

MEMORANDUM

TO: Interested Parties
FR: Chris Jennings and Jennifer Klein
RE: Interesting Background Materials on the Medicare Trust Fund and Ross Perot

August 29, 1995

Tomorrow morning, the Senate Finance Committee will be holding a hearing on the Medicare Trust Fund and options for reform. The witness testifying who will likely receive the most attention will be Ross Perot. (Because of the late notice and the fact it is in the middle of the recess, no Democratic Finance Committee Member will be attending; incidentally, no Administration witness was invited to testify or even to submit testimony.)

Attached for your information and use are:

- (1) a one page summary reviewing the positions of the President, Ross Perot and the Republicans on Medicare reform;
- (2) a table that compares some of Mr. Perot's specific suggestions with those of the Administration;
- (3) a copy of the less than balanced hearing witness list; and
- (4) a reprint of the August 28th *Los Angeles Times* Medicare Trust Fund Fact vs. Fiction Op Ed piece, which was written by Trustees' Shalala, Rubin, Reich, and Chater.

Despite suggestions by some that Ross Perot is advocating a similar set of reforms being suggested by the Republicans, Mr. Perot is not on record of supporting Medicare and Medicaid cuts totaling anywhere near \$450 billion (\$270 billion in Medicare cuts + \$182 billion in Medicaid cuts.) In fact, he has explicitly stated in his book that the program should not rush to throw people into managed care and should instead utilize pilot studies to see what is feasible in this area.

The President agrees with Mr. Perot that we need to strengthen the Medicare Trust Fund and has, in fact, made a proposal to do just that in his balanced budget initiative. (His \$124 billion in savings over seven years strengthens the Trust Fund through October, 2006, leaving the Fund stronger than it has been in 9 out of the last 14 years.) The President's own proposal therefore proves that it is not necessary to decimate the program and the 37 million people it serves (with an unnecessary \$270 billion cut) in order to "save" the program from going bankrupt.

Clinton, Perot, Republicans on Medicare

Strengthening The Medicare Trust Fund. President Clinton shares Ross Perot's commitment to strengthen the Medicare Trust Fund so that Medicare will be there for our parents and grandparents -- and our children and grandchildren.

Fixing the Trust Fund Without Putting Beneficiaries in a Fix. Since taking office the President has acted three times to extend the life of the Trust Fund. In 1993, he signed into law proposals that Perot supported to strengthen the Trust Fund -- over unanimous Republican opposition. Most recently, he has acted through his balanced budget plan to:

- Extend the life of the Trust Fund through 2006 -- eleven years from now.
- Protect beneficiaries from paying any new cost increases -- because we can solve the short-term problems of the Trust Fund without new out-of-pocket costs for older Americans on Medicare.

No Excuse to Cut Benefits. Some are trying to exaggerate the Medicare Trust Fund solvency problem to justify cutting Medicare benefits. The facts are that President Clinton's plan would put the Medicare Trust Fund in better shape than it has been in 12 out of the last 20 reports the Trustees have issued. The costs increases for beneficiaries that the Republicans have proposed do not go to improve the financial health of the Trust Fund. They would be used to pay for the big GOP tax cut.

Giving Medicare Beneficiaries More Choice President Clinton also agrees with Ross Perot that we need to make other changes to address the long-term problems in Medicare. But, as Perot says, we need to do this in a thoughtful way -- by giving Medicare beneficiaries more choices, rather than financially forcing them into a radically new and untested system.

- The President has proposed to expand managed care choices including a new preferred provider option and a new point-of-service option for beneficiaries in health maintenance organizations.
- He is also making sure that Medicare gives beneficiaries the clear and simple information they need to make choices.

Republicans Would Place Extreme Financial Burdens on Older Americans. The Republicans would cut Medicare by \$270 billion -- \$71 billion in the year 2002 alone. Because the Republicans need so much so fast from Medicare, they are, despite Mr. Perot's warnings, plunging ahead too quickly on vouchers. The choice for people on Medicare will be simple: pay more or get less.

- Beneficiaries who wish to keep their fee-for-service plan and a guarantee of their choice of doctor will have to pay significantly more. Since 75 percent of these beneficiaries have incomes below \$25,000, it is hard to see how they will be able to do that.
- Those who are financially forced into managed care will have their current benefits threatened. This is because the overly tight growth rates proposed by the Republicans will over time diminish the value of the voucher and the type of coverage it can buy.

