

## National Bipartisan Commission on the Future of Medicare

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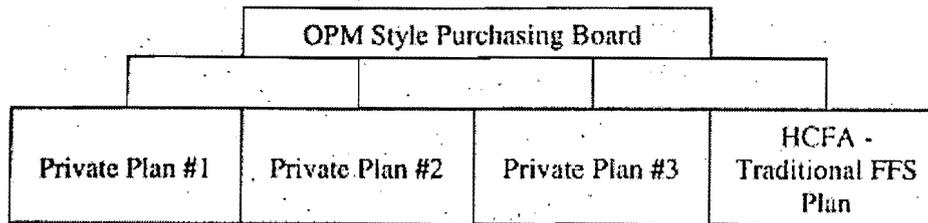
### **GO TO: [Medicare HOME](#)**

### **The Medicare Board**

#### **Overview**

There is a critical need for an administrative body that would perform a number of functions to ensure that a premium support system is successful. This administrative body--probably in the form of a Medicare Board--would look like other federal boards, for example, the Federal Reserve Board or the Thrift Savings Plan Board. The Medicare Board would:

1. Be established outside of the Health Care Financing Administration (HCFA) for the purpose of administering the Medicare program.
2. Be an active purchaser of health care for beneficiaries, negotiating benefits and premiums with private plans wishing to participate in the Medicare market.
3. Have full negotiating authority, similar to that of the board that administers the California Public Employees' Retirement System (CalPERS). The CalPERS board controls health insurance plans' access to the Medicare market in that state. Plans failing to meet the Board's criteria for price, quality, efficiency, and other factors would not be able to offer coverage to the Medicare population.
4. Have the authority to make all determinations regarding covered benefits. The Board would provide clear explanations of exactly what plans, including HCFA, are being asked to bid during each contract period. Plans would have the opportunity to offer their own ideas of how benefits might be structured, such as cost-sharing differences in and out-of-network, but the Board would have final authority.
5. As part of its annual negotiations with plans, would ensure that benefits offered by plans would not lead to an unintended government contribution expansion. If plans wished to offer additional benefits the Board believed would lead to an expanded government contribution--"benefit creep"--they could do so under certain conditions. Those benefits might be offered as a separate "rider," fully funded by the beneficiaries and not included in any computation of the government contribution.
6. Operate an annual open enrollment process similar to the one operated by the Federal Employees Health Benefits Program (FEHBP). The process would offer beneficiaries a wide choice of plans and stimulate active competition among plans for the beneficiaries' business. Beneficiaries would have been exposed to this type of process through their Medicare+Choice open-enrollment experiences.
7. HCFA would continue to offer the traditional fee-for-service (FFS) plan and compete for beneficiaries like all other plans. There would be an updated benefit package with combined deductibles. The FFS plan would be available in all markets. HCFA could use third party administrators in some areas or for some services.



### Board Responsibilities:

The Medicare Board would be established outside of HCFA, which would run the FFS program and deal with the Board as any private plan. The Board would have the same authority and responsibility regarding FFS as it has for private plans. The traditional Medicare fee-for-service (FFS) program would be one of the plans under premium support and be available nationwide to all beneficiaries.

The Board's management processes would be similar to those used by the CalPERS Board with its health insurance program and by the Office of Personnel Management (OPM) with FEHBP.

The Board would be responsible for determining beneficiary eligibility. Coordinating and contracting with the Social Security Administration, currently done by HCFA, would fall to the Board.

The Board would issue an annual request for proposals from health plans to furnish benefits to Medicare beneficiaries. The request would specify all the requirements a plan must meet to have its bid considered acceptable including core benefits, adequacy of access to care through the plan's provider network, financial solvency, quality assurance, and beneficiary appeals. The request would highlight any changes in requirements enacted by Congress and the President as well as any new requirements administratively adopted by the Board.<sup>1</sup>

The Board would review submitted bids to assure that all statutory requirements have been met. Benefit packages offered in the bids would be reviewed with an eye toward assuring that each package adequately meets core benefit requirements and is not designed to attract a non-representative subpopulation of beneficiaries and thus lead to either favorable or adverse selection. The Board would also review benefit packages to prevent benefit creep resulting in increased costs to both beneficiaries and taxpayers. If benefits are not acceptable, the Board would negotiate with the plan a package that is acceptable or not permit the plan to solicit enrollees. The Board would assess the premiums each plan intends to charge to assure that premiums are neither too high nor too low for the benefit package agreed upon.

After approving benefits packages and premium rates, the Board would inform beneficiaries of the plans available to them, including Medicare FFS, in preparation for the annual open enrollment period when beneficiaries can choose to change plans. The Board manages the open enrollment and notifies plans of any beneficiary enrollment changes. Based on beneficiary selections and the statutory formula for establishing the beneficiary and government contributions toward the premium, the Board will compute a beneficiary premium for each plan.<sup>2</sup> The Board cannot change the statutory formula, but will merely apply it.

The Board would be responsible for monitoring health plan performance throughout the year, arranging for quality monitoring through organizations like the current Peer Review Organizations (PROs). Quality indicators of plan performance based on enrollee rating results would be sent to every enrollee annually. Plans would be rated according to their performance regarding coverage, access to care, emergency care,

choice of doctors, and other factors. Accreditations, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission on the Accreditation of Health Organizations (JCAHO), would be encouraged and reported to enrollees.

The Board would set up a mechanism to provide an outside-of-plan process for beneficiary grievances and denials of services appeals. Ombudsman services and other services to facilitate the relationship between beneficiaries and plans would be established.

Members would be appointed by the President and confirmed by the Senate. Terms would overlap and be long enough length so no one President would be able to appoint the majority of the Board, and a significant percentage of the Board would not turn over at the same time.

Members would be chosen to reflect the interests of beneficiaries, working taxpayers and providers. "Providers" include health plans and health care providers--such as hospitals and physicians. The Board would have a staff of full time civil servants, as well as contracting authority for outside assistance, such as consulting actuaries.

#### **Characteristics of HCFA under premium support:**

The FFS program would be subject to the Medicare Board. HCFA would have the same relationship with the Board as would private plans. For example, the FFS bid would be submitted to the Board and subject to the same requirements/review as private plans.

