmark to the lowest-cost plan, which is \$700. Then the government will contribute 88 percent of \$700, or \$616, to the beneficiary's premium of \$1,000. The beneficiary pays an additional \$264.

<sup>7</sup> National Bipartisan Commission on the Future of Medicare, "Fiscal Analysis of Senator Breaux's Premium Support Proposal," distributed Feb. 24, 1999, at a meeting of the Commission. Along with this formula, another formula was included in a description of the Breaux-Thomas proposal dated Feb. 16, 1999. Under that formula, beneficiaries would pay: 10 percent of the benchmark premium for plans with premiums up to 90 percent of the benchmark, one-third of the cost of the premium increment between 90 percent and 100 percent of the benchmark, and all of the premium beyond that. This formula contains an incentive for beneficiaries to choose plans at or below the average cost plan.

<sup>8</sup> Balanced Budget Act of 1997, Section 402, 42 USC 1395b.

<sup>9</sup> Health Care Financing Administration (HCFA) Office of the Actuary. In the *Profile of Medicare Chartbook*, May, 1998, p. 33.

<sup>10</sup> Sheila Smith, Mark Freeland, Stephen Heffler, David McKusick, "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs*, Vol. 17, No. 5, 1988: 128-140.

<sup>11</sup> National Bipartisan Commission on the Future of Medicare, "Premium Support Estimate from the HCFA Actuary," Feb. 23, 1999. Memorandum distributed at Commission meeting.

<sup>12</sup> Families USA, *Shortchanged: Billions Withheld from Medicare Beneficiaries* (Washington, DC: Families USA, 1998).

<sup>13</sup> Physician Payment Review Commission (now MedPAC), *1996 Annual Report to Congress*, Washington, DC, Chapter 15.

<sup>14</sup> Physician Payment Review Commission (now MedPAC), *1997 Annual Report to Congress*; Washington, DC., p. 81.

<sup>15</sup> National Bipartisan Commission on the Future of Medicare, "Preliminary Staff Estimate: Senator Breaux's Premium Support Proposal," February 16, 1999, p. 7.

<sup>16</sup> Congressional Budget Office, *Economic and Budget Outlook 1998*, Washington, DC.

<sup>17</sup> National Bipartisan Commission on the Future of Medicare, "Draft Working Document," January 22, 1999, p. 4.

<sup>18</sup> Marilyn Moon, "Restructuring Medicare: Impacts on Beneficiaries," Urban Institute, Washington DC, Jan. 1999. The Urban Institute built an economic model to examine what would happen to long-term out-of-pocket costs for beneficiaries who choose the traditional Medicare plan in a system modeled after the Breaux-Thomas proposal. In a model having a government contribution of 85% of the median-priced plan that achieves a moderate reduction in private plan costs, out-of-pocket costs for beneficiaries in traditional Medicare would rise to \$6,054 (in 1998 dollars), or 36.6% of median income, by 2025. In a model having an 80% government contribution, out-of-pocket costs for beneficiaries in traditional Medicare would rise to \$6,512, or 39.4% of income.

<sup>19</sup> Bruce Vladeck, "The Political Economy of Medicare," *Health Affairs*, Jan/Feb 1999; Commission Transcripts, Aug. 10, 1998.

<sup>20</sup> John Coster, "Medicare Outpatient Prescription Drug Coverage: Issues and Options," (Washington, DC: Alzheimer's Association, January 1997), p. 17.

<sup>21</sup> Timothy Waidman, "Potential Effects of Raising Medicare's Eligibility Age," *Health Affairs*, Vol. 17, no.2, March/April 1998.

<sup>22</sup> AARP, "A Medicare Buy-In: Examining the Costs for Two Populations," Washington, DC, April 1998.

<sup>23</sup> Paul Fronstin, "Features of Employment-Based Health Plans," Issue Brief No. 201, (Washington, DC: Employee Benefits Research Institute, September 1998).

CREDITS

**This report was written by:**

*Kathleen Haddad, Director of Health Policy, Families USA*

**The report was edited by:**

*Peggy Denker, Director of Publications*

**The following Families USA Foundation staff  
contributed to the preparation of this report:**

*Ron Pollack, Executive Director*

*Lorie Slass, Communications Director*

*Judy Waxman, Director of Government Affairs*

*Lisa Swirsky, Health Policy Analyst*

CBO

[Describes the New Way THAT  
TRADITIONAL MEDICARE WOULD  
Be Limited]

## OVERVIEW

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

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

## BACKGROUND

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

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

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

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

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

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

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

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

## THE PROPOSAL

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

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

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

- Medicare would offer beneficiaries a choice of enrolling in a private health plan or a government-run fee-for-service program. The traditional program would receive capitation payments like any other participating plan, and the federal government would refrain from bailing it out even if the program ran into financial difficulties. Moreover, the federal government would regulate the Medicare market without giving preference to the traditional program, thus ensuring a level playing field for all plans. ✱  
assumes that it does
- In order to survive in a competitive environment, the fee-for-service program would be allowed to compete aggressively with private plans. Traditional Medicare would adopt the same tools that private plans use to manage costs. Cost-cutting or revenue-raising strategies might include:
  - Authority to negotiate prices with providers;
  - Exclusive contracting;
  - Restricted provider panels;
  - Increases in premiums and cost-sharing requirements; and
  - Reductions in covered benefits. ←
- The government's contribution would depend on the premium charged by each health plan but would be capped. The maximum premium contribution paid by the government would equal about 88 percent of the national average.
- Under Option I of the proposal, beneficiaries would pay:
  - 10 percent of the total premium for plans with premiums set at 90 percent of the national average or below.
  - Approximately 33 percent of the additional costs for plans with premiums that were between 90 percent and 100 percent of the national average. (Beneficiaries would pay about 12 percent of the premium for plans charging the national average.)

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

(Option II is discussed later in this attachment.)

- Under both options, the premium contributions made by beneficiaries would depend solely on the plan that they chose. People choosing the same plan in different parts of the country would make the same contribution, regardless of the local cost differences. By the same token, plans seeking to serve a particular market would quote a premium to Medicare that reflected their charges for a national average population. *Bones*
- A newly created Medicare Board would oversee the program. It would have greater responsibilities than the Office of Personnel Management (OPM) exercises in its oversight of the FEHBP.
  - The board would negotiate with the private plans regarding their core benefits and the premiums they charged for those benefits. The government's contribution would be based on the national weighted average of those premiums and the premium charged by the traditional fee-for-service program. The board would ensure that the actuarial value of the core benefits varied by no more than 10 percent among plans. //
  - For the purpose of calculating the government's contribution, private plans could include prescription drugs among their core benefits. The costs of dental, vision, and hearing benefits would not be included in the calculation, even though many M+C plans now offer those benefits as an integral part of their coverage. The traditional fee-for-service plan would not offer a drug benefit. //
  - The board would adjust payment amounts to plans to reflect the costs of doing business in different geographic locations. Whether that adjustment would incorporate some of the cost differences that result from differences in the use of health services is unclear. But the proposal's intent is for per capita payments to vary less among plans than they do today.
  - Payments to health plans would be adjusted for risk as well, but the proposal does not specify the form of risk adjustment. CBO has assumed the same course for risk adjustment as

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

### KEY ISSUES REQUIRING CLARIFICATION

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

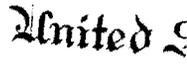
- *The terms on which the traditional fee-for-service program would compete with private plans.* Would the traditional program have to survive on the capitation payments it received, without the possibility of receiving additional federal subsidies were losses to occur? Would it be able to use all of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

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

SENATOR JOHN BREAUX  
LOUISIANA

Jennings

Podesta

United   
WASHING

To: POTUS

From: BreauX

2-10-99

Re: Medicare Commission

- Enclosed is:
- (1) D-C / PPI paper on Premium Support proposal
  - (2.) 2 page Summary of Draft
  - (3.) More Detailed description of Working Document

Daschal suggested that the three of us should meet on this - Chris Jennings has been kept informed - Your 3 appointees are key to what we do - whatever you think I should do now please let me know - Thanks

John

C Jennings  
BreauX

(1)



For Immediate Release:  
Robin Swanson

Contact Information:  
(202) 547-0001

## **BREAUX PROPOSAL TO RESCUE MEDICARE AIMS SQUARELY AT POLITICAL CENTER**

*Without Reform, Medicare Will Go Bankrupt in 2008, Before First Baby Boomer Retires*

WASHINGTON, D.C. -- As the National Bipartisan Commission on the Future of Medicare nears a vote on Senator John Breaux's (D- LA) Medicare reform proposal, the Progressive Policy Institute urges President Clinton to support the initiative and push for a bipartisan consensus in order to avoid Medicare's certain bankruptcy by 2008.

In "Medicare Breakthrough: Senator Breaux's Reform Proposal," PPI Senior Health Care Analyst David Kendall highlights the key components essential to maintaining the solvency of the Medicare program. "Medicare needs a fundamental overhaul for more than fiscal reasons: its benefits are frozen in time," says Kendall.