"INTENSIVE CARE" ROSS PEROT'S KEY ASSERTIONS AND ADMINISTRATION'S RESPONSE

Perot's Assertion	Supporting Arguments and Strategies	Administration's Response
<p>WE NEED TO ACT NOW BECAUSE:</p>	<ul style="list-style-type: none"> o the Medicare trust fund is going bankrupt. o it is critical to have a safety net for the needy, but Medicaid is overwhelming federal, state and local budget o health care inflation reduces wages, increases taxes, and is a barrier to balancing the budget. o program savings can benefit all consumers; however, the goal is not to finance a tax cut. 	<ul style="list-style-type: none"> o The President's Plan maintains trust fund solvency through 2006, without new beneficiary cuts. o Agree that Medicaid is both critically important and in need of reform; concerned that deep cuts would jeopardize states and beneficiaries. o Agree that we should aim to alleviate the tax payers' burden and reduce the deficit; however, not by simply shifting the financial burden onto beneficiaries. o Agree
<p>WE SHOULD PURSUE A TWO-PART STRATEGY:</p> <p>1) Take immediate steps to reduce projected spending</p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> o provides a list of Medicare savings options but does not recommend specific budget targets or policies. o Savings proposals include both provider and beneficiary options; on the beneficiary side, proposals include increases in Part B deductible and premiums, and provision prohibiting Medigap plans from paying first \$1,500 in cost sharing. <p><u>Medicaid</u></p> <ul style="list-style-type: none"> o No specific budget or savings targets recommended. Significantly divergent programmatic changes considered. For example, either block grant the program or make it fully federal. 	<ul style="list-style-type: none"> o Agree that there should be spending reductions, but limit them to \$124 Billion without any new beneficiary cuts. o The Administration has proposed spending reductions totaling \$54 Billion. This level of cuts will improve program efficiency while safeguarding coverage.
<p>2) "Modernize" the Programs; i.e. pilot test and then implement long-term solutions</p>	<ul style="list-style-type: none"> o For both programs, we should: <ul style="list-style-type: none"> - increase the use of managed care - consider replacing current financing mechanisms with vouchers for private insurance - explore the use of Medical Savings Accounts 	<ul style="list-style-type: none"> o Pilot testing is in line with the Administration's policy. We are currently: <ul style="list-style-type: none"> - sponsoring a demonstration of innovative Medicare managed care approaches - working with the private sector to develop Point-of-Service and PPO options for seniors o We have concerns about Voucher programs and MSAs. <ul style="list-style-type: none"> - Voucher programs could force seniors into managed care while increasing their financial liability significantly. - MSAs may lead to greater risk selection and underutilization of cost-effective preventive services



Committee On Finance

Bob Packwood, Chairman

NEWS RELEASE

FOR IMMEDIATE RELEASE
AUGUST 23, 1995

PRESS RELEASE #104-108
CONTACT: Eric L. Bolton
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FINANCE COMMITTEE TO HEAR TESTIMONY ON THE FUTURE OF MEDICARE

Washington, D.C.--Senator Bob Packwood (R-OR), Chairman of the Senate Finance Committee, today announced that two panels of witnesses will testify before the Committee on the next thirty years of the Medicare program.

"Ross Perot has again made a significant contribution to the public policy debate with his new book Intensive Care: We Must Save Medicare and Medicaid Now," Senator Packwood said.

"Medicare is thirty this year, and the testimony of Mr. Perot and groups representing current and future Medicare recipients will be important for improving the Medicare program so it may celebrate many more birthdays."

In his book, Mr. Perot summed up the challenge facing Congress this Fall, "If the United States can put men on the moon and bring them back, then surely we can figure out how to save and improve Medicare and Medicaid. It must be done to preserve health care for the sake of people who truly need it while improving the financial strength of our nation for our children."

The hearing will be held on Wednesday, August 30, 1995, in room SD-215 of the Dirksen Senate Office Building, beginning at 9:30 a.m.

Oral testimony will be heard from invited witnesses only. Witnesses scheduled to testify are:

Panel I

Mr. Ross Perot, The Perot Group; Dallas, Texas.

Panel II

Mr. Jake Hansen, Vice President for Government Affairs, The Seniors Coalition; Washington, D.C.

Mr. Jonathan D. Karl, Co-Founder, Third Millennium; Darien, Connecticut.

Commentary

PERSPECTIVE ON MEDICARE

Rehabilitation Needed, Not Surgery



The trust fund's crisis isn't new; the President offered a solution to insolvency.

By ROBERT E. RUBIN, DONNA E. SHALALA, ROBERT B. REICH and SHIRLEY S. CHATER

Our nation is involved in a serious examination of the status and future of Medicare. Congressional Republicans have called for \$270 billion in cuts over the next seven years, claiming that Medicare is facing a sudden and unprecedented financial crisis that President Clinton has not dealt with, and that all of the majority's cuts are necessary to avert it.

While there is a need to address the financial stability of Medicare, the congressional majority's claims are simply mistaken. As trustees of the Part A Medicare Trust Fund, which is the subject of the current debate, and authors of an annual report that regrettably has been used to distort the facts, we would like to set the record straight.

Concerns about the solvency of the Medicare Part A Trust Fund are not new. The solvency of the trust fund is of utmost concern to us all. Each year, the Medicare trustees undertake an

examination to determine its short-term and long-term financial health. The most recent report notes that the trust fund is expected to run dry by 2002. While everyone agrees that we must take action to make sure that the fund has adequate resources, the claim that it is in a sudden crisis is unfounded.

The Medicare trustees have nine times warned that the trust fund would be insolvent within seven years. On each of those occasions, the sitting President and members of Congress from both political parties took appropriate action to strengthen the fund.

Far from being a sudden crisis, the situation has improved over the past few years. When President Clinton took office in 1993, the Medicare trustees predicted the fund would be exhausted in six years. The President offered a package of reforms to push back that date by three years and the Democrats in Congress passed the plan. In 1994, the President proposed a health reform plan that would have strengthened the fund for an additional five years.

So what has caused some members of Congress to become concerned about the fund? Certainly not the facts in this year's trustees report that these members continually cite. The report found that predictions about the solvency of the fund had improved by a year. The only thing that has really changed is the political needs of those who are hoping to use major Medicare cuts for other purposes.

President Clinton has presented a plan to extend the fund's life. Remarkably, some in Congress have said that the President has no plan to address the Medicare Trust Fund issue. But he most certainly does. Under the President's balanced budget plan, payments from the trust fund would be reduced by \$89 billion over the next seven years to ensure that Medicare benefits would be covered through October 2006—11 years from now.