The Congress and the President would retain authority over benefit modifications to the FFS program through an appropriate legislative approval/disapproval process. The process would be expeditious to enable FFS to make any necessary changes in time to compete for enrollees.

The current FFS administrative structure should meet FFS' needs in a premium support system. Continued use of intermediaries and carriers to process claims, PROs to review quality and necessity of care, and other contractors for various functions would be appropriate. Additional flexibility to select and compensate contractors is desirable so better efficiency and effectiveness incentives could be realized.

HCFA would submit FFS coverage bids like other plans. There would be one national bid, likely based on expected average cost per beneficiary on a national basis. This is similar to the United States per capita cost (USPCC) used in the former risk contract HMO program so it is not new to HCFA. The geographic adjuster should minimize high cost area/low cost area cross subsidization and its effect on plan competition.

HCFA would be required to submit a bid for every area. FFS would be required to bid on all geographic areas to ensure that it is an available choice everywhere. Except for this requirement, FFS would face the same bid requirements as private plans.

There are new issues concerning the effect of FFS making or losing money on its bids. FFS would need a reserve fund similar to those generally required of private insurers and HMOs. Initially, all or part of the current surplus in the Medicare trust funds might be used to establish a contingency reserve for FFS. FFS would cover losses from the reserve fund and use gains to increase the level of the reserve fund.

FFS would need to adjust its premium bids up or down over time as the reserve fund decreased or increased to assure that beneficiaries do not pay too much or too little. As with all other plans in the system, the Board would annually review the amount in the reserve fund and premium levels to ensure that the fund does not become too high or

too low. OPM reviews health plans under FEHBP to assure their reserve funds remain within reasonable ranges and can require premium adjustments if it determines plans have not done so.

Whatever financing method--appropriations and/or trust funds--is chosen, private plans could also be used for FFS. Under a premium support model, sufficient funding must be made available to cover the government's share of the premium for all plans selected by beneficiaries.

The distinction between Part A and Part B services could be maintained and premium costs divided into and funded separately by the two trust funds, just as today.

The distinction could be eliminated and premium costs funded through payroll tax receipts combined with appropriated general revenues. This would remove the current artificial difference among services and facilitate viewing the overall benefit package as an integrated whole.

The FFS program would compete for enrollees and participate in the annual enrollment period just like other plans. The Medicare Board would send all beneficiaries information on all plans available to them, including FFS, and FFS would prepare and distribute brochures like other plans.

#### Endnotes

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1 In the premium support system, low income beneficiaries would receive a larger government contribution, resulting in the opportunity to enroll in zero-premium plans, a situation similar to CalPERS. In these cases, the Board might act more like the CalPERS Board than OPM. If necessary, it would negotiate more actively to ensure that low income beneficiaries receive a high quality of care in a cost efficient manner.

2 The statute would set the government's premium percentage as a set percent of the weighted average national premium. The percentage would vary based on the beneficiary's income. Low income beneficiaries would not pay premiums, moderate income beneficiaries would pay the same portion as under current law (12 percent in 2003), and high income beneficiaries would pay 25 percent of the costs of an average plan.

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IMPORTANT -

Milee + Bonnie are waiting to talk about Board, but OMB not on call - How  
dowe do this gracefully?



# **The National Bipartisan Commission on the Future of Medicare**

**Senator John Breaux**  
Statutory Chairman

**Congressman Bill Thomas**  
Administrative Chairman

**Contact: Rusty Jabour, (202) 252-3394**  
**Website: <http://medicare.commission.gov>**

## **Commission Meeting**

**Tuesday, March 16, 1999 / 5:00 p.m.**  
Longworth House Office Building, Room 1100  
Washington, D.C.

**This package contains the:**

**List of Commissioners**  
**Discussion Materials**



# The National Bipartisan Commission on the Future of Medicare

**Senator John Breaux**  
Statutory Chairman

**Congressman Bill Thomas**  
Administrative Chairman

## List of Commission Members

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*Photos and biographical sketches of the  
Commission members are available through our  
website at <http://medicare.commission.gov>*

## SUMMARY OF BREAUX - THOMAS PROPOSAL

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### **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.

## SUMMARY OF BREAUX - THOMAS PROPOSAL

### **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. In areas where all high option plans cost more than this 85% threshold, the percentage will be determined locally to ensure that all low-income beneficiaries

have access to high option plans. 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 HCEA 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 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
<b>Baselines</b>													
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
<b>Viability Standard Based on Spending</b>													
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
<b>Preliminary Estimate</b>													
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
<b>Medicare Spending as a Percent of GDP</b>													
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
<b>Medicare Spending as a Percent of Payroll <sup>1</sup></b>													
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
<b>Medicare Spending as a Percent of the Federal Budget <sup>2</sup></b>													
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
<b>Medicare Spending in Billions of Dollars</b>													
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
<b>Average Annual Growth in Spending from Previous Year Shown</b>													
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
<b>Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)</b>													
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
<b>Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) <sup>3</sup></b>													
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
<b>Medicare Spending as a Percent of GDP</b>													
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
<b>Medicare Spending as a Percent of Payroll <sup>1</sup></b>													
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
<b>Medicare Spending as a Percent of the Federal Budget <sup>2</sup></b>													
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
<b>Medicare Spending in Billions of Dollars</b>													
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
<b>Average Annual Growth in Spending from Previous Year Shown</b>													
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
<b>Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)</b>													
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
<b>Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) <sup>3</sup></b>													
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
<b>Billions of Dollars</b>													
<b>Trustees Intermediate Baseline</b>													
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
<b>March 14 Proposal</b>													
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
<b>Percent Distribution</b>													
<b>Trustees Intermediate Baseline</b>													
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
<b>March 14 Proposal</b>													
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
<b>Memorandum: Part A Fund (in billions of dollars)</b>													
<b>Trustees Intermediate Baseline</b>													
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
<b>Billions of Dollars</b>													
<b>No Slowdown Baseline</b>													
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
<b>March 14 Proposal</b>													
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
<b>Percent Distribution</b>													
<b>No Slowdown Baseline</b>													
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
<b>March 14 Proposal</b>													
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
<b>Memorandum: Part A Fund (in billions of dollars)</b>													
<b>No Slowdown Baseline</b>													
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
<b>Billions of Dollars</b>											
<b>Inflows</b>											
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
<b>Total, Inflows</b>	<b>307</b>	<b>329</b>	<b>352</b>	<b>373</b>	<b>395</b>	<b>418</b>	<b>443</b>	<b>469</b>	<b>496</b>	<b>525</b>	<b>559</b>
<b>Outflows</b>											
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
<b>Total, Outflows</b>	<b>307</b>	<b>329</b>	<b>352</b>	<b>376</b>	<b>402</b>	<b>431</b>	<b>461</b>	<b>494</b>	<b>530</b>	<b>570</b>	<b>617</b>
<b>Net</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3)</b>	<b>(7)</b>	<b>(13)</b>	<b>(18)</b>	<b>(25)</b>	<b>(34)</b>	<b>(45)</b>	<b>(57)</b>
<b>Balance</b>	<b>150</b>	<b>150</b>	<b>150</b>	<b>147</b>	<b>140</b>	<b>127</b>	<b>109</b>	<b>84</b>	<b>49</b>	<b>4</b>	<b>(53)</b>
<b>Memorandum:</b>											
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.