"Democrats on the Commission who have raised concerns about the Breaux proposal have to make a choice: either improve the Breaux proposal or come up with their own plan," said Kendall commenting on a recent letter to Senator Breaux from all the Democratic members of the commission except Senator Robert Kerrey (D - NE), who supports many elements of the Breaux proposal.

According to the PPI report, the Breaux proposal draws together a wide variety of reforms that harness competitive forces to restrain health care costs while ensuring seniors basic entitlement coverage.

### **PPI highlights three key elements in the Breaux Proposal that would:**

1. Establish a new purchasing system for Medicare modeled on the Federal Employees Health Benefits Program (FEHBP).
2. Target benefits by income, including prescription drugs.
3. Raise the retirement age to be consistent with social security.

- MORE -

### Medicare Breakthrough - Add one

The FEHBP proposal, currently used by almost 10 million federal workers, retirees, and their families, combines a unique blend of government financing and market competition while giving consumers a broad choice of health plans with competitively low prices. Breaux also has proposed a Medicare Board in order to set the ground rules for competition between traditional Medicare and private plans for this initiative.

Another key provision in the Breaux proposal requires higher income beneficiaries to pay more for Medicare coverage, in addition to paying more for high-cost plans. This ensures that low-income beneficiaries would have drug coverage while allowing the consumer to select coverage through a menu of private, competing pharmacy benefit managers in exchange for higher deductibles or premiums.

Finally, by raising the Medicare retirement age consistent with Social Security (from age 65 to 67), the proposal addresses the reality of America's aging population, while providing for the disabled and uninsured.

For more information on the report or to speak David Kendall, please call the Communications Department at (202) 547-0001 or visit our web site at [www.dlcppi.org](http://www.dlcppi.org).

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## Backgrounder

February 1999

# Medicare Breakthrough

## *Senator Breaux's Reform Proposal*

*David B. Kendall*

While Social Security is at the top of the nation's agenda, Medicare poses a more daunting challenge. Unlike Social Security, Medicare will go bankrupt in 2008—before the first baby boomer retires. Without reform, Medicare spending will triple from 2.4 percent to 7.1 percent of gross domestic product and will exceed even Social Security spending by 2030.

Medicare needs a fundamental overhaul for more than fiscal reasons: its benefits are frozen in time. Its 1965 benefit structure does not include prescription drug coverage that is now common among private health plans. And Medicare's eligibility age remains fixed at age 65 while Social Security's eligibility is slowly increasing to age 67.

Rising to this enormous challenge, Senator John Breaux (D-LA), chairman of the National Bipartisan Commission on the Future of Medicare, has offered a breakthrough proposal to the commission. This proposal draws together a wide variety of reforms that would: 1) establish a new purchasing system for Medicare modeled on the Federal Employees Health Benefits Program (FEHBP); 2) target benefits by income including prescription drugs; and 3) raise the retirement age to be consistent with Social Security.

Senator Breaux's proposal aims squarely at the political center, and it follows the "third way" principle of achieving public goals through market means. While it would harness competitive forces to restrain health care costs, it does not go as far as a voucher system that would leave seniors without an entitlement to basic coverage, as Republicans proposed in 1995. It also challenges the assumption of many Democrats that a tax increase is the only appropriate solution to Medicare's fiscal problems. The Breaux plan would help ensure that the baby boomer generation does not take more out of Medicare than it adds to it.

The Medicare commission consists of Chairman Breaux plus 16 members who were appointed by the President and leaders of both political parties in Congress. At this writing, the Breaux proposal has 10 likely votes and needs one more for a super-majority, which is required by statute to prevent a party-line vote. The remaining vote or votes need to come from the four presidential appointees who have not yet declared their position on the Breaux proposal. The Progressive Policy Institute (PPI) urges President Clinton to seize this opportunity to push for a bipartisan agreement that uses the Breaux approach as the basic blueprint for Medicare reform. This backgrounder briefly describes the key features of the Breaux proposal, which are fully described in two previous PPI reports: *Three Principles to Guide the Medicare Debate* and *A New Deal for Medicare and Medicaid: Building a Buyer's Market for Health Care*.

## The FEHBP Model

Nearly 10 million federal workers, retirees, and their families—including members of Congress—have a broad choice of health plans with lower prices than most other health care systems in the country. FEHBP also guarantees that the government's contribution will keep pace with health care costs over time. This unique blend of government financing and market competition makes it a good model for Medicare reform.

In fact, Medicare has already begun to evolve toward the FEHBP model. The Medicare+Choice program enacted in 1997 greatly expanded the range of private plan choices available to beneficiaries. The final step is to bring Medicare's traditional fee-for-service plan into head-to-head competition with private plans.

Under the Breaux proposal, traditional Medicare and private plans would submit their premium prices for a core set of benefits annually so that beneficiaries could make side-by-side comparisons. The government would provide "premium support," a financial contribution that would enable beneficiaries to choose among competing health plans. If beneficiaries chose a low or average cost plan, their premium support would be 88 percent of the premium. Those beneficiaries would pay the same amount as they now pay for Medicare Part B, which covers doctors' bills (currently \$45 a month). Beneficiaries would pay more than 12 percent of their plan's premium only if they chose a higher cost plan.

No one knows whether traditional Medicare or private plans would provide the best value in the long run. Competition is necessary, however, to create the incentive for all types of plans to restrain costs and improve quality. Nonetheless, the Breaux proposal guarantees that coverage for the core benefits will always be affordable. In addition, traditional Medicare would be freed from the political micromanagement that today constrains its operations by dictating prices and contract rules. Finally, Senator Breaux has proposed a Medicare Board that would set the ground rules for competition between traditional Medicare and private plans.

## Benefits Targeted by Income

The Breaux proposal would require higher income beneficiaries to pay more for Medicare coverage in addition to paying more for high cost plans. This reform is not only a progressive alternative to across-the-board benefit cuts, it also blazes a new path for expanding benefits such as prescription drugs.

In the State of the Union address, President Clinton's call for a prescription drug benefit helped raise public awareness about the one-third of Medicare beneficiaries who lack any drug coverage and the millions more who have inadequate coverage. But a broad guarantee of drug coverage could increase Medicare's costs by 10-to-20 percent annually and dramatically exacerbate Medicare's long term financial problems.

Upper income beneficiaries can certainly afford to pay for drug coverage themselves and do so today. The Breaux proposal ensures that all low income beneficiaries would have drug coverage as well. For middle class seniors, the details of a drug benefit have not been worked out, but the government should make sure drug coverage is broadly available without becoming the primary source of financing.

Since most managed care plans would likely offer drug coverage as they do today, beneficiaries remaining in traditional Medicare would need the most help with access to coverage. Traditional Medicare could offer a drug benefit in a non-traditional way. Beneficiaries could select coverage through a menu of private, competing pharmacy benefit managers in exchange for higher deductibles or premiums.

## **A Retirement Age Consistent with Social Security**

Beyond rising health care costs and political pressures to expand benefits, Medicare's social contract is coming undone for the fortunate reason that people are living longer. Medicare (and Social Security) were founded on the principle that the young support the old so that generation after generation has support in their old age. But Medicare's promise of ever-expanding benefits is not sustainable fiscally, politically, or morally.

The double whammy of a greater number of older Americans who will live longer than ever before has already prompted an extension of Social Security's age of eligibility for full benefits from 65 to 67 over a 21-year period. Breaux's proposal would copy that change to Medicare.

An open question is how to prevent the ranks of the uninsured from rising due to an increase in the eligibility age, either because some people age 65 to 67 cannot work due to disability, or if they do work their employer does not provide insurance. Medicare's program for the disabled would help, and its eligibility rules might need to be loosened further. More importantly, workers without job-based coverage regardless of their age should receive a tax credit when they purchase their own coverage. This idea is winning support from members of Congress as diverse as Representative Jim McDermott (D-WA) and Representative Richard Arney (R-TX).

## **Long Term Solvency**

Medicare's fiscal problem is so large that no single solution will solve it. The Breaux proposal will go a long way, but more steps will be needed in the future. That is why the President's proposal to reserve 15 percent of the surplus for Medicare is so important.

The danger, however, is that infusing new funds into Medicare will create unjustified complacency about the need for reform. Or worse, it could create the illusion that a vast reservoir of funding exists for new benefits. The President can readily avert these problems by endorsing the Breaux proposal. Such action could turn out to be decisive in preparing Medicare for the challenges of the 21<sup>st</sup> century.

*David B. Kendall is senior analyst for health policy at the Progressive Policy Institute.*

*Kerry Dobbins, research assistant, provided background material for this report.*

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*For further information about PPI publications, please call the publications department at 800-546-0027, write the Progressive Policy Institute, 600 Pennsylvania Ave., Suite 400, Washington, DC, 20003, or visit PPI's web site at: <http://www.dlcpipi.org>.*

2.

## SUMMARY OF BREAUX WORKING DRAFT

This proposal models Medicare on the Federal Employees Health Benefits Program (FEHBP). The premium support system based on an FEHBP model would allow for a blend of existing government protections and market-based competition.