The congressional majority's Medicare cuts are excessive; it is not necessary to cut benefits to ensure the fund's solvency. The congressional majority says that all of its proposed \$270 billion in Medicare cuts

over seven years are necessary. Certainly, some of those savings would help shore up the fund, just as in the President's plan. But a substantial part of the cuts the Republicans seek—at least \$100 billion—would seriously hurt senior citizens without contributing one penny to the fund. None of those savings (taken out of what is called Medicare Part B, which basically covers visits to the doctor) would go to the Part A Trust Fund (which mostly covers hospital stays). As a result, those cuts would not extend the life of the trust fund by one day.

And those Part B cuts would come out of the pockets of Medicare beneficiaries, who might have to pay an average of \$1,650 per person or \$3,300 per couple more over seven years in premiums alone. Total out-of-pocket costs could increase by an average of \$2,825 per person or \$5,650 per couple over seven years. According to a new study by the Department of Health and Human Services, these increases would effectively push at least half a million senior citizens into poverty and dramatically increase the health care burden on all older and disabled Americans and their families. The President's plan, by contrast, protects Medicare beneficiaries from any new cost increases.

As Medicare trustees, we are responsible for making sure that the program continues to be there for our parents and grandparents as well as for our children and grandchildren. The President's balanced budget plan shows that we can address the short-term problems without taking thousands of dollars out of peoples' pockets; that would give us a chance to work on a long-term plan to preserve Medicare's financial health as the baby boom generation ages. By doing that, we can preserve the Medicare Trust Fund without losing the trust of older Americans.

Robert E. Rubin is secretary of the Treasury. Donna E. Shalala is secretary of health and human services. Robert B. Reich is secretary of labor. Shirley S. Chater is commissioner of Social Security.

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Talking Points on February Treasury Statement/Archer Press Release

- There is no news here. We have already reported -- and testified before the Ways and Means Committee -- that the Trust Fund performance in 1995 was somewhat worse than originally projected. And, the 1996 data are no surprise.
- Instead of trying to make political points about the numbers, lets let the actuaries complete their annual report and make their projections about the status of Trust Fund.
- The fact is that Trust Fund still maintains a substantial balance.
- The President is committed to improving the Medicare program and upholding our commitment to current beneficiaries and future generations. We have spent the better part of the past year focusing on developing Medicare proposals to do this.
 - As part of his comprehensive plan to balance the Federal budget, the President has proposed Medicare savings provisions totaling \$124 billion over the next seven years.
 - The President's budget plan would extend the life of the HI Trust Fund through at least the next decade, defusing the short term problem and giving us more time to address the longer term problem.
- Given the urgency of the broader issue, and the fact that we are working for a budget agreement that will extend the solvency of the Trust Fund in the short term, the month-to-month performance of the Trust Fund is not a major issue at this time.
- The cash flow to and from the Trust Fund varies substantially from month to month. In December and June, the HI Trust Fund receives substantial interest payments on the surplus. In addition, in the first month of each quarter, the Trust Fund receives income from the taxation of Social Security benefits.
- The February Treasury data do not significantly alter our overall assessment of the financial status of the HI Trust Fund.
- Rather than focus on the performance of the Trust Fund in any particular month, we should focus on the most important issue -- protecting the Medicare Trust Fund to uphold our commitment to current beneficiaries and future generations.
- The President's plan significantly improves the financial status of the Trust Fund and extends the depletion date, without imposing draconian cuts in benefits and provider payments that could undermine the health security of current beneficiaries.

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NEWS

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
April 1, 1996

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Medicare Trust Fund Reports \$3.2 Billion February Drop

Unexpected 1995 Deficit Worsening as Fiscal 1996 Approaches Midway Point

Washington - The balance in the Medicare Trust Fund declined by \$3.15 billion in February, according to new Treasury Department data released today by Congressman Bill Archer, Chairman of the Ways and Means Committee.

As a result, for the 1996 fiscal year-to-date (October 1, 1995 - February 29, 1996), the Trust Fund balance has declined by \$3.017 billion, compared to a \$2.5 billion surplus after the first five months of 1995.

It was recently revealed that Medicare ended 1995 with an unexpected \$36 million shortfall, although the Medicare Board of Trustees had anticipated a \$4.7 billion surplus for last year. Based on Medicare's accelerating rate of decline for the first five months of fiscal year 1996, the Trust Fund deficit appears to be worsening.

"If President Clinton hadn't vetoed the Congressional plan to save Medicare," Archer said, "this wouldn't be happening. Congress passed a plan that saved Medicare, provided seniors with more choices, and fought fraud and abuse.

"But because the President preferred to scare seniors and play politics instead of saving Medicare," Archer continued, "the Medicare Trust Fund is in decline."

"This new information," Archer continued, "underscores the need for President Clinton to join with Congressional Republicans and blue-dog Democrats to save Medicare from bankruptcy."

QUESTION: A recent study by HCFA reported that Medicare costs grew by 11.8 percent in 1994, compared to private health expenditure growth of 4.0 percent. Isn't this evidence that Medicare has continued to grow unchecked by the President?

RESPONSE: First, a closer reading of the study shows that the real difference between Medicare and private rates is 5.6 percent versus 3.6 percent.

- The difference is narrower than the raw numbers because you need to take into account differences in benefits, policy changes, and enrollment growth. Medicare covers more high-growth services such as home health than do private plans. If private plans also covered these services, their rates would be higher. Additionally, the 1994 Medicare spending includes a payment adjustment from the new Medicare physician payment system. Third, and most importantly, the number of Medicare beneficiaries grew at almost twice the national population growth. In sharp contrast, private health coverage declined in 1994.

Second, the President has made significant advances in reducing Medicare spending growth by (1) passing a budget with real savings, (2) proposing a budget that would reign in costs, and (3) promoting managed care.

