

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Gene Sperling to POTUS re: Medicare High Income Premium: Pros and Cons (3 pages)	12/23/96	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23748 Box 20

FOLDER TITLE:

Medicare Reform- Extended Solvency [6]

gf41

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

\$44 Billion in FY 2002

A = LY Slipped + \$27bil b/	\$7.5	\$13.8	\$18.4	\$26.8	\$31.6	\$ 98.0	\$135.1	\$175.8	7/08
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$7.7	\$15.0	\$21.2	\$31.4	\$44.0	\$130.8	\$183.5	\$243.3	
A = LY Slip + 7.2% PPS hit	\$11.7	\$17.0	\$20.8	\$27.4	\$31.6	\$108.5	\$146.8	\$186.4	1/09
B = FY 97 Slipped, w/FDO	\$ 1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$13.2	\$20.6	\$26.8	\$36.7	\$44.0	\$141.3	\$195.2	\$253.9	

a/ All estimates assume refined pricing of the home health transfer. All packages deleted savings from fraud and abuse since they were enacted in HIPAA.

b/ Additional money is added in proportion to savings stream. It may be difficult to develop policies to match this savings stream.

c/ Last year's Medicare package priced by CBO at \$116 billion contained a proposal to eliminate hospital outpatient formula-driven overpayment (FDO). However, the savings from that proposal were excluded in the Administration's priced \$124 billion Medicare package. If the FDO proposal was included in the Administration pricing, then the 6-years savings total would have been \$135 billion. Following are the savings stream from last year's package slipped one year excluding FDO. The 6-year total is now \$135 billion (rather than \$124 billion) because slipping the package one year also requires that certain extender proposals that occur on an out-year date certain not be slipped.

A = FY 97 Slipped 1 Year	\$5.4	\$10.0	\$13.3	\$19.4	\$22.9	\$ 71.0	\$ 97.9	\$127.4	12/05
B = FY 97 Slipped, w/oFDO	\$0.5	\$ 2.3	\$ 4.4	\$ 7.2	\$ 9.9	\$ 24.3	\$ 36.8	\$ 52.1	
Total	\$6.9	\$12.3	\$17.7	\$26.6	\$32.8	\$ 95.3	\$134.7	\$179.5	

d/ The 6-year total of \$146 billion compares to last year's estimate of \$135 billion. The difference is due to several extender proposals not being slipped one year (i.e., the Part B premium, OPD extenders and MSP extenders) because they occur on a out-year date certain.

Note: These Trust Fund exhaustion estimates are sensitive to assumptions about treatment of some parameters from last year's package. These Trust Fund exhaustion figures should be considered preliminary estimates "plus or minus a few months"; the estimates are likely to change as the package is specified, when the new baseline is available or with official actuary pricing.

Alternative Medicare Savings Streams

	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>5-years FY 98-02</u>	<u>6-years FY 98-03</u>	<u>7-years FY 98-04</u>	<u>Trust Fund Exhaustion</u>
<u>Last Year Slipped One Year c/</u>									
A = FY 97 Slipped 1 Year	\$5.4	\$10.0	\$13.3	\$19.4	\$22.9	\$ 71.0	\$ 97.9	\$127.4	12/05
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$6.9	\$13.6	\$19.3	\$28.7	\$35.3	\$103.8	\$146.3 d/	\$194.9	
<u>\$34 Billion in FY 2002</u>									
A = LY Slipped + \$10bil b/	\$6.2	\$11.4	\$15.2	\$22.1	\$26.1	\$ 81.0	\$111.6	\$145.2	10/06
B = Minimal B Sav w/Spend	\$0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$17.6	\$ 27.1	\$ 40.1	
Total	\$6.4	\$12.9	\$18.6	\$27.2	\$33.5	\$ 98.6	\$138.7	\$185.3	
A = LY Slip + 3% PPS hit	\$8.0	\$12.9	\$16.4	\$22.7	\$26.5	\$ 86.5	\$117.3	\$151.0	2/07
B = Minimal B Sav w/Spend	\$0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$17.6	\$ 27.1	\$ 40.1	
Total	\$8.2	\$14.4	\$19.8	\$27.8	\$33.9	\$104.1	\$144.4	\$191.1	
<u>\$39 Billion in FY 2002</u>									
A = LY Slipped + \$10bil b/	\$6.2	\$11.4	\$15.2	\$22.1	\$26.1	\$ 81.0	\$111.6	\$145.2	10/06
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$7.7	\$15.0	\$21.2	\$31.4	\$38.5	\$113.8	\$160.0	\$212.7	
A = LY Slip + 3% PPS hit	\$8.0	\$12.9	\$16.4	\$22.7	\$26.5	\$ 86.5	\$117.3	\$151.0	2/07
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$9.5	\$16.5	\$22.4	\$32.0	\$38.9	\$119.3	\$165.7	\$218.5	
A = LY Slip + 7.2% PPS hit	\$11.7	\$17.0	\$20.8	\$27.4	\$31.6	\$108.5	\$146.8	\$186.4	1/09
B = Minimal B Sav w/Spend	\$ 0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$ 17.6	\$ 27.1	\$ 40.1	
Total	\$11.9	\$18.5	\$24.2	\$32.5	\$39.0	\$126.1	\$173.9	\$226.5	

Notes to Tables

- (1) These tables illustrate various Medicare savings packages to get to \$34 billion, \$39 billion and \$44 billion in total savings in FY 2002. The tables show the Part A Trust Fund exhaustion date, and the 5, 6 and 7 year savings totals for Part A, Part B and total Medicare.
- (2) The base is last year's package slipped one year. Fraud and abuse savings have been dropped because they were enacted in HIPAA. The repricing does not slip the effective dates for three extender provisions (the Part B premium, MSP and OPD extenders) because these occur on specific out-year dates. The Part B premium offset was repriced to be consistent with the Part B premium revenue stream. Not slipping the extenders and repricing the premium offset has the effect of increasing the 6-year savings from last year's (\$135 billion) package to \$146 billion now. (Last year's CBO pricing of \$116 billion (which includes the FDO proposal) compares to Administration pricing of \$135 billion (including the FDO proposal). The Administration's pricing of \$124 billion excluded the FDO proposal and compares to CBO pricing of \$103 billion).
- (3) In all packages, adding an income-related premium and transferring the revenues to Part A are considered as alternative ways to reduce Part A outlays.
- (4) Packages to get \$34 billion in FY 2002 could be achieved by increasing last year's Part A package and with a Part B package comprised of minimal Part B savers and the Part B spenders.
 - o The minimal Part B package contains: extension of the Part B 25 percent premium, the physician single conversion factor and revised target/update system, the Part B impact of proposals that also have Part A impact (e.g., Medicare Choice, MSP, etc.), the preventive benefits, respite care beginning in FY 1998, an increase in the ESRD facility rate, elimination of the x-ray requirement for chiropractors, payment of free-standing IHS clinics, an actuarially determined Part B premium late enrollment surcharge, and a hospital outpatient department proposal that is budget-neutral over 7-years (eliminates FDO in 1998, begins PPS in 1999, uses FDO savings to buy-down coinsurance which would transition to 20 percent over 15 years).
 - o While the minimal package displays less total Medicare savings, if the spenders are taken out, then the gross savings are deeper. A likely early criticism of the package will focus on the gross Medicare cuts before offsetting them for the spending provisions.

- (5) Packages to get \$44 billion in FY 2002 would need to use last year's Part B package slipped one year and a deep Part A cut that would extend exhaustion to 2008 or 2009. This approach would bring total Medicare savings to \$131 to \$141 billion over 5-years and \$243 to \$254 billion over 7-years.
- (6) There are two different types of packages to get \$39 billion in FY 2002.
- o The first would use last year's Part B package slipped one year and a small increase in last year's Part A cuts. This approach would be more consistent with the balance of cuts between Part A and Part B used last year.
 - o The other strategy would be to use the minimal Part B package but much larger Part A cuts. This approach has the advantage of extending the Trust Fund further and also allows for the spending provisions (including beginning to fix the OPD problem). The disadvantages are that it skews the distribution of cuts to Part A and requires deeper gross cuts to pay for the spenders.

The President's and Republicans' FY97 Medicare Plans

	President's Plan	Republicans' Plan*
Premiums	Extends Part B premium at 25% of program costs	Extends Part B premium at 25% of program costs and possibly adds high income premium
Reinstate Home Health Policy	Yes	No
Trust Fund Impact	Extends Trust Fund to 2006	Impact on Trust Fund is unclear: May extend to 2005.
Part A Savings	Traditional Part A savings plus reinstatement of home health policy	Traditional Part A savings

*This analysis based on the Republican FY97 budget resolution; previous analysis assumed that additional cuts would be necessary to offset Senator Dole's more than \$500 billion tax cut.

	President's Plan	Republicans' Plan
Per Capita Growth**	6 percent	5 percent
Structural Reforms/New Plan Options	Includes new managed care options (e.g., PPOs, PSNs, HMOs with POS option), academic health center reimbursement reforms, and beneficiary protections such as Medigap reforms	Includes similar reimbursement reforms, but also likely assumes flawed structural reforms such as an arbitrary cap, MSAs, and elimination of balanced billing protections for some plans -- Does not include new beneficiary protection provisions
New Benefits	Includes significant preventive health care expansions and a new Alzheimer's respite benefit	Includes similar preventive health benefits, but not respite care

** CBO estimates of private insurance premium growth has been running at 7%; this number is expected to be lowered to about 6%.

Possible Medicare Budget Streams (in billions)

Savings in FY02	FY98	FY99	FY00	FY01	FY02	5 Years FYs 98-02	6 Years FYs 98-04	Trust Fund Exhaustion*
\$34	\$6.4	\$12.9	\$18.6	\$27.2	\$33.5	\$98.6 ((\$81.0 Part A \$17.6 Part B)	\$138.7 ((\$111.6 Part A \$27.1 Part B)	10/06
\$39	\$7.7	\$15.0	\$21.2	\$31.4	\$38.5	\$113.8 ((\$81.0 Part A \$32.8 Part B)	\$160.0 ((\$111.6 Part A \$48.4 Part B)	10/06
\$44	\$7.7	\$15.0	\$21.2	\$31.4	\$44.0	\$130.8 ((\$98.0 Part A \$32.8 Part B)	\$183.5 ((\$135.1 Part A \$48.4 Part B)	7/08

*Assumes current policy of reinstating home health policy.

PRESIDENT'S MEDICARE PROPOSAL

The Medicare savings and structural reforms included in the President's balanced budget proposal have been carefully designed to strengthen the Medicare Trust Fund, expand health plan options for beneficiaries and assure that Medicare benefits continue to be affordable for the 37 million elderly and people with disabilities the program serves.

The Medicare Trust Fund is Strengthened through 2011. The savings and structural changes assure the financial health of the Medicare Trust Fund through 2011 -- placing the Fund in a better position than it has been in 18 out of the last 20 years.