### PREMIUM SUPPORT

#### *MEDICARE BOARD*

- A Medicare Board would be created to oversee and negotiate with private plans and the government run fee-for-service plan, approve plan service areas, ensure quality standards, approve benefit packages, minimize adverse selection and provide information to beneficiaries.

#### *BENEFITS PACKAGE*

- Medicare beneficiaries could stay in the government-run fee-for-service plan or enroll in a private plan. Regardless of the plan chosen, beneficiaries would be entitled to a core set of Medicare benefits defined by statute, including access to a prescription drug benefit.
- Private plans would be required to offer the same benefits offered in the government-run fee-for-service plan. Plans would have some flexibility on design details, subject to final approval by the Medicare Board.
- Plans could offer additional benefits beyond the core package but the board would be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan should be reformed to modernize cost-sharing. For example: a combined Parts A and B deductible of \$350; 20% coinsurance for everything except hospital stays and preventative care; 10% coinsurance for home health.

#### *GOVERNMENT CONTRIBUTION*

- The government contribution would be based on a percentage of the national weighted average under a national bidding system. Absent an income-related system, beneficiaries would pay 12% towards the premium for plans at the national weighted average. This is roughly equivalent to the share of Medicare costs currently represented by the Part B premium.
- Beneficiaries would pay the incremental costs of choosing more expensive plans. Both the beneficiary and government contribution toward the cost of

## **DRAFT WORKING DOCUMENT**

### **Medicare Commission**

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January 22, 1999 (9:30am) c://breaux/wpwin/mark.2

This document is guided by the statute creating the National Bipartisan Commission on the Future of Medicare and is a product of what the Chairman learned through the process of the Commission's meetings and work over the past year.

As directed by statute, the Commission must address Medicare's financial instability and make recommendations addressing the solvency crisis facing the program. Once Medicare is on firmer fiscal footing, our first priority should be to modernize and rationalize Medicare's benefit package. Using a portion of any budget surplus that materializes to shore up Medicare can help, but it won't solve the problem. Premium or tax increases should not be considered until the Commission addresses the government's ability to meet its commitment to fund Medicare's current benefit package.

One of our early witnesses, Robert Reischauer, expressed the problems facing the Medicare program in terms of the four "i's": insolvency, inadequacy, inefficiency and inequity. In terms of its solvency, there are many indicators of Medicare spending and its projected impact on the budget. For example, Medicare will grow from 12 percent of the federal budget to 28 percent in 2030 under our most optimistic baseline. Medicare's Hospital Insurance (HI) trust fund, which is funded primarily with payroll taxes, will be insolvent beginning in 2008.

The program is inadequate insofar as its benefits package does not reflect modern notions of comprehensive health care coverage and isn't comparable in scope, quality and structure to the health benefits generally available to employed persons and their dependents. The system of government-administered pricing causes inefficiencies in the way health care services are delivered to seniors and providers have little incentive to provide the most cost-effective care. Lastly, the current program is inequitable in that there is no geographically uniform or constant set of benefits. If a beneficiary lives in southern California or Florida, Medicare will pay for prescription drugs or dental benefits if the person joins an HMO. If a beneficiary lives in rural Nebraska, he or she gets nothing approaching such benefits. Additionally, Medicare only covers approximately half of the health care costs of beneficiaries and one survey indicates that the actuarial value of Medicare's benefit package is in the 20th percentile of those of most private employers.

The proposal outlined below, which is based on a premium support model, aims to modernize Medicare's benefit design and correct the four "i's". It will allow beneficiaries to combine in an integrated and comprehensive form all sources of support for their health care coverage while ensuring that Medicare is more efficient and more responsive to beneficiaries needs. It also guarantees low-income protections so that all beneficiaries have meaningful access to quality health care, including the traditional Medicare fee-for-service plan.

These recommendations should be a blueprint for Congress to enact comprehensive legislation to fundamentally restructure Medicare over the next several years. Our nation's health care delivery system is constantly evolving and given the uncertainty of long-term health care spending projections and the advances in medical technology, Medicare will have to be revisited at regular intervals.

## **SUMMARY**

- This proposal would model Medicare on a system patterned after the Federal Employees Health Benefits Program (FEHBP). It would allow for a blend of existing government protections and market-based competition. It would also guarantee financial protection for low-income beneficiaries.
- Medicare's fee-for-service program will operate as part of this new system and HCFA will be given the tools it needs to modernize and compete accordingly.
- This proposal will reform the Medigap program to make it more efficient and to try to minimize the adverse effects of first dollar coverage.
- The eligibility age for Medicare will increase to conform with the eligibility age increase scheduled for Social Security. A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.

## **I. PREMIUM SUPPORT**

### **A. Administrative Structure**

- A Medicare Board will be established to oversee and negotiate with private plans and the government run fee-for-service plan and to approve plan service areas. The board will have authority to ensure financial and quality standards, protect against adverse selection, approve benefit packages, negotiate premiums, compute payments to plans (including risk and geographic adjustment), and provide information to beneficiaries.

### **B. Benefits Package**

- Plans participating in Medicare would be required to offer a standardized core benefit package defined in statute (e.g., hospital, surgical, inpatient, etc.).

Participating plans would have some flexibility on design details (i.e. cost-sharing, copays) but the Medicare Board would have final approval. Private plans participating in premium support will be required to offer benefits at least equivalent to the package offered in the government-run fee-for-service plan.

- Plans can offer additional benefits beyond the core package. Much like the negotiations process between plans and OPM in FEHBP, benefits will be updated through the annual negotiations process between plans and the board. The board will be empowered to ensure that all benefits packages do not vary to the point that they produce ineffective or unfair competition.
- The benefits package in the government-run fee-for-service plan will be revamped by modernizing cost-sharing and by combining the Parts A and B deductibles. One example of a modernized cost-sharing structure would be to have a combined deductible of \$350, charging 20% coinsurance for everything except hospital and preventive care and charging 10% coinsurance for home health.

### **C. Calculating Medicare's Premium**

The government-run fee-for-service plan will bid nationally based on its actual and projected claims costs. Other plans can choose to bid nationally, regionally or in local areas. The Board would oversee the designation of service areas to ensure access in areas that would otherwise have limited plan availability.

- Under an FEHBP system, total Medicare premiums for plans in a given area will be based on a national schedule similar to that used in the FEHBP system. The overall cost of plans will be based directly on their bids and the negotiations process with the Medicare Board.

#### **a) Government's Contribution**

- The government's contribution will be based on a percentage of the national weighted average premium. Based on the cost of the benefits package, the government's contribution will be capped at some point so that beneficiaries pay the incremental costs of choosing more expensive plans. The government's contribution as it is made to the plan that the beneficiary chooses will be adjusted for health risk and other factors.

#### **b) Beneficiary's Contribution**

- The beneficiary's contribution will be based on the cost of the plan chosen with beneficiaries paying a minimum percentage of the premiums based on their income. The government contribution will stop increasing and beneficiaries will pay the full incremental costs for plans above a certain threshold (e.g., 100% of the cost of average plan). Both the beneficiary and government contribution toward the cost of the average plan will rise and fall in the same proportion as the cost of that plan changes from year to year.
- Higher-income Medicare beneficiaries should be required to pay a larger share

of their Medicare premiums than moderate and low-income beneficiaries. Income-related premiums will apply to both private plans and the government-run fee-for-service option.

- Premium support subsidies should be sufficient to ensure that low-income beneficiaries have access to necessary health services and have a meaningful choice of plan options. The revenue generated by income-relating the premium for upper-income beneficiaries will be primarily dedicated to subsidizing premiums for low-income beneficiaries.

## **II. MODERNIZING MEDICARE FEE-FOR-SERVICE**

- The traditional government-run fee-for-service plan will be preserved and improved so that it can compete with private plans and to ensure that it remains a viable, affordable option for all beneficiaries. In accordance with Congressional and Board oversight and approval, the government-run plan will have flexibility to modify its payments rates and its arrangements with contractors as well as offering benefit enhancements if they are financially feasible in a competitive environment.
- The government-run fee-for-service plan will have a premium just like the private plans participating in a premium support system. To enable the government-run fee-for-service plan to compete with private plans in a premium support system, HCFA would be given management tools adopted by the private sector. These reforms include things such as enhanced demonstration authority, flexible purchasing authority, competitive bidding, negotiated pricing authority, selective contracting and preferred provider arrangements.

## **III. MEDIGAP REFORM**

- In order to keep fee-for-service costs affordable, Medigap should be reformed to minimize the effects of first-dollar coverage on utilization and so that the price of Medigap policies reflect their true cost.