- The President's 1993 budget succeeded in both halving the deficit and saving an estimated \$56 billion in Medicare — and it passed with no Republican support. The President's 1993 budget is the only serious Medicare savings proposal passed during the 1990s — and it passed without a single Republican vote. CBO estimated that the President would save \$56 billion over 5 years, beginning in 1994. Its real effects occur in subsequent years.
- The President has advocated since June of 1995 reducing Medicare spending growth per beneficiary to 5.8 percent — with \$124 billion in Federal savings over six years. The President's Medicare plan offers a balanced approach to bringing Medicare spending growth in line with private growth. In fact, according to CBO data, the President's Medicare total spending per beneficiary will grow at rates below private spending per person.
- During the Clinton Administration, Medicare managed care enrollment growth has accelerated. One of the main reasons for the decline in private rates is the one-time savings attributed to managed care enrollment. Medicare is just catching up: in 1993 Medicare HMO enrollment grew by 6.8 percent, but in 1996 CBO projects it will increase by over 20 percent.

Projected Growth in Spending per Beneficiary: 1996 - 2002		
	Current Law	President's Plan
Private	7.1%	7.1%
Medicare	7.5%	5.8%

Medicare spending growth from CBO's April 1996 gross baseline and estimates of the President's FY 1997 budget. The private spending per person rates come from CBO's national health expenditure baseline from August 1995

"COMMON GROUND" PIECE

PREMISE: The Administration plan on Medicare and the Republican Medicare plan have much in common. While important and significant differences remain, there is enough in common between the two plans to forge an agreement that can satisfy all concerned.

STATEMENT:

The President has stated many times recently that we have enough in common between our respective plans to balance the budget to achieve that goal, if a few extreme measures in the Republican plan were removed.

The Republicans have now apparently concluded that, as we have said repeatedly, it is not necessary to slash Medicare in order to balance the budget. One year ago, the Republican Congressional Budget Resolution called for \$270 billion in Medicare savings. Over the course of a year, they have gradually reduced their Medicare savings figure to the current \$168 billion. This current figure is much closer to the President's Budget Medicare plan, scored at \$116 billion by CBO.

Both Proposals would extend the life of the HI Trust Fund for about a decade, according to CBO. It is difficult to discuss details at this point given the lack of specifics included in the current Congressional Budget Resolutions. It appears, however, that the Republicans have made some specific improvements when compared to that previous plan to cut \$270 billion. And there are areas of clear common ground, for example:

- All plans would lower the rate of increase for Medicare hospital and physician payments.
- All plans would reduce the rate of increase in nursing home and home health payments, and move to some type of prospective payment approach.
- All plans would restructure how Medicare pays managed care organizations.
- All plans would strengthen certain elements of fraud and abuse controls

However, the remaining hurdles to an agreement, beyond the overall savings level, are as follows. Republicans must give up on their extreme harmful, provisions. For example:

- Converting Medicare to a voucher program (Medicare Plus) that would impose heavy, new financial burdens on beneficiaries and cause traditional Medicare to "whither on the vine."
- Medical Savings Accounts -- MSA plans are both a gift for the wealthy as well as a cost burden on the rest of the Medicare program. They will destroy the Medicare risk pool with cherry picking.

- Reduced financial protections for beneficiaries- this category includes many regressive initiatives like: allowing harmful cost-shifting to beneficiaries, reducing financial protections for low-income beneficiaries, and reduced coverage of costly long-term care stays.
- Finally, the Republicans have adopted an unusual budget reconciliation process this year, under which the Congress will not even consider Medicare legislation until Congress and the President have completed debate on welfare reform and Medicaid. Given the Republican's apparent interest intent to resubmit legislation to destroy Medicaid -- which the President has already vetoed -- the Republican budget reconciliation process is a preordained train wreck and we will never have the opportunity to take up especially needed Medicare reform.

If the Republicans would agree to remove from their plan these (and a few other) extreme measures, we could hammer out an agreement on Medicare which would ensure the life of the Trust Fund for about a decade from today. That would give us enough time to study the demographic changes that are coming and plan accordingly when the baby boomers begin to retire.

PROJECTED YEAR OF INSOLVENCY HASN'T CHANGED MUCH

QUESTION:

Looking back at previous Trustees reports, it appears that the real crisis began only a few years ago. In each year from the middle 1980s through the early 1990s, the Trust Fund was projected to be solvent for at least 10 years or more. What happened?

ANSWER:

- In fact the projected data of insolvency has remained relatively constant over the past few years. With one exception, in each year since 1987 the Trustees have projected the date of insolvency to be shortly after the turn of the century.
- The problem is that as each year passes, the turn of the century grows closer and closer.
- The President understands that the need to extend the solvency of the HI Trust Fund, and his balanced budget proposal would ensure solvency for about 10 years. This would give Congress and the Administration plenty of time to develop a bipartisan approach to address the long-term solvency issue.

FLUCTUATION IN TRUST FUND BALANCE

QUESTION:

In general, the HI Trust Fund balance is declining each month, but in December it increased, and the deficit in January was small relative to other monthly deficits. Why does the level of assets in the Trust Fund fluctuate like this?