Savings Achieved Without Any New Beneficiary Cost Increases or Arbitrarily Imposed Budget Caps. The Administration's proposal has specific and scorable policy changes that assure program efficiency and produce \$124 billion in savings. This is achieved without undermining the structural integrity of the program, imposing new costs on beneficiaries, or arbitrarily capping the program's growth to an index that has nothing to do with health costs.

The Cuts are Significantly Smaller than the Republican Conference Agreement. The Administration proposes smaller cuts for all major categories of the Medicare program (i.e., beneficiaries, hospitals, physicians, home health care providers and nursing homes). The differences in beneficiary and hospital cuts are particularly significant. The Administration has \$42 billion less in beneficiary cuts and \$44 billion less in hospital cuts than the Republican conference agreement. (See attached charts.)

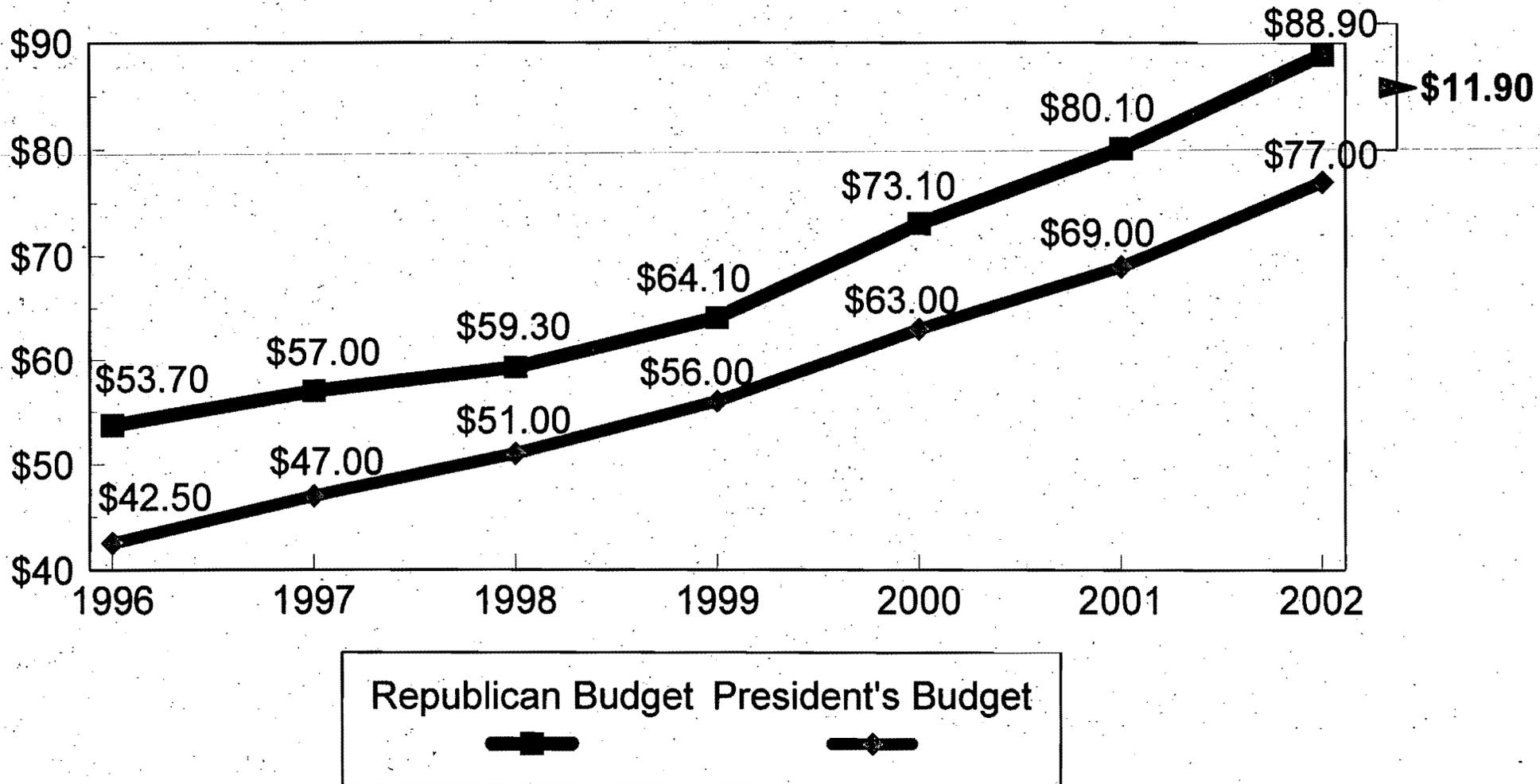
The Reforms Hold the Medicare Per Beneficiary Program Growth Rate to Approximately that of the Private Sector. On a per person level, the President's proposal holds the Medicare program to a growth rate that is slightly lower than the 7.1 percent per person private sector growth rate as estimated by the Congressional Budget Office. In contrast, the Republican Conference Medicare cuts would constrain Medicare growth per beneficiary to over 20 percent below the private sector per person growth rate. (See attached chart.)

Republican Cuts Will Lead to Cost Shifting or Access and Quality Problems. The Administration believes that cuts of the magnitude advocated by the Republicans would result in significant cost-shifting (\$84.7 billion according to the bipartisan National Leadership Coalition on Health Care) or reduced quality and access to needed health care providers. This is why the American Hospital Association has stated: "the reductions in the conference report will jeopardize the ability of hospitals and health systems to delivery quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

Choices of Plans are Expanded Under Medicare in a Pragmatic, Responsible Way. The President's plan retains a strong Medicare fee-for-service program and significantly increases choices of alternative health plans, including new managed care options (PPOs and HMOs with point of service options) as well as provider networks. In contrast, the Republican approach -- which includes Medical Savings Accounts and other options that tend to manage risk rather than manage costs -- will fragment the Medicare risk pool.

Medicare is Improved by Expanding Preventive Programs, including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

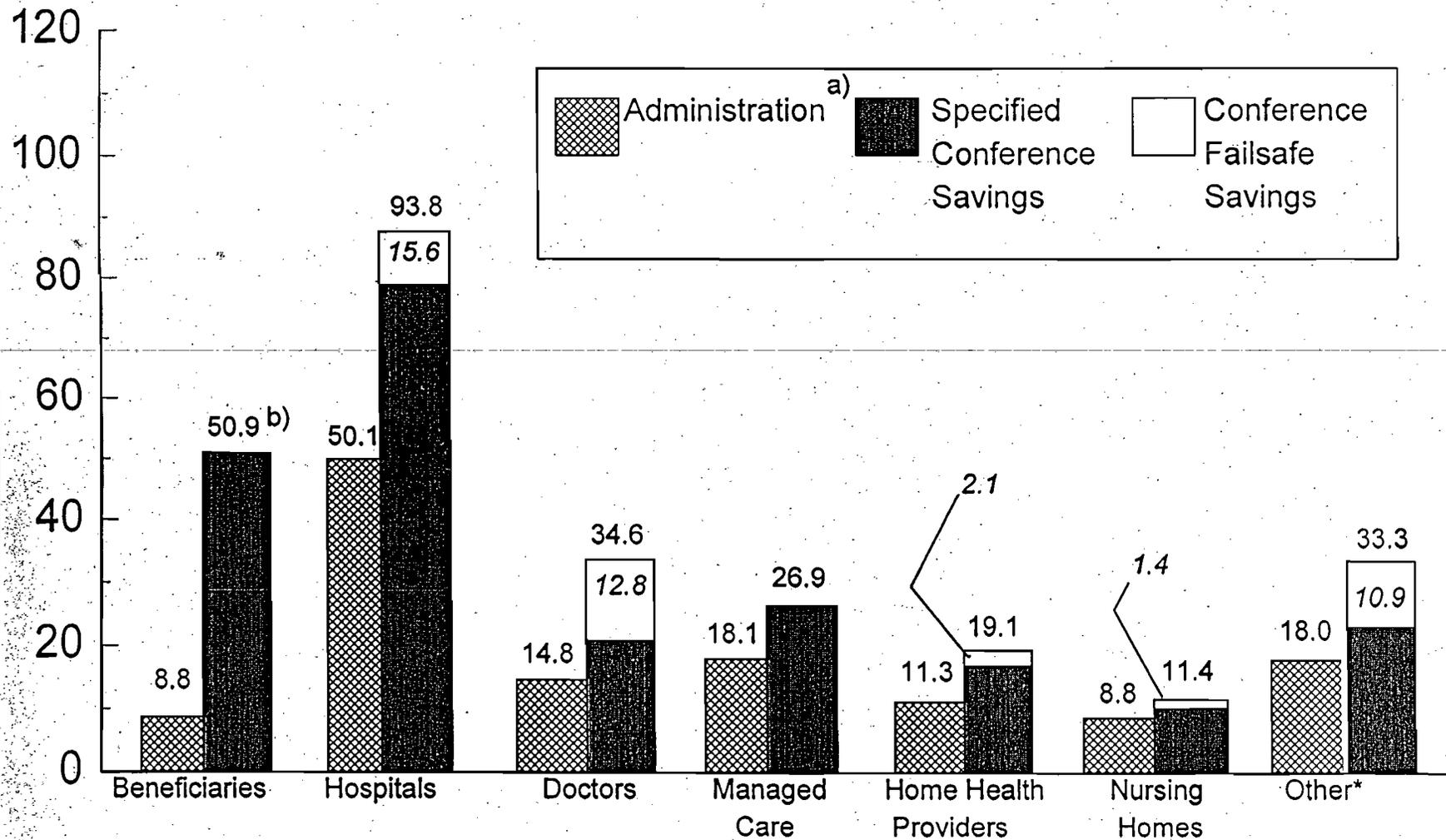
Medicare Monthly Premiums



CBO estimates of Republican premiums, as published in the November 16 letter to Senate Domenici; HCFA's estimates of premiums under the President's proposal. SOURCE: US DHHS.