## **IV. MISCELLANEOUS**

- Medicare's eligibility age will be gradually increased to match the Social Security retirement age. It is also recommended that Social Security and Medicare be reformed in conjunction with each other because of the interrelated effects of these programs on the retirement security of older Americans.
- A proposal to allow seniors with delayed eligibility to participate in Medicare will be established but the exact details are to be determined.
- Graduate Medical Education: Payments for Direct Medical Education (DME) would be carved out of the Medicare program--financed and distributed

independent of a premium support system. The Chairman assumes that federal support for DME would continue through either a mandatory or discretionary appropriations program. Since the funding source would shift from the HI payroll tax to general revenue, the Chairman believes that it is appropriate to include institutions not currently eligible for Medicare GME support that conduct approved residency programs, such as free-standing children's hospitals. Similarly, the long-term solution for indirect medical education (IME) may involve a carve-out from Medicare. For now, however, the Chairman believes that the Medicare program should continue to pay for differences in costs between teaching and non-teaching hospitals through the indirect medical education (IME) adjustment. However, the Chairman recognizes that the level of the Medicare IME adjustment may need to be aligned gradually over several years with what analyses show is the actual statistical difference between teaching and non-teaching hospital costs. The Chairman believes that Disproportionate-Share Hospital (DSH) payments and other subsidies within the Medicare program should be revisited to ensure that Medicare's support is reasonable and appropriate. The Chairman notes that these subsidies could be carved out of the Medicare program and financed through a mandatory or discretionary appropriation program. However, the Chairman recognizes that any changes in federal support should continue to recognize the additional costs to hospitals of treating large numbers of low-income individuals.

## **V. REVENUE AND FINANCING**

- The primary source of income to the Hospital Insurance (HI) trust fund is the payroll tax. The 2.9 percent tax on all earned income accounts for 88.3 percent of the total \$121.1 billion in income in 1996. Additional income sources include premiums paid by voluntary enrollees, government credits, interest on Federal securities, and taxation of a portion of Social Security benefits.
- The Supplementary Medical Insurance (SMI) trust fund is financed from premiums paid by the users of Part B and from general revenues. When the program first went into effect in July 1966, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Premiums over time dropped to 25% of program costs because Part B costs increased much faster than the inflation computation that was used to compute the upward premium adjustment.
- Under current law, the proportion of financing sources are expected to change over time, with the portion represented by payroll taxes decreasing and the portion represented by general revenue increasing. By 2030, premiums and payroll taxes are expected to fund only 31-35 percent of Medicare's

expenditures compared to 63 percent in 1997. In 2030, 64-70 percent of Medicare will be funded through general revenue (or other funding) as compared to approximately 37 percent in 1997.

- The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms will result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and will enhance our ability to stand by our commitment to today's and future beneficiaries. Even if projected budget surpluses materialize, without these changes, significantly greater revenues and/or beneficiary sacrifices will be required in the future and beneficiaries will not receive the greatest value for the total health dollars spent on their behalf.

## **VI. AREAS THAT NEED RESOLUTION**

- DRUGS--open issue--the Chairman is exploring several options for including a prescription drug coverage.
- Changes to provider payments

## **VII. ALTERNATIVE DESIGN OPTIONS**

The following are examples of elements of a premium support system that could be changed to arrive at a different model than the one described above.

- National vs. Regional Bidding: Under a national bidding structure, a geographic adjuster is necessary to create a fair and equitable system. A geographic adjuster would also address the fact that Medicare spending varies by a factor of more than three across regions with seemingly similar populations and with no demonstrable differences in health outcomes. Under a national schedule, national plans such as the government-run fee-for-service could compete in a straightforward and fair way. Beneficiaries in national plans would pay the same amount regardless of where they lived. Under a regional bidding system, a geographic adjuster would not be required but some provision would have to be made to allow fair competition between local and national plans such as fee-for-service and to prevent regional inequities in beneficiary premiums.
- Benefits Package: Plans would be required to offer and compete on a core benefits package. Unlike the model described above, additional benefits could only be offered in a supplemental plan that would have to be sold and marketed separately from the core package. This would ensure that plans compete on the basis of cost and quality, not on the basis of the benefits offered.



## BIPARTISAN COMMISSION ON ENTITLEMENT AND TAX REFORM

The Honorable William J. Clinton  
The White House  
Washington, DC

mark Weinberger  
re: Kerry Commission

Dear Mr. President:

When you created the Bipartisan Commission on Entitlement and Tax Reform, you charged us with addressing perhaps the most challenging fiscal issues facing this country. Left unchecked, the Federal government's long-term spending commitments on entitlement programs and will lead to excessively high deficit and debt levels, unfairly burdening America's children and stifling standards of living for this and future generations of Americans. The problem, however, is not simply one of numbers. In addition to demographic problems created by the aging of America's population, we are also faced with human problems caused by the increasing inadequacy of Federal health care and retirement programs.

The Commission was not formed to "sugar coat" the issues or provide easy but dishonest answers. Rather, it was created to frame the long-term issue, educate the American people and policy leaders about the problem and potential choices, and make specific recommendations on how to bring our future entitlement commitments and revenues into balance.

On August 8, 1994, the Commission adopted by a 30-to-1 vote an Interim Report that graphically lays out the economic and social future the country faces if action is not taken. It is a stark call to action, alerting Americans about the burden that is being shifted to future generations, about the deteriorating national savings rate, the squeezing out of public funds for essential and appropriate government investment, and the impending insolvency of both the Social Security and Medicare Trust Funds. The Commission echoed the urging of the Trustees of two of our most successful support programs — Medicare and Social Security — by calling for action that would result in their continued solvency for this and future generations of Americans. The issue has been framed.

Educating the American public is the second essential step to a successful reform effort. With public education, people will have an unprecedented opportunity to participate in the problemsolving process. A person with any ideological orientation can solve the problem, provided that we — as a Nation — acknowledge it exists.

Bipartisan Commission on Entitlement and Tax Reform

The Commission has taken its public education obligation very seriously. All Commission hearings and meetings were carried on C-SPAN. Our meetings and hearings were aimed at defining the problem in a way that the American people could understand and evaluate. In addition, Commission charts and materials were used by Commission members, and other Members of Congress, on the House and Senate floors and in town meetings.

The Commission has published materials designed to stimulate debate about the future of Federal entitlement programs, and to help the public better understand options for reform. The Commission has published an Interim Report and a Final Report. The Reports are short and graphic. By presenting the information in a short and understandable manner, the Commission sought the broadest base of readership for the Reports.

The Commission Staff created "Budget Shadows," a user-friendly interactive computer model that lets the American people see the fiscal future and design different policies to alter it. The Commission has given the public access to the computer model by placing it on numerous on-line computer networks as well as preparing diskettes for those who do not have access to these services. While the computer model is not meant to be an exhaustive list of policy options, it provides the user with more than 50 choices and lets him or her see the range of potential solutions and the tradeoffs that must be evaluated. The model went one step beyond problem identification and invited the American people to join the debate on potential solutions.

The Commission Staff has also prepared "Crossroads," a CD-ROM available to the American public starting in January — that contains a comprehensive database of Commission documents, transcripts and reports. Finally, the Commission Staff prepared a report containing more than 50 options (most with numerous variations) compiled from Commission member suggestions, government, and other sources. All of these tools should be useful in furthering the public debate.

In the end, the Commission was unable to settle on a specific set of recommendations on how to combat the issue it framed in the Interim Report. That should not be surprising in an environment where political leaders in both parties are focusing more on short-term initiatives than the long-term, politically sensitive economic and social issues that sit on the horizon.

But there is encouraging news. Before this Commission began, entitlement reform was a hollow concept. The Commission fostered a shift in the entitlement reform debate. By the end of the Commission's tenure, members were openly speaking about the need for reform and the magnitude of the economic and social consequences we face as a Nation if action is not taken. In this Final Report, we are forwarding to you many recommendations for reform submitted by various Commission members. You will find that many of the individual proposals are common to more than one reform plan. The debate now centers on the best means for reform. The sea change in the debate has been important. There is no turning back.

The Commission voted 24 to 6 to recommend broad principles to be used when crafting solutions to our fiscal problems. *First*, reform of our tax and spending programs should be made with reference to a time period longer than the traditional five-year budget window, such as the 30-year timeframe relied upon in the Commission's Interim Report. This will not only enable future beneficiaries to plan for program changes, but will also provide for informed debate and decisions with less reliance on gimmicky that so often plays a role in five-year budget plans. *Second*, current laws must be changed to create a future in which we balance our entitlement commitments and the funds available to honor those promises. This is important for generational equity. *Third*, we must empower the American people to participate in developing satisfactory solutions. Washington does not have all of the answers and unless the public participates, reform will not take place until more dramatic solutions are required. *Fourth*, the Administration and Congress should consider reform of the tax system. *Fifth*, the Commission, in this Final Report, restates its plea for *immediate* action on reform.

**iv** We strongly believe that the Commission's work is the beginning of the process. While the road to reform may be difficult, we are embarked on a course of hope and promise. Our solutions can embrace the notions we cherish as a people: we are self-reliant; we welcome responsibility and accountability; and we are eager to ensure greater opportunities and better lives for our children.

We thank you for establishing this Commission and thank the Commission members for their dedicated commitment. We look forward to working with you and Congress in guiding a course for a sound and prosperous future for all Americans.

Respectfully,



J. Robert Kerrey  
Chairman



John C. Danforth  
Vice-Chairman



## BIPARTISAN COMMISSION ON ENTITLEMENT AND TAX REFORM

Dear Mr. President:

The Bipartisan Commission on Entitlement and Tax Reform concluded in its Interim Report that:

*... the government must act now. A bipartisan coalition of Congress, led by the President, must resolve the long-term imbalance between the government's entitlement promises and the funds it will have available to pay for them.*

According to our Report, we acquire false optimism when we look only five years ahead, as we do with our traditional budgeting process. Only when we look at the next 30 years — the horizon of our children — does the problem and its size come into full view.