ANSWER:

- Although Trust Fund outlays vary from month to month based on utilization of services, most of the month to month variation in Trust Fund performance is explained by variation in receipts.
- Trust Fund receipts include payroll taxes, premium income, interest payments, and taxes from social security benefits of high income Medicare beneficiaries.
- Payroll taxes and premium income (for beneficiaries who are not eligible for premium-free Part A) are deposited in the Trust Fund every month, and therefore do not account for a significant portion of the month-to-month variation in receipts.
- By contrast, interest paid on Trust Fund assets is deposited only twice a year, in December and June. In December 1995, after several months of deficit, the Trust Fund realized a monthly surplus as a result of the interest payment.
 - In December 1995, the monthly surplus of \$3.9 billion reflected a \$5.05 billion interest payment.
- Revenues from 1.) the additional taxation of social security benefits for high income beneficiaries and 2.) payroll taxes from self-employed workers are deposited four times a year in January, April, June and September. The monthly surplus in April reflected a deposit to the trust fund of revenues from these sources.

ADMINISTRATION GIMMICKS

QUESTION:

The Administration's budget plan relies, in part, on a "gimmick" in extending the trust fund depletion date. The Administration's plan would transfer home health coverage from Part A to Part B. In essence, home health spending goes from a trust fund financed by payroll taxes to a trust fund financed by general revenues and premiums. How can the Administration justify this "gimmick"?

ANSWER:

- ▶ Let me make clear that not all home health expenditures would be transferred to Part B. Only home care not following an acute event and hospitalization would be transferred. Part A was never to cover this kind of long-term care.
- ▶ We do not believe that the transfer of some of the financing of home care from Part A to Part B is a gimmick. By capping Part A financing of Medicare's home health benefit, one of the most rapidly growing components of Medicare, we would be limiting the HI trust fund expenditures. According to CBO, the home health transfer would save the financially vulnerable HI Trust Fund about \$55 billion over FYs 1997-2002.
- ▶ This idea is not new, nor unique to the Administration. A shift in some home health financing from Part A to Part B has been recognized by Democrats and Republicans alike as a sensible way to help the HI trust fund. Similar proposals were offered by the Republican House in their balanced budget bill (H.R. 2425) and in the so-called "Blue Dog" Coalition bill.
- ▶ The proposal would not in any way adversely impact beneficiary access to home health care, even for those beneficiaries who have only Part A coverage or only Part B coverage. The three-day prior hospitalization requirement only dictates how the benefit is financed and has no bearing on coverage or eligibility. Our plan explicitly states that no co-payments or deductibles would apply regardless of whether the benefit is financed under Part A or Part B.

- ▶ Under our proposal there would be no related increase in the Part B premium.

BACKGROUND:

There are other good policy rationales for this shift.

- ▶ Utilization and expenditure patterns show that home health has evolved into two distinct benefits: care to persons surrounding an acute event and hospitalization, and care where there is no hospitalization but long-term care services are required.
- ▶ This proposal acknowledges this evolution and seeks to bring Medicare financing in line with current utilization patterns. Medicare Part A was not envisioned to accommodate long-term care, and the Part A trust fund can no longer support non-post-acute care home health services.
- ▶ There is historical precedent for the Medicare home health benefit to be financed under both Part A and Part B. Until the Omnibus Reconciliation Act of 1980, 100 post-hospital visits were financed under Part A for each beneficiary and all remaining visits during a year were financed under Part B. When Congress lifted the 100 visit limit in 1980, the benefit became fully financed by Part A. This shift in financing to Part A was not viewed as a gimmick at the time. The consequence has been to burden the HI Trust Fund with complete financing of home health services whether furnished as acute or long-term care.
- ▶ This shift in financing leaves open to us the opportunity to build in the future a long term care home health benefit that is not constrained by considerations of trust fund solvency.
- ▶ It is also worth remembering that Republicans also shift money into the Trust Fund to extend its solvency: The Conference Agreement included a proposal that would impose a 6.5 percent surcharge on beneficiary Part B premiums, by raising premiums from 25 percent to 31.5 percent of Part B costs, and transferring this revenue to the HI Trust Fund. Not only did this proposal lack any policy-based justification, it would adversely affect beneficiaries by increasing their premiums.

UNDERLYING CAUSES OF MEDICARE SPENDING GROWTH

QUESTION:

What are the underlying causes of the increase in Medicare Part A expenditures?

ANSWER:

- ▶ There are many factors that contribute to increasing Medicare Part A expenditures, including increases in beneficiary enrollment, the aging of current beneficiaries, and changes in health care technology.
- ▶ In addition, greater utilization of hospital and post-acute services like home health and nursing facility services (which are also covered under Part A) contributes to rising expenditures.

WHAT HAPPENS WHEN TRUST FUND RUNS OUT?

QUESTION:

What will Medicare do when the trust funds are depleted? Do you borrow, not pay claims, what?

ANSWER:

- ▶ Letting the trust fund run out of money is not an option and we intend to work with the Congress to make sure it does not happen. This is a situation that we must prevent.

BACKGROUND:

- ▶ If the trust fund assets are depleted, Medicare would still be able to pay a portion of claims using current income from the HI payroll tax and other sources. However, this income would not be sufficient to pay all claims.
- ▶ Initially there would be delays in provider payments, which would quickly lead to a curtailment of health care services to beneficiaries.
- ▶ Under current law, the Trustees cannot borrow from other Trust Funds or from the General Fund, and there is no other source for payment of Part A benefits.
- ▶ If we hold claims more than 30 days, they will incur interest charges, an additional cost to the government.

INACCURATE PREDICTIONS

QUESTION:

The HI Trust Fund Income fell short of expenditures last year. Given that you didn't predict this would happen until FY 1997, isn't this a significant problem?