**Administration vs. Republican Conference Agreement Medicare Cuts By Category
(7-yr. OMB and CBO Pricing, respectively)**

Dollars in Billions

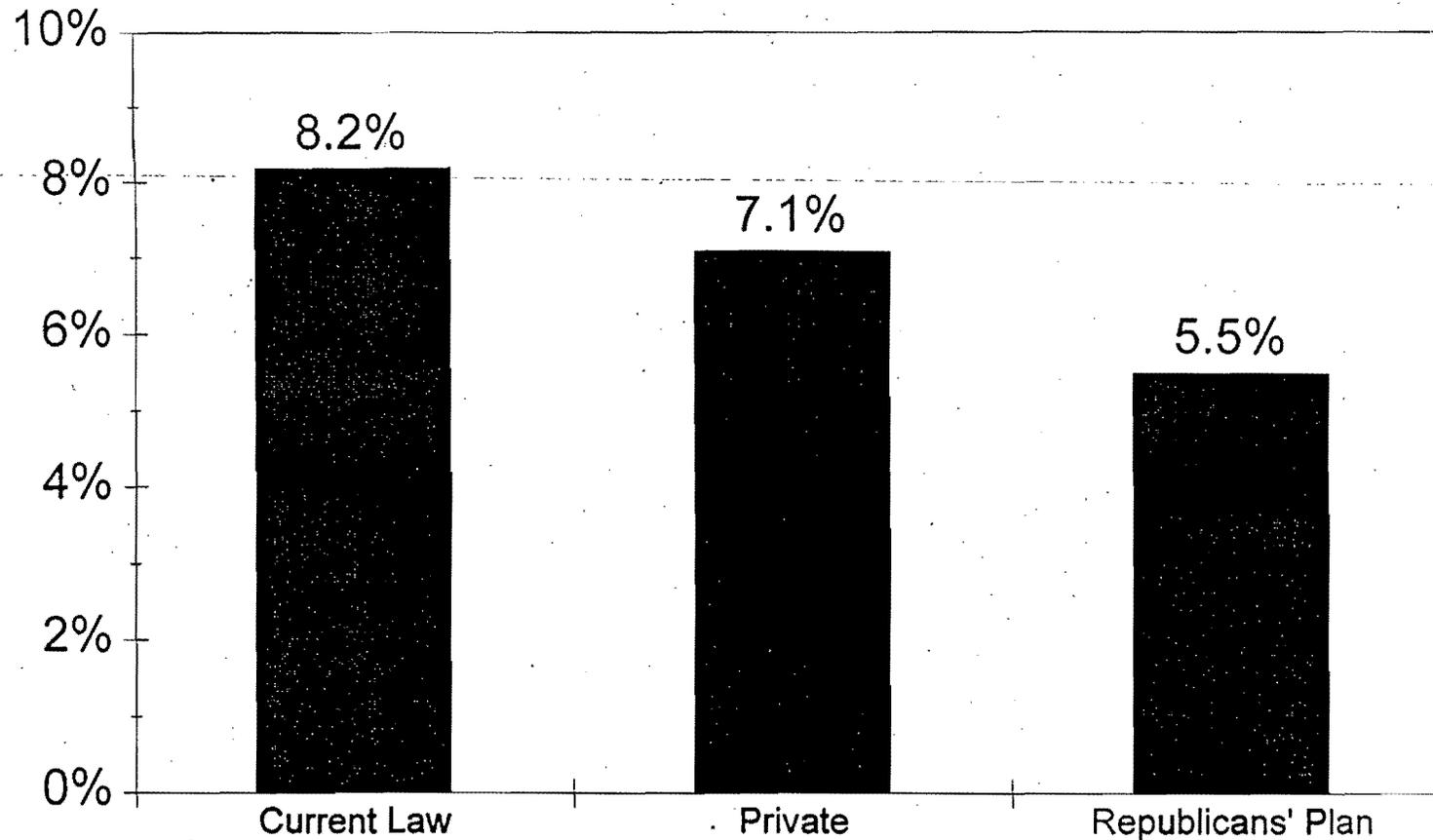


* Other includes interactions, Medicare secondary payer, lab services, durable medical equipment, ambulatory surgical centers, fraud and abuse provisions, and centers of excellence.

^{a)} Administration managed care savings include both direct managed care payment reductions and the indirect effect of fee for service cuts on managed care. All Conference managed care savings are direct because the link between fee for service expenditures and managed care payments is severed. Administration savings do not include \$5.3 billion cost of additional preventive benefits

^{b)} The indirect reduction in Part B premiums due to failsafe spending reductions is reflected in the Conference Agreement "Beneficiaries" total.

Comparison of Growth in Total Medicare Spending Per Beneficiary, 1996-2002



CBO baseline as of October 1995; CBO estimates of savings under the Conference Agreement, 11/16/95; Administration projections of beneficiaries. Administration estimates of private health spending per insured person, using CBO data. DHHS estimates of the President's proposed rate of growth in spending per beneficiary: 6.8%. Source: US DHHS

**TO MODERNIZE THE MEDICARE PROGRAM AND BRING IT INTO THE
21ST CENTURY, THIS BUDGET:**

- ✓ **Extends the life of the Medicare Trust Fund at least a decade.**

- ✓ **Makes positive structural reforms.** The President's budget contains a series of structural reforms which modernize the program, bringing in line with the private sector and preparing it for the baby boom generation. It:
 - ☞ ***Increases the number of health plan options*** -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities.

 - ☞ ***Improves Medicare managed care payment methodology and informed beneficiary choice.*** The President's budget addresses geographic disparities in payments; removes graduate medical education and disproportionate share hospital payments from managed care rates; and adjusts managed care rates for overpayments due to favorable selection.

 - ☞ ***Guarantees that beneficiaries can enroll in Medigap plans annually without being subject to preexisting condition exclusions,*** enabling beneficiaries to enroll in managed care without fearing that they would not be able to re-enroll in traditional Medicare.

 - ☞ ***Builds on the successful hospital prospective payment system model,*** implementing prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments.

 - ☞ ***Adopts successful approaches to purchasing other types of services,*** including: competitive pricing for durable medical equipment; laboratories; other items and supplies; expanded "centers of excellence"; and increased flexibility from program rules in negotiating rates.

- ✓ **Expands preventive benefits.** The President's budget:
 - ☞ ***Waives cost-sharing for mammography services and provides annual screening mammograms*** for beneficiaries age 40 and older to help detect breast cancer;

 - ☞ ***Establishes a diabetes self-management benefit;***

 - ☞ ***Covers colorectal screening*** (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure);

 - ☞ ***Increases reimbursement rates for certain immunizations*** to protect seniors from pneumonia, influenza, and hepatitis.

Historic Achievement

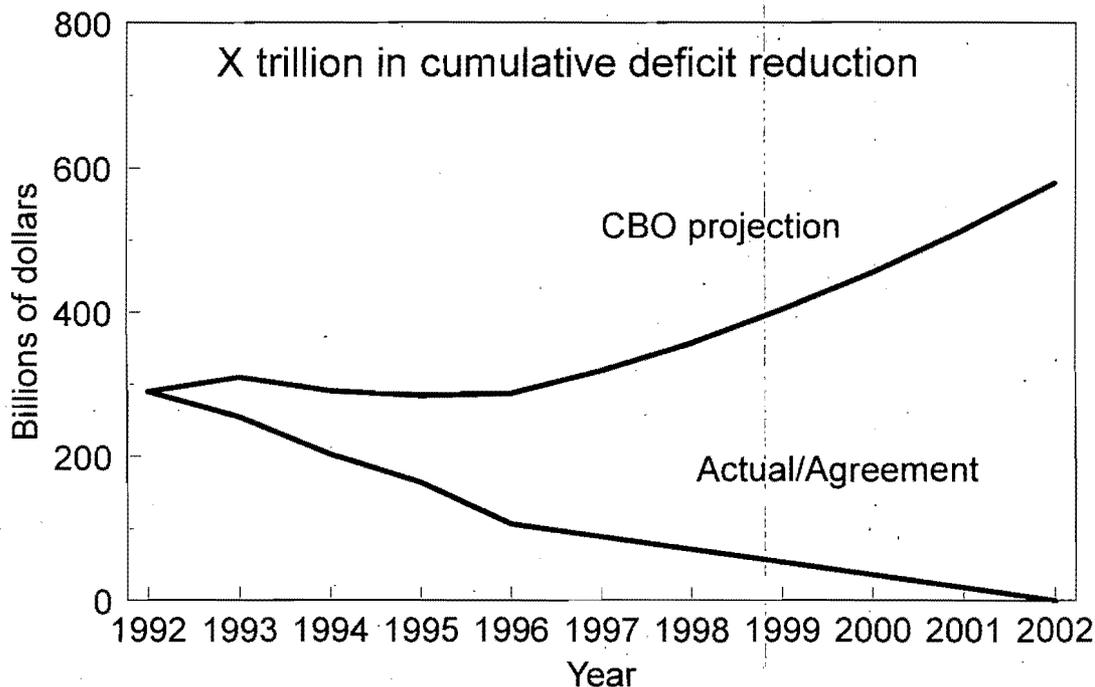
The First Balanced Budget in a Generation

This bipartisan balanced budget agreement continues our strong economic progress, restores faith in our ability to govern ourselves, and bolsters our preeminent position in the world economy as we head into the 21st century.

Look How Far We've Come

- **The President inherited a budget deficit of \$290 billion that was expected to explode to over one-half trillion dollars in 2002.** A decade of large deficits had weakened the foundation of our economy, cast doubt on the country's ability to self-govern, and sapped our power and prestige abroad.
- **President Clinton has boldly addressed this challenge since Day 1.** Working with a Democratic Congress in 1993, he implemented an economic plan that reduced the deficit 63% to \$107 billion last year and provided a solid foundation for a robust economic expansion with nearly 12 million new jobs created.
- **Now working with both Democrats and Republicans, the President is delivering the first balanced budget in a generation.**

Balanced Budget Agreement Inherited Deficits vs. Agreement



A Credible But Fair Budget to Finish the Job

The bipartisan balanced budget achieves balance in 2002. Both credible and fair, its components include:

I.) Major Entitlement Reforms. Structural and permanent entitlement reforms produce xxx billion of the overall five year budget savings. Medicare and Medicaid are strengthened and modernized:

Medicare

- **Medicare is modernized through a series of structural changes**, including: reforming the way it pays for managed care, expanding health plan options, providing consumers with information to make educated choices, and introducing effective payment systems for fast-growing Medicare services.
- **The structural changes are designed to align the growth of Medicare with that of the private sector.** Per beneficiary spending will be constrained to close to the private sector growth rates, producing \$115 billion in savings over five years. These savings, in combination with structural reforms, extends the life of the Medicare Trust Fund for at least a decade.
- **Beneficiaries are protected and preventive benefits are added.** The agreement holds the line on putting premiums to 25% of program costs and improves benefits by adding annual mammograms, diabetes self-management, and colorectal screening.

Medicaid

- **Preserves the federal guarantee of health care coverage for our most vulnerable populations, while, for the first time, introducing incentives in Medicaid to restrain cost growth.** Growth in Medicaid spending per beneficiary will be brought into line with private premium growth. Restrains cost growth, while ensuring the guarantee of quality coverage of this vulnerable population.

II.) Discretionary Spending is Cut and Capped at Realistic Levels. Overall discretionary spending is cut \$xx over five years from an inflation adjusted baseline. Spending in the year 2002 is cut x% on an inflation adjusted basis. Cuts are significant, but importantly they are realistic, credible, and enforceable.

III.) Reasonable Tax Cuts. The agreement includes net tax cuts of xx billion over five years. It includes tax cuts to make it easier for working families to raise their kids and send them to college. The agreement avoids back loaded tax cuts that would have put pressure on deficit as baby boom prepares to retire.

