

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:

The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries premiums. Board would approve plan service areas and benefit package designs.

Benefits Package:

- The standard benefits package is specified in law and would consist of all services covered under the existing Medicare statute. Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:

Private Plans

All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income

The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty (\$10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service

The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Medigap

All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:

Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:

The government-run fee-for-service plan would have a \$400 combined deductible, indexed to the growth in Medicare costs. 10 percent coinsurance would be charged for home health, laboratory services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Special Payments:

Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. The proposal would also recommend exploring funding Indirect Medical Education (IME) and other non-insurance subsidies outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program. Any special payments remaining in Medicare would not be included in the calculation of premiums for the government-run fee-for-service plan or private plans.

Retirement Age:

The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. A non-subsidized buy-in would be available at age 65. Congress should develop a special category of eligibility based on specific needs-based criteria (i.e. ADLs) for individuals between 65 and the then-current eligibility age.

Long-Term Care:

Long-term care issues should be separated from Medicare (an acute care program), and long-term care improvements should be made through pension, Social Security, and investment reforms. The proposal would require a study of various long-term care issues.

Financing:

Part A and Part B trust funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare outlays, Congress would be required to authorize any additional contributions to the Medicare Trust Fund. This new test (40% of outlays) would probably not be reached until after 2005. Even if general revenue contributions were limited to 40% of program outlays, this proposal would extend solvency to 2013. (2017 under CBO's new baseline.)

Budgetary Impact:

Between 2000 and 2009, this proposal would save approximately \$100 billion. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from \$500 to \$700 billion.

BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW

I. INTRODUCTION

This recommendation is in three parts:

- the design of a premium support system,
- improvements to the current Medicare program, and
- financing and solvency of the Medicare program.

We believe it is important to address the current program now because of the transition time necessary to implement this premium support system. We assume the enactment of this proposal in 1999 and that the premium support system would be fully operational in 2003.

We believe a premium support system is necessary to enable Medicare beneficiaries to obtain secure, dependable, comprehensive high quality health care coverage comparable to what most workers have today. We believe modeling a system on the one Members of Congress use to obtain health care coverage for themselves and their families is appropriate. This proposal, while based on that system, is different in several important ways in order to better meet the unique health care needs of seniors and individuals with disabilities. Our proposal would allow beneficiaries to choose from among competing comprehensive health plans in a system based on a blend of existing government protections and market-based competition. Unlike today's Medicare program, our proposal ensures that low income seniors would have comprehensive health care coverage.

Because the implementation of a premium support system will take a number of years, we recommend immediate improvements to the current Medicare program. In Section II we outline the incremental improvements to enhance the beneficiaries' security and quality of care now. We recommend immediate federal funding of pharmaceutical coverage through Medicaid for seniors up to 135% of poverty (\$10,568 for an individual and \$13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing.

In reviewing the three parts of this proposal, it is important to keep in mind the different government roles in the premium support system and in current law. We believe the guarantee our society makes to every senior is to ensure that they can obtain the highest quality health care, and that their health care coverage not be allowed to fall behind that available to people in their working years. We believe that our society's commitment to seniors, the Medicare entitlement, can be made *more secure* only by focusing the government's powers on ensuring comprehensive coverage at an affordable price rather than continuing the inefficiency, inequity, and inadequacy of the current Medicare program.

I. PREMIUM SUPPORT SYSTEM TO PROVIDE COMPREHENSIVE COVERAGE

The Medicare Board

A Medicare Board should be established to oversee and negotiate with private plans and the government-run fee-for-service plan. Some examples of the Board's role are: direct and oversee periodic open enrollment periods; provide comparative information to beneficiaries regarding the plans in their areas; transmit information about beneficiaries' plan selections and corresponding premium obligations to the Social Security Administration to permit premium collection as occurs today with Medicare Part B premiums; enforce financial and quality standards; review and approve benefit packages and service areas to ensure against the adverse selection that could be created through benefit design, delineation of service areas or other techniques; negotiate premiums with all health plans; and compute payments to plans (including risk and geographic adjustment).

This Board would operate under a government charter that would describe its responsibilities and operating standards including the ability to hire without regard to civil service requirements and salary restrictions.

Ensuring Plan Performance and Dependability

All plans (private plans and the government-run FFS plan) would compete in the premium support system; all plans would have Board-approved benefit designs and premiums. The Board would ensure that the benefits provided under all plans are self-funded and self-sustaining, determining whether plan premium submissions meet strict tests for actuarial soundness, assessing the adequacy of reserves, and monitoring their performance capacity.

Management of Government-run Fee-for-service in Premium Support

The government plan would have to be self-funded and self-sustaining and meet the same requirements applied to all private plans, including whether its premium submissions meet strict tests for actuarial soundness, the adequacy of reserves, and performance capacity.

Cost containment measures would be necessary. The provisions of the Balanced Budget Act of 1997 should be extended, or comparable savings achieved. In any region where the price control structure of the government run plan is not competitive, the government-run fee-for-service plan could operate on the basis of contracts negotiated with local providers on price and performance, just as is the case with private plans. The government plan would be run through contractors as it is today; contractors in one region would be able to bid in other regions; the Board should have powers to assure that the government-run plan would not distort local markets.

Benefits Package

A standard benefits package would be specified in law. This benefits package would consist of all services covered under the existing Medicare statute. Plans would be able to offer additional benefits beyond the core package and plans would be able to vary cost sharing, including copay and deductible levels, subject to Board approval. Benefits would be updated through the annual negotiations process between plans and the Board, although the Board would not have the power to expand the standard benefit package without Congressional approval. Health plans would establish rules and procedures to assure delivery of benefits in a manner consistent with prevailing private standards and procedures offered to employer groups and other major purchasers.

The Medicare Board would approve benefit offerings and could allow variation within a limited range, for example not more than 10% of the actuarial value of the standard package, provided the Board was satisfied that the overall valuation of the package would be consistent with statutory objectives and would not lead to adverse or unfavorable risk selection problems in the Medicare market.

New benefit to be instituted in the premium support system: Outpatient prescription drug coverage and stop-loss protection***In Private Plans:***

Private plans would be required to offer a high option that includes at least Medicare covered services plus coverage for outpatient prescription drugs and stop-loss protection. Plans would be able to vary copay and deductible structures. Minimum drug benefits for high option plans would be based on an actuarial valuation. High option and standard option plans each would be required to be self-funded and self-sustaining.

In Government-run Fee-For-Service Plan:

The government-run fee-for-service plan would be required to offer high option (including outpatient prescription drugs and stop-loss) in addition to standard option plans. The Medicare Board approval process would be the same as for private plans. High option and standard option plans would be required to be separately self-funded and self-sustaining. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Comprehensive coverage for low-income beneficiaries:

Coverage would be provided through high option plans. The federal government would pay 100% of the premiums of the high option plans at or below 85% of the national weighted average premium of all high option plans for all eligible individuals up to 135% of poverty (\$10,568 for an individual and \$13,334 for a couple) on a fully federally funded basis. This financial support does not limit

these beneficiaries' choice of plans nor restrict plans' design with regard to cost-sharing or other flexibility authorized by the Board. State would maintain their current level of effort, but the federal government would pay 100% of additional costs for these individuals. In this context, Congress should review DSH payments to ensure that double payments do not occur.

Premium Formula Basics

On average, beneficiaries would be expected to pay 12 percent of the total cost of standard option plans. For plans that cost at or less than 85 percent of the national weighted average plan price, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries' premiums would include all costs above the national weighted average.

Only the cost of the standard package would count toward the computation of the national weighted average premium. Plans with a high option, whether private plans or government-run, would separately identify the incremental costs of benefits beyond the standard package in their submissions to the Board, and the government contribution would be calculated without regard to the costs of these additional benefits.

Premium for government-run fee-for-service plans

The government-run fee-for-service plan would be treated the same as private plans.

Government-run plan premium excludes costs of special subsidies in premium calculation

All non-insurance functions and special payments now in Medicare would not be included in calculation of premiums for the government-run FFS plan or private plans.

Guaranteed premium levels where competition develops more slowly

In areas where no competition to the government-run fee-for-service plan exists, beneficiaries' obligations would be no greater than 12 percent of the FFS premium or the national weighted average, whichever is lower. The Medicare Board should periodically review those areas with a fixed percentage premium to ensure that the fixed percentage premium is not anti-competitive.

Medicare's Special Payments in a Premium Support System

Congress should examine all non-insurance functions, special payments and subsidies to determine whether they should be funded through the Trust fund or from another source. For example, payments for Direct Medical Education (DME) would be financed and distributed independent of a Medicare premium support system. Since the Part A and Part B trust funds would be combined and the traditionally separate funding sources of payroll taxes and general revenues would be blurred, Congress should provide a separate mechanism for continued funding through either a mandatory entitlement or multi-year discretionary appropriation program. On the other hand, Indirect Medical Education (IME) presents a unique problem since it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals.

Therefore, for now Congress should continue to fund IME from the Trust Fund as an adjustment to hospital payments.

II. IMMEDIATE IMPROVEMENTS TO THE CURRENT MEDICARE PROGRAM AND OTHER ASPECTS OF SENIORS HEALTH CARE SPENDING

Provide Outpatient Prescription Drug Coverage for 3 million more low-income beneficiaries

Immediately provide federal funding for coverage of prescription drugs under Medicaid for beneficiaries up to 135 percent of poverty (\$10,568 for an individual and \$13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing. All funding obligations related to the coverage under this provision would be federal.

Improve access to outpatient prescription drug coverage for seniors

Revise federal directives to National Association of Insurance Commissioners (NAIC) to develop new Medigap state model legislation immediately. All private supplemental plans would include basic coverage for prescription drugs. One plan would be a prescription drug-only plan.

Combine Parts A and B

Health care delivery changes have blurred the distinctions originally contemplated when Parts A and B of Medicare were enacted. Parts A and B should be combined in a single Medicare Trust Fund. (See Section III on Financing and Solvency.)

Lower deductible for 8 million beneficiaries

The current Medicare program subjects beneficiaries entering the hospital to extremely high costs just at a time when they face the many other expenses associated with serious illness. Virtually no private health plan imposes such costs. We propose to combine the current Part A (\$768) deductible and B (\$100) deductible, and replace it with a single deductible of \$400, which should be indexed to growth in Medicare costs.

Improve utilization of health care services

A fee-for-service plan is best maintained by financial incentives, without which costs spiral out of control or freedom of choice must be restricted. To protect against unnecessary rises in beneficiary Part B premiums, 10% coinsurance would be established for all services except inpatient hospital stay and preventive care, and except where higher copays exist under current law.

Revise federal directives to NAIC to develop new state model legislation to conform to the changes proposed for Medicare cost-sharing. These directives should also be

designed to achieve more affordable and more efficient supplemental insurance and to minimize Medicare outlays. The new single Medicare deductible and coinsurance schedule would be insurable in part or in whole.