## 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.

## **MEDICARE REFORM:**

### **Republican Leadership's "Premium Support" Plan**

- **OVERVIEW OF MEDICARE DEBATE**
- **CHALLENGES FACING MEDICARE**
- **REPUBLICAN QUOTES IN SUPPORT OF BREAUX-THOMAS "PREMIUM SUPPORT"**
- **SHORTCOMINGS OF REPUBLICAN LEADERSHIP'S MEDICARE REFORMS**
- **ISSUES WITH "PREMIUM SUPPORT"**
- **PRESIDENT'S ALTERNATIVE TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21<sup>ST</sup> CENTURY**

## OVERVIEW OF MEDICARE DEBATE

- **Great Challenges Facing Medicare.** Medicare's enrollment will double by 2035 (from 39 to 80 million). As a result, Medicare's trust fund will become insolvent in 2015 – about 20 years earlier than Social Security. In addition to these financing challenges, about 75 percent of beneficiaries lack decent, dependable, private-sector drug coverage.
  
- **Republican Leadership's Commitment to Premium Support Plan**
  - Republican leadership has publicly supported the Breaux-Thomas "premiums support" proposal. This plan would:
    - Create "premium support" that would coerce beneficiaries into managed care by raising premiums for traditional Medicare by 10 to 30 percent.
    - Dedicate no new revenue to extend the life of the Medicare trust fund and no revenue to moderate the Medicare provider payment reductions in the Balanced Budget Act
    - Not include a meaningful drug benefit that is affordable and accessible to all beneficiaries
    - Raise the age eligibility
    - Include an unlimited home health and nursing home copay.
  
- **Democrats' Commitment to Strengthening and Modernizing Medicare**
  - The President's Medicare plan: (1) makes Medicare more efficient and competitive – without premium increases; (2) modernizes Medicare's benefits – including adding a long-overdue prescription drug benefit for all beneficiaries and eliminating preventive services cost sharing; and (3) dedicates surplus to strengthen Medicare.

## CHALLENGES FACING MEDICARE

- **Medicare population will double:** Enrollment in Medicare will increase by over 100 percent -- from 39 to 80 million by 2035 -- as the baby boom generation retires.
- **Cost growth will rise -- as will need for more competition and greater efficiency in Medicare:** Although Medicare has recently reined in cost growth, increasing costs are projected to return after most of the Balanced Budget Act Medicare provisions expire in 2003.
- **Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security.** Just as the baby boom generation starts to retire, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries.
- **About 75 percent of beneficiaries lack decent, dependable, private-sector drug coverage.**
  - At least 13 million beneficiaries have absolutely no coverage at all.
  - Medigap is inadequate, expensive, and increases with age.
  - Most Medicare managed care plans have inadequate and declining coverage. Nearly 3/5<sup>ths</sup> of managed care plans will cap drug spending below \$1,000 in 2000. The proportion of plans with caps of \$500 or less will increase by 50 percent. However inadequate, at least 11 million Medicare beneficiaries have no managed care option at all.
  - Medicaid and other public programs cover another 17 percent of beneficiaries, but eligibility is restrictive and participation is very low (less than 50 percent).
- **Private retiree health plans, which cover less than one-quarter of beneficiaries, are declining.** The number of firms offering retiree health insurance coverage dropped by 25 percent between 1993 and 1998. This trend will almost inevitably continue without new incentives to retain it.

## REPUBLICAN LEADERSHIP SUPPORT FOR BREAU-THOMAS MEDICARE "PREMIUM SUPPORT" PLAN

### **CONGRESSMAN DENNIS HASTERT (R-IL)**

"I think that the Breau Commission certainly did credible work on this, and there seems to be bipartisan support for it in the Senate. I would like to see that start to jell, and to see how it moved through the Senate. And if there's bipartisan support for such a bill here (in the House), then I'm going to take a look at it." (Interview with The National Journal on March 20, 1999)

### **REP. DICK ARMEY (R-TX)**

Armeay said it would have been 'nice' to have the recommendation as a 'departure point' for consideration as Congress looks at other proposals." (Houston Chronicle, March 17, 1999)

### **SENATE MAJORITY LEADER TRENT LOTT (R-MS)**

"We had a Medicare commission chaired by Democrat John Breau and co-chaired by Republican Bill Thomas. **They came up with a good proposal.**" (Meet the Press, July 11, 1999)

"... we had a Medicare Commission that came up with a very positive bipartisan proposal that we should act on." (Press conference on 7/27/99 – FDCH Political Transcripts).

### **SENATOR DON NICKELS (R-OK)**

"Let's work off that [Breau-Thomas proposal]. **Let's see if we can enact that, make it into law and save Medicare.**" (FOX News Sunday, July 11, 1999)

### **GOVERNOR GEORGE W. BUSH (R-TX)**

"I thought **many elements of the Breau plan were attractive to me.**" (Washington Post April 25, 1999)

### **SENATOR JOHN MCCAIN (R-AZ)**

"I'm glad we started the debate. **I'd like to go back to the Breau Commission, John Breau, Democrat from Louisiana commissioned the recommendations. I think they would form a good basis for us to try to move forward with.**" (CNBC Hardball with Chris Matthews, June 30, 1999)

### **SENATOR ORRIN HATCH (R-UT)**

**Most all of us would support the Breau -Thomas Medicare reform, that literally would reform Medicare, rather than just take the surplus and spend it on Medicare. ... we should go with Breau -Thomas and get this thing done right.** (CNN Late Edition, July 4, 1999).