Agreement Promotes President's Priorities

President Clinton was not going to agree to a budget deal that did not include critical investments in education, health care, and the environment. This agreement reflects the President's priorities:

1) Expands educational opportunity

- ✓ Largest Pell Grant increase in two decades - 3.6 million students will get increase.
- ✓ A tax cut to make college more affordable for middle income families.
- ✓ Expansion of Head Start - to achieve goal of 1 million kids in 2002.

2) Expands health coverage for as many as 5 million children.

3) Strengthens environmental protection and enforcement

- ✓ Accelerates Superfund cleanups by almost 500 sites by the year 2000.

- ✓ Expands the Brownfield Redevelopment Initiative to help communities cleanup and redevelop contaminated areas.
- ✓ Boosts environmental enforcement by 9 percent

4) Treats legal immigrants fairly

- ✓ Restores disability and health benefits for legal immigrants who work hard, pay taxes, and will otherwise lose their health care coverage.
- ✓ Restores Medicaid coverage for poor legal immigrant children.

THE 1995 REPUBLICAN BUDGET WOULD REQUIRE A CUT OF 200,000 CHILDREN FROM HEAD START BY 2002.

- **Over the past 4 years, the President has, working with allies in Congress, secured a 43% increase in funds for Head Start.** The program will serve 800,000 this year and the President is committed to enrolling 1 million kids in Head Start in 2002.

America Reads Challenge

- **The President has launched the America Reads Challenge to ensure that all kids read well and independently by the end of the third grade.** This five-year, \$2.75 billion commitment includes:
 - ✓ **America's Teaching Corps.** Will provide individualized after-school and summer help for over three million children in grades K-3. Federal aid would be used to help communities recruit and train over 1 million tutors.
 - ✓ **Parents as First Teachers.** Because research shows that the first three years of life are so important to development, a grant fund is proposed to expand successful programs that provide parents help and information in teaching their children to read.

Major Mandatory Programs

Medicare

(outlay savings in billions of dollars)

	1998	1999	2000	2001	2002	5-Year Savings	10-Year Savings
Medicare, net	-6.5	-16.8	-22.7	-29.0	-40.0	-115.0	-434.2

- Reduce projected Medicare spending by \$115 billion over five years.
- Extend solvency of the Part A Trust Fund for at least 10 years through a combination of savings and structural reforms (including the home health reallocation).
- Structural reforms will include provisions to give beneficiaries more choices among competing health plans, such as provider sponsored organizations and preferred provider organizations.
- The Medicare program reforms provide beneficiaries with comparative information about their options, such as now provided Federal employees and annuitants in the FEHB program.
- Maintain the Part B premium at 25 percent of program costs and phase in over seven years the inclusion in the calculation of the Part B premium the portion of home health expenditures reallocated to Part B.
- Reform managed care payment methodology to address geographic disparities.
- Reform payment methodology by establishing prospective payment systems for areas such as home health providers, skilled nursing facilities, and outpatient departments.
- Funding for new health benefits including: (1) expanded mammography coverage; (2) coverage for colorectal screenings; (3) coverage for diabetes self-management; and (4) higher payments to providers for preventive vaccinations to the extent it will lead to greater use by beneficiaries. Invest \$4 billion over five years (and \$20 billion over ten years) to limit beneficiary copayments for outpatient services, unless there is a more cost-effective way to provide such services to beneficiaries as mutually agreed.

Medicaid

(outlay savings in billions of dollars)

	1998	1999	2000	2001	2002	5-Year Savings	10-Year Savings
Medicaid, net	0.0	-1.5	-2.4	-3.6	-6.2	-13.6	-65.5

- Include net Medicaid savings of \$13.6 billion over five years.
- Net Medicaid savings include a higher match for D.C., an inflation adjustment for programs in Puerto Rico and other territories, Part B premium interactions, and \$1.5 billion to ease the impact of increasing Medicare premiums on low-income beneficiaries.
- The \$13.6 billion in Medicaid savings do not reflect the health care investments for children's coverage, protections for legal immigrants under welfare reform, or the extension of veterans' Medicaid income protections.
- Savings derived from reduced disproportionate share payments and flexibility provisions.
- Include provisions to allow States more flexibility in managing the Medicaid program, including repeal of the Boren amendment, converting current managed care and home/community-based care waiver process to State Plan Amendment, and elimination of unnecessary administrative requirements.

Children's Health

(outlay increases in billions of dollars)

	1998	1999	2000	2001	2002	5-Year Expenditures	10-Year Expenditures
Children's Health	2.3	2.7	3.2	3.7	3.9	16.0	38.9

- Spend \$16 billion over five years (to provide up to 5 million additional children with health insurance coverage by 2002)
- The funding could be used for one or both of the following, and for other possibilities if mutually agreeable:
 1. Medicaid, including outreach activities to identify and enroll eligible children and providing 12-month continuous eligibility; and also to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility; and
 2. A program of capped mandatory grants to States to finance health insurance coverage for uninsured children.
- The resources will be used in the most cost-effective manner possible to expand coverage and services for low-income and uninsured children with a goal of up to 5 million currently uninsured children being served.

POTENTIAL MEDICARE FY98 LEGISLATIVE PROPOSALS

*Note: When available, a crude estimate of the FY 98-02 savings or cost of each proposal (in billions), using the President's 1997 baseline, is included in the left margin. The savings figures are for stand alone provisions and do not include interaction effects.

Choice

Medigap

- o Pre-Existing Condition Exclusion
- o Open Enrollment Expansions
- o Re-examine Standardized Packages
- o Provide Beneficiaries with Comparative Information
- o Community Rating

Medicare Managed Care

- \$24.5 o Modify Payment Methodology
- o Partial-Risk Payment Methodology
- o Competitive Pricing Demonstration
- o Enrollment of ESRD Beneficiaries
- o FQHMO Program
- o Expand Beneficiaries' Managed Care Choices
- o Provide Beneficiaries with Comparative Information
- o Coordinated Open Enrollment and Additional Open Enrollment Periods
- o Standardized Additional Benefits Packages
- o Limit Beneficiary Liability for Unauthorized, Out-of-Network Services
- o Modify Limit on Urgent, Out-of-Area Coverage
- o Plan Enrollment
- o Permit States with Programs Approved by the Secretary to Have Primary Oversight Responsibility
- o Strengthen Implementation of Intermediate Sanction Authority
- o Reallocation of Managed Care Expenditures

HIPAA

- o Insurance Reform
- o User Fees
- o Eliminate Redundant EOMBs
- o Administrative Simplification Changes

Combating Fraud and Abuse

- o Social Security Numbers
- o Provider Enrollment Process
- o Exclusion for Felony Convictions
- o Enrollment Waiting Period After Denial

Improved Quality

Accreditation

- o Modify the Deeming Provisions for Hospitals to Require that the JCAHO/AOA Demonstrate that All of the Applicable Hospital Conditions are Met or Exceeded and to Enhance Monitoring and Enforcement of Compliance
- o Permit the Secretary to Disclose Accreditation Survey Data from Accrediting Organizations for Purposes Other than Enforcement

Survey and Certification

- o Allow Collection of Fees for Initial Surveys for all Providers
- o Conduct demonstrations to implement an integrated quality management system in Medicare, Medicaid, and CLIA program.
- o Create legislative authority for an integrated quality management system across HCFA programs.

Managed Care

- o Deem Privately Accredited Plans to Meet Internal Quality Assurance Standards
- o Replace 50-50 Rule with Quality Measurement System

Nursing Aide Training

- o Permit Waiver of Prohibition of Nurse Aide Training and Competency Evaluation Programs in Certain Facilities.
- o Clarify the Trigger for Disapproval of Nurse Aide or Home Health Aide Training and Competency Evaluation Programs as Substandard Quality of Care.

Beneficiary Improvements

Improved Preventive Services

- +\$0.3 o Waive Cost Sharing for Mammography Services
- +\$0.5 o Cover Annual Screening Mammograms for Beneficiaries age 50 and over
- +\$1.6 o Cover Colorectal Screening
- +\$1.6 o Diabetes Management Training and Coverage of Glucose Monitors
- +\$0.5 o Increased Payments for Injections

Beneficiary Protections

- o Part B Refund Requirement
- +\$0.7 o Part B Enrollment Surcharge
- +\$0.0 o Provide Premium-Free Part A Coverage to All Working Disabled Beneficiaries
- o Add protection for beneficiaries when payment for hospice services are denied due to ineligibility for the benefit.

Program Improvements

- +\$0.9 o Respite Benefit for Beneficiaries with Alzheimer's Disease

- o DME definition of "home"
- o ESRD Composite Rate Increase

Prudent Purchasing

Post-Acute Payment Reform

- o Future Post-Acute Integrated Payment System
- o Collection of Patient Assessment Data for SNF, HH, and Rehabilitation and LTC Hospitals

Part B Issues

- \$2.6 o Competitive Bidding for Part B Services
- o Exclusion Authority in Competitive Bidding Demonstrations

Parts A&B Issues

- \$0.5 o Centers of Excellence

Contracting Reform

- o Reform contracting for FI's and carriers
- o Clarify the extent of the Secretary's discretion in PRO contract renewals
- o Replace current procedures for terminating PRO contracts for failure to maintain eligibility of performance with procedures outlined in the Federal Acquisitions Regulations
- o Give the Secretary option of extending PRO contracts for up to one year when it would be in the government's best interest

Improving Efficiency and Eliminating Overpayments

Hospitals

- \$33.0 o Reduce Updates for PPS Hospitals (including reducing base rates)
- \$4.7 o Redefine the Meaning of Transfers and Discharges
- \$4.2 o Reform Graduate Medical Education Payments
- \$6.2 o Reduce the Indirect Medical Education Adjustment
- o Medicare Payment for Bad Debt
- \$7.4 o Reduce PPS Capital Payments
- \$3.1 o Eliminate Add-on for Outliers
- o DSH Adjustment
- o Puerto Rico Standardized Amount
- o Revise payments to certified transplant centers
- \$0.0 o Remove IME/GME/DSH from AAPCC
- \$2.0 o Rebasing PPS-Exempt Hospitals and other Payment Improvements
- o Reduce Updates for PPS Exempt Hospitals
- \$0.4 o LTC Hospital Moratorium
- \$1.0 o Reduce Capital Payments for PPS Exempt Hospitals
- o Commission on Medical Education and Workforce Priorities

Home Health Care

- \$6.6 o Home Health Interim System (including savings from freeze extension)
- \$3.7 o Home Health Prospective Payment System
- \$0.4 o Home Health Payment at Location of Service
- o Establish Post-Hospital Home Health Benefit in Part A and Transfer Other Home Health Costs to Part B
- o Clarify Definition of "Homebound"
- \$1.3 o Eliminate PIP for HHAs

Hospice

- o Eliminate Double-Payments for Dually Eligible Beneficiaries
- o Hospice Payment at Location of Service
- o Replace 3rd and 4th benefit periods with finite number of additional 30 and/or 60 day periods after initial 2 periods.
- o Limitation of liability and beneficiary protection.