Eligibility Age

Medicare eligibility age should be conformed to that of Social Security. A non-subsidized buy-in should be available at age 65. In addition, Congress should develop a special category of eligibility based on specific needs-based criteria, for example selected activities of daily living, for individuals between age 65 and then-current eligibility age.

III. FINANCING AND SOLVENCY

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 would result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and would enhance our ability to meet our commitment to today's and future beneficiaries. Without these changes, quality of care could suffer, and significantly greater revenues and/or beneficiary sacrifices would be required. Beneficiaries and the taxpayers would not receive the greatest value for the total health dollars spent on seniors' behalf.

Medicare's financing needs would be dictated by the Medicare growth rate achieved under the premium support system. By moving to a premium support system, Medicare's growth rate would be reduced by 1 to 1.5 percentage points per year from the current long-term annual growth rate of 7.6 percent (Trustees Intermediate) or 8.6 (Commission's No Slowdown Baseline.) If this reduction in growth rate can be achieved, the fiscal integrity and Medicare would be significantly improved.

Even if the estimated reduction in growth rate is achieved, Medicare will require additional resources as the percent of population that is eligible for Medicare increases. As revenue is needed, how much should be funded through the payroll tax, through general revenue, and through beneficiary premiums?

The answer to this question is difficult because it would require knowing today the health care system of the future. We do not know what the future holds in terms of the evolution of the health care delivery system, or the impact that technology will have on health care costs.

At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs" Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future "technology cuts both ways with respect to both saving medical expenditures and

potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology--and I could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity."

Notwithstanding the magnitude of uncertainty contained in the task, the statute establishing the Commission directed us to recommend measures to attain the long-term "solvency" of the Medicare program. Because of recent history the meaning of "solvency" has come under question. We believe a new measure of solvency must be developed that couples the uncertainty inherent in the task with the real need for the public to evaluate the cost of Medicare and how we should choose to fund this program over time.

The solvency test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

In addition, the payroll tax supporting the OASDI Trust Funds is limited both by its rate and the wage base on which that rate is applied. No portion of Medicare's funding contains these limitations. In Medicare, there is no cap on the wage base; the Part A Trust Fund is funded by a payroll tax of 2.9% on all earnings, and pays only for the Part A benefits of Medicare. Medicare's Part B benefits are paid 75% by general revenues and 25% by beneficiaries.

Consequently, the historic concept of Medicare's solvency is one that has been partially and inappropriately borrowed from Social Security and has never fully reflected the fiscal integrity, or lack thereof, of the Medicare program. In Medicare, "solvency" has meant only whether the Part A Trust Fund outlays were poised to exceed Part A reserves and collections. That is all.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A "solvency" or rather "insolvency" has been used to shift more program costs to the general fund. An act of Congress shifted major home health expenditures from Part A to Part B in 1997, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A "solvency".

The ever increasing estimates of general fund exposure should be part of any definition of solvency. Absent reform, general fund exposure jumps from 37% of program funding in FY2000 to 43% in FY2005 and 49% in FY2010. General fund demand will increase from \$92 billion in FY2000 to \$156 billion in FY2005 to \$261 billion in FY2010.

Consequently, the "solvency" of the Part A Trust Fund is not useful as a guide to policy making or even as a tool to educate the public on the security and financial condition of the Medicare program.

Therefore, Part A and Part B Trust Funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. This concept should more accurately reflect the implications of the program's financing structure, i.e., the ratio of relative financing burdens on the general fund, the Hospital Insurance payroll tax, and the premiums beneficiaries pay. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. This could be referred to as a programmatic solvency test.

Congress should enact this revised definition of Medicare solvency so that decisions can be made in the context of competing demands for general revenue. Congress should require the Trustees to publish annual projections regarding the ratio in program financing. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent. The Trustees Report should provide for necessary and important public debate leading to potential adjustments to the payroll tax and/or the beneficiary premium as well as any adjustment of the general fund devoted to Medicare. Congressional approval would be required to authorize any additional contributions to the Medicare Trust Fund.

With the reforms contemplated under this proposal, that new test would probably not be activated until after 2005. Even if we limit general revenue contributions to 40% of program outlays, however, this proposal would extend the solvency of Medicare to 2013. This calculation, based on the most recent CBO baseline, would indicate that solvency under this test would extend to 2017 or beyond.

Long-term care

The Commission recognizes that its proposal is focused on acute care, and does not address the issue of long-term care. In 1995, Americans spent an estimated \$91 billion on long-term care, with 60 percent coming from public sources. Despite these large public expenditures, the elderly face significant uncovered liabilities. The Commission recommends that the Institute of Medicine conduct a study to 1) estimate future demands for long-term care; and 2) analyze the long-term care financing options available to seniors, including long-term care insurance, tax policy and community-based, state and federal government programs.

To: Medicare Commission

3/14/99

From: Jeff Lemieux

Subject: Cost estimate of March 14 proposal

The attached estimate is based on the proposal specified below. The estimate is displayed in annual figures for the 10-year budget window used in the Senate (and slightly beyond). Long-term tables developed by the Modeling Task Force, which display the impact of the proposal using several different measures, are also included. In addition, a simulation of a combined trust fund is attached. The explanation of the basis of the estimate is limited to new items in the proposal. The February 17 estimate of the original Breaux proposal contains a general explanation of the premium support plan. Since the current proposal is similar to the nontraditional estimate on February 17, simulations of the impact on beneficiary premiums from that estimate continue to apply.

DESCRIPTION OF THE PROPOSAL

Medicare Board:

The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries' premiums (collected via Social Security system as with Part B premiums now). Board approval would be required for plan service areas and benefit package designs.

Benefits:

The standard benefits package specified in law would consist of all services covered under the existing Medicare statute (Medicare covered services). Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:

Private Plans

All private plans would be required to offer a high option that included at least the standard benefits package plus coverage for prescription drugs. The minimum drug benefit for high option plans would be based on an actuarial valuation, with standards and examples set by the Board.

Low-Income

The proposal would immediately extend coverage of prescription drugs to qualifying beneficiaries under 135 percent of poverty under Medicaid with full federal funding of the additional cost. That coverage

could be provided through high option plans when the premium support system was implemented. (A special premium support schedule could be used to combine premium and drug subsidies for low-income beneficiaries.)

Fee-For-Service

The Health Care Financing Administration (HCFA) would be allowed to contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would allow a public/private high option plan or plans, with HCFA providing coverage for Medicare covered services and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, HCFA would be allowed to transition the government-run fee-for-service plan to a more private-managed basis overall, possibly with different alternatives available regionally.

Medigap

The National Association of Insurance Commissioners would develop new model plans immediately under a federal directive. All plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:

Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. (An example of this type of premium schedule was included in the estimate from February 17.)

Although all plans would be available on the national premium schedule, only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board for that purpose.

If early versions of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:

The government-run fee-for-service plan would have a \$400 combined deductible, indexed to the growth in Medicare costs. Ten percent coinsurance would be charged for home health, laboratory

services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Management of the Government-Run Fee-for-Service Plan:

All plans, private plans and the government-run fee-for-service plan, would compete in the premium support system; all plans would have premiums and would be available on the national schedule. The fee-for-service plan would have a premium like any other plan—it would adjust its premium in subsequent years based on its cost experience.

The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate. The estimate assumes that the growth of fee-for-service spending would be moderated somewhat by a combination of HCFA and Congressional efforts. Without some such ongoing savings, the fee-for-service plan could gradually lose its competitive position with private plans.

Special Payments (Education, Disproportionate Share, Rural Subsidies):

Under the proposal, federal support for Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. Depending on the nature of the replacement program for DME, the federal budget as a whole might not be affected by the carve-out. The proposal would also recommend exploring funding disproportionate share hospitals (DSH) and Indirect Medical Education (IME) outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program.

Any special payments remaining in Medicare would not be included in premiums for the government-run fee-for-service plan or private plans.

Retirement Age:

The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. Congress would develop an exemption process for affected beneficiaries with special needs, such as those unable to work and otherwise get health coverage. Eligibility requirements under that exemption process would not necessarily be the same as the requirements for eligibility based on disability for those under 65, although the waiting period for eligibility based on disability could also be waived or shortened for those affected by the change.

Long-Term Care:

The proposal indicates that long-term care issues should be separated from Medicare (an acute care program). The proposal would require a study of various long-term care issues. The cost estimate

does not include any impact on the budget from long-term care items.

Financing:

The proposal would implement a combined trust fund, with guaranteed general revenue funding to grow at the same rate as overall program costs if it otherwise would exceed 40 percent of the program's cost (without further Congressional approval). The initial balance in the combined fund would equal the balance in the Part A and Part B funds at the time of enactment.

BUDGETARY IMPACT

Table 1 lays out the estimate in the style of an annual Congressional cost estimate. The savings attributed to the individual policies result from a top-down ordering of the estimate. Premium support was estimated first, in the absence of any other policies. Then the subsequent policies were added one by one—the savings represent the incremental impact of that policy on Medicare spending. Because Medicare spending would be reduced compared with current law, premium collections from beneficiaries would be reduced as well. That is why the impact of the proposal on premiums is displayed as a cost item in the table—lower government premium collections reduce the budget surplus (or increase the deficit).

Excluding the optional items, the proposal would be approximately budget neutral in the 5-year budget window between 2000 and 2004. That is because the new assistance for low-income beneficiaries would begin immediately, while the savings provisions would not be implemented until 2003. Over the 10 years between 2000 and 2009, the proposal would save approximately \$100 billion.

Tables 2-6 show the detailed cost estimate of the March 14 plan in the format developed by the Modeling Task Force. That format was designed to gauge the impact of proposals using many different measures. Because the Part A trust fund would be replaced by a combined fund, tables 2-6 do not show results for the Part A fund under the proposal. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from \$500 to \$700 billion.

Table 7 shows the projected impact of a combined trust fund under the proposal, with general revenue funding growing at the same rate as program costs overall. As noted in the February 17 estimate, the growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30-year baselines

used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short-run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in Table 7 should be extended by 3 or 4 years as well, to 2016 or 2017.

BASIS OF THE ESTIMATE AND DISCUSSION

Premium Support

The basic estimate of the premium support plan is largely unchanged from the February 17 estimate. Tying the national average to the cost of Medicare covered services reduces transition costs by a small amount, increasing slightly the savings attributed to premium support. The provision protecting beneficiaries in areas with only one plan from paying more than 12 percent of the cost of that plan or the national weighted average would add slightly to the cost of the proposal.

Requiring all plans to offer a high option plan and allowing the Board to maintain an appropriate price difference between plans' high and standard options until the risk adjuster was proven over time greatly reduces concerns about adverse selection in high option plans.