## REPUBLICAN LEADERSHIP'S MEDICARE REFORM PLAN

- **Adopts “premium support” proposal that raises premiums and effectively coerces beneficiaries into managed care:** Their “premium support” proposal caps the government contribution for all plans. Since the cost of traditional Medicare will be above the cap, its premium will rise nationwide – from 10 to 30 percent, depending on the plan. This financial penalty for staying in traditional Medicare will force many beneficiaries to enroll in managed care.
- **Lack of dedication of surplus threatens Medicare’s financing and ability to modernize benefits:** The Republican Leadership’s tax bill dedicates:
  - No new revenue to extend the life of the Medicare trust fund by a single day and protect against the need for excessive provider/beneficiary cuts in the future.
  - No funding for moderating the Medicare provider payment reductions in the Balanced Budget Act (BBA) of 1997 which are excessive.
  - No funding for a prescription drug benefit that is affordable and accessible to all beneficiaries.
- **Inadequate prescription drug benefit leaves out millions of middle-class Medicare beneficiaries:** The Republicans’ plan gives a tax deduction to buy Medigap insurance with prescription drugs. About 55 percent of elderly do not have tax liability and thus would not qualify for a deduction and even those that do often lack access to Medigap because they are sick or have no plan options. It also limits additional coverage to those with incomes below 150 percent of poverty (about \$12,750 a year for a single, \$17,000 for a couple). This does not help the more than half of beneficiaries without drug coverage who are middle class nor the millions more who have expensive and/or poor coverage.
- **Raises the age eligibility for Medicare to 67, increasing the number of uninsured:** Since people ages 55 to 65 are the most rapidly growing group of uninsured, raising the eligibility age without a policy alternative will cause many of these seniors to become uninsured .
- **Includes an unlimited home health and nursing home copay:** The more than 1 million beneficiaries who need more than 60 home health visits per year (who tend to be older, sicker and widows) would pay more than \$300. In addition, beneficiaries would pay about \$60 per day for the first 20 days of nursing home care which is high for those without supplemental coverage.

## ISSUES WITH “PREMIUM SUPPORT” PLAN

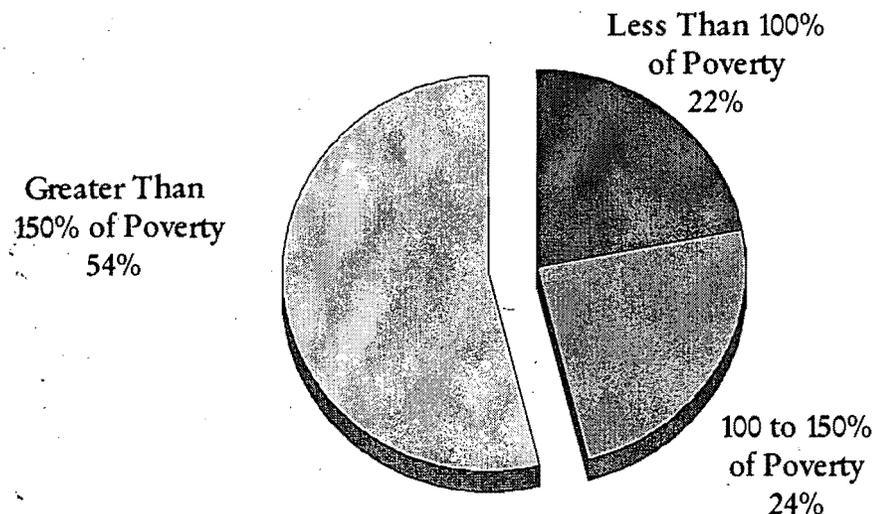
- **“Premium support” proposal increase premiums and coerces beneficiaries into managed care:** The cost of traditional Medicare will rise nationwide – 10 to 30 percent according to the independent Medicare actuary, forcing many beneficiaries to enroll in managed care.
- **Catch-22 for rural beneficiaries.** Medicare beneficiaries in rural areas would pay different premiums for the same traditional Medicare for the first time ever, and still have little or no access to prescription drug benefits.
  - Beneficiaries with one private plan option or more would have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their needs.
  - Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even one plan enter the area. Since managed care plans with no competition tend to have lower benefits, rural beneficiaries – who rarely have more than one or two plan options – would still lack access to a meaningful drug benefit.
- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries would not be protected against higher traditional program premiums. They also would frequently pay more for private plans, since the government payments would not fully account for local costs, which are higher in most urban areas.
- **Requires beneficiaries to compare plans based on confusing benefits, not price and quality.** The premium support proposal does not alter the anti-competition status quo. As a result:
  - Hard to make “apples-to-apples” comparisons, especially since few beneficiaries know the dollar-value of benefits.
  - Easy to manipulate benefits to attract healthy/discourage sick beneficiaries from enrolling. Managed care plans could offer subsidized benefits like travel emergency coverage or extra prevention to attract healthier seniors.
  - Discriminates against beneficiaries in low-cost or rural areas. Over 11 million beneficiaries, including 75 percent of rural Medicare beneficiaries, lack have access to Medicare managed care plan. Although these people pay the same Part B premium, they do not have access to drugs and other benefits.

## PRESIDENT'S ALTERNATIVE TO STRENGTHEN MEDICARE FOR THE 21<sup>st</sup> CENTURY

- **Makes Medicare more competitive and efficient – without premium increases.** The President's plan restructures Medicare to:
  - Give traditional Medicare new private-sector purchasing and quality improvement tools and constrains cost growth in the out-years.
  - Inject price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money for both beneficiaries and Medicare.
  - Moderate Balanced Budget Act. The plan also takes administrative and legislative actions, including a \$7.5 billion quality assurance fund, to smooth out provisions in the Balanced Budget Act that may be too excessive.
  