The future impact of current law is described in the chart that follows this letter. It is clear from this chart why we are lulled into complacency. Life looks good for the next five years. However, the next 30 years is a period of significant increases in entitlement costs plus net interest. Two crucial moments conspire to make our lives miserable.

The first moment is the year 2001 when the Medicare Hospital Insurance program (currently funded with a 2.9 percent payroll tax) becomes insolvent. Rapidly rising health care costs and longer life-spans combine to make our policy choices very difficult.

The hard fact is that we must confront the inexorable laws of arithmetic and demographics. As important as it is to identify and eliminate waste, fraud, and abuse, and as vital as it is for reform to begin with congressional and government programs, our principal challenge is the good news that we are living longer. We are an aging population.

This condition becomes painfully evident when we arrive at the second crucial moment. In 2008, the first of the Baby Boom generation — Americans who are now 48 years old — will begin to retire. In a single decade, while our overall population increases by 2 percent, our retired population will increase nearly 30 percent. Thus, in a single decade, the ratio of the number of Americans working versus Americans retired will be cut by 40 percent, from 5:1 to 3:1.

While this situation may have relatively little impact on Americans over the age of 48, it may have considerable impact on younger Americans. Specifically, if we delay action now, the choices will be higher taxes for Americans still in the workforce or larger benefit reductions for retirees.

Thus, the first and most important of our recommendations is that our major spending and tax decisions should be made with reference to a time period longer than the traditional five-year budget window, such as the 30-year timeframe relied on in the Commission's Interim Report (or a 10- or 20-year period when available data does not allow use of a 30-year timeframe), so that appropriate planning is incorporated in budget decisions. When discretionary spending was the largest share of our budget, short-term planning may have been appropriate. However, today we are in the business of operating the world's largest social insurance programs, and their costs are expected to exceed their revenues substantially over coming decades.

The Commission's Interim Report has established that the projected imbalance between spending and revenues — particularly with regard to health care and retirement entitlement programs — will, together with interest on the Federal debt, undermine America's capacity to make appropriate investments in the well-being of our citizens and undertake other essential government functions, such as national defense.

**2**

Our second recommendation is that we change our current laws to create a future in which we balance our entitlement commitments and the funds available to honor those promises. We must restore balance to our Social Security Trust Fund and strengthen the confidence of all Americans that Social Security will endure on a sound footing.

To be clear, this Commission could not reach agreement on the details of a plan to achieve our objective. Nonetheless, those of us who are prepared to recommend partial or complete solutions have included our proposals in this Report.

Our third recommendation is that we empower the American people to participate in developing satisfactory solutions. To that end, we believe the computer program produced by this Commission should be maintained and improved by the Office of Management and Budget and/or the Congressional Budget Office. The program can be part of the public education process and help us honestly and calmly assess the options that affect our economic future.

This Report contains the numerous policy options which the Commission staff has developed, none of which have been specifically endorsed by the Commission as a whole. While the list is by no means all inclusive, it makes clear that few easy and popular decisions are available to the American people. That is where leadership is so urgently needed. We must describe the future that current law dictates so that Americans will know why tough action is needed sooner rather than later. And, we must describe the alternative future as well as the benefits that will accrue to all Americans.

Eliminating this long-term problem will go a long way towards balancing our budget. It also will help stabilize our currency and preserve a low inflation-high growth economy which lifts the American standard of living.

Report of the Commission on Entitlement and Tax Reform

The Commission believes there is a window of opportunity for policymakers to enact reforms now. Acting sooner rather than later enables us to protect current beneficiaries from financial hardship and allow future beneficiaries to take steps to offset the effects of any changes.

On the question of tax reform, the Commission heard criticism of the structure of the current tax system. This is a topic that has been getting increased attention. The Commission recommends that the Administration and Congress consider reform of the tax system.

While this Commission does not endorse detailed recommendations — our most ambitious goal — this Final Report forwards many solutions to be considered in addressing the problem and underscores the need for immediate action.

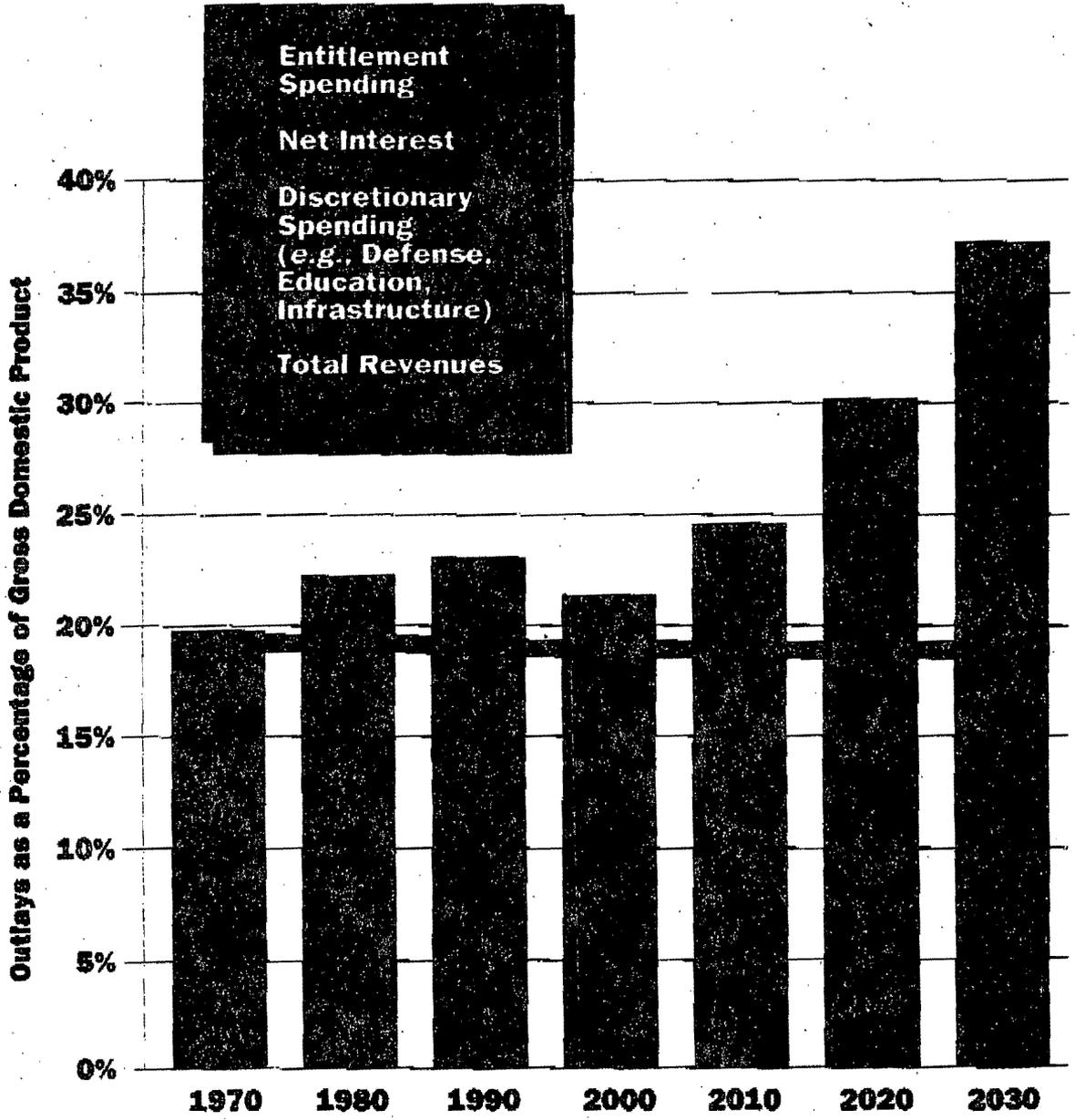
Respectfully,

|                     |                    |                     |
|---------------------|--------------------|---------------------|
| Dale Sampson        | Sandra W. Freedman | J. Amherst          |
| Michael R. Luttrell | Porter Soss        | Carol Kennedy Brown |
| Phad Cochran        | W. J. [Signature]  | Peter Y. Piletski   |
| Chris Cox           | Robert [Signature] | Harold [Signature]  |
| David [Signature]   | John Gray          | Ray Storer          |
| B. deBorja          | Karen N. Hain      | Alan [Signature]    |
| Robert E. Dunham    | W. H. Keen         | A. Simpson          |
| D. [Signature]      | E. [Signature]     | Melinda [Signature] |

**THE PRESENT TREND IS NOT SUSTAINABLE**

The gap between Federal spending and revenues is growing rapidly. Absent policy changes, entitlement spending and interest on the national debt will consume almost all Federal revenues in 2010. In 2030, Federal revenues will not even cover entitlement spending.