Low-Income Subsidies

Currently, state Medicaid programs cover drugs for only so-called dually-eligible Medicare beneficiaries, often limiting such coverage to those well under the poverty line. Medicaid covers Medicare premiums and cost sharing for those between the limit of Medicaid dual eligibility and the poverty line. Between 100 and 135 percent of poverty, Medicaid covers Medicare premiums only. The cost of such Medicaid coverage under current law is split between the states and the federal government. About 50 percent of beneficiaries between the limit of dual eligibility and the poverty line participate in premium and cost sharing subsidies; about 20 percent of beneficiaries between 100 and 135 percent of poverty participate.

This estimate assumes that the federal government would pay 100 percent of the cost of extending drug coverage to qualifying beneficiaries under 135 percent of poverty via the Medicaid program. (States would continue to be responsible for their share of the cost of drug coverage for dually-eligible beneficiaries.) In addition, the federal government would make grants to the states in amounts set to cover 100 percent of the cost of the extra participation in the current assistance programs (for premiums and cost sharing) that the new drug coverage would cause. The estimate assumes that the participation rate for those under 135 percent of poverty, but not dually eligible, would be 60 percent. Thus the federal government would effectively cover the cost of expanding participation for those not dually eligible but under poverty from 50 to 60 percent, and from 20 to 60 percent for those between 100 and 135 percent of poverty.

Management of the Fee-for-Service Plan

In the short run, the proposal would allow the government-run fee-for-service plan to partner with private plans to offer drug benefits under one high option premium. The estimate assumes that such partnerships would not involve HCFA regulation of that industry.

The estimate assumes that a combination of HCFA and Congressional initiatives would slow the growth of spending in the fee-for-service program somewhat. That slowdown was explained in the description of the nontraditional estimate of February 17. The estimated impact of the specified cost sharing changes in the fee-for-service plan is shown separately.

Financing

The Part A fund covers only part of Medicare spending, and an act of Congress recently aided the fund simply by transferring a portion of its spending out of Part A into Part B (which is funded mostly by general revenues). Current budget proposals would transfer additional funds from the general Treasury to the Part A fund in order to postpone its insolvency date. Because the Part A fund never covered all of Medicare, and because of the recent and proposed transfers of obligations and funds, the Part A fund no longer adequately summarizes the financial condition of the Medicare program. A combined fund could make it more clear who pays for Medicare and would allow a more transparent discussion of how to aid Medicare's finances.

Table 1. March 14 Proposal

(by calendar year)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	00-04	00-09
Cost (+) or Savings (-) in Billions of Dollars																
Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 135 Percent of Poverty ¹¹	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs ¹²	2	2	2	3	3	3	3	4	4	4	4	5	5	5	12	30
Cost sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-8	-8	-4	-24
Removal of DME ¹³	0	0	0	-4	-5	-5	-5	-5	-6	-6	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-5	-1	-11
Slowdown of Growth in Gov't FFS plan ¹⁴	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
Total	4	4	5	-6	-9	-11	-16	-20	-24	-29	-34	-41	-48	-55	-1	-102
Average Monthly Premium:																
Government-run FFS plan				\$76	\$80	\$84	\$89	\$93	\$98	\$103	\$108	\$114	\$119	\$125		
Government-run plan in no alternative areas				\$75	\$79	\$84	\$88	\$92	\$96	\$101	\$106	\$111	\$116	\$120		
Private plans				\$75	\$79	\$82	\$86	\$90	\$93	\$97	\$102	\$106	\$110	\$114		
Average of all plans				\$75	\$79	\$84	\$88	\$92	\$96	\$101	\$106	\$111	\$116	\$120		
Monthly Part B Premium under Current Law				\$71	\$77	\$84	\$91	\$98	\$106	\$115	\$123	\$132	\$141	\$151		

Source: Medicare Commission Staff.

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items.

Estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003.

The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003.

Over time, that percentage would gradually fall; if national private plans developed, it would fall to zero.

In this time period, the results are approximately the same using either of the Commission's baselines.

The premium support schedule is calibrated to Medicare spending after the home health transfer is fully phased in (2006).

¹¹ Assumes 100% federal funding with a state maintenance of effort for dually-eligible beneficiaries. Participation rate assumed to be about 60 percent.

¹² Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).

¹³ Savings to Medicare, but not necessarily to the overall budget.

¹⁴ Follows the method of the nontraditional estimate of Feb. 17, which assumed that the fee-for-service plan would compete to some extent.

Table 2.

14-Mar-99

March 14 Proposal

DRAFT

	Medicare Spending Growth Rate, 2000-		Medicare Spending as a Percent of GDP /1/2		Medicare as a Percent of Federal Revenues		Medicare Spending (in billions of dollars) /3		Part A or Combined Fund Insolvency /4	Premiums as a Percent of Beneficiaries' Income		Budgetary Costs (+) or Savings (-) (in billions) /5	
	2015	2030	2015	2030	2015	2030	2015	2030		2015	2030	2015	2030
Baselines													
Trustees Intermediate	8.2%	7.6%	4.4%	6.3%	19%	28%	801	2,212	2008	7%	7%	0	0
No Slowdown	8.3%	8.6%	4.5%	8.5%	19%	38%	817	2,972	2008	7%	10%	0	0
Viability Standard Based on Spending													
Slow Growth of Per Beneficiary Spending to that of Per Capita GDP													
Trustees Intermediate	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-182	-615
No Slowdown	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-195	-1272
Preliminary Estimate													
March 14 Proposal													
Trustees Intermediate	6.9%	6.4%	3.7%	4.5%	16%	20%	676	1,596	~2013	5%	5%	-99	-514
No Slowdown	7.1%	7.4%	3.8%	5.9%	17%	27%	688	2,087	~2013	5%	6%	-101	-740

Policy:

The Part B premium and the Medicare+Choice system for private plans would be replaced by a premium support with standard and high options under formula that allowed zero-premium plans. Normal age of eligibility would be gradually increased, but waiting period for eligibility for disabled would be waived or reduced for those affected. Low-income subsidies expanded with drug coverage for qualifying beneficiaries under 135 percent of poverty. Benefits package change would include coinsurance for home health and lab services with combined deductible (indexed to program costs). Direct education carved out. HCFA can organize public/private fee-for-service plan, with standard and high option. Premium formula anchored to standard option/Medicare covered services.

SOURCE: Medicare Commission Staff.

1. In 2000, Medicare spending will be 3 percent of GDP and 12 percent of the federal budget (revenues). Total projected Medicare spending will be \$247 billion in 2000.
2. Payroll is approximately half of GDP. For example, in 2015 under the Trustees Intermediate baseline, Medicare spending would be 9.0 percent of payroll.
3. All spending estimates after Part A fund insolvency are hypothetical.
4. Updated estimates from HCFA and CBO will probably extend insolvency date by 3 or 4 years under current law. This cost estimate does not include that update.
5. Medicare cost or savings in the year shown.

Table 3.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
Trustees Intermediate Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.4	5.0	5.7	6.3
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.7	4.0	4.3	4.5
Medicare Spending as a Percent of Payroll ¹													
Trustees Intermediate Baseline	1	2	3	4	4	5	6	6	8	9	10	12	13
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	8	9	9
Medicare Spending as a Percent of the Federal Budget ²													
Trustees Intermediate Baseline	3	5	6	8	9	11	12	14	16	19	22	25	28
March 14 Proposal	3	5	6	8	9	11	12	13	14	16	18	19	20
Medicare Spending in Billions of Dollars													
Trustees Intermediate Baseline	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
Average Annual Growth in Spending from Previous Year Shown													
Trustees Intermediate Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.1	8.4	7.5	7.0	6.6
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.2	6.4	5.7	5.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
Trustees Intermediate Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.3	6.0	4.9	4.3	4.2
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	4.9	3.8	3.0	3.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) ³													
Trustees Intermediate Baseline						3	4	5	6	7	7	7	7
March 14 Proposal						3	4	5	5	5	5	5	5

Source: Medicare Commission Staff.

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

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP.

Table 4.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
No Slowdown Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.5	5.5	6.9	8.5
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.8	4.4	5.1	5.9
Medicare Spending as a Percent of Payroll ¹¹													
No Slowdown Baseline	1	2	3	4	4	5	6	6	8	9	11	14	17
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	9	10	12
Medicare Spending as a Percent of the Federal Budget ¹²													
No Slowdown Baseline	3	5	6	8	9	11	12	14	16	19	24	30	38
March 14 Proposal	3	5	6	8	9	11	12	13	14	17	19	23	27
Medicare Spending in Billions of Dollars													
No Slowdown Baseline	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
Average Annual Growth in Spending from Previous Year Shown													
No Slowdown Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.2	8.7	9.0	9.2	8.8
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.6	7.8	7.6	7.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
No Slowdown Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.4	6.4	6.4	6.4	6.4
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	5.3	5.2	4.9	5.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) ¹³													
No Slowdown Baseline						3	4	5	6	7	8	9	10
March 14 Proposal						3	4	5	5	5	6	6	6

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP.

Table 5.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Billions of Dollars													
Trustees Intermediate Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	110	156	217	299
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	432	668	992	1,416
Total, Medicare Spending	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	84	114	150	196
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	333	484	666	902
Total, Medicare Spending	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
Percent Distribution													
Trustees Intermediate Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	13
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	28	25	22
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	54	58	62	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	35	33	31
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	49	53	55	57
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
Trustees Intermediate Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	262	388	607	949	1,450
Net	1	1	1	5	13	-3	1	-10	-40	-109	-258	-517	-914
Balance	3	11	14	21	99	130	110	87	(49)	(438)	(1,388)	(3,411)	(7,090)

Source: Medicare Commission Staff.

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

Part A estimates here computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical. Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 6.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Billions of Dollars													
No Slowdown Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	112	171	263	401
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	445	763	1,285	2,073
Total, Medicare Spending	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	85	124	179	257
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	344	555	868	1,333
Total, Medicare Spending	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
Percent Distribution													
No Slowdown Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	14
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	26	21	17
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	55	61	66	70
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	32	28	24
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	50	55	60	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
No Slowdown Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	263	397	669	1,159	1,969
Net	1	1	1	5	13	-3	1	-10	-41	-117	-320	-727	-1434
Balance	3	11	14	21	99	130	110	87	(49)	(457)	(1,581)	(4,308)	(9,872)

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

Part A estimates computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical. Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 7. A Combined Trust Fund Under the March 14 Proposal

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Billions of Dollars											
Inflows											
Premiums	32	36	39	42	46	50	55	60	65	70	77
Payroll Taxes	149	156	164	171	180	188	197	206	216	226	237
General Revenues	117	128	140	150	161	172	184	198	212	228	245
Interest	9	9	9	9	9	8	7	5	3	0	0
Total, Inflows	307	329	352	373	395	418	443	469	496	525	559
Outflows											
Medicare Spending	307	329	352	376	402	431	461	494	530	570	613
Interest	0	0	0	0	0	0	0	0	0	0	3
Total, Outflows	307	329	352	376	402	431	461	494	530	570	617
Net	0	0	0	(3)	(7)	(13)	(18)	(25)	(34)	(45)	(57)
Balance	150	150	150	147	140	127	109	84	49	4	(53)
Memorandum:											
General Revenue Share of Medicare Financing	38%	39%	40%	40%	40%	40%	40%	40%	40%	40%	40%

Source: Medicare Commission Staff.