- **Modernizes Medicare's benefits – including adding a long-overdue prescription drug benefit for all beneficiaries.**
  - Prescription drug benefit. All Medicare beneficiaries would have the option to purchase a drug benefit that provides for privately-negotiated price discounts and coverage of 50 percent of the costs from the first prescription for spending up to \$5,000 when fully phased in. Premiums would be \$24 in 2002 and \$44 per month in 2008.
  - Prevention initiative. Copays and deductibles for all preventive services would be eliminated and new services would be studied.
  - Rationalizes cost sharing. The plan would add a 20 percent lab copay and index the Part B deductible to inflation.
  - Medicare Buy-In. The plan includes a proposal to provide an affordable, coverage option for vulnerable Americans between ages 55 and 65.
  
- **Dedicates surplus to strengthen Medicare.** Over \$300 billion over 10 years would be dedicated from the surplus to Medicare. These funds would contribute towards extending the life of the Medicare Trust Fund to 2027 and help offset the new prescription drug benefit and the \$7.5 billion quality assurance fund for moderating excessive Balanced Budget Act provider cuts.

# Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

## Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



## Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

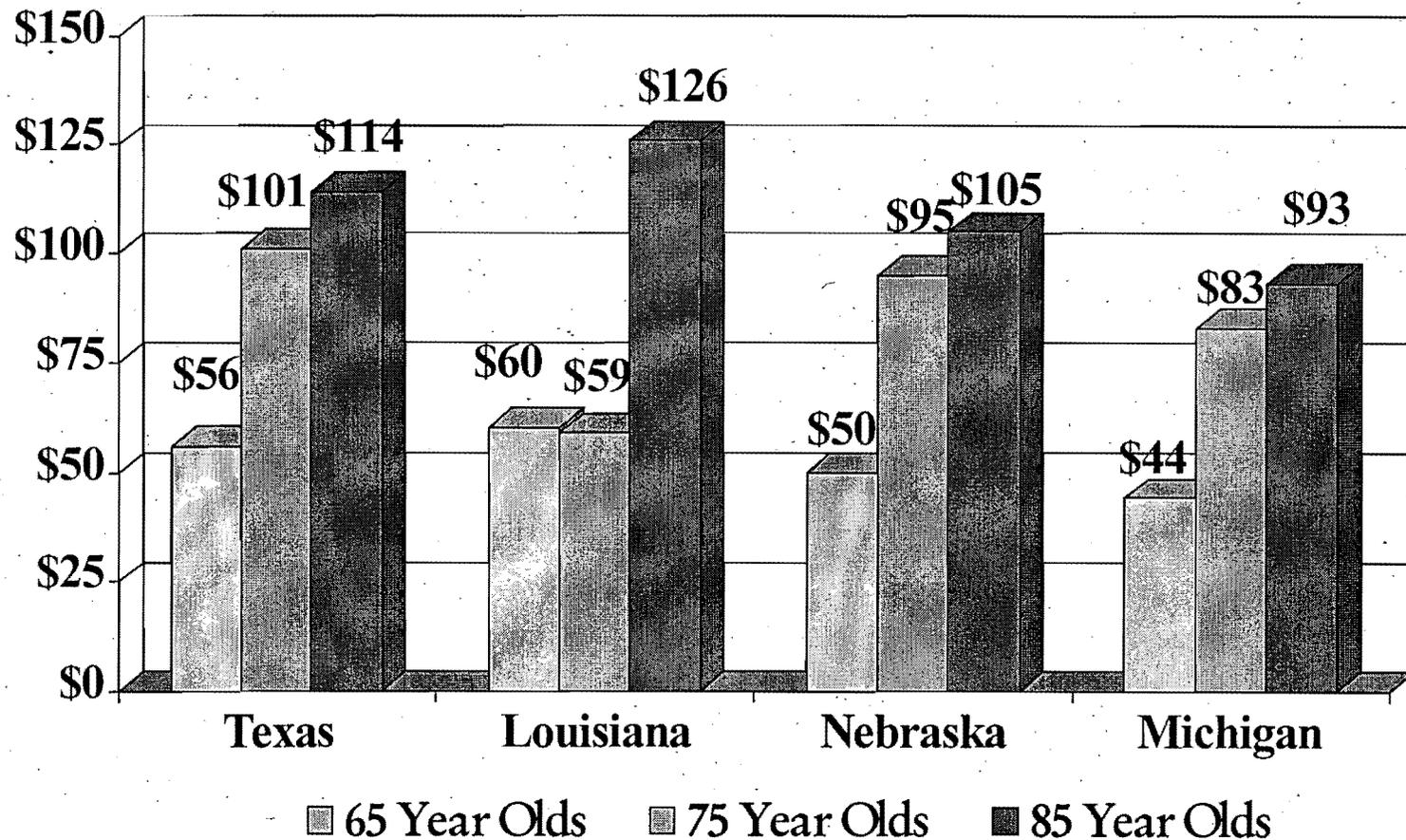
### Disproportionately Affects:

- Rural beneficiaries, since nearly half have no coverage
- Older women, for whom total prescription drug spending averages \$1,200 -- 20% more than men's

SOURCE: Actuarial Research Corporation for HHS, 2000

In 2000, 150% of poverty for a single person is about \$12,750, for a couple is about \$17,000

# Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age

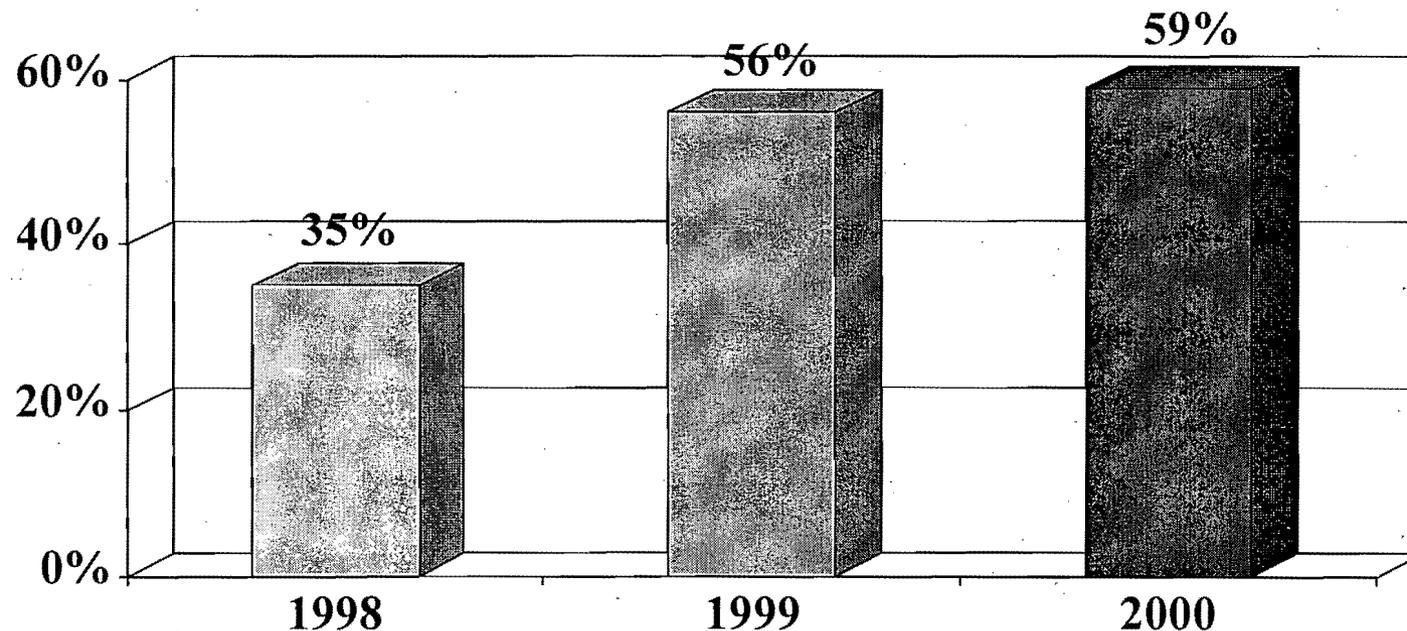


Sample Premiums for 1999. Difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost \$24 per month.