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|---|--|
| <b>BIPARTISAN COMMISSION ON ENTITLEMENT AND TAX REFORM<br/>aka Kerrey-Danforth Commission</b> | Established by President Clinton by Executive Order 12878, November 5, 1993.   |
| <b>Membership</b>   | 32 Members: Ten from House (5 Dem./5 Repub.); Twelve from Senate (6 Dem./6 Repub.); Ten from public or private sector.   |
| <b>Functions</b>  | Recommend potential long-term budget savings measures involving: 1) revisions to statutory entitlement and other mandatory programs; and (2) alternative tax reform proposals.   |
| <b>Staff</b>  | 27 members. Funded by HHS. No staff from HHS or other agencies. Most staff came from private sector or were ex-congressional staff.  |
| <b>Time Frame</b>   | Began early 1994. Final report was originally due 6 months after establishment but was extended to one year after establishment.   |
| <b>Meetings</b>   | Approximately 6 hearings, all in Washington, DC, and televised on C-Span. 2 mark-ups, one for interim and one for final report, also televised on C-Span.  |
| <b>Reports</b>  | Published an interim and a final report. Final report was published in January 1995, but did not include any recommendations supported by the entire commission. Also created "Budget Shadows", an interactive computer simulation, and "Crossroads", a CD-Rom with all of the Commission documents. |
| <b>Result</b>   | None. Commission could not agree on final recommendations, so various commissioners outlined their proposals. Final Report includes a multitude of ideas for changes. None have been acted upon.   |

**Membership of Bipartisan Commission on Entitlement and Tax Reform:**

**U.S. Senators**

**J. Robert Kerrey, Chairman. (D-NE)**  
**John C. Danforth, Vice-Chairman. (R-MO), Finance Committee**  
**Dale Bumpers (D-AR)**  
**Thad Cochran (R-MS)**  
**Pete Domenici (R-NM), ranking minority of Budget Committee**  
**Judd Gregg (R-NH), Budget Committee**  
**Carol Moseley-Braun (D-IL)**  
**Daniel Patrick Moynihan (D-NY), Chairman of Finance Committee**  
**Harry Reid (D-NV)**  
**Jim Sasser (D-TN)**  
**Alan K. Simpson (R-WY), Finance Committee**  
**Malcolm Wallop (R-WY)**

**U.S. Representatives**

**Bill Archer (R-TX), ranking minority of Ways and Means Committee.**  
**Michael N. Castle (R-DE)**  
**Eva M. Clayton (D-NC)**  
**Christopher Cox (R-CA), Commerce Committee**  
**E. (Kika) de la Garza (D-TX)**  
**John D. Dingell (D-MI), Chairman, Commerce Committee**  
**Porter J. Goss (R-FL)**  
**J. Alex McMillan (R-NC)**  
**Dan Rostenkowski (D-IL), Chairman, Ways and Means Committee**  
**Martin O. Sabo (D-MN), Chairman, Budget Committee**

**Private Sector Representatives**

**Thomas J. Downey, Thomas J. Downey & Associates, Inc.**  
**Sandra W. Freedman, Mayor, city of Tampa, FL.**  
**William H. Gray, III, President and CEO, United Negro College Fund**  
**Robert Greenstein, Center on Budget and Policy Priorities**  
**Karen N. Horn, Chairman and CEO, Bank One Cleveland**  
**Thomas H. Kean, President, Drew University**  
**Peter G. Peterson, Chairman of the Blackstone Group**  
**Roy Romer, Governor, State of Colorado**  
**Richard L. Trumka, President, United Mine Workers of America**



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OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 6

Date: 11/4/96

|                      |                          |
|----------------------|--------------------------|
| To:                  | From:                    |
| <u>Chris</u>         | <u>Debbie</u>            |
| Fax: <u>456-5542</u> | Fax: <u>202 690-8168</u> |
| Phone: _____         | Phone: _____             |

REMARKS: Medicare Trust Fund Commercial File

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**HEALTH CARE FINANCING ADMINISTRATION**  
 200 Independence Ave., SW  
 Room 341-H, Humphrey Building  
 Washington, DC 20201

*Dec. 16 / Administration of Ronald Reagan, 1981*

## National Commission on Social Security Reform

*Executive Order 12335.  
December 16, 1981*

By the authority vested in me as President by the Constitution of the United States of America, and to establish, in accordance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. App. I), the National Commission on Social Security Reform, it is hereby ordered as follows:

**Section 1. Establishment.** (a) There is established the National Commission on Social Security Reform. The Commission shall be composed of fifteen members appointed or designated by the President and selected as follows:

(1) Five members selected by the President from among officers or employees of the Executive Branch, private citizens of the United States, or both. Not more than three of the members selected by the President shall be members of the same political party;

(2) Five members selected by the Majority Leader of the Senate from among members of the Senate, private citizens of the United States, or both. Not more than three of the members selected by the Majority Leader shall be members of the same political party;

(3) Five members selected by the Speaker of the House of Representatives from among members of the House, private citizens of the United States, or both. Not more than three of the members selected by the Speaker shall be members of the same political party.

(b) The President shall designate a Chairman from among the members of the Commission.

**Sec. 2. Functions.** (a) The Commission shall review relevant analyses of the current and long-term financial condition of the Social Security trust funds; identify problems that may threaten the long-term solvency of such funds; analyze potential solutions to such problems that will both assure the financial integrity of the Social Security System and the provision of appropriate benefits; and provide appropriate recommendations to the Secretary of Health and

Human Services, the President, and the Congress.

(b) The Commission shall make its report to the President by December 31, 1982.

**Sec. 3. Administration.** (a) The heads of Executive agencies shall, to the extent permitted by law, provide the Commission such information as it may require for the purpose of carrying out its functions.

(b) Members of the Commission shall serve without any additional compensation for their work on the Commission. However, members appointed from among private citizens of the United States may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the government service (5 U.S.C. 5701-5707), to the extent funds are available therefor.

(c) The Commission shall have a staff headed by an Executive Director. Any expenses of the Commission shall be paid from such funds as may be available to the Secretary of Health and Human Services.

**Sec. 4. General.** (a) Notwithstanding any other Executive Order, the responsibilities of the President under the Federal Advisory Committee Act, as amended, except that of reporting annually to the Congress, which are applicable to the Commission, shall be performed by the Secretary of Health and Human Services in accordance with the guidelines and procedures established by the Administrator of General Services.

(b) The Commission shall terminate thirty days after submitting its report.

Ronald Reagan

The White House,  
December 16, 1981.

[Filed with the Office of the Federal Register, 2:22 p.m., December 16, 1981]

## National Commission on Social Security Reform

*Appointment of the Membership.  
December 16, 1981*

The President today announced his intention to appoint/designate the following indi-

viduals to serve on a 15-member bipartisan National Commission on Social Security Reform. Alan Greenspan will serve as Chairman.

Establishment of the Commission fulfills a pledge made by the President in September to create a bipartisan task force to work with the President and Congress to reach two specific goals:

- To propose realistic, long-term reforms to put social security back on a sound financial footing, and
- To forge a working, bipartisan consensus so that the necessary reforms can be passed into law.

**Robert A. Beck**, chairman of the board and chief executive officer, Prudential Insurance Co. of America, Newark, N.J. He is a member of the President's Export Council.

**Mary Falvey Fuller**, vice president, finance, Shaklee Corp., San Francisco, Calif. Previously she was senior vice president and director, Blyth Eastman Dillon & Co., Inc., New York, N.Y.

**Alan Greenspan**, chairman and president, Townsend-Greenspan and Co., Inc., New York, N.Y. He is a member of the President's Economic Policy Advisory Board.

**Alexander B. Trowbridge**, president, National Association of Manufacturers, Washington, D.C. He is a member of the President's Task Force on Private Sector Initiatives.

**Joe D. Waggoner, Jr.**, consultant, Bossier Bank & Trust Co., Plain Dealing, La. He represented the Fourth Congressional District of Louisiana during the 87th to 95th Congresses.

Senate Majority Leader Howard Baker, in consultation with Senate Minority Leader Robert Byrd, selected the following individuals to serve on the Commission:

**William Armstrong**, United States Senate (R-Colo.), chairman of the Subcommittee on Social Security of the Senate Finance Committee.

**Robert Dole**, United States Senate (R-Kans.), chairman of the Senate Finance Committee.

**John Heinz**, United States Senate (R-Pa.), chairman of the Senate Special Committee on Aging.

**Lane Kirkland**, president of the American Federation of Labor-Congress of Industrial Organizations.

**Daniel Patrick Moynihan**, United States Senate (D-N.Y.), ranking minority member of the Subcommittee on Social Security of the Senate Finance Committee.

House Speaker Thomas P. O'Neill, in consultation with House Minority Leader Robert Michel, selected the following individuals to serve on the Commission:

**William Archer**, United States House of Representatives (R-Tex.), ranking minority member of the Subcommittee on Social Security, House Ways and Means Committee.

**Robert M. Ball**, was Commissioner of Social Security in 1962-73. He is senior scholar, Institute of Medicine, National Academy of Sciences.

**Barber Conable**, United States House of Representatives (R-N.Y.), ranking minority member, House Ways and Means Committee.