Note: The growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30 year baselines used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in this table should be extended by 3 or 4 years as well, to 2016 or 2017.

David Rymar Phone number

QUESTIONS ABOUT MEDICARE COMMISSION PROPOSAL

1) ***What is premium support?*** Premium support is a new way of delivering health care to our nation's seniors modeled on the Federal Employees Health Benefits Program (FEHBP). Premium support brings together the best of competitive, market-based forces while ensuring seniors basic entitlement coverage by preserving the social safety net.

2) ***Is premium support a voucher?*** NO--Premium support is no more a voucher than the health care program for U.S. Senators and Congressmen or the current Medicare+Choice program. Under premium support, the government's contribution is tied directly to the cost of health care and the level of government support is explicitly outlined in statute. Seniors will not be handed a voucher and told to find health coverage on their own. The government will continue to directly reimburse the government-approved health plan chosen by the beneficiary.

3) ***Does premium support end Medicare as an entitlement?*** NO--This proposal guarantees a statutorily defined set of benefits and guarantees a government commitment to pay 88% of the national weighted average premium. Medicare beneficiaries will continue to be entitled to a defined set of benefits and entitled to have the government pay 88% of the cost.

4) ***What will happen to beneficiaries who live in areas where there are no private plans?*** Beneficiaries everywhere, including those in areas with no private plans, will continue to have access to traditional fee-for-service. The beneficiary premium for those who live in areas with no private plans will be limited to 12% of the fee-for-service premium or 12% of the national weighted average, whichever is lower.

5) ***Will premium support result in older, sicker beneficiaries remaining in the government-run fee-for-service plan, causing fee-for-service premiums to increase more than they would under current law?*** NO--In addition to guaranteeing that beneficiaries in areas where the government-run fee-for-service plan is the only option pay no more than 12% of the national weighted average, this proposal includes a provision to risk adjust the premium to account for beneficiary health status. A risk adjuster will ensure that plans treating sicker patients receive higher government payments.

6) ***Will premium support shift more costs to beneficiaries?*** NO--Beneficiaries now pay 25% of the Part B premium. This will represent 12% of Medicare's costs in 2002. This proposal retains the share of responsibility between the government and beneficiary. Low-income beneficiaries (those under 135% of poverty or \$11,000/individual) will pay no premiums.

7) ***What benefits will be guaranteed under premium support?*** All plans will be required to offer at least the same benefits that are covered under Medicare today. A new Medicare Board would ensure that all plans offer these benefits as a condition of participating in Medicare. The Board would minimize variation in the benefit package to prevent adverse selection.

8) ***What does this proposal do on prescription drugs?*** The proposal for the first time provides a drug benefit to all beneficiaries living below 135% of poverty at a cost of \$61 billion over 10 years in drug and cost-sharing assistance. The proposal also expands access to coverage for all other beneficiaries by requiring both traditional and private plans to offer drug coverage through a "high option" plan.

9) ***How does premium support address Medicare's solvency crisis?*** Clearly, more revenue will be needed to pay for Medicare for future beneficiaries. In addition to combining Parts A and B of Medicare, this proposal includes developing a new definition of solvency which focuses on the amount of general revenue, beneficiary premiums and payroll taxes being used to pay for Medicare in a given year. Although recognizing the need for new revenue, the proposal envisions reforming Medicare before committing future general revenues.

It don

THE WHITE HOUSE
WASHINGTON

March 1, 1999

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

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

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

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

~~CONFIDENTIAL~~ - NOT TO BE QUOTED

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: DT DATE: 7-21-99

DRAFT 3/1/99

Recommended Changes to the Breaux Medicare Reform Plan

Stuart H. Altman
Laura Tyson

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

A. Inadequate Benefits

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

B. Future High Cost

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

C. Inflexible Program

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

PROPOSED CHANGES TO BREAUX REFORM PLAN

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

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

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

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

1. Lacks a specified and adequate set of benefits.

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

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

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

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

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

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

3. Raising age could increase uninsured

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

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

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

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

5. Need an adequate financing plan

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

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

6. No discussion of Long-term care needs.

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

REVISED COMMISSION PROPOSAL: February 16, 1999

PREMIUM SUPPORT

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

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

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

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

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

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

MEDICARE FEE-FOR-SERVICE

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

RAISING THE AGE ELIGIBILITY FOR MEDICARE

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

GRADUATE MEDICAL EDUCATION

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

FINANCING

- **No proposals**

DRAFT: MEDICARE REFORM PLANS, February 18, 1999

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

WHY DEFINED BENEFITS IS IMPORTANT

Improves Competition

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

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

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

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

SENATOR JOHN BREAUX
Testimony before the Senate Finance Committee
"Using the FEHBP Model to Reform Medicare"
May 26, 1999

Page - 253 of 24
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65 - 67 days

Mr. Chairman, Senator Moynihan and my fellow colleagues, I appreciate this opportunity to speak to you today about the work of the Bipartisan Medicare Commission and the legislation we are working on that reflects a FEHBP style Medicare reform proposal supported by a bipartisan supermajority of the Commission. The intent of the commission proposal was to get the basic design of the Medicare program right--not for the next year or two but for the coming decades. We realize that with advances in medical technology and the changing demographics of the Medicare population, there will be an ongoing need to revisit specifics of the Medicare program. Our proposal purposely does not attempt to prescribe every specific rule in advance. Our goal is to create a more flexible, less rigid Medicare program for future generations of Medicare beneficiaries.

We also approached reform from the basic premise that Medicare as we know it is inadequate in terms of what it provides. It does not even reflect what most Americans with employer-sponsored coverage receive. As I have said many times, prescription drugs are as important today as a hospital bed was in 1965, and Medicare's current benefit package does not cover them. In addition, Medicare covers only about half of the current health care costs of today's beneficiaries with seniors paying an average of \$2000 out-of-pocket each year for health care. And even this inadequate coverage is not sustainable in its current form. Premiums for beneficiaries will double by 2007 even though benefits will not improve and the trust fund, our measure of solvency at this point, will be insolvent beginning in 2015.

Before I describe the basic elements of our proposal, I think it is also necessary to spend a little time telling you what it does not do. Since the work of the commission ended, there has been a great deal of misinformation disseminated about our proposal, namely, that it is a voucher plan or an end to Medicare as an entitlement or that it is a strict defined contribution. Let me be clear: it is NONE of these things. I am eager to engage in an honest debate about the implications of moving Medicare to a premium support system but attempts to characterize this proposal as "voucherizing" Medicare are just plain wrong. Premium support is no more a voucher plan than the health insurance program that we as federal employees receive.

The use of the word voucher implies that beneficiaries are given a set dollar amount- defined contribution- and told to go buy insurance, leaving them exposed to whatever the difference is between the government contribution and the plan premium. That notion misrepresents how a FEHBP style system would really work. The competitive, market-based approach inherent in this system gives beneficiaries an incentive to choose a plan that best fits their health care needs--it gives them a choice. Under our proposal, beneficiaries would pay on average 12 percent of the premium for a plan. Beneficiaries choosing costlier-than-average plans would pay the full extra cost themselves and beneficiaries choosing plans with premiums less than 85 percent of the average would not pay any premium at all. Currently, all beneficiaries must pay at least the Part B premium.

And if the government fee-for-service plan is the only one available in an area and the beneficiary has no choice of plans, we have guaranteed that beneficiary premiums in those areas will be limited to 12 percent of the fee-for-service premium or 12 percent of the national weighted average, whichever is lower. This provision will help protect beneficiaries, particularly those in rural areas, from paying higher fee-for-service premiums if they have no other plan from which to choose.

Premium support is also not an end to Medicare as an entitlement. In the legislation we are drafting, we make it explicitly clear that all Medicare beneficiaries will at a minimum continue to be entitled to the same benefits now described under Title 18. No plan can be approved by the Medicare Board if it does not cover at least the same benefits that beneficiaries are entitled to today.

Another concern raised by detractors is that premiums for beneficiaries who stay in the government run fee-for-service plan will skyrocket. Before we talk about what will happen in a FEHBP style system, remember that premiums under the current system are set to double in the next ten years. In addition to that, the trust fund is running out of money. Under our plan, government run fee-for-service will continue to be a national plan with a national premium, as it is under current law. We would recommend that cross-subsidies or payments for Medicare's non-insurance functions not be included in calculating the premium for either public or private plans in order to ensure a level playing field between the two. The government fee-for-service plan, therefore, will not be put in a position where its premiums are made uncompetitively high by the inclusion of these additional payments. There will also be a risk adjuster so that the fee-for-service plan is not penalized for serving an older and sicker population.

The Commission's analysis showed that premiums for beneficiaries choosing to remain in the government fee-for-service program would be 17 percent lower in ten years than they otherwise would be under current law--\$1,500 instead of \$1,820--if the plan is able to compete and slow its growth rates. I should note, however, if fee-for-service spending continues to grow as projected under current law, even as competing private plans offer the same benefits at a lower cost, then beneficiaries choosing to remain in this plan (or any other more expensive and less efficient plan) would have to pay a higher premium unless they live in an area where there is no choice of plans.

Others have attacked our plan as not saving enough or doing enough to address Medicare's solvency problem. Commission staff estimates of the Medicare Commission's plan were based on the assumption that spending in the current unrestrained fee-for service program would grow faster than the blend of fee-for-service and private plan premiums that would determine Medicare spending under premium support. Therefore the premium support plan would slow the growth of Medicare spending. The estimated savings were roughly in line with those used by CBO during the debate on health reform proposals that would have spurred competition among health plans, or about 1 to 1.5 percentage points per year from the current long-term annual growth rate. Over time this results in substantial savings--\$800 billion in 2030 alone.

But even if this growth rate is achieved, we recognize that Medicare will require additional resources as the percent of population that is eligible for Medicare increases. At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending

in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs." Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future: "Technology cuts both ways with respect to both saving medical expenditures and potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology--and I could allude to all sorts of forecasts over the recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity." These are Allan Greenspan's words.

Still we were instructed by statute to address the issue of Medicare solvency. We concluded that the test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A insolvency has been used to shift more program costs to the general fund. In 1997, we shifted nearly 2/3 of home health expenditures from Part A to Part B, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A solvency. Because of these blurry distinctions, we recommend that Part A and Part B Trust Funds be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare be developed. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. When the funding from general revenues reaches a certain level--we suggested 40 percent--the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent and Congress would be required to act before more general revenues could be added to the program.