ANSWER:

- ▶ The Administration and the Congress spent the better part of the past year focusing on the need to improve the Medicare program and uphold our commitment to current beneficiaries and future generations. The Trust Fund performance in 1995 does not significantly alter our overall assessment of the financial status of the HI Trust Fund. We are still facing fund depletion in the very near future, and a major increase in costs coincident with the baby boomers' retirement.
- ▶ Actual Trust Fund expenditures were about 3 percent higher than projected. Actual income was about 1.2 percent lower than projected. These results were well within the range of normal estimation errors.
- ▶ Even if the Trust Fund had performed as the Trustees projected, legislation is needed in the near future to address short-term solvency.
- ▶ As part of his comprehensive plan to balance the Federal budget, the President has proposed Medicare savings provisions totaling \$124 billion over the next seven years. The President's Medicare plan would extend the life of the HI Trust Fund for about the next decade.
- ▶ While it appears that the projections were off by two years, it was really just one. The actuaries had projected that the fund would approximately break even in FY '96 (surplus of \$45 million). In fact, FY '95 turned out to be the break-even year (deficit of \$36 million)

IS THERE A DANGER THAT BILLS WON'T BE PAID

Q: Is there any imminent danger that bills won't be paid?

- No, the HI Trust Fund has over \$120 billion in assets, which the HI Trustees project is enough to ensure that Medicare Part A benefits will be paid for about five years. This is plenty of time to enact legislation that will extend the life of the trust fund and avoid any disruption of benefits.

BACKGROUND:

The Trustees report urges Congress to enact corrective legislation soon. The report also notes that without such legislation, the fund would be exhausted shortly after the turn of the century. Exhaustion would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

REP. THOMAS QUOTE ON "90 BILLION IN SOLVENCY LOST"

Q: Rep. Thomas was quoted as saying that "\$90 billion in solvency has been lost because of the past year's inactivity on Medicare reform." What does that mean and is it true?

- I don't know what he meant, but since the Republican Conference Agreement only proposed \$6 billion (?) in Part A savings in 1996, and since we are still dedicated to passing Medicare reform, I do not believe it is true.
- The discussions over the past year have been less about the need for savings than about our vision for the Medicare program in the long run and the need for protecting the beneficiaries of the program. President Clinton vetoed the proposals put forth by the Republican Congress because they would severely harm its beneficiaries and undermine the integrity of the program itself.

DOES THE PRESIDENT HAVE A PLAN

Q: Does the President have a plan to save the trust fund? What happens when the baby boomers retire?

A.

- The Administration has spent the better part of the past year focusing on the need to improve the Medicare program and uphold our commitment to current beneficiaries and future generations. As part of his comprehensive plan to balance the Federal budget, the President has proposed a Medicare plan that would ensure the solvency of the HI trust fund for about the next decade.

The President's Medicare proposal would guarantee Medicare solvency long enough to ensure that Congress and the Administration have time to develop a bipartisan approach to address the long-term solvency issue that will arise when the baby boomers retire, beginning in 2010.

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Chris - This is Treasury's rewrite of the Skakala
Response to Auer on the trust fund.
Gene edits are attached for your review. Pauline

Thank you for your letter. As you know, the Administration has always been and remains committed to the fiscal integrity of the Medicare Trust Funds and to the health security of all our elderly.

First, you may have been misinformed by a news article into concluding that the Trust Fund is "broke." This is simply not true. The Trust Fund's balance today is \$129.520 billion.

The President's 1993 economic plan extended the life of the Trust Fund by three years. Last April, the Trustees reported that, if no additional actions were taken, the Trust Fund would be depleted in 2002. Based on current estimates, the President's seven year balanced budget would extend the life of the Trust Fund to at least 2011, fifteen years from today.

Second, you question whether information about the Trust Fund's status was withheld from the public. Let me assure you that nothing could be further from the truth.

The Administration made public over three months ago the fact that Trust Fund income fell short of revenues by \$36 million during fiscal year 1995. The information, contained in the Treasury Department's Final Monthly Statement, was publicly released on October 27, 1995. Nearly 4,000 copies of the Statement were distributed to the public, including individual copies for every Member of Congress, with numerous additional copies for the House and Senate Budget, Appropriations, and Banking Committees, the House Ways and Means Committee, the Senate Finance Committee, and the Congressional Budget Office.

Third, you ask for the latest solvency projections for the Trust Fund. As was true at the time the FY 1995 data was publicly released, we are still uncertain as to whether the performance of the Trust Fund in FY 1995 will affect the Trust Fund's depletion date. That is presumably why neither technical experts for the Congressional majority nor those in the Administration found it wise to place undue emphasis on this information.

HCFA actuaries have provided me with the following preliminary information. After taking into account all factors, including actual experience in FY 1995, additional months experience in FY 1996, new analyses of the factors affecting HI benefit growth during 1990-1995, updated projections of HI payroll tax income and revenue from the taxation of OASDI benefits, current interest rate expectations, and several other factors, the estimated depletion date for the Trust Fund will probably be earlier than that estimated in the Trustees' 1995 report. A more precise estimate will not be known until the new projections are completed.

CSO
Actuaries

Replace
with
attached
paragraphs

Replace paragraphs beginning "Third, you ask for the latest..." and "HCFA actuaries have provided me..." with the following paragraphs:

Both CBO and outside experts analyzed the information made available in the Treasury Department's Final Monthly Statement. CBO Deputy Director, Jim Blum, analyzed the Treasury report in a memo on November 7, 1995. The American Academy of Actuaries, chaired by Guy King, noted the new information on the performance of the Trust Fund in fiscal year 1995 in its public "Comments and Recommendations on Medicare Reform" on December 21, 1995.