**Martha E. Keys**, former Assistant Secretary of Health and Human Services. She served in the 94th and 95th Congresses.

**Claude D. Pepper**, United States House of Representatives (D-Fla.), chairman, House Select Committee on Aging.

**S6082**

**CONGRESSIONAL RECORD — SENATE**

June 11, 1996

the wing's first Air Force inspection in July, 1995, the first ever for a composite wing and the largest in Air Force history; and

"Whereas, the opening of a training range near Mountain Home Air Force Base is essential to maintain the readiness and strike force capabilities of this unique military asset:

Now, therefore, be it "Resolved, by the members of the Second Regular Session of the Fifty-third Idaho Legislature, the House of Representatives and the Senate concurring therein, That we urge the Congress of the United States to pass necessary legislation to establish and fund the training range at the Mountain Home Air Force Base, Idaho.

"Be it further resolved, That the Chief Clerk of the House of Representatives be, and she is hereby authorized and directed to forward a copy of this Memorial to the President of the Senate and the Speaker of the House of Representatives of Congress, and the congressional delegation representing the State of Idaho in the Congress of the United States."

POM-579. A joint resolution adopted by the Legislature of the State of Alaska, to the Committee on Commerce, Science, and Transportation.

**"RESOLVE No. 39**

"Whereas more fish were discarded in the federally managed fisheries of the North Pacific Ocean than were landed by American fishermen in the North Atlantic Ocean in 1992; and

"Whereas, in 1994, 25,881,596 kilograms of halibut and 1,868,272 kilograms of herring were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 15,459,253 crab were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

"Whereas, in 1994, 195,609 salmon were harvested in groundfish fisheries of the North Pacific Ocean and the Bering Sea; and

"Whereas these discarded herring, crab, and salmon are resources managed by the State of Alaska that were intercepted in off-shore federal waters; and

"Whereas these resources are the economic and cultural lifefood for many Alaskans who depend on the sea for their livelihoods and subsistence; and

"Whereas marine wildlife species in Alaska marine waters that depend on fish for food are faced with declining populations and a potential for becoming endangered species; and

"Whereas the continued wanton waste undermines and hampers term management strategy for sustaining commercial subsistence, and recreational fisheries, and places the rural communities of Alaska at risk; and

"Whereas it is necessary to implement severe penalties against vessels responsible for high bycatch and discard rates have failed; and

"Whereas minimizing the catch of undersized fish and reducing wanton waste will conserve fisheries resources for present and future generations of subsistence users, commercial and recreational fishermen, seafood industries, coastal communities, consumers, and the nation; and

"Whereas fisheries can technically or operationally reduce waste and the incidental taking of nontarget species if given economic incentives or if appropriate regulatory measures are applied; be it

"Resolved, by the Alaska State Legislature That the wanton waste now occurring in federal fisheries of the North Pacific Ocean and the Bering Sea is of utmost ecological, social, and economical importance; and be it

"Further resolved, That the Alaska State Legislature respectfully urges the Congress to amend the Magnuson Fishery Conserva-

tion and Management Act, or to enact other legislation, encompassing a broad range of measures to reduce wanton waste in North Pacific Ocean and Bering Sea fisheries, including harvest priority incentives for clean fishing practices and other management tools."

**REPORTS OF COMMITTEES**

The following reports of committees were submitted:

By Mr. SPECTER, from the Select Committee on Intelligence, with amendments:

S. 1745. An original bill to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes (Rept. No. 104-278).

By Mr. STEVENS, from the Committee on Governmental Affairs, without amendment:

S. 1488. A bill to convert certain excepted service positions in the United States Fire Administration to competitive service positions, and for other purposes.

**INTRODUCTION OF BILLS AND JOINT RESOLUTIONS**

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

By Mr. GRAHAM (for himself, Mr. BAUCUS, and Mr. FRYOR):

S. 1858. A bill to provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse; to the Committee on Finance.

By Mr. GRAHAM (for himself and Mr. BAUCUS):

S. 1859. A bill to create a point of order against legislation which diverts savings achieved through medicare waste, fraud, and abuse enforcement activities for purposes other than improving the solvency of the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act, to ensure the integrity of such trust fund, and for other purposes; to the Committee on Rules and Administration.

By Mr. MCCONNELL (for himself, Mr. DOLE, Mr. MOYNIHAN, and Mr. LIEBERMAN):

S. 1860. A bill to provide for legal reform and consumer compensation relating to motor vehicle tort systems, and for other purposes; to the Committee on Commerce, Science, and Transportation.

S. 1861. A bill to provide for legal reform and consumer compensation, and for other purposes; to the Committee on the Judiciary.

By Mr. PRESSLER (for himself and Mr. HATCH):

S. 1862. A bill to permit the interstate distribution of state-inspected meat under ap-

propriate circumstances; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DASCHLE:

S. 1863. A bill to require the Secretary of the Army to acquire-permanent flowage and saturation easements over land that is located within the 10-year floodplain of the James River, South Dakota, and for other purposes; to the Committee on Environment and Public Works.

**SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS**

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. NICKLES (for himself, Mr. DASCHLE, Mr. LOTT, Mr. FORD, Mr. THURMOND, Mrs. KASSEBAUM, Mr. ABRAHAM, Mr. AKAKA, Mr. ASHCROFT, Mr. BAUCUS, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BRADLEY, Mr. BREAUX, Mr. BROWN, Mr. BRYAN, Mr. BUMPERS, Mr. BURNS, Mr. BYRD, Mr. CAMPBELL, Mr. CHAFFEE, Mr. COATS, Mr. COCHRAN, Mr. COHEN, Mr. CONRAD, Mr. COVERDELL, Mr. CRAIG, Mr. D'AMATO, Mr. DEWINE, Mr. DODD, Mr. DOMENICI, Mr. DORGAN, Mr. EXON, Mr. FAIRCLOTH, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRIST, Mr. GLENN, Mr. GORTON, Mr. GRAHAM, Mr. GRAMM, Mr. GRAMS, Mr. GRASSLEY, Mr. GREGG, Mr. HARKIN, Mr. HATCH, Mr. HATFIELD, Mr. HEFLIN, Mr. HELMS, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUE, Mr. JEFFORDS, Mr. JOHNSTON, Mr. KEMPTHORNE, Mr. KENNEDY, Mr. KERREY, Mr. KERRY, Mr. KOHL, Mr. KYL, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mr. LUGAR, Mr. MACK, Mr. MCCAIN, Mr. MCCONNELL, Mr. MIKULSKI, Mrs. MOSELEY-BRAUN, Mr. MOYNIHAN, Mr. MURKOWSKI, Mrs. MURRAY, Mr. NUNN, Mr. PELL, Mr. PRESSLER, Mr. PRYOR, Mr. RED, Mr. ROBB, Mr. ROCKEFELLER, Mr. ROTH, Mr. SANTORUM, Mr. SARBANES, Mr. SHELBY, Mr. SIMON, Mr. SIMPSON, Mr. SMITH, Mr. SNOWE, Mr. SPECTER, Mr. STEVENS, Mr. THOMAS, Mr. THOMPSON, Mr. WARNER, Mr. WELLSTONE, and Mr. WYDEN):

S. Res. 258. A resolution to designate the balcony adjacent to rooms S-230 and S-231 of the United States Capitol Building as the "Robert J. Dole Balcony"; considered and agreed to.

**STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS**

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

**THE MEDICARE RESTORATION ACT**

Mr. DOLE, Mr. President, last Wednesday the Medicare trustees released their report on the state of the Medicare trust fund, and the report was grim. Instead of going bankrupt in 2002, as they previously forecasted, the

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Trustees conclude that Medicare will go bankrupt in 2001—just 5 years from now.

For the past year and a half, this Republican Congress has attempted to deal honestly and forthrightly with the impending Medicare meltdown.

We put forward a budget that would protect, preserve, and strengthen Medicare by reducing its unsustainable rate of growth, while still allowing for a healthy growth rate.

We did not claim that our plan was perfect or that it solved the long-term problem. But it was a real attempt to alleviate a crisis that will immediately impact 37 million seniors and disabled Americans, and will have repercussions on tens of millions more.

In May 1995, I called for a bipartisan Commission to be set up to save Medicare similar to the one that saved Social Security. Unfortunately the White House dismissed the idea and decided to attack Republican plans to save the Medicare system.

That is why I rise today to introduce the Medicare Restoration Act to establish a blue-ribbon bipartisan advisory commission to help deal with this crisis.

In my view, leadership means more than just talking about problems. It also means doing something to solve them.

This Commission will be responsible for reviewing the current, short-term and long-term condition of the Medicare Trust funds. The Commission will be composed of 15 members appointed by the President, Senate, and House of Representatives. The members of this Commission will be from both political parties, because it is clear to me that if we are to be successful we must put politics aside and work on a bipartisan basis.

Unfortunately, President Clinton has been unwilling to do that.

In February 1995, President Clinton submitted a budget that contained no provisions for saving Medicare.

In April 1995, the Medicare trustees—three of whom are members of his Administration—issued their original report and urged "prompt, effective and decisive action." The administration instead chose to attack Republican plans to save the system.