Now I would like to turn to a brief description of our plan. Broadly our proposal is based on the following principles:

- fair competition between the government-run-fee-for-service plan and private plans
- minimal disruption for current beneficiaries in either the fee-for-service or private plans
- fair competition between local, regional and national plans
- real opportunities for national and other wide-area plans to enter the Medicare market
- a competitive fee-for-service plan

For beneficiaries it offers reasonably-priced drug coverage, a reduced need for supplemental coverage, and the promise of lower premiums. For the government (and by extension, the taxpayer) it would aid the budget and reduce the need for federal micro management. For health plans, it offers greater stability and a more businesslike atmosphere, with fairer, but tougher, competition.

For hospitals and health providers, it would bring a less heavy-handed approach to cost control than has been used in the past.

PROPOSAL BASICS

Premiums

The Breaux/Thomas proposal would change the Medicare entitlement from the government paying all of Part A and 75 percent of Part B to the government paying 88 percent of a combined Medicare. The 88 percent figure approximates what the government share of overall program costs would be under current law when the new system was implemented. The combined Medicare spending would grow at the average rate of growth in the premiums of plans beneficiaries chose, including the traditional Medicare fee-for-service plan and private plans. That would be a significant change from current Medicare spending, which is based only on growth in fee-for-service.

Each year, beneficiaries would have incentives to choose efficient plans. On average, beneficiaries would pay 12 percent of the premium for a standard plan. But beneficiaries choosing plans more expensive than average would pay the full extra cost themselves while beneficiaries choosing plans with premiums less than 85 percent of the national average would pay no premium at all. Currently, all beneficiaries must pay at least the Part B premium.

Competition

Under current law HCFA runs the fee-for-service plan and controls the terms of competition between that plan and private plans. Under our proposal, a new Medicare Board would administer the competitive system. HCFA's role in Medicare would be focused on administering the fee-for-service plan, and the fee-for-service plan would be treated like any other plan by the Board.

As under current law, the fee-for-service plan would set a national premium and its enrollees would pay one flat amount, regardless of where they live or move. The fee-for-service plan's large enrollment (currently 85 percent of all Medicare beneficiaries) guarantees that its premium would be very close to the national weighted average for several years after the premium support system was implemented. Therefore, in both method and amount, the initial fee-for-service premium under our proposal would be similar to the Part B premium under current law.

Payments to all plans would be adjusted for the demographics, risk, and geographic location of their enrollees. The payment adjustments are needed to ensure that plans serving more or less expensive enrollees are paid fairly, and that differences in their premiums reflect efficiencies.

Benefits

The standard benefits specified in law would consist of all services covered under the existing Medicare statute. As under current law, private plans could establish their own rules on exactly how the benefits would be provided. Board approval would be required for all benefit design offerings and changes but ALL PLANS would be required to offer, at a minimum, the same benefit package beneficiaries are entitled to under current law. The hope is that premium support would enable plans to offer better benefits than beneficiaries receive today but under premium support, no beneficiary will be entitled to fewer benefits than they are entitled to under current law. This will be

spelled out explicitly in statute.

Although Parts A and B would be merged into a combined program, Medicare's standard benefits would not change. The current Part A per-admission hospital deductible (currently \$768) and the annual Part B deductible of \$100 would be replaced by a combined annual deductible of \$400. Ten percent coinsurance would be charged for home health and laboratory services. No coinsurance would be charged for inpatient hospital stays and preventive care.

Trust Fund

As I noted earlier, the Breaux/Thomas plan would create a combined Medicare trust fund that would include all three sources of funds: payroll taxes, premiums, and general revenue contributions. Without further Congressional action, general revenue contributions would be allowed to grow only as fast as program spending if they otherwise would exceed 40 percent of Medicare's finances. While we must acknowledge that Medicare needs more revenue, we cannot continue to give the program an open-ended commitment of general revenues.

Prescription Drugs

There has been a great deal of discussion in recent months on the need to add a prescription drug benefit to Medicare. Our proposal took an important first step by creating a viable prescription drug benefit in Medicare, fully subsidized for the poor, and available to all beneficiaries.

The proposal we are putting forward would spend an estimated \$61 billion over 10 years on drug coverage and cost subsidies for the poor. In the short run, this new coverage would be provided through the Medicaid program, fully paid for by the federal government. When the premium support system was implemented, the coverage would be provided through special subsidies for high option plans in Medicare. The new drug subsidies would likely increase the participation in subsidies available under current law (for premiums and cost-sharing) and the \$61 billion estimate includes this increased federal spending.

While the Commission's final proposal did not explicitly subsidize drug coverage for those above 135 percent of poverty, I strongly favor including some kind of subsidy for all beneficiaries. We need to keep in mind, however, that 65 percent of beneficiaries currently have some kind of prescription drug benefit and we have to be careful not to displace that coverage. We should also remember the valuable lesson we learned during Medicare catastrophic—it is a very difficult political proposition to ask seniors to pay more money for a benefit they already have.

As I have said many times, I support adding a subsidized drug benefit to Medicare but ONLY in the context of fundamental reform. Adding prescription drugs is the easy part but we must also take the tough medicine inherent in comprehensive reform and I would not support any effort to do one without the other.

Medigap Reform

The proposal would significantly remake the Medigap market to conform with the combined Medicare program by requiring Medigap coverage of prescription drugs and allowing varying

degrees of coverage of Medicare coinsurance and deductibles.

Conclusion

A Our proposal is a starting point and not an ending point. We have heard from many people concerned about raising the eligibility age from 65 to 67 and have decided against including this change in our latest proposal. We know the administration has been looking at various proposals to reform Medicare and we look forward to seeing those, as well. Nobody has the corner on the Medicare reform market.

I think I speak for Congressman Thomas as well when I say that we look forward to a vigorous debate about how to reform Medicare. The debate shouldn't be about whether to reform Medicare. We know we need to make structural changes and we need to do it now. The longer we wait, the more difficult and dramatic the changes will have to be. We can't keep waiting for someone else to go first. If someone doesn't go first, nothing will ever get done. Let's solve the problem and argue about who should get the credit rather than continue to do nothing and blame the other side for failure. I look forward to working with Democrats, Republicans and the Administration to meet this challenge.

MEDICARE--THE FACTS

- ⇒ Medicare only covers half of seniors health care costs
- ⇒ Medicare beneficiaries spend an average of \$2,000 out-of-pocket each year on health care expenses
- ⇒ Traditional Medicare doesn't cover prescription drugs, vision care, or dental care
- ⇒ Medicare Trust Fund will be insolvent in 2015 or earlier if the economy worsens, just as 77 million baby boomers begin to retire

Medicare's 1965 model needs to be updated for the 21st century!

PREMIUM SUPPORT--THE FACTS

- Statutory, guaranteed ENTITLEMENT to at least the same benefits beneficiaries have today
- Government commitment to pay 88% of the average premium
- Protection for beneficiaries in areas where fee-for-service is the only option
- Competition between private plans and government fee-for-service plan results in:
 - ⇒ A competitive fee-for-service premium
 - ⇒ More efficient system produces long-term savings

MODELING MEDICARE ON FEHBP

Better for BENEFICIARIES

- ⇒ Modernized health care delivery system
- ⇒ Integrated prescription drug coverage
- ⇒ Reduced need for supplemental coverage
- ⇒ Lower premiums, more choice

Better for GOVERNMENT/TAXPAYERS

- ⇒ Reduced need for government micro-management
- ⇒ Increased efficiency and long-term savings
- ⇒ Reduced pressure on discretionary spending

Better for PROVIDERS

- ⇒ Less regulatory burden
- ⇒ Less micro-management by Congress

⇒ Health care delivery system that integrates advances in medical technology

Kerrey Questions Clinton Opposition To Medicare Plan

HEALTH

SEN. BOB KERREY, D-Neb., a member of the now-defunct National Bipartisan Commission on the Future of Medicare, earlier this week called into question President Clinton's reasoning for not embracing the Medicare reform plan authored by the commission's chairman, **Sen. John Breaux**, D-La., and supported by Kerrey.

In an interview Tuesday with *CongressDaily* while visiting the White House, Kerrey declined to charge Clinton outright with seeking to politicize the issue — but he accused White House officials of “saying some things that are not right.”

And in questioning the validity of several problems Clinton said he had with the Breaux plan — problems Kerrey indicated the commission could have quickly resolved to the satisfaction of the needed supermajority of panel members — Kerrey suggested Clinton was voicing objections mainly to help sell to the public his refusal to back the proposal.

The Breaux proposal failed to muster support from 11 of the commission's 17 members, the number needed for the panel to make a formal

recommendation. All of Clinton's appointees opposed Breaux.

Breaux repeatedly attempted to convince Clinton to prod his appointees to come to terms with panel Republicans.

White House officials said that because Clinton viewed the panel as independent, he decided not to exercise any influence. Some critics said Clinton chose not to work for a deal and instead made Medicare a political football by proposing his own plan. The White House rejects the charge.

Noting the Breaux plan contemplated a very gradual increase in the retirement age from 65 to 67, Kerrey indicated White House officials have in recent days intentionally issued overheated complaints that the idea would swell the ranks of the uninsured unless there were a “buy-in” plan for those younger than 65.

“To use rhetoric saying it's a dangerous and drastic change — that's too much,” Kerrey complained. “We were that far apart,” Kerrey said — holding two fingers an inch apart — on a deal “for a reasonable buy-in.”

Similarly, conflict over a prescription drug benefit would have been

“easy to resolve,” according to Kerrey. “The Republicans wanted to do it,” he said. “We had provided \$60 billion” for the benefit, he added.

The White House wanted wider coverage than that offered by the Breaux plan, which would have guaranteed a prescription drug benefit for all Medicare recipients earning up to 135 percent of poverty.

The one significant issue where Kerrey acknowledged commission members were not close to a supermajority was Clinton's insistence on reserving 15 percent of the surplus for Medicare.

White House officials “really have only one” argument against the Breaux plan, Kerrey insisted, adding, “It's a bit misleading to emphasize other things.”

But Clinton would not have wanted “to say he was against the plan just because of the 15 percent issue,” Kerrey contended.

On the other hand, White House speeches “emphasizing more eligibility [are] an easier way to get an audience upset” about the Breaux proposal, Kerrey quipped.

— BY KEITH KOFFLER

Census Battle May Be Delayed Until Later This Year

GOVERNMENT OPERATIONS

House Commerce-Justice-

State Appropriations Subcommittee Chairman Harold Rogers, R-Ky., said Wednesday that House Republicans may wait until the FY2000 appropriations process later this year to oppose the administration's plan to use sampling in the 2000 census — but added that suggestion has yet to be accepted as a GOP strategy.

“The June 15 [deadline] is not very important because there is very little in the balance of the fiscal year that can be done as far as sampling is concerned,” Rogers told *CongressDaily*.

Congress must release the rest of the FY99 Commerce-Justice-State funding by June or the three departments could be shut down.