# Value of Medicare Managed Care Drug Benefits Is Declining

*Nearly Three-Fifths Of Plans Will Cap Benefit Payments  
Below \$1,000 In 2000*

Proportion of All Plans With Limits of  
Less Than \$1,000

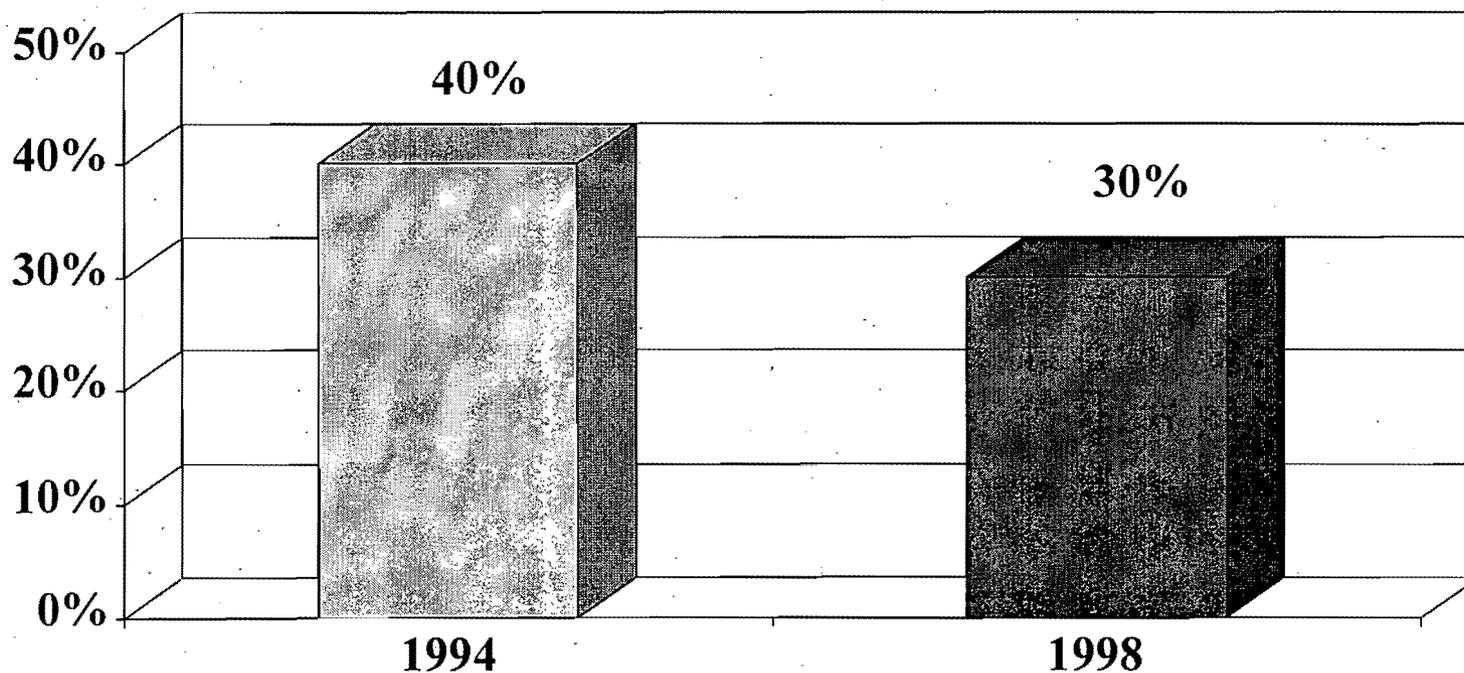


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

# Retiree Health Coverage Is Declining

*25% Fewer Firms Are Offering Retiree Health Benefits*

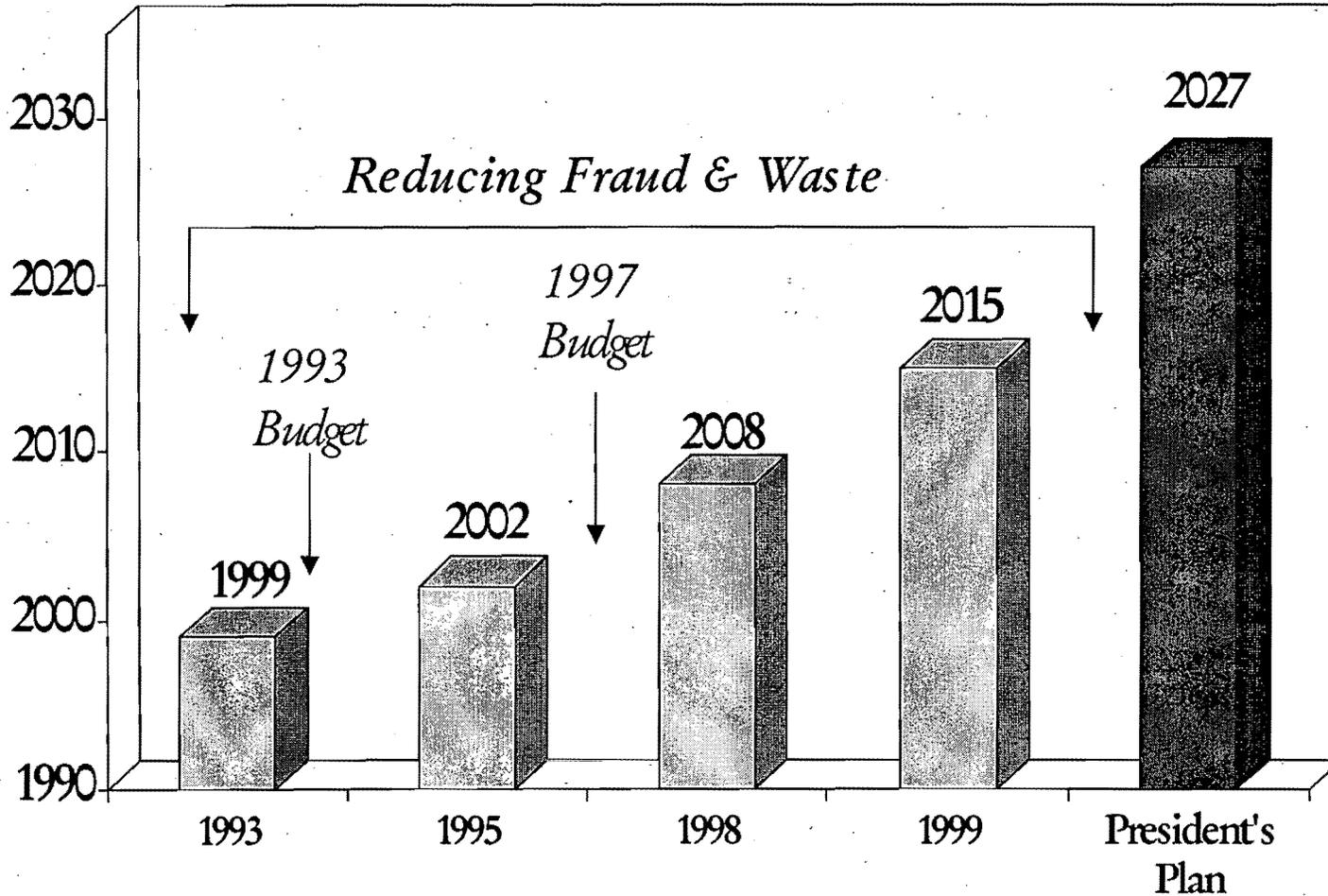
Firms Offering Retiree Health Coverage



SOURCE: Foster-Higgins, 1998

# Modernizing and Strengthening MEDICARE

*Extending The Solvency Of Medicare To 2027*



Statement of Mr. Anthony Watson  
Chairman and CEO  
March 16, 1999

Mr. Chairman, Mr. Thomas, Members of the Commission, I regret that I cannot support the proposal that has been placed before the Commission. As I stated at the outset of our deliberations, a society will be judged by the quality of its consideration and concern for its elders. In my mind this means that in our efforts to assure the long-term stability of Medicare, we must first make sure that we do no harm. I am sorry to say that I do not believe the plan as proposed meets that standard.

I have stated publicly on a number of occasions that I am opposed to raising the Medicare eligibility age from 65 to 67. We know that this idea saves very little money, because the young elderly use few services, yet this idea may be discriminatory to minority populations who have lower than average life expectancy. It also may discriminate against workers in physically demanding occupations who simply cannot work as long as white-collar office workers. Moreover, this proposal will increase the number of uninsured in this country at a time when the uninsured population is already expanding.

I am very concerned that this proposal does not do enough to ensure that all Medicare beneficiaries have access to an affordable prescription drug benefit. To me that is a major flaw,

I am particularly troubled by the lack of any consideration of new financing for Medicare. Some people seem to think that you can wave a magic wand called "reform" and Medicare will somehow magically be made solvent. Nothing could be further from the truth. New moneys are needed to keep Medicare solvent, regardless of what proposal for reform is adopted. The President made one such proposal to provide new funding for Medicare. I am sad to say that the Commission never even considered it.

When I was appointed to this commission, I was very hopeful that we would lay our differences aside and work together to make recommendations to strengthen Medicare and ensure its financial solvency, while doing no harm to our elders. Unfortunately, I do not believe we have accomplished that goal and so I regretfully must vote against this proposal. Thank you, Mr. Chairman.

Medicare Breaux/Thomas File

Should we send to Bonnie Hoyer? - Polking - CRJ

**COMPARISON OF THE BREAUX-THOMAS PLAN AND THE PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE**

<b>POLICY</b>	<b>BREAUX-THOMAS</b>	<b>PRESIDENT</b>
Dedicates surplus funding to extend Medicare's solvency	No	Yes <i>Extends Medicare to 2027</i>
Adds Medicare prescription drug option for <u>all</u> beneficiaries	No <i>Limits benefit to low-income</i>	Yes
Add competition that does not financially coerce beneficiaries into managed care	No <i>Includes "Premium Support" plan that raises premiums in traditional Medicare</i>	Yes <i>Adds price competition without raising premiums for traditional Medicare</i>
Modernizes traditional Medicare	Yes	Yes
Extends provider payment reductions in the BBA of 1997	Yes <i>Keeps most provisions; no cuts in home health, DSH</i>	No <i>Modifies most provisions; no cuts in outpatient services, home health, DSH, or nursing homes</i>
Provides funding to address early-year BBA problems	No	Yes <i>Sets aside \$7.5 billion</i>
<u>Cost sharing changes:</u> Adds 10% home health copay Adds 20% nursing home copay Adds 20% lab copay Changes Part B deductible Eliminates preventive copays Eliminates hospital copays	Yes Yes Yes Combine A & B, indexes Yes Yes	No No Yes Indexes to inflation Yes No
Includes Medigap reforms	Yes <i>Prohibits covering deductible</i>	Yes <i>Improves access for those losing access to HMOs, people with disabilities; Adds new, low cost option</i>
Raises Medicare's age eligibility	Yes	No
Allows Medicare buy-in for people ages 62-64, displaced workers ages 55 to 65	No	Yes
Ends Medicare funding for portion of graduate medical education by carving it out	Yes	No

## Republican Arguments Against Modernizing Medicare In 1999 Echo Their Arguments Against Creating Medicare In 1965

Thirty-four years ago, on July 30, 1965, President Lyndon Johnson signed Medicare into law. Arguments that Republicans opposed to the creation of Medicare used were very similar to those used by Republicans today opposed to strengthening and modernizing Medicare.