Technical experts for both the Congressional Majority and the Administration did not raise concerns to their superiors about this new information, presumably because it was not clear whether the performance of the Trust Fund in fiscal year 1995 would affect the Trust Fund's projected depletion date. The performance of the Trust Fund in fiscal year 1995 is just one of many factors on which the HCFA actuaries base their estimates of the depletion date. Without analysis of these other factors, there was not reason to assume that the depletion date would necessarily change.

Third, you ask for the latest solvency projections for the Trust Fund. As was true at the time the fiscal year 1995 data were publicly released, it is still uncertain whether the performance of the Trust Fund in fiscal year 1995 will affect the Trust Fund's depletion date. HCFA actuaries are still analyzing data on all the factors that affect the Trust Fund depletion date, including the actual experience in fiscal year 1995, additional months experience in fiscal year 1996, new analyses of the factors affecting HI benefit growth during 1990-1995, updated projections of HI payroll tax income and revenue from the taxation of OASDI benefits, and current interest rate expectations.

Based on preliminary analysis by the actuaries of all the factors affecting the Trust Fund depletion date, the estimated depletion date for the Trust Fund will probably be earlier than estimated in the Trustees' 1995 report. A more precise estimate will not be known until the new projections are complete.

MEDICARE TRUST FUND TALKING POINTS

***Times and Post* Articles Show Why Republicans Should Agree to Resume Balanced Budget Negotiations:**

- The latest Congressional Budget Office (CBO) report on the Medicare Trust Fund simply confirms what the President has said all along -- that we should work together to balance the budget and strengthen Medicare. As CBO said in its April 30th testimony on Capitol Hill, "... the projected date of insolvency should be viewed not as telling us something new, but confirming what we already know."
- The President's balanced budget proposal contains enough Medicare savings to extend the life of the Trust Fund for a decade from now. It builds on his previous successes in strengthening the Medicare Trust Fund.
- In 1993, without one Republican vote, he signed into law Medicare savings and other financing changes that extended the life of the Trust Fund by 2 years.
- The attention recently focused on the Trust Fund simply provides additional validation for the President's position that we should move forward and balance the budget and strengthen the Trust Fund.

Information Should Not Be Used to Scare Medicare Beneficiaries:

- The updated information should not be used to scare the 37 million elderly and people with disabilities and should not be used for partisan, political purposes.
- Over \$120 billion remains in the Trust Fund and there is no imminent danger that claims will not be paid.

MAJOR CONCERNS ABOUT THE REPUBLICAN PRESCRIPTION DRUG PLAN

- **Not a Medicare benefit.** Outpatient prescription drugs would not be part of the Medicare benefits package like doctor or hospital care. Beneficiary premiums would pay expensive premiums to private Medigap plans rather than to Medicare for an affordable option.
 - **Insurers unlikely to participate – unless bribed.** The Republican plan builds on the already-flawed private Medigap insurance market rather than adding a prescription drug benefit to Medicare. The insurance industry itself claims that an insurance model will not work for prescription drug coverage – and that insurers will not voluntarily participate. If they don't, the new Medicare bureaucracy could increase payments to insurers to bribe them to participate. This will make insurers hold out to get higher payments.
 - **Unstable, unreliable plans.** Like Medicare managed care plans, private drug insurance plans would come in and out of the market, move to profitable market areas, and significantly modify their benefit design from year to year.
- **Not affordable.** Under the Republican plan, Medicare would not provide a single dollar of direct premium assistance for middle-class Medicare beneficiaries (any senior with income above \$12,600). Instead, it relies on a flawed “trickle-down theory” that would end up subsidizing insurers, not seniors. The Republican proposal subsidizes insurers for part of the cost for the most expensive enrollees, hoping that this will result in lower premiums for all enrollees. Even if an insurer passed through every dollar of its subsidy, premiums would still be too expensive for many seniors.
- **Not a set benefit.** Private insurers would define deductibles, copays and benefit limits, promoting competition on confusion rather than price and quality. Because insurers charge one premium for all enrollees – no matter how sick – they could discourage enrollment by the oldest seniors and most disabled beneficiaries by offering no deductible, low copays and a low benefit cap that leaves a large gap in coverage before the stop-loss kicks in.
- **Limits choice of drugs and pharmacies.** The so-called “choice” model offered by the Republicans breaks up the pooled purchasing power of seniors, forcing insurers to reduce prices through restrictive formularies and limited choice of pharmacies. Not all prescription drugs that a doctor determines are medically necessary would be available – only after an inappropriate drug has been taken can a beneficiary can appeal for a needed drug. Additionally, insurers can restrict access to local pharmacies.

THE WHITE HOUSE

HR 4680 - - 06/28/2000

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Office of Management and Budget



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

STATEMENT OF ADMINISTRATION POLICY
(THIS STATEMENT HAS BEEN COORDINATED BY OMB
WITH THE CONCERNED AGENCIES.)

June 28, 2000
(House)

H.R. 4680 - Medicare Rx 2000 Act
(Thomas (R) CA and seven cosponsors)

The Administration strongly opposes House passage of H.R. 4680 because its private insurance benefit does not meet the President's test of being a meaningful Medicare prescription drug benefit that is affordable and accessible for all beneficiaries. H.R. 4680 builds on an unstable and unreliable Medigap market, an approach which the insurance industry itself has concluded is unworkable. If H.R. 4680 were presented to the President, he would veto it.

The President has made passing a voluntary Medicare prescription drug benefit one of his highest priorities. His principles for a drug benefit are that it be voluntary; be accessible to all beneficiaries; be meaningful; give eligible seniors and people with disabilities bargaining power to reduce drug prices; assure access to medically necessary drugs; and be affordable to beneficiaries and the Medicare program.