Skilled Nursing Facilities

- \$7.2 o SNF Prospective Payment System
- o Consolidated Billing
- \$1.0 o Therapy Salary Equivalency Guidelines

Other Part A

- o Eliminate PIP for All Providers
- \$6.9 o Expand Medicare Coverage to Include State and Local Government Workers not Now Covered
- o PRRB Reform

Medicare Secondary Payer

- \$7.7 o Extend Expiring Provisions from OBRA-93
- \$2.0 o Insurer Reporting and Improving Payment Recovery

Physicians

- \$5.1 o Modify Physician Updates
- \$0.6 o Make Single Payment for Surgery
- \$0.9 o Drugs Incident to a Physician's Service
- +\$0.2 o Chiropractic Services
- +\$1.4 o Payments to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists
- o Eliminate Mandatory PRO Prior Approval of Use of Assistants at Cataract Surgery
- o Independent Physiological Labs
- o Require Ordering Physicians to Provide Diagnostic Information

Part B Issues

- \$3.4 o Eliminate Formula Driven Overpayment, Outpatient PPS, Beneficiary Coinsurance
- \$0.8 o Lab Savings Proposals
- \$10.4 o Extend 25 percent premium (net savings)
- \$1.2 o Reduce Oxygen Payments
- \$0.4 o Payment Limits for Prosthetics and Orthotics
- \$0.4 o Reduce Updates to ASCs
- o Simplify Inherent Reasonableness Process for DMEPOS
- o Introduce Fee Schedules for Services Still Paid on "Reasonable Charge"

Rural Health

- +\$0.3 o Sole Community Hospitals
- +\$0.1 o EACH/RPCH Program

Regulatory Reform Relief

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Possible Budget Policies

Part A assumptions: all managed care credited to HI, Income-related Part B Premium credited to HI, big HH shift
(Dollars in billions, fiscal year; positive numbers are savings, negatives are costs)

	1998	1999	2000	2001	2002	98-02
PART A PROPOSALS						
Hospitals						
PPS Update (MB-1.5)	0.6	1.7	2.8	4.0	5.4	14.6
Extend PPS Capital Reduction from OBRA 1990	1.4	1.5	1.5	1.6	1.8	7.7
Reduce PPS-Exempt Update w/ Rebasing	0.0	0.2	0.3	0.5	0.7	1.6
Reduce PPS-Exempt Capital Payments	0.1	0.2	0.2	0.2	0.2	0.9
Moratorium on Long-Term Care Hospitals	0.0	0.0	0.1	0.1	0.1	0.4
Expand Centers of Excellence	0.1	0.1	0.1	0.1	0.1	0.3
Lower IME	0.7	1.0	1.3	1.4	1.5	6.0
GME Reform	0.2	0.4	0.7	0.9	1.2	3.3
Eliminate Add-Ons for Outliers (1998 start)	0.5	0.5	0.6	0.6	0.6	2.8
PPS Redefined Discharges (1998 start)	0.8	0.8	0.8	0.9	0.9	4.2
SCH Rebasing (w/ hold-harmless)	-0.1	0.0	0.0	0.0	0.0	-0.2
RPCH expansion	0.0	0.0	0.0	0.0	0.0	-0.1
Medicare dependent hospitals	-0.1	0.0	-0.1	-0.1	0.0	-0.2
phase in 50% giveback	-0.8	-0.9	-1.4	-1.4	-1.3	-5.8
Home Health						
HH Freeze Extension	-0.4	-0.5	-0.5	-0.6	-0.6	-2.6
HH Interim System	0.2	0.5	0.6	0.7	1.5	3.5
HH PPS	0.0	0.0	0.0	1.4	1.6	3.0
HH Location of Service	0.0	0.1	0.1	0.1	0.1	0.3
Eliminate HH PIP (start 2002)	0.0	0.0	0.0	0.0	1.0	1.0
Shift to Part B	10.9	13.8	15.1	15.3	17.1	72.2
Skilled Nursing Facilities						
SNF Freeze Extension	0.2	0.3	0.3	0.4	0.4	1.6
Interim SNF PPS	0.1	0.3	0.4	0.5	0.5	1.8
Full SNF PPS	0.0	0.6	0.7	0.8	0.8	2.9
Therapy Guidelines (removed)	0.0	0.0	0.0	0.0	0.0	0.0
HMOs						
Medicare Choice	2.9	4.6	7.2	9.9	13.0	37.7
Medicare Secondary Payer (Part A)						
Insurer Reporting, Contract Limits, TPA's, etc.	0.1	0.2	0.2	0.3	0.3	1.0
MSP Extenders	0.0	0.8	1.0	1.1	1.3	4.2
Fraud and abuse						
	0.0	0.0	0.0	0.0	0.0	0.0
New Benefits						
Colorectal Screening	-0.1	-0.2	-0.2	-0.3	-0.4	-1.1
Part A Interactions						
Interactions Among Hospital Proposals	0.0	-0.1	-0.2	-0.3	-0.4	-1.0
TOTAL PART A	7.4	12.8	17.4	23.7	31.4	92.8
PART B PROPOSALS						
Physicians						
Physician Placeholder	0.1	0.3	0.5	0.5	0.6	2.0
Physician Reg Drug Policy	0.1	0.1	0.2	0.2	0.2	0.8
Single Fee For Surgery (removed)	0.0	0.0	0.0	0.0	0.0	0.0

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Possible Budget Policies

Part A assumptions: all managed care credited to HI, Income-related Part B Premium credited to HI, big HH shift

(Dollars in billions, fiscal years; positive numbers are savings, negatives are costs)

	1998	1999	2000	2001	2002	98-02
Reduce Overhead Payments (removed)	0.0	0.0	0.0	0.0	0.0	0.0
Incentives for In-hospital MD Services	0.0	0.0	0.0	0.3	0.6	0.8
Phys Assistants, Nurse Pract, Clinical Nurse Specialists	-0.2	-0.2	-0.2	-0.3	-0.3	-1.2
Interaction among physician proposals (removed)	0.0	0.0	0.0	0.0	0.0	0.0
Hospital OPD						
Extend OBRA 1993	0.0	0.4	0.4	0.4	0.4	1.7
Eliminate FDO (2002)	0.0	0.0	0.0	0.0	3.0	3.0
OPD PPS	0.0	0.0	0.0	0.0	0.0	0.0
GME Reform	0.0	0.0	0.0	0.1	0.1	0.2
Medicare Secondary Payer (Part B)						
Insurer Reporting, Contract Limits, TPA's, etc.	0.1	0.1	0.1	0.2	0.2	0.6
MSP Extenders	0.0	0.3	0.5	0.6	0.7	2.0
Fraud and abuse id	0.0	0.0	0.0	0.0	0.0	0.0
Other Providers						
Competitive Bidding for DME (2000)	0.0	0.0	0.2	0.2	0.3	0.7
Competitive Bidding for labs (2000)	0.0	0.0	0.4	0.4	0.4	1.2
Expand Centers of Excellence	0.0	0.0	0.0	0.0	0.0	0.0
Therapy Guidelines (removed)	0.0	0.0	0.0	0.0	0.0	0.0
Reduce ASC update: CPI-2 (98-02) (removed)	0.0	0.0	0.0	0.0	0.0	0.0
SNF Consolidated Billing	0.1	0.1	0.1	0.1	0.1	0.3
HHA Shift to Part B	-10.9	-13.8	-15.1	-15.3	-17.1	-72.2
HMOs						
Medicare Choice	0.0	0.0	0.0	0.0	0.0	0.0
New Benefits						
Waive Mammography Costsharing	0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Annual Mammogram w/Interaction of Waiving Costsharing	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4
Respite Care	0.0	0.0	0.0	0.0	0.0	-0.4
Colorectal Screening	0.0	-0.1	-0.1	-0.2	-0.2	-0.7
Diabetic Screening	-0.2	-0.3	-0.3	-0.3	-0.3	-1.5
Flu Shot Administration	0.0	-0.1	-0.1	-0.1	-0.1	-0.4
Income-related Premium	1.1	1.2	1.6	1.9	2.2	8.0
Part B Premium	0.0	0.9	2.4	4.4	6.5	14.2
Part B Premium Offset	0.0	-0.1	-0.3	-0.5	-1.2	-2.2
Part B Premium Net Savings	0.0	0.8	2.0	3.9	5.3	12.0
TOTAL PART B	1.0	2.6	5.0	7.7	12.4	28.6
NET SAVINGS FROM TOTAL PACKAGE	8.4	15.4	22.4	31.4	43.8	121.4

THE PRESIDENT'S FY 1998 BUDGET: HOME HEALTH CARE REFORM

The President's budget proposes a number of initiatives to control spending in home health expenditures. It implements a prospective payment system and also takes steps to reduce fraud and abuse on home health services. Both of these proposals achieve significant savings. Finally, the budget proposes to reallocate all home health expenditures to the Part B side of program, with the exception of the post-acute portion of the benefit.

- ▶ **Expenditures for Home Health Services are Increasing Faster than for Any Other Medicare Service.**
 - ▶ **Home health care utilization has risen.** The average number of home health visits per user has grown from 26 visits in 1984 to 69 visits in 1994.
 - ▶ **Highest growth in home health services in excess of 100 visits.** The 10 percent of beneficiaries who use more than 200 home health visits per year account for over 40 percent of home health spending.
- ▶ **Implements a Prospective Payment System.** The President's budget implements payment reforms, which would modify costs and lead to separate prospective payment system for home health services. Prospective payments would reduce incentives for overutilization, save billions of dollars, and begin to bring the current double-digit rise in spending on these services under control. **This proposal would save \$14 billion over five years.**
- ▶ **Combats Fraud and Abuse in Home Health Services.** A March, 1996 GAO report on Medicare home health growth recommended that the Congress provide additional resources to HCFA to enhance enforcement controls against fraud and abuse. **The President's Fraud and Abuse initiatives would achieve approximately \$1.4 billion over five years.**
 - ▶ **Home Health Payments on Location of Service.** This proposal would require that payment be determined by the location of the service, rather than the location of the billing office. (Billing offices tend to be in urban areas where rates are higher).
 - ▶ **Eliminate Periodic Interim Payments (PIP) for Home Health.** This proposal would eliminate PIP and simultaneously phase-in a prospective payment system. PIP was initially established to help simplify cash flow for new home health providers by paying them a set amount, and reconciling PIP with actual expenditures at the end of the year.

- o However, with 100 new HHAs joining Medicare each month, access to home health is no longer a problem.
- o Further, the Office of Inspector General has found that Medicare continually overpays PIP and has a hard time recovering the money. This proposal achieves \$1 billion over five years.

▶ **Home Health Expenditure Reallocation.** Under the President's budget, the post-acute part of the budget would remain in Medicare Part A and all other home care services would be transferred from Medicare Part A to Medicare Part B. This proposal would protect Medicare beneficiaries from additional out-of-pocket costs because Part B home care services would not be subject to the 20 percent Part B coinsurance and would not be included in the Part B premium. This shift does not count towards any of the \$100 billion savings in the President's Medicare proposal.