1965 Arguments Against Medicare Hospital and Physician Coverage	1999 Arguments Against Medicare Prescription Drug Coverage
<p><b>Sen. Milward Simpson (R-WY)</b> “Presently, over 60 percent of our older citizens purchase hospital and medical insurance without Government assistance. This private effort would cease if Government benefits were given to all our older citizens.” [Sen. Congressional Record (#15874), 7/8/65]</p> <p><b>Sen. John Williams (R-DE)</b> “Such a program of complete coverage without regard to need is socialized medicine and it has failed in practically every country which has thus far tried it. In every instance it has resulted in a deterioration of doctors’ services.” [Senate Congressional Record (#16147), 7/9/65]</p> <p><b>Rep. John Anderson (R-IL):</b> “It will needlessly force duplication of coverage for those over 65 who are already adequately covered at no cost to themselves under adequate programs of group health insurance, provided by their employers, their unions or by other organization. These people have no need for a government program.” [House Congressional Record (#7376), 4/8/65]</p> <p><b>Rep. Tim Carter (R-KY)</b> “We are now embarking on a new adventure in medical practice, one in which the rich will enjoy the same free medical care we have always given the poor. I would ask if the expenditure of these vast sums of money is necessary to help the rich instead of the poor who really need the help.” [House Congressional Record (#7410), 4/8/65]</p>	<p><b>Senate Majority Leader Trent Lott (R-MS)</b> “Why would you want to make it available to people, many of whom already have it now? In fact, 68 percent of people on Medicare have prescription drugs in one way or another.” [Federal News Service, 6/29/99]</p> <p><b>House Majority Leader Dick Armey (R-TX)</b> “It's been the tradition in the president's party to do one size fits all. If you have 31 percent of people with a problem, you ought to put together a 31 percent solution, not a 100 percent solution.” [Associated Press, 6/29/99]</p> <p><b>Sen. Phil Gramm (R-TX)</b> “It isn't a matter of whether there ought to be a prescription drug benefit offered by Medicare, but whether we're going to help those who need it most or launch a "universal" program we don't need and can't afford.... New drug benefits should go to those who need them – roughly a third of retirees – not to the two-thirds who are already covered,” [Op-Ed by Sen. Phil Gramm, USA Today, 6/30/99]</p> <p><b>Sen. Rick Santorum (R-PA)</b> “What we need to do is focus our resources toward lower income people and really narrow the benefits, particularly to those who have higher prescription drug bills.” [Morning Call (Allentown), 6/30/99]</p>

- Sperling
- Stein
- Richetti

**UNITED STATES  
SENATOR JOHN BREAUX**

Facsimile Transmission

Return to  
Potus

TO: President Clinton

Attn: Ms.  
Currie

FROM: Senator Breaux

FAX NUMBER TRANSMITTED TO: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

NUMBER OF PAGES INCLUDING COVER SHEET: 8

RE: Note - For an 11 vote deal,  
we could have gotten a 25%  
 subsidy for dress

**PLEASE DELIVER THIS INFORMATION AS SOON AS POSSIBLE**

**UNITED STATES SENATE  
 WASHINGTON, D.C. 20510  
 (202) 224-4623**

**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.

DRAFT

*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 \$380 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.

(2)

**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.

**Optional Policies:**

*Extra Subsidies for High Option Plans*

An extra subsidy for high option plans equal to 10 (or 25) percent of the average cost of prescription drug benefits in private plans as determined by the Board (via surveys or reporting) would be implemented through the premium schedule.

*Carve Out DSH*

Like the carve out of DME, carving DSH out of Medicare would not necessarily reduce the federal budget overall.

**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.

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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.

### **Benefits**

The proposal would maintain the current system where the government-run fee-for-service plan has well defined benefits in law and private plans must cover at least those items. The Board would attempt to create a balance between strict benefit standardization and the flexibility to bring new benefit designs to the market. In any given year, the stricter the standardization of benefits, the easier it would be for beneficiaries to choose plans on price and quality alone. But over time, strict benefit standardization could prevent plans from developing new ways to deliver benefits and testing those innovations in the market.

### 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 approximately 50 percent of 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.

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 for those between 100 and 135 percent of poverty from 20 to 60 percent.

### 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. Over the long term, the proposal implies that HCFA should take a more supervisory (and less regulatory) approach to ensuring that a national fee-for-service plan was available to all beneficiaries. Likewise, Congress should take more of an oversight role as opposed to actively managing payment rates and benefit delivery.

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.

### Extra Subsidies for High Option Plans

This optional policy would reduce premiums for beneficiaries in high option plans by either 10 or 25 percent of the average cost of drug benefits in private plans, as determined by the Board. This estimate assumed an average cost of \$875 in 2003, growing to \$1,890 by 2013. That is consistent with the expected cost of a lightly managed drug benefit with a \$500 deductible, 25 percent coinsurance, and a \$2,500 out-of-pocket maximum. With a 10 percent subsidy, the estimate assumed that 30 percent of beneficiaries over 135 percent of poverty received the extra subsidy in 2003, and 50 percent were in high option plans by 2013. With a 25 percent subsidy, 40 percent of beneficiaries were assumed to

have chosen high option plans in 2003, and 67 percent were in high option plans by 2013.

### Financing

The Part A fund only covers 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 would make it more clear who pays for Medicare and would allow a more transparent discussion of how to aid Medicare's finances.