Before Republicans settle on a strategy, Rogers said the GOP is waiting for the Census Bureau to present its revised FY2000 budget request — which must include more funding to comply with a January Supreme Court decision that mandates a traditional count for apportionment purposes.

At a subcommittee hearing Wednesday, Rogers repeatedly asked Census Bureau Director Kenneth Prewitt for the bureau request, saying the administration has already begun to manipulate the census.

“I want to know it. The time is up,” Rogers declared. “What's the cost? Please tell us the cost. Tell me your cost.”

Prewitt responded the bureau

would not produce a number until it had a final request — which he said would not be before mid-April.

“Mr. Chairman, the accurate number is not ready,” Prewitt responded, eliciting a stern response.

“I do not trust the operatives in the White House, and the way they are manipulating you is shameful. It's sad,” Rogers said. “I know you can't answer that because you've been told not to.”

Based on a compromise reached in the FY98 C-J-S budget, Republicans contend the bureau should have prepared full operational plans and budgets for both a sampling and traditional count — giving the Supreme Court time to rule.

After question- *continued on page 12*

BREAUX-THOMAS MEDICARE REFORM PLAN

March 19, 1999

Medicare Commission has made an important contribution. Thanks to the leadership both of the Commission and the President, the problems facing the Medicare program are getting the attention it deserves.

The Breaux-Thomas proposal has advanced the debate. The plan has recommended a number of ideas worth serious consideration, including:

- **Making Medicare's traditional plan more competitive:** It recommends that the program use the same effective, competitive management tools that are used in the private sector.
- **Simplifying Medicare's complicated, confusing and multiple deductible structure:** It recommends creating a single, simple deductible. It also eliminates cost sharing for preventive services, an Administration priority for years.
- **Recognizes need for expanded coverage of prescription drugs:** By expanding Medicaid prescription drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries. But we can and must do better than providing coverage for fewer than one in ten beneficiaries. The widespread use of drugs in modern medicine, their high cost, and the inaccessibility and unaffordability of drug coverage present problems for all Medicare beneficiaries, not just the poorest.

Despite important contributions, the Breaux-Thomas proposal falls short.

- **It does not address Medicare's financing:** Because it includes no additional commitment for financing, the proposal ducks the economic reality that every independent Medicare expert confirms -- the demographic explosion of the Medicare program will require more financing. No amount of structural reform or cost cutting can compensate for this. The lack of financing makes the problem much larger to solve in the future and shifts more of the burden to our nation's children. This is why the President proposed to dedicate 15 percent of the surplus over the next 15 years to Medicare, to save some of today's prosperity for tomorrow's needs. We cannot waste this historic opportunity.
- **Raises the age eligibility for Medicare:** We are extremely skeptical of any plan that would increase the numbers of uninsured. The most rapidly growing group of the uninsured are between the ages of 55-65; raising the eligibility age of Medicare without a policy that assures that there will not be even more uninsured elderly is simply the wrong thing to do.
- **Includes flawed "premium support" proposal:** The President is committed to adding competition to Medicare, but not at the risk of harming the existing program or its beneficiaries. The current construction of the Breaux-Thomas premium support plan would raise premiums for traditional Medicare by 10 to 20 percent for most beneficiaries, according to the independent Medicare actuary. Although the plan attempts to address this problem for beneficiaries with no private plan options, those with limited or unattractive private options would be forced to pay more to stay in the system. We believe that this is unacceptable.

MODERNIZING TRADITIONAL MEDICARE

BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Breaux-Thomas Proposal. “The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate.”

[Building a Better Medicare for Today and Tomorrow, March 16, 1999 (10:20am)]

Senator John Breaux. “For instance, my premium support approach would create a new and improved HCFA by giving it powers that it has long sought including competitive bidding, which they really don’t have; negotiated pricing authority, which they desperately need; selective contracting, which would be helpful; and preferred provider arrangements, which I think would improve the system. These are ideas that are incorporated. There may be more than are needed that would make the current fee-for-service a more efficient and more productive program.” *[January 26, 1999 Commission meeting]*

Senator Bill Frist. “I think we absolutely have to give HCFA not necessarily more power, but the flexibility to compete, and that means some management tools. We’re modernizing. We’re improving. I think that’s what, at least, I would like to see.” *[January 26, 1999 Commission meeting]*

Senator Bob Kerrey. “But I would hope for those of us who would like to support and like the general outline of it [Breaux-Thomas proposal], I would hope that you will help us and make certain that the fee-for-service component is vigorous, it is competitive, that HCFA can have a competitive offering out there. Because, like Jay Rockefeller, I have got at least half of my population who have no competitive alternative right now. They are going to go with fee-for-service. And it has got to be vigorous.” *[February 24, 1999 Commission meeting]*

NATIONAL ACADEMY OF SOCIAL INSURANCE

“Given that FFS Medicare will continue to cover a substantial numbers of people, its beneficiaries (as well as the taxpayers who help pay for the program) deserve to realize the benefits of management innovations developed in private health plans and elsewhere.”

“Among the key features of private managed care that the Study Panel concludes may hold promise for FFS Medicare are: disease and case management; incentives to use selected providers; competitive procurement.”

“While experimentation [as encouraged by laws in 1996 and 1997] on a small scale is necessary in order to learn, these activities lack a broad mandate from Congress for the flexibility necessary for ongoing improvement of FFS Medicare.”

[Final Report of the Study Panel on Fee-For-Service Medicare: From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare. January 1998.]

PRESIDENT'S BUSH'S COMPREHENSIVE HEALTH PLAN

"To bring these excessive payments under control [for Medicare Durable Medical Equipment], the Secretary of the Department of Health and Human Services should be authorized to revise DME payment rates to reflect market considerations, using such procedures as **competitive bidding** to establish payment rates for oxygen and oxygen products." [*The President's Comprehensive Health Reform Program*, "issued on February 6, 1992].

CONGRESSIONAL BUDGET OFFICE

"The President's proposal would give the Secretary of HHS authority to adopt some of those techniques, including contracting with preferred provider organizations (PPOs), negotiating discounted rates for specific services, and developing systems to manage the care (in a fee-for-service setting) of certain diseases or beneficiaries. The potential savings from those changes are substantial." [*Director Dan Crippen, Senate Finance Committee, July 22, 1999*].

CONSERVATIVE EXPERTS

Gail Wilensky, President Bush's Administrator of the Health Care Financing Administration. "At a recent retreat on Medicare reform put together for this Committee, Lynn Etheridge outlined a series of changes that would be needed to modernize the traditional Medicare program. These included the use of selective contracting, centers of excellence, disease management programs, best practice programs, variations in benefit structures and other changes that are commonplace in the better-run private sector plans. The question in my mind is whether the Congress will allow HCFA the flexibility that would be needed to run such a program and whether the Congress and the Administration will provide HCFA with the resources needed to carry out such a task." [*Senate Finance Committee, May 27, 1999*]

Stuart Butler, The Heritage Foundation. "Specifically, Congress should refrain from locking HCFA into a statutory straightjacket, where its primary function is the rigid and increasingly onerous and ineffective micro-management of the financing and delivery of health care services for senior citizens under fee-for-service. Instead, Congress should give HCFA greater flexibility to run the traditional fee-for-service program in ways that would make it an aggressive competitor to managed care plans and other emerging private sector health care options in the next century. Thus HCFA should be permitted to introduce innovations into the management of traditional fee-for-service Medicare. It should be allowed, for instance, to make extensive use preferred provider organizations of those physicians and hospitals giving the best value for money. It should also be allowed to contract out the management of the traditional program in areas where that might improve Medicare." [*Senate Finance Committee, May 27, 1999*]

Lynn Etheredge, consultant. "There are many ..., but they start primarily with targeted areas where purchasing initiatives, as we can see in health plans and private employers, where purchasing initiatives would offer the most benefit to the Medicare Program. They range from using competitive bidding for standard services and supplies like DME to offering new Centers of Excellence, building on HCFA's very successful program such as for hip replacements and cancer care, buying disease management and case management services, even offering new benefits like prescription drugs on a competitively purchased basis from PBM's." [*August 10, 1998, Bipartisan Commission on the Future of Medicare testimony*]