- ▶ **Restores original intent of the policy.** Prior to 1980, the home health benefit was originally designed as a post-acute care service under Part A for beneficiaries who had been hospitalized. Home health care benefits were limited to 100 visits per year and could only be provided after a hospital stay of three or more days.

In 1980, Congress altered the home care benefit by eliminating the 100-visit and the 3-day hospital stay requirement. As a result of these changes, home health care has increasingly become a chronic care not linked to hospitalization. Part A now absorbs about 99 percent of the rapidly growing home health costs.

The President's proposal restores the original intent of the policy so that payments for more than 100 visits are not be in Part A of the program, the part of Medicare that pays for acute -- not long-term care services. Under the proposal, the post-acute care portion of the home health benefit would remain in Part A and all other home care services would be transferred from Part A to Part B.

▶ **Protects Medicare, Without Excessive Program Cuts**

- ▶ This policy avoids the need for excessive reductions in Medicare payments to hospitals, physicians, and other health care providers, and protects beneficiaries from unjustifiable increases in premiums and other out-of-pocket expenses.
- ▶ Without this policy, Medicare's total growth for Part A would have to be constrained to 3.4 percent per year (2.2 percent per capita), according to CBO -- below the rate of inflation.
- ▶ This proposal is an integral part of the President's Medicare plan which extends the life of the Medicare Trust Fund to 2007 without imposing any new costs on beneficiaries or undermining the high quality services.

Dave
document

The President's FY 1998 Budget: Proposals To Improve Medicare For Beneficiaries

The President's Budget includes a number of proposals that would improve the Medicare program for beneficiaries. These proposals would: expand preventive care, create a respite care benefit, make coinsurance in hospital outpatient departments affordable, improve enrollment procedures, assist disabled beneficiaries, increase Medigap options, and strengthen financial protections for managed care enrollees.

IMPROVED BENEFITS FOR PREVENTION, RESPITE CARE, AND THE FRAIL ELDERLY

o **Cover Colorectal Screening**

Proposal: Expand Medicare coverage to include common screening procedures for detection of colorectal cancer, subject to certain frequency limits, effective for services provided on or after January 1, 1998. Covered procedures would include barium enemas, colonoscopies, flexible sigmoidoscopies, fecal-occult blood tests, and other procedures determined appropriate by the HHS Secretary.

Rationale: Current law provides coverage of these procedures only as diagnostic services, not as routine screening purposes. This proposal would improve access to colorectal screening, thereby increasing early detection and treatment of colorectal cancer and other conditions.

o **Waive Cost-Sharing for Mammography Services**

Proposal: Waive payment of coinsurance and applicability of the Part B deductible for both screening and diagnostic mammograms, effective for services provided on or after January 1, 1998.

Rationale: Waiving cost-sharing would improve access to mammography, thereby increasing early detection and treatment of breast cancer and other breast conditions. Although Medicare has covered screening mammography since 1991, only 14 percent of eligible beneficiaries without supplemental insurance receive mammograms.

o **Expand Screening Mammography Coverage for Beneficiaries Age 65 and Over**

Proposal: Cover annual screening mammograms for beneficiaries age 65 and over, effective for services provided on or after January 1, 1998.

Rationale: Current law already provides coverage of annual screening mammograms for women ages 50-64, and those at high risk, ages 40-49. Screening mammograms for

women age 65 and over are now covered only biennially, even though breast cancer mortality increases with age. This proposal would remove this anomaly in current law and make coverage consistent with the frequency recommendations of most major breast cancer authorities.

o **Expanded Benefits for Diabetes Outpatient Self-management Training and Blood Glucose Monitoring**

Proposal: Expand coverage of diabetes outpatient self-management training to non-hospital-based programs, and expand coverage of blood glucose monitoring (including testing strips) to all diabetics, effective January 1, 1998.

Rationale: Under current law, Medicare covers diabetes outpatient self-management training only in hospital-based programs, and covers blood glucose monitoring (including testing strips) only for insulin-dependent diabetics. This proposal would expand these benefits to enable many more diabetic beneficiaries to utilize services that are crucial to managing their chronic disease.

o **Increase Payments to Providers for Preventive Injections**

Proposal: Increase payment amounts for the administration of pneumonia, influenza, and hepatitis B vaccines, and waive payment of coinsurance and applicability of the Part B deductible for hepatitis B vaccine, effective for services provided on or after January 1, 1998.

Rationale: Current law provides payment for the administration of pneumonia, influenza, and hepatitis B vaccines, and already waives payment of coinsurance and the Part B deductible for pneumonia and influenza vaccines. This proposal would improve access to adult vaccinations and make the cost-sharing waiver consistent for all types of covered vaccines.

o **Respite Benefit**

Proposal: Provide for a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia beginning in fiscal 1998. The benefit would cover up to 32 hours of care per beneficiary per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. Services would be provided in the home or in a day care setting.

Rationale: This new benefit is not only needed, it is potentially cost-effective, since it could improve a families' ability to provide care at home rather than in an institution.

- o **PACE Demonstrations**

Proposal: Grant full permanent provider status for Program of All-inclusive Care for the Elderly (PACE) demonstration sites that currently meet the PACE protocol.

Rationale: PACE is a unique service delivery system designed to prevent the institutionalization of frail elderly.

COINSURANCE REFORM AND ENROLLMENT IMPROVEMENTS

- o **Reform Beneficiary Coinsurance for Hospital Outpatient Department Services**

Proposal: Reduce beneficiary coinsurance to 20 percent by 2007.

Rationale: Coinsurance for Part B services is generally based on Medicare's payment amount. However, for certain OPD services, coinsurance is a function of hospital charges, which are significantly higher. Combined with a flaw in the statutory formula determining Medicare's payment, this practice now makes the effective coinsurance rate for these OPD services nearly 50 percent rather than 20 percent. This proposal would address this inequitable situation, reducing the coinsurance rate to 20 percent by 2007.

- o **Part B Enrollment and Premium Surcharge**

Proposal: Replace the general enrollment period for Part B (and Part A for those beneficiaries who pay a premium) with a continuous open enrollment period. Beneficiaries could enroll in the program at any time, and coverage would begin six months after enrollment. Also, base the Part B premium surcharge for late enrollees on the actuarially determined cost of late enrollment.

Rationale: This proposal would simplify the enrollment process and eliminate the onerous nature of the current rules where some beneficiaries have to wait as long as 15 months prior to receiving coverage. The surcharge revision, while still encouraging timely enrollment, would provide particular relief to individuals who do not enroll initially in Part B. Some beneficiaries come late into Medicare, such as military retirees who receive health care from a military treatment facility that subsequently closes, and retirees whose employer group coverage is reduced or eliminated.

PROPOSALS ASSISTING DISABLED BENEFICIARIES

o Demonstration to Extend Premium-Free Part A to Working Disabled

Proposal: Establish a four-year demonstration to encourage Social Security Disability Insurance (SSDI) beneficiaries to work. During the demonstration period, certain SSDI beneficiaries would be provided premium-free Part A Medicare coverage for additional years. SSDI beneficiaries would be eligible after completion of the trial work period and extended period of eligibility.

Rationale: Despite existing work incentives in the SSDI program, fewer than one-half of one percent of beneficiaries return to substantial gainful employment annually. The fear of losing medical benefits has been identified as one of the potential barriers to SSDI beneficiaries returning to work. This demonstration is intended to test whether strengthening the existing work incentives by providing additional years of premium-free Part A Medicare coverage would encourage more SSDI beneficiaries to work.

o Definition of Durable Medical Equipment (DME)

Proposal: Modify the definition of durable medical equipment (DME) to include items needed "for essential community activities." The HHS Secretary would have the authority to limit the benefit to assure the efficient provision of items needed by the beneficiary (e.g. through the use of prior authorization of equipment).

Rationale: Under current law, DME is limited to those items appropriate for use in the home. This definition was developed in 1965, when Medicare only applied to the elderly, and beneficiaries who used DME were not expected to function outside the home. The expanded definition would encourage independent activity by permitting beneficiaries to obtain equipment necessary for them to participate in activities outside the home.

PROPOSALS RELATED TO MEDIGAP AND MANAGED CARE OPTIONS

o Pre-Existing Condition Exclusion

Proposal: Eliminate the Medigap insurer's option of imposing a six-month pre-existing condition exclusion period for initial enrollment and maintain this prohibition for as long as coverage (Medigap, managed care, or employer coverage) is maintained (with no break in coverage of 63 days).

Rationale: As a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the use of pre-existing condition exclusion periods is now limited as long as coverage is maintained. Individuals becoming eligible for Medicare and purchasing a

Medigap policy should not be subject to a pre-existing condition exclusion period. Similarly, a beneficiary changing supplemental coverage should not have to face a pre-existing condition exclusion period.

- o **Open Enrollment Expansions**

Proposal: Expand open enrollment opportunities for Medigap and Medicare managed care options. All beneficiaries would have an open enrollment period when they first become eligible for Medicare. They also would have an open enrollment opportunity during an annual 30-day coordinated open enrollment period and under certain specified circumstances (for example, for beneficiaries who move).

Rationale: These expanded open enrollment opportunities would ensure that all beneficiaries have the choice of the full range of coverage options.

- o **Permit Managed Care Enrollment of End-Stage Renal Disease (ESRD) Beneficiaries**

Proposal: Permit beneficiaries with ESRD to enroll in a managed care plan.

Rationale: ESRD beneficiaries should not have their coverage options limited because of their health status.

- o **Managed Care Coverage for Out-of-Area Dialysis Services**

Proposal: Require managed care plans to pay for out-of-area dialysis services when an enrollee is temporarily out of the plan's service area.

Rationale: Under current law, plans are only obligated to pay for out-of-area services in two instances: emergency care and unforeseen urgent care. Since dialysis services are foreseeable, plans have no obligation to pay for them outside of their network. As a result, managed care enrollees receiving dialysis services are effectively barred from ever leaving their home town.

- o **Limit Beneficiary Liability for Out-of-Network Services**

Proposal: Apply normal fee-for-service limits to the amount that non-contracting entities may charge a Medicare managed care enrollee for unauthorized out-of-network services.

Rationale: Providers should not receive a windfall from charges to beneficiaries for providing an unauthorized service outside of their managed care plan. Beneficiaries who decide to receive unauthorized services should have the same protections as beneficiaries who remain in fee-for-service Medicare.