Last March, the President submitted a budget which, according to the Congressional Budget Office, would only delay off Medicare's bankruptcy for one more year.

It is an undeniable fact that the Republican proposal allowed Medicare spending per beneficiary to increase from \$4,800 per person to \$7,200 per person over 7 years.

It is also an undeniable fact that in his ill-fated health care reform program, the Clinton administration advocated allowing Medicare's rate of growth.

Despite these facts, however, the President vetoed our Medicare program, and we have heard nothing but attacks on Republicans for slashing and cutting Medicare.

And when the President was asked, not long ago at a news conference, why he continued to use these terms even though they are not true, his response was essentially that the media made him do it.

With the release of the trustee's report, the inescapable conclusion is that while the rhetoric flew, Medicare was put at further risk.

And those who say that talk is cheap should know that 18 months of misleading rhetoric may have gained one side points in the opinion polls, it also put Medicare another \$90 billion-plus in the red.

The bottom line is that the 37 million Americans who depend on Medicare deserve better. Future generations of Americans who will need Medicare deserve better.

I call on the President to come forward and support this bipartisan commission so we can preserve the Medicare Program and to join with Republicans on a bipartisan basis, as I have proposed before, to address this very serious problem.

I send the bill to the desk and ask it be appropriately referred. It is cosponsored by Senators ROTH, SIMPSON, PRESSLER, HATCH, CHAFEE, and MURKOWSKI, who are on the Senate Finance Committee. I certainly welcome additional cosponsors on either side of the aisle. This will be a bipartisan commission.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1856

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Medicare Restoration Act of 1996"

**SEC. 2. ESTABLISHMENT.**

There is established a commission to be known as the National Commission on Medicare Reform (referred to in this Act as the "Commission").

**SEC. 3. FINDINGS.**

- The Congress finds that—
- (1) the Medicare program under title XVIII of the Social Security Act provides essential health care insurance to this Nation's senior citizens and to individuals with disabilities;
  - (2) the Federal Hospital Insurance Trust Fund will be bankrupt in the year 2001, and faces even greater solvency problems in the long-run with the aging of the baby boom generation;
  - (3) the trustees of the trust funds of the Medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund is unsustainable; and
  - (4) expeditious action is needed in order to restore the fiscal health of the Medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

**SEC. 4. DUTIES OF THE COMMISSION.**

- The Commission shall—
- (1) review relevant analyses of the current, short-term, and long-term financial condition of the Federal Hospital Insurance Trust

Fund and the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act;

- (2) identify problems that threaten the solvency of such trust funds;
- (3) analyze potential solutions to such problems that will both assure the financial integrity of the Medicare program under such title and the provision of appropriate benefits under such program;
- (4) make recommendations to restore the short-range and long-range solvency of the Federal Hospital Insurance Trust Fund, to provide for sustainable growth of the Supplementary Medical Insurance Trust Fund, and on related matters as the Commission deems appropriate; and
- (5) review and analyze such other matters as the Commission deems appropriate.

**SEC. 5. MEMBERSHIP.**

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

- (1) five shall be appointed by the President, of whom not more than 3 shall be of the same political party;
- (2) five shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 3 shall be of the same political party; and
- (3) five shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 3 shall be of the same political party.

(b) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with section 4.

(c) TERM OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(d) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(e) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(f) CHAIRPERSON AND VICE CHAIRPERSON.—Not later than 15 days after all the members of the Commission are appointed, such members shall designate a Chairperson and Vice Chairperson from among the members of the Commission.

(g) VACANCIES.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(h) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(i) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

**SEC. 6. STAFF AND SUPPORT SERVICES.**

- (a) DIRECTOR.—
  - (1) APPOINTMENT.—Upon consultation with the members of the Commission, the Chairperson shall appoint a Director of the Commission.
  - (2) COMPENSATION.—The Director shall be paid the rate of basic pay for level V of the Executive Schedule.
  - (b) STAFF.—With the approval of the Commission, the Director may appoint such personnel as the Director considers appropriate.
  - (c) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of

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title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) **EXPERTS AND CONSULTANTS.**—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) **STAFF OF FEDERAL AGENCIES.**—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(f) **OTHER RESOURCES.**—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(g) **PHYSICAL FACILITIES.**—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

#### SEC. 7. POWERS OF COMMISSION.

(a) **HEARINGS.**—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(b) **DELEGATION OF AUTHORITY.**—Any member or agent of the Commission may, if authorized by the Commission, take any action the Commission is authorized to take by this section.

(c) **GIFTS, REQUESTS, AND DEVICES.**—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission.

(d) **MAILS.**—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

#### SEC. 8. REPORTS.

Not later than June 30, 1997, the Commission shall submit a report to the President and to the Congress on the findings and conclusions of the Commission.

#### SEC. 9. TERMINATION.

The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to the Congress under section 8.

#### SEC. 10. FUNDING.

The Secretary of Health and Human Services shall provide to the Commission, out of funds otherwise available to such Secretary, such sums as are necessary to carry out the purposes of the Commission.

Mr. ROTH. Mr. President, I rise as a cosponsor of legislation introduced by the majority leader to establish a National Commission on Medicare Reform.

According to the Medicare trustees' report released last Wednesday, June 5, the Medicare hospital insurance trust

fund will be bankrupt earlier than expected. In fact, the trustees, of which three of the six trustees are members of President Clinton's Cabinet, indicate that the trust fund may run out of money as early as calendar year 2000.

Senator DOLE's proposal is consistent with the recommendations of the Medicare trustees. The trustees recommend:

\*\*\* the establishment of a national advisory group to examine the Medicare Program. The advisory group would collect and disseminate information and help develop recommendations for effective solutions to the long-term financing problem. This work will be of critical importance to the administration, the Congress and the American public in the extensive national discussion that any changes would require.

We are now 2 years closer to insolvency of the Medicare trust fund than we were at this time last year. We lost a year trying to address the problem, and the program is 1 more year closer to bankruptcy than we expected. Yet, I regret, we are miles away from reaching an agreement on a solution.

Given the very short time that Medicare will remain solvent, and given the large number of baby boomers who will be joining the Medicare Program in just a few years, we cannot afford more delay. It is time to put politics aside and find a solution.

What is happening to the Medicare trust fund is pretty basic. The program is paying out more than it is taking in. This simple dynamic, if left unchecked, will lead Medicare to bankruptcy in less than 5 years. And, simply put, bankruptcy of the trust fund means there will not be money to pay the hospital bills of our senior citizens and disabled individuals reliant on Medicare.

Again, I believe it is time to put politics aside. A Medicare Reform Commission is an important step in the right direction to bringing together a bipartisan, lasting agreement on resolving Medicare's fiscal crisis.

The 1983 National Commission on Social Security Reform was an essential catalyst to resolving the then-loomng bankruptcy of Social Security. The 1983 Commission brought together people in a cooperative bipartisan spirit. Ultimately, the work of the Commission laid the ground for a solution to the solvency crisis. I believe a Medicare Reform Commission might be able to do the same today.

We are facing a crisis. A crisis requires action. We cannot be a government of empty promises. We must restore Medicare to robust health for our children and our grandchildren.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration to the Committee on Rules and Administration.

#### THE BIPARTISAN CAMPAIGN PRACTICES COMMISSION ACT OF 1996

Mr. DOLE. Mr. President, as I prepare to leave an institution in which I

have served for over 35 years, I am mindful that in many ways the public has lost confidence in the ability of legislators to represent their interests, not special interests.

We should not allow this to continue. Representative Democracy, founded on fair and competitive elections, is at the core of what makes America great. Yet, concern over how we finance elections threatens to erode the trust the American people have in our elected officials.

As my colleagues know, Congress has tried repeatedly to grapple with this issue and largely failed. However, I continue to believe that the very nature of the problem makes it difficult to resolve in the normal give and take of the legislative process.

In 1990, for example, Senator Mitchell and I appointed a six-member commission of outside experts to look at this issue and report back to us, but the report was unfortunately ignored by Congress.

I suggested in 1994 and repeatedly since then that a similar commission be constituted to report back to Congress, but with an important difference. This time, the report should be in the form of recommended legislative language which provides a solution and Congress should have an opportunity for an up and down vote.

As my colleagues know, both President Clinton and Speaker Gingrich endorsed a similar concept last year when they met in New Hampshire.

I therefore send to the desk a bill that establishes an eight-member commission of outside experts. They would have the broadest possible mandate to think through this problem, come up with solutions and report back to Congress not more than 30 days after the convening of the 105th Congress.

The commission will send Congress legislative language for those recommendations on which seven members agree. Congress will consider those recommendations under expedited procedures that mirror the fast-track authorities in our trade laws.

I know my colleagues will be grappling with this issue soon. However, I believe that it would be better to take this issue out of what is already a super-heated partisan atmosphere, and allow a bipartisan approach to be developed that Congress cannot ignore.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1857

As enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

#### SECTION 1. SHORT TITLE.

This Act may be cited as the "Bipartisan Campaign Practices Commission Act of 1996".

#### SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the "Bipartisan Commission on