Draft Presentation
for Daschle

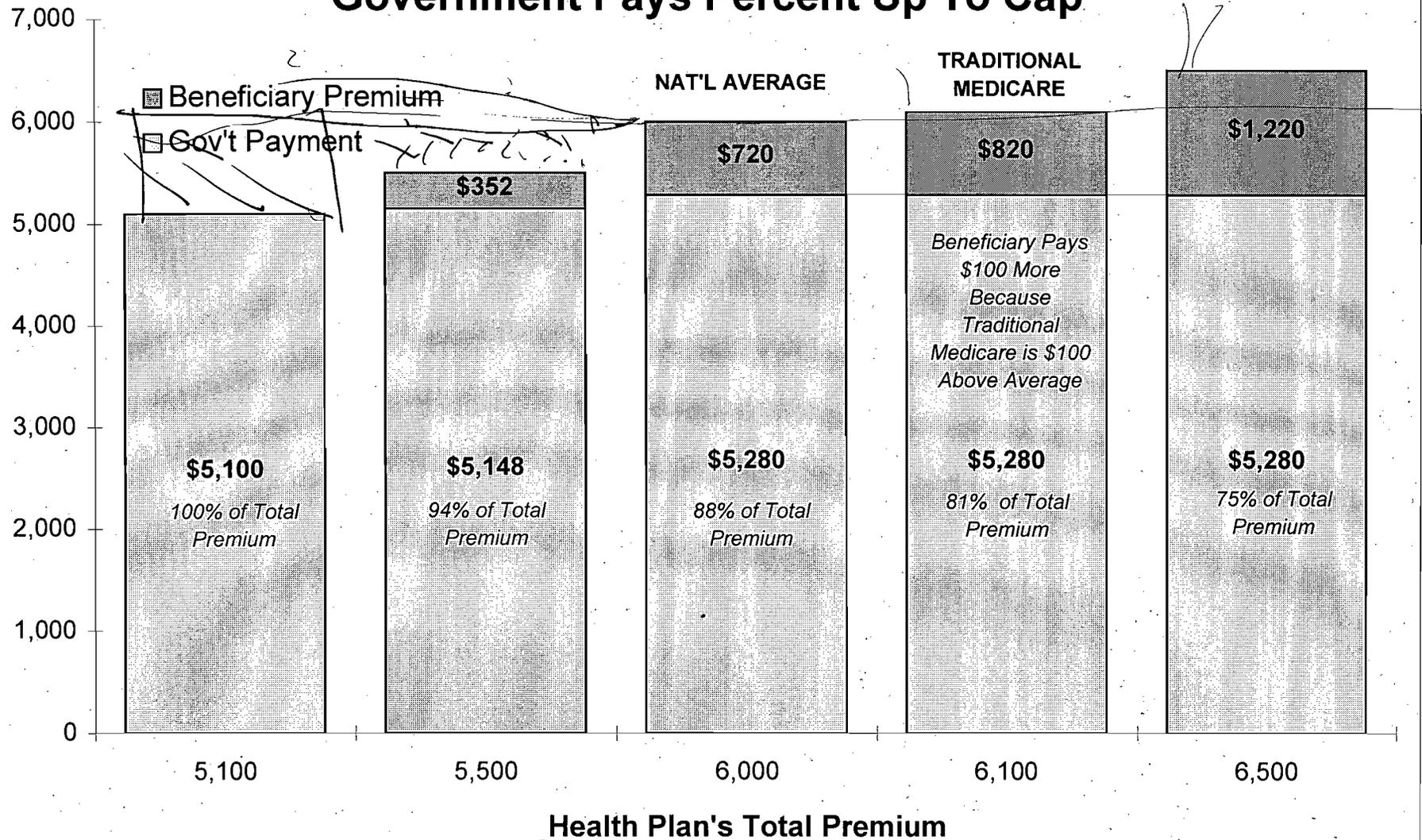
BREAUX-THOMAS PREMIUM SUPPORT PROPOSAL

- **Flexible benefits:** Requires that private plans offer at least the same benefits as traditional Medicare, but allows "variation within a limited range."
- **Government pays a percent of the premium up to a cap:** Medicare's payments would be based on the national weighted average premium for all plans. The government would pay 88% for an average-cost plan (roughly equal to the 25% Part B premium). It would pay less for lower cost plans, but no more for higher cost plans. Specifically, it would pay:
 - Premiums < 85% of average: Government pays 100% of the premium
 - Premiums 85-100% of average: Government pays from 100 to 88% of the premium.
 - Premiums > 100% of average: Government pays 88% percent of the national average
- **Beneficiaries pay the difference between the premium and the government payment --** including all of the additional premium for plans above the national average premium.

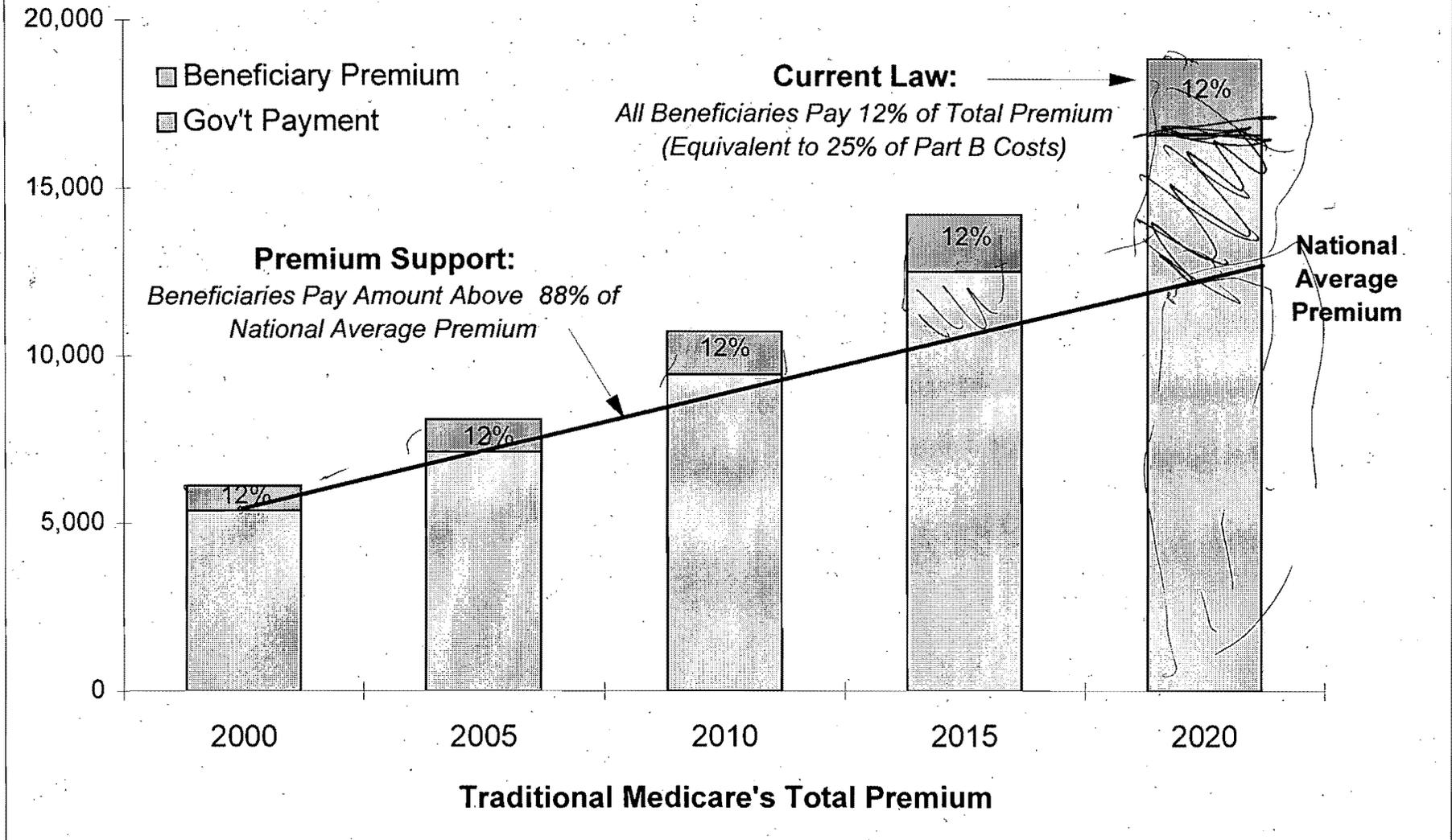
EXAMPLE: HOW PLANS WOULD BE PAID

Total Premium		Gov't Payment		Beneficiary Payment	
\$	% of Nat'l Average	\$	% of Total	\$	% of Total
\$5,100	85%	\$5,100	100%	0	0%
\$5,500	92%	\$5,180	94%	\$320	6%
\$6,000 Avg	100%	\$5,280	88%	\$720	12%
\$6,100 Traditional	102%	\$5,280	87%	\$820	13%
\$6,500	108%	\$5,280	81%	\$1,220	20%

Breaux-Thomas Premium Support Proposal: Government Pays Percent Up To Cap



Breaux-Thomas Premium Support Proposal: How It Works Over Time



MEDICARE BENEFICIARIES' ACCESS TO PRIVATE PLANS, 1999

	Medicare Population	Beneficiaries in Counties with Plans	Percent with Plans Available
Alaska	33,857	0	0%
Alabama	692,967	216,339	31%
Arkansas	447,444	138,681	31%
Arizona	669,634	669,634	100%
California	3,926,369	3,796,142	97%
Colorado	467,034	379,366	81%
Connecticut	522,954	522,954	100%
District of Columbia	78,990	78,990	100%
Delaware	111,420	64,722	58%
Florida	2,827,909	2,517,595	89%
Georgia	918,897	356,430	39%
Hawaii	165,086	165,086	100%
Iowa	487,822	14,048	3%
Idaho	164,166	56,462	34%
Illinois	1,677,552	1,218,574	73%
Indiana	867,239	319,952	37%
Kansas	398,488	139,957	35%
Kentucky	632,519	163,288	26%
Louisiana	618,923	542,874	88%
Massachusetts	980,467	980,467	100%
Maryland	646,783	646,783	100%
Maine	217,456	136,536	63%
Michigan	1,423,655	891,541	63%
Minnesota	663,069	320,265	48%
Missouri	876,690	507,141	58%
Mississippi	425,916	0	0%
Montana	138,454	0	0%
North Carolina	1,132,363	545,903	48%
North Dakota	105,450	0	0%
Nebraska	258,367	67,211	26%
New Hampshire	169,792	109,481	64%
New Jersey	1,222,342	1,222,342	100%
New Mexico	234,080	144,823	62%
Nevada	230,776	204,580	89%
New York	2,757,325	2,555,046	93%
Ohio	1,737,055	1,628,861	94%
Oklahoma	516,437	422,362	82%
Oregon	495,255	421,245	85%
Pennsylvania	2,137,439	2,137,439	100%
Rhode Island	174,273	174,273	100%
South Carolina	567,020	65,437	12%
South Dakota	121,606	0	0%
Tennessee	836,547	614,430	73%
Texas	2,269,772	1,690,653	74%
Utah	204,742	0	0%
Virginia	883,916	468,927	53%
Vermont	89,392	0	0%
Washington	741,426	632,992	85%
Wisconsin	797,556	341,362	43%
West Virginia	344,636	124,975	36%
Wyoming	65,648	0	0%
TOTAL	39,174,975	28,416,169	73%

SOURCE: HHS estimates; March 1999

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE

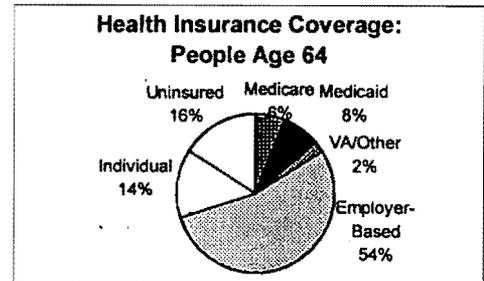
PROPOSAL: The Breaux-Thomas proposal increases the Medicare age eligibility from 65 to 67, one month per year, parallel to Social Security. Some proposals include an unsubsidized Medicare buy-in proposal, similar to what the President has proposed for certain people ages 55 to 65.

ISSUES:

- **The availability and affordability of health insurance for people in their early 60s has not improved -- and in fact has deteriorated.**
 - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups.
 - **Fewer have employer-based health insurance.** Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.
 - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is the most expensive and inaccessible insurance option for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.
- **Different than Social Security because it is more difficult to postpone health care needs than retirement.** Unlike preparation for income security in retirement, illness and disability are rarely foreseeable. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would affect people with the greatest risk of health problems and lowest probability of finding affordable private health insurance.
- **Breaux-Thomas proposal does not conform to Social Security.** Even under current law, Social Security provides the option for a partial benefit at age 62. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62. Thus, it does not accurately conform to Social Security policy.

- **Raising Medicare's age eligibility could have serious consequences.** Although the Federal government and Medicare Trust Fund would save from raising Medicare's eligibility age, it could create other costs and problems.

- **Increase the uninsured.** Nearly one in ten Medicare beneficiaries today is either age 65 or 66. In 1998, 16 percent of people age 64 were uninsured. If the 3.7 million people age 65 and 66 were to lose Medicare, it could be assumed that 16 percent of this group would also be uninsured -- nearly 600,000. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance.