Withdrawal/Redaction Marker

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001. memo	Gene Sperling to POTUS re: Medicare High Income Premium: Pros and Cons (3 pages)	12/23/96	P5

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Presidential Records Act - [44 U.S.C. 2204(a)]

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

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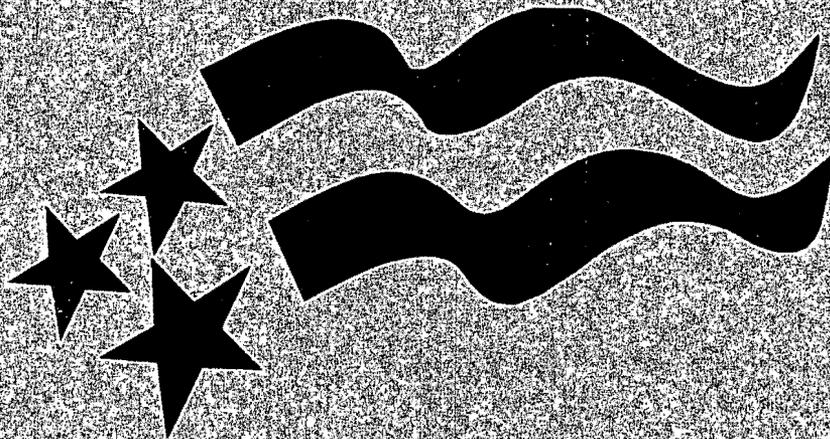
- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
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**Status of the
Social Security
and Medicare
Programs**

**A SUMMARY OF THE
2000 ANNUAL REPORTS**

**Washington, D.C.
March 2000**

**Social Security and Medicare
Boards of Trustees**

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1966	At least 1990	At least 25 years	na
1967	At least 1991	At least 25 years	na
1968	At least 1992	At least 25 years	na
1969	1975	6	na
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	At least 1997	At least 25 years	na
1974	At least 1998	At least 25 years	na
1975	1999	25 years	na
1976	"Early 1990s"	14-19 years	na
1977	"Late 1980s"	8-13 years	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
1994	2001	7	- 4.14
1995	2002	7	- 3.52
1996	2001	5	- 4.52
1997	2001	4	- 4.32
1998	2008	10	- 2.10
1999	2015	16	- 1.46
2000	20xx		-x

LOCK BOX - PUBLIC

Medicare Reform Lockbox File

THE WHITE HOUSE
WASHINGTON

7:45 →

8:00

FAX COVER SHEET

9:30

TO:

Andie King 6-0938	Jane Lowenson 4-2047
Bill Vaughan 5-5680	Liz Fowler 82904
Bridget Taylor 5-5288	Paul Neeson 4-3533

~~10:30~~

10:40

FROM:

Chris + Jeanne

FYI - Here's THE LockBox
Language that includes the
Medicare Reserve, per the President's
announcement yesterday.

Please call w/ questions.

Medicare Reform:
~~Res~~
Surplus Reserve File

Draft 10/21/99 7:00pm
Terry Edmonds

**PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON SOCIAL SECURITY
THE WHITE HOUSE
October 22, 1999**

Good morning. Today I want to talk about how the current budget debate in Washington relates to one of the most important challenges of the next century—the aging of America. This week, I sat down with Congressional leaders at the White House to ask them to work with me to construct an overall framework for completing our work on spending bills that reflect the priorities and values of the American people.

The cornerstone of that framework must be paying down the debt, investing in education and other critical priorities and saving Social Security. As I have said many times, if we value the financial well being of our parents and grandparents...if we believe that all Americans deserve to retire with dignity...if we want to make sure we do not place an unfair burden on the backs of the next generation...we must seize this moment of unprecedented prosperity and budget surpluses to strengthen and extend the life of Social Security.

Let's remember what's at stake here. Since 1935, Social Security has provided a solid foundation for retirement. It has also lifted millions of Americans out of poverty. As late as 1959, 35 percent of seniors lived in poverty. Today, the poverty rate for seniors is 10 percent – a 70 percent decline, thanks in large part to Social Security. Earlier this week, we announced a Social Security cost of living increase to continue to protect the benefits that so many seniors have come to rely on.

But, the number of older Americans is expected to double as the baby boomers retire, while at the same time, the number of workers supporting each beneficiary will also decline. Today, there are 3.4 workers for each beneficiary. By the year 2030, there will only be two. This will put a tremendous strain on the system. So much so, that if nothing is done, the Social Security Trust Fund will be completely depleted by the year 2034.

Today, we have an historic opportunity to extend the life of Social Security. We have seen seven consecutive years of fiscal improvement for the first time in our nation's history. We have had back to back budget surpluses for the first time since 1957. Now, we must make the tough choices necessary to stay on this course of fiscal discipline – pay down the debt by 2015 and strengthen Social Security.

There has been too much confusion and too much delay on this issue. It is time to put, a clear, straight-forward bill on the table. Next week, I plan to do just that. In a few days, I will send to Congress legislation that ensures that each and every year all Social Security payroll taxes will go to savings and debt reduction for Social Security. Over 15 years, this will allow us to pay down more than \$3 trillion dollars of debt.

But my plan goes even further. After a decade of debt reduction from protecting Social funds --- essentially putting it in a lock box -- all the interest savings will be reinvested in Social Security, extending its solvency into the middle of the next century. This is a big, first step towards truly saving Social Security.

The Republicans also claim they too want to lock away the Social Security surplus. But, they haven't told us the whole story. First, even their own Congressional Budget Office has said they have already violated that pledge. They are already dipping into the Social Security surplus but using budget gimmicks to mask that fact. And second, their plan does not extend the solvency of Social Security one single day.

My proposal creates a real Social Security lock-box that protects the Social Security surplus. It pays down the debt by 2015 and extends the life of Social Security.

Social Security is one of the greatest and most enduring accomplishments of the generation of President Franklin Roosevelt. For almost 65 years, it has made America a better place. We owe it to this legacy and to future generations to protect this promise for all time.

Thanks for listening.

October 22, 1999

this is for
today's mtg
w/ gae.

MEMORANDUM

FROM: JASON FURMAN

There are two remaining issues that need to be resolved as soon as possible in order to have the lockbox, and the supporting documents, ready on time as public background for the President's radio address and for transmittal to Congress. The attached agenda, developed by the Technical Working Group, describes these two issues in more detail. Briefly they are:

How explicit should the actuaries letter be about equities? The actuaries letter will say that the lockbox legislation will extend solvency to 2049. It will also include an additional paragraph that could say either of the following:

- Letter A: If there is investment in equities, then solvency would be extended still further.
- Letter B: In response to your written request, if there was investment in broad-based equities up to 15 percent of the trust fund, then solvency would be extended to 2053.

Staff have divided opinions about letter A vs. letter B.

Should we change the treatment of Medicare in the lockbox?

- Option A: Status quo with specified Medicare transfers.
- Option B: No Medicare in lockbox.
- Option C: Reserve one-third of the 10-year on-budget surplus for Medicare and specify conditions for use (including that it must be part of or subsequent to legislation that "significantly extends solvency.") This is similar to Conrad.

Staff have developed legislative language for Option C and generally believe that it is preferred to the current lockbox. Under this revised lockbox, the Medicare legislation could still specify specific dollar transfers that would be scored as extending solvency. The one-third lockbox would require essentially no revision of the President's Medicare proposal, which in the Mid-Session Review used 34 percent of the surplus over 10 years.

REMAINING LOCKBOX ISSUES

October 22, 1999

OUTLINE

1. How should the actuaries letter discuss equities?

Letter A. A qualitative statement only

Letter B. Specific statement about extending solvency to 2053

2. Administration lockbox vs. Senate Democratic lockbox

3. Should we include Medicare in the lockbox legislation?

Option A. Maintain Status Quo: Current lockbox with Medicare transfers

Option B. Do not include Medicare transfers in Lockbox

Option C. Lockbox reserves one-third of the surplus for Medicare

4. Background on the President's Medicare plan

DESCRIPTION

There are two variants of the Actuaries letter. Both of them say that the President's Social Security lockbox extends solvency to 2049. They differ in their discussion of equities.

Letter A: Qualitative Statement

Letter A only says that if some of the transfers were invested in equities, then solvency would be extended for longer:

“If some of all of the transfers under this bill were invested in stock, as was considered in the Mid-Session Review of the President's Fiscal Year 2000 Budget, the effects on the financial status of the OASDI trust funds would be expected to be more positive than indicated above. However, no authority exists either in current law or in this bill for investment of trust fund assets in any private securities.”

Letter B: Specific Statement About Solvency to 2053

If the Administration writes a letter asking for SSA's solvency estimates under a plan that capped investment in broad-based equities at 15 percent of the trust fund, then SSA would specifically include the 2053 number:

“While no authority exists either in current law or in this bill for investment of trust fund assets in any private securities, the National Economic Council (NEC) has requested an estimate for a possible variation of this legislation... then the date of expected OASDI combined trust fund exhaustion would be extended to 2053.”

Two Considerations In Deciding Between the Letters

- Would we like to have official documentation for the 2053 number that has been used in many official documents?
- Are we concerned that a specific letter and explicit discussions of equities would make the President's plan more vulnerable to criticism?

ADMINISTRATION LOCKBOX VS. SENATE DEMOCRATIC LOCKBOX

<u>Feature</u>	<u>Administration</u>	<u>Senate Democrats</u>
Social Security Transfers	Makes transfers starting in 2011 based on a formula linked to interest savings from devoting the Social Security surplus to debt reduction. These transfers extend solvency to 2049.	No provision.
Medicare	Makes Medicare transfers in pre-specified amounts over the next 15 years, which, by themselves, extend solvency to 2025. With reform, solvency is extended to 2030.	Reserves one-third of the on-budget surplus for Medicare. Can only be used for (1) prescription drugs and extending solvency or (2) Medicare transfers. This Medicare reserve is protected by a point of order.
Discretionary Caps	Extends the Discretionary caps through 2009 and increases them for 2001 and 2002.	No provision.
Pay-As-You-Go	Extends the pay-as-you-go sequester system that prevents use of the on-budget surplus.	Same.
Social Security Points of Order	Creates new points of order against considering any budget resolution or subsequent legislation that would cause or increase (relative to the baseline) an on-budget deficit for any fiscal year.	Same.

**OPTION A: MAINTAIN STATUS QUO: CURRENT LOCKBOX WITH SPECIFIED
MEDICARE TRANSFERS**

DESCRIPTION

Would maintain pre-specified Medicare transfers to extend HI solvency as in the current draft of the lockbox legislation.

The legislation could still be described as devoting one-third of the ten-year on-budget surplus to Medicare.

ADVANTAGES

- Current position; signals that our Medicare commitment remains unchanged
- Would extend Medicare solvency
- Would include an additional more than \$700 billion of debt reduction through Medicare transfers that was not in the competing lockboxes

DISADVANTAGES

- Criticism of the Medicare transfers could undermine the lockbox as a whole
- Limits flexibility to change amounts or rationale of Medicare transfers in the future

OPTION B: MEDICARE NOT INCLUDED IN LOCKBOX

DESCRIPTION

This would take the current version of the lockbox legislation and delete the sections related to Medicare transfers.

These Medicare transfers would be included as a separate Title in the legislation to implement the President's Medicare proposal.