- **Cost shift to employers.** About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage if these older people continue to work. Costs would result not only from covering workers longer, but from higher premiums for all workers since this older group would raise the average costs of all employees. The few firms that offer retiree coverage would pay more as well, since their insurance would be the primary source of coverage, not a wrap-around to Medicare. This could accelerate the trend of dropping retiree coverage. Finally, the Federal government would lose revenue as employers deduct additional cost of premiums.
- **Unfunded mandate to states.** State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.
- **No viable policy has been offered to prevent the elderly uninsured from increasing.**
 - **Medicare buy-in cannot replace Medicare.** Some proponents of raising the age eligibility of Medicare have suggested that the President's Medicare buy-in proposal as a health insurance alternative for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in.
 - **Costs of subsidies for buy-in would reduce savings.** The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about \$27,000 for a single), the cost of subsidies would be high, lowering savings.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 16, 1999

REMARKS BY THE PRESIDENT
UPON DEPARTURE
ON MEDICARE REFORM

Outside Oval Office

3:55 P.M. EST

THE PRESIDENT: Good afternoon. I would like to begin by saying that our thoughts and prayers are with all those people who were involved in this morning's Amtrak crash in Illinois. We've dispatched safety officials from the National Transportation Safety Board and other federal investigators to the site to lead the investigation. I want you to know that we will do everything we can to help the victims and their families, and to ensure that the investigation moves forward with great care and speed.

Now, before I leave for Florida I would also like to comment on an issue of vital importance to our future -- how to strengthen the Medicare program for the 21st century.

Today, Senator Breaux and Representative Thomas will hold a final meeting of their Medicare Commission. Although it did not achieve consensus, the commission has helped to focus long overdue attention on the need to modernize and prepare the program for the retirement of the baby boom generation, and for the present stresses it faces. The commission has done valuable work, work that we can and must build on to craft Medicare reform.

Make no mistake, we must modernize and strengthen Medicare. For more than three decades, it has been more than a program. It has been a way to honor our parents and grandparents, to protect our families. It has been literally lifesaving for many, many seniors with whom I have personally talked.

In my 1993 economic plan that put our country on the path to fiscal responsibility, we took the first steps to strengthen Medicare. In 1997, in the bipartisan balanced budget agreement, we took even more significant actions to improve benefits, expand choices for recipients, to fight waste, fraud and abuse, and to lengthen the life of the trust fund.

But as the baby boomers retire, and medical science

extends the lives of millions, we must do more -- we must take some strong and perhaps difficult steps to modernize Medicare so that it can fully meet the needs of our country in the new century. If we don't act, it will run out of funds. That would represent a broken promise to generations of Americans, and we cannot allow it to happen.

As I said in January, we must act, and when we do our actions should be grounded in some firm principles. We must seize the opportunity created by our balanced budget and surplus to devote 15 percent of the surplus to strengthen the trust fund.

We must modernize Medicare and make it more competitive, adopting the best practices from the private sector and maintaining high quality services. We must ensure that it continues to provide every citizen with a guaranteed set of benefits. And we must make prescription drugs more accessible and affordable to Medicare beneficiaries.

The plan offered by Senator Breaux and his colleagues included some very strong elements, which should be seriously considered by Congress. However, I believe their approach falls short in several respects. First it would raise the age of eligibility for Medicare from 65 to 67, without a policy to guard against increasing numbers of uninsured Americans.

I know that back in 1983, the commission voted in Social Security and the Congress ratified a decision to slowly raise the Social Security age to 67. But there is a profound difference here. Perhaps the fastest growing number of uninsured people are those between the ages of 55 and 65. We cannot simply raise the age to 67 without knowing how we're going to provide for health insurance options for those who are already left out in the cold between the ages of 55 and 65. It is simply not the right thing to do.

Also, the proposal has the potential to increase premiums for those in the traditional Medicare program beyond the ordinary inflation premiums that keep the percentage paid by the beneficiaries the same. It does not provide for an adequate, affordable prescription drug benefit.

But most important of all, it fails to make a solid commitment of 15 percent of the surplus to the Medicare trust fund. That is the biggest problem. Even if all the changes recommended by the commission were adopted, because of the projected inflation rates in health care costs, it would not be sufficient to stabilize the fund. Only by making this kind of commitment can we keep the program on firm financial ground well into the next century.

Every independent expert agrees that Medicare cannot

provide for the baby boom generation without substantial new revenues. Beyond that, it is clear the it will also require us to make difficult political and policy choices. Devoting 15 percent of the surplus to Medicare would stabilize the program -- and improve our ability to modernize and improve its services, and to make those hard choices.

I want to thank the members of the Medicare Commission for their hard work and for their recommendations. Today, I am instructing my advisors to draft a plan to strengthen Medicare for the 21st century, which I will present to this Congress. I look forward to a good and healthy debate about how best to strengthen this essential program. We must find agreement this year. Medicare is too important to let partisan politics stand in the way of vital progress. I believe if we make the hard choices, if we work together, if we act this year, we can secure Medicare into the future.

Thank you very much.

Q. Mr. President, your critics are suggesting that by not endorsing the Breaux plan you're simply assuring that there will be a campaign issue, something the Democrats can run on.

THE PRESIDENT: I want an agreement this year. I have given my best assessment of where we are now, of what my

objections are. I think it is now incumbent upon me to present an alternative proposal, and I will do that.

But I want to make it clear that I believe we owe it to the American people to make an agreement this year, and I'm going to do my dead-level best to get it done.

Thank you.

END

4:19 P.M. EST

BREAUX-THOMAS MEDICARE REFORM PROPOSAL

Senator Breaux has made a constructive contribution toward addressing the challenges facing Medicare. After more than a year of work, the Medicare Commission has helped to focus long-overdue attention on the need to modernize the program and prepare it for retirement of the baby boom generation. Some of its recommendations should be seriously considered by the Congress. The President wants to thank Senator Breaux, Congressman Thomas and all the members of the Commission, particularly his appointees (Laura Tyson, Stuart Altman, Bruce Vladeck and Tony Watson), for all their hard work.

The Breaux-Thomas plan, however, falls short in a number of key areas and therefore the President cannot support it. In January, the President outlined the principles that he would use to evaluate the Commission's work product. This plan does not appear to include elements that are essential to strengthening Medicare and better preparing it for the twenty-first century. In particular, the plan:

- **Does not provide necessary new revenues for Medicare and passes up an historic opportunity to dedicate 15 percent of the surplus to the program.** Every independent Medicare expert agrees that the program cannot provide the baby boom generation with Medicare benefits without substantial new revenue. Unfortunately, the Breaux-Thomas plan does not provide these new revenues. Instead, it recommends waiting to act until Medicare's solvency is at risk. But waiting will make the problem harder to solve and shift more of the burden to our children. This is why the President proposed to dedicate part of the surplus to Medicare immediately, to save some of today's prosperity for tomorrow's needs.
- **Increases Medicare eligibility age without a policy to protect against large increases in the numbers of the uninsured.** As you know, the President is deeply concerned about the increase in the uninsured population, particularly among older Americans. That is why he proposed allowing some people ages 55 to 65 to buy into Medicare. These problems will only get worse under a proposal that postpones Medicare eligibility without providing premium assistance for alternative health coverage.
- **Proposes a premium support model that could adversely affect premiums for the traditional Medicare program.** The President is committed to adding competition and private sector approaches to the Medicare program, but will not risk harming the existing program or its beneficiaries. Senator Breaux's premium support model has the potential to increase premiums for the traditional Medicare program and, as such, make it more difficult to access. The President cannot support this premium support concept until these and other fundamental questions are adequately answered.
- **Provides inadequate coverage of prescription drugs.** While the President recognizes Senator Breaux's leadership in acknowledging the need for prescription drug coverage, the Breaux-Thomas proposal does not provide an accessible, affordable option for all beneficiaries. Most respected health economists agree that the current system's patchwork coverage of prescription drugs is highly inefficient and expensive. Senator Breaux's proposal goes part of the way but not far enough to reform this system.

The President will build on the Commission's work and develop and propose a plan that can go the next step in attracting even greater consensus. He has instructed his health care advisors to take the best ideas from the Breaux-Thomas plan, from members of the Commission not voting for its plan, and from other members of Congress to craft a proposal that can receive bipartisan support and truly prepare Medicare for its future challenges. Medicare is not and should not become a partisan, political issue and the President is determined to work across party lines to strengthen and improve the program this year.

MAJOR ISSUES WITH THE BREAUX-THOMAS PLAN

- **No specific plan for Medicare financing:** The plan contains no options for raising new revenue for Medicare -- and does not reference the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding. By waiting, the size of the funding needed becomes larger, and the burden of paying for it increasingly gets shifted to younger generations.
- **Overly optimistic estimates of premium support savings:** The Commission's document uses Commission staff estimates of the impact of premium support on growth -- suggesting that it could reduce Medicare spending by 1 percentage point. This is considerably larger than what the HCFA Actuaries -- who also report to the Medicare Trustees -- project. Their estimates suggest that premium support reduces growth by about 0.2 percentage over time.
- **Vague premium support plan:** The premium support proposal is missing essential information on how it would work-- which, in turn, determines how much it will save and how much it will affect beneficiaries. For example, it is not clear when and how payments will be adjusted for the beneficiaries' risk. There is no mention of geographic adjustment, implying that a beneficiary could end up paying more for a private plan -- not because the plan is more expensive -- but because they live in an urban area. And, since private plans can offer unstandardized extra benefits, possibly at the government's expense, price competition -- the goal of premium support -- could be replaced by competition on benefits and risk.
- **No meaningful prescription drug benefit:** Although the proposal would require private managed care plans, Medigap, and Medicare fee-for-service to offer a drug benefit, there appears to be no definition of what this benefit is. Moreover, it would only provide premium assistance for beneficiaries with premiums below 135 percent of poverty through Medicaid. This would move Medicare towards a means-tested, Medicaid-like program. It also would inevitably result in large adverse selection in the unsubsidized Medicare fee-for-service option, especially since beneficiaries would have to purchase stop-loss as well as drug coverage, which attracts sicker beneficiaries.
- **Age eligibility increase without a viable insurance alternative:** Although there is a suggestion that vulnerable sick people ages 65 to 67 would get Medicare, the proposal explicitly states that the Medicare buy-in would be unsubsidized and would not begin at 62 (which is truly conforming to Social Security). This plan would lead to a potentially large increase in the uninsured.
- **Removing direct medical education is the same "gimmick" that the Commission criticizes:** The Commission's report criticizes proposals to transfer liabilities out of Medicare to improve solvency. Yet, the Commission itself proposes to do this. About one-fifth of the "savings" of the Commission is not Federal budget savings, but movement of education spending from Medicare to other parts of the budget.
- **Board could end up being a new bureaucracy:** Although there are legitimate reasons for a new independent board, it appears to have so many functions -- including a negotiation with each and every plan interested in participating in Medicare -- that it would end up being a large bureaucracy -- but one that is exempted from government oversight.