ADVANTAGES

- Would sharpen the focus on Social Security and simplify the lockbox
- Would not be vulnerable to the charge that the Administration has only proposed Medicare transfers, and has not yet sent up reform legislation
- Would preserve greater flexibility to alter the mechanics or amounts of Medicare transfers in the future

DISADVANTAGES

- Would remove one major attraction of our lockbox: it strengthens Medicare as well as Social Security
- The lockbox, by itself, would not lead to as much debt reduction, another major attraction
- The lockbox is meant to implement the President's framework as a whole

OPTION C: RESERVE ONE-THIRD OF THE SURPLUS FOR MEDICARE IN THE LOCKBOX

DESCRIPTION

Like Senate Dems, would include a provision in the lockbox legislation to reserve one-third of the on-budget surplus for Medicare over 10 years. This would be protected by a point of order.

Like Senate Dems, could specify that this money could only be used under certain conditions (e.g., for extending solvency and prescription drugs).

DESIGN OPTIONS

(1) Should the on-budget surplus reserve be one-third each year for Medicare or one-third total for Medicare?

(2) Should there be solvency conditions attached to use of the Medicare reserve?

- A. No solvency condition
- B. The plan must extend solvency (Lautenberg-Conrad)
- C. The plan must ensure solvency for at least 25 years

ADVANTAGES

- Would be attractive to Senate Democrats since it maintains commitment to Medicare, without containing any potentially objectionable transfers
- Would preserve some flexibility to alter the Medicare policy in the future

DISADVANTAGES

- By itself, would not lead to debt reduction or extending the solvency of Medicare
- Would potentially lock the Administration into Medicare numbers that were the wrong size when developing the next budget
- Would not explicitly set aside any surplus from 2010-2014

BACKGROUND ON THE PRESIDENT'S MEDICARE PLAN

PRESIDENT'S ALLOCATION OF THE ON-BUDGET SURPLUS FOR MEDICARE		
(percent of on-budget surplus)		
	TOTAL MEDICARE	MEDICARE SOLVENCY
2000-04	22	13
2000-09	34	30
2000-14	28	25
2000	100	92
2001	6	1
2002	25	18
2003	23	9
2004	18	9
2005	17	11
2006	25	21
2007	37	34
2008	43	41
2009	49	48
2010	52	50
2011	22	20
2012	20	18
2013	17	16
2014	14	13

Note: Surplus is for policy pending reform, Medicare is based on actuaries 8/9 scoring.

**THE PRESIDENT'S FRAMEWORK FOR MEDICARE:
HOW IT WORKS IN THE BUDGET, DRAFT: April 14, 1999**

The President's framework ensures that we protect and extend the solvency of Social Security and Medicare before taking on new obligations. The framework would lock in our commitment to debt reduction and guarantee the benefits of debt reduction for Social Security and Medicare.

- **President's Commitment to Addressing Medicare's Long-Term Solvency:** The President has an unparalleled record of strengthening and improving Medicare. When he took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be bankrupt this year -- 1999. Today, the Trust Fund is projected to be solvent through 2015 and its growth rate per beneficiary is below that of private health spending. However, Medicare's Trust Fund will become insolvent about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries. As such, the President has proposed a framework for dedicating part of the surplus to Medicare. This will be combined with a plan to modernize the program, make it more efficient and competitive, and add a long-overdue prescription drug benefit.
- **A Time-Tested Use of Funds:** The President's framework would extend the solvency of the Medicare Trust Fund by another decade by adding new financial resources -- about \$690 billion over the next 15 years. These bonds will guarantee that Medicare will get the benefits from the fiscal improvement that debt reduction and lower net interest costs will bring about.
- **Lower Interest Costs:** By reducing debt held by the public, the framework would dramatically reduce the amount of net interest that the government would have to pay to service debt in the future. This reduction in net interest costs will help free up the resources to allow the government to meet its existing Social Security and Medicare commitments.
- **A Stable Share of the Economy:** Social Security and Medicare costs are projected to rise in the future, but the reduction in net interest costs resulting from the President's framework for Social Security and Medicare will offset those rising program costs. As a result, under the President's framework, the sum of Social Security, Medicare, and net interest costs will remain the same (or smaller) share of the economy through 2020.
- **Additional Benefits to the Economy:** These results flow from the simple benefits of carrying less debt. They do not depend on improvement in the economy, even though most economists project that a significant improvement will result from reduced federal government borrowing. As the government borrows less (that is, reduces its demand for credit), interest rates (the price of credit) should come down, making private sector investment more economical, and increasing economic growth, yielding a fiscal dividend of increased budget surpluses in addition to the effects of declining net interest costs.

**The Sum of Social Security,
Medicare, and Net Interest Payments
as a Share of GDP**

<u>Year</u>	<u>Share of GDP</u>
1999	9.4 %
2010	8.2 %
2020	9.1 %

HOW THE PRESIDENT'S FRAMEWORK FOR MEDICARE WOULD WORK

Budget surpluses would be used to reduce the debt held by the public. The Medicare Trust Fund would receive bonds that would extend its solvency. And new safeguards would protect these funds from being used for other purposes. Here is how the President's framework would work step by step:

- **Step 1 -- Reduce the Debt:** The Treasury would use 15 percent of the budget surpluses we now project to pay down \$686 billion in publicly held debt over the next 15 years, reducing the government's demands on the credit market.
- **Step 2 -- Extend Medicare Solvency:** The Treasury would then convey to the Medicare Trust Fund additional special purpose bonds (above and beyond the amount called for under current law), thus extending the solvency of the Medicare Trust Fund roughly a decade (as certified by Medicare's independent career actuaries).
- **Step 3 -- Lock-Box Protections:** Legally binding procedures -- a Social Security and Medicare Lock Box -- would prevent the government from using these funds for any other purpose.

Like a Thrifty Family: The President's framework is like a family that pays off credit card debt now so that they will not have monthly bills to pay later. When its children get ready for college, the family can take the money that they would have been spending each month on the credit cards and use it to help with college. In contrast, the Republican budget, with its expanding tax cuts, is like a family that goes on a spending spree on credit that comes due just when their children reach college age.

WHAT WOULD HAPPEN IF THE SURPLUS IS USED FOR A TAX CUT RATHER THAN FOR MEDICARE

- **Without the President's framework, Medicare would have to rely on unrealistic provider payment reductions, beneficiary payment increases and/or tax increases to extend the life of the Trust Fund.**

- **The Republican Budget Neglects Medicare:** The Republican budget fails to extend the life of Medicare by one day, fails to set aside even one penny of the surplus to strengthen Medicare, fails to guarantee any specific allocation for Medicare, and fails to make a rock-solid commitment to debt reduction. While it ignores Medicare, the Republican budget also fails to strengthen and extend the life of the Social Security Trust Fund; undermines key investments in our children, the environment, and law enforcement -- forcing cuts of 10 percent in 2000 and more than 20 percent in 2004; and chooses instead large tax breaks targeted to the wealthy.

- **Using the surplus for tax cuts would have the following effects:**
 - **Effect # 1:** It would create permanent and growing federal government obligations.

 - **Effect # 2:** It would allow federal debt and interest costs to continue at high levels.

 - **Effect # 3:** It would yield no extension of the life of the Medicare Trust Fund.

MYTHS ABOUT THE PRESIDENT'S MEDICARE FRAMEWORK

MYTH: The President's framework increases the future obligations of the government.

FACT: We already have a commitment to pay benefits to current workers when they retire. The President's framework does not increase these benefits. Instead, it pays down debt and frees up resources so that we can better meet our existing obligations.

MYTH: By providing additional funds to the Medicare Trust Fund, the framework creates a commitment to pay benefits after 2015.

FACT: We now have both the commitment and the fiscal resources to pay benefits through 2015; after that we have resources to pay part of the benefits for many years to come. The President's framework provides the additional resources to pay benefits for roughly another decade after that.

MYTH: The bonds in the Medicare Trust Fund will be merely IOUs, just an unenforceable paper promise.

FACT: Treasury bonds convey the soundest promise in the world -- the full faith and credit of the United States. The federal government has never failed to honor Treasury bonds. One can imagine no better guarantee of paying a debt. As well, the framework creates the fiscal soundness and additional resources that will help make it easier to honor those obligations when they come due.

MYTH: The President's framework will have no effect on the unified budget surpluses or the on-budget surpluses and therefore have no effect on the debt held by the public.

FACT: The President's framework would lock in \$686 billion from the unified surplus for debt reduction that, under the Republican plan, would go for tax cuts, not debt reduction or Medicare. Merrill Lynch praised the President's overall strategy: "Allocating a portion of the budget surpluses to debt reduction, as the President proposes, is a conservative strategy that makes sense. Reduced debt will result in increased national savings, lower interest rates, and stronger long-term economic growth than would otherwise be the case." (Merrill Lynch, February 10, 1999).

MYTH: Because the President's framework gives a dollar in bonds to the Trust Fund for every dollar of debt reduction, it does not really pay down the total government debt.

FACT: The President's framework pays down debt held by the public exactly as much as paying down the debt without crediting the trust fund. Thus, it creates the same economic

benefits of lower net interest payments, higher savings, higher incomes, and additional revenue. The difference is that the President's framework guarantees Social Security and Medicare the benefits of debt reduction. The President believes we must meet our existing commitments to these programs before we think of allocating the benefits of debt reduction to other purposes.

MYTH: The money devoted to Medicare is already committed to the Social Security Trust Fund.

FACT: The money devoted to Medicare is in addition to the funds devoted to Social Security. Over the next 15 years, the President's framework devotes to Social Security an amount equivalent to the Social Security surplus over that period. By 2014, the President's framework would just about double the balances that the Social Security Trust Funds would have under current law. The 15 percent that the framework devotes to Medicare represents funds in addition to those.

MYTH: The President's framework does not devote 15 percent of the budget surpluses to the Medicare program, as the federal budget process does not provide a mechanism for setting aside current surpluses for future obligations.

FACT: We propose changes in the budget rules to lock in the transfer of 15 percent of the surplus to Medicare. The President's framework would dedicate \$686 billion to debt reduction and the Medicare Trust Fund. The independent career Medicare actuary -- repeatedly cited by Republicans in 1995 -- confirmed that this proposal would extend the life of the Trust Fund by roughly a decade. Paying off debt and reducing future interest costs is a real way to create the resources we will need to pay Medicare benefits in the future. For example, even in 2020, net interest savings under the President's framework will more than offset the anticipated increase in Social Security and Medicare payments.

MYTH: Transferring IOUs will require raising taxes, cutting benefits, or increased gross debt to pay for Medicare in the future.

FACT: OMB projects that there will be a surplus well into the middle of the next century even after making full payment of currently promised Social Security and Medicare benefits. By paying down the publicly held debt, the President's framework reduces net interest costs to the federal government and increases economic growth. Thus, even after using the surplus to pay for Medicare and Social Security, there will still be a budget surplus. In contrast, if the nation were to use the surplus for tax cuts and still meet our future obligations to Medicare, then we would be forced to raise the payroll tax, make tough benefit cuts, or take other difficult measures.