The President's plan would ensure that Medicare pays half of all participants' prescription drug costs up to \$5,000 when fully phased in and that no eligible senior or person with a disability pays more than \$4,000 out-of-pocket. In addition, seniors would benefit from price discounts negotiated by private pharmacy benefit managers. Beneficiaries would have a choice of getting coverage through traditional Medicare, managed care, or retiree plans. Those who voluntarily opted for the new benefit would pay a monthly premium of \$25 in the first year, and low-income seniors would pay no or lower premiums and cost sharing. This coverage would start in 2002 and is part of the President's overall plan to strengthen and modernize Medicare.

The Democratic substitute, which the President strongly supports, also provides an affordable, meaningful Medicare drug benefit. It, too, covers half of costs up to \$5,000 when fully phased in, includes a stop-loss of \$4,000, and ensures that seniors have a choice of coverage through Medicare fee-for-service, managed care or retiree coverage. The President is dismayed that the Republican leadership refused to allow a vote on a true Medicare benefit that provides the resources necessary to ensure that premiums are affordable.

H.R. 4680 does not meet the President's principles for a meaningful prescription drug benefit.

Specifically:

- **Private insurance model does not ensure access to a dependable benefit.** H.R. 4680 relies on private insurers to offer Medicare beneficiaries a prescription drug benefit. The private insurance industry itself has repeatedly stated that they would not participate in this flawed plan. Even if they do participate, insurers could not be relied on to provide continuous coverage in all areas -- the same problem that we have in Medicare managed care today. Under the President's plan and the Democratic substitute, all beneficiaries -- including those in rural or otherwise underserved areas -- would be guaranteed a defined, accessible, reliable Medicare benefit for the same premium.
- **Private insurance model would not be affordable to all beneficiaries.** Under H.R. 4680, Medicare would not provide a single dollar of direct premium assistance for middle-class beneficiaries (any senior with income above \$12,600). Instead, the plan relies on subsidies to insurers, not seniors. Insurers would set premiums. Thus, seniors would pay different premiums from plan to plan and place to place. A rural senior would be at particular risk of facing excessive premiums since insurers would likely face little competition and less incentive to offer affordable coverage. The premium cited by the Republican leadership for H.R. 4680 has not been confirmed by the Congressional Budget Office or any other independent entity, unlike the President's plan. Even accepting the Republicans' claim that the premium would average \$37 per month, this premium would be over 40 percent higher than the President's plan premium of \$25 per month.
- **Seniors would pay more for less valuable and meaningful coverage.** Under H.R. 4680, seniors and people with disabilities would pay a higher premium for less generous coverage. According to an analysis by the Department of Health and Human Services, the President's benefit would be 25 percent more valuable in 2003 and 50 percent more valuable when fully phased in than that of H.R. 4680. Moreover, private insurers may vary their benefits by setting their own deductibles, copays, and benefit limits within an actuarial value. This allows insurers to discourage enrollment by the oldest seniors and most disabled beneficiaries by offering no deductible and low copays, but also a low benefit cap that leaves a large gap in coverage before the stop-loss kicks in. In addition, private plans could limit access to community pharmacists and needed medications. Under the President's plan, seniors and people with disabilities would have a real choice: choice of using their community pharmacist and access to prescriptions that their doctor -- not their insurance company -- determines are necessary.

The Administration also objects to creating a new bureaucracy to administer the new drug benefit and Medicare+Choice. This is inconsistent with the President's principles of efficient administration of the drug benefit. The Administration believes that the prescription drug benefit should be integrated into the Medicare program like all other Medicare benefits. In addition, provisions in H.R. 4680 related to the Medicare Advisory Board and its reporting requirements raise constitutional concerns.

Pay-As-You-Go Scoring

H.R. 4680 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's estimate of the pay-as-you-go cost of this legislation is under development. The Congressional Budget Office estimates that H.R. 4680 will increase direct spending by a total of \$39.7 billion over five years.

SIDE-BY-SIDE COMPARISON OF PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT VERSUS REPUBLICANS' PRIVATE INSURANCE PLAN

June 29, 2000

	Clinton/Gore & Democrats	House Republicans
Who's Covered	<u>All</u> seniors and people with disabilities who lack drug coverage today would gain coverage under this plan.	<u>Less than half</u> of seniors and people with disabilities who lack drug coverage today would join the plan. <i>"Of those who purchase Part B but do not have drug coverage, CBO assumes that 46 percent purchase a qualified drug plan."</i> [Congressional Budget Office analysis of H.R. 4680, 6/28/00]
Does the Plan Provide an Affordable, Workable Prescription Drug Benefit	Yes. All Medicare beneficiaries would have the option of a reliable benefit, including those in rural and underserved areas. Seniors with retiree health coverage could keep it. <i>The proposal "...sets the nation on exactly the correct course to guarantee that Medicare will continue to provide first-class medical care."</i> [National Council of Senior Citizens, 5/10/00] <i>"We applaud the President's strong leadership on this issue. His proposed prescription drug benefit is voluntary, affordable, and covers all seniors through the Medicare program."</i> Martha McSteen, National Committee to Preserve Social Security and Medicare [6/29/00] <i>"The President's plan will provide consistency and stability in premiums regardless of region, and predictability in terms of coverage."</i> [Older Women's League, 6/29/00]	No. Assumes private insurers will volunteer to offer coverage and collect premiums, which the insurance industry itself says won't work: <i>"Private, stand-alone prescription drug coverage will not work. To pass legislation to provide access to such coverage would constitute an empty promise to Medicare beneficiaries."</i> [The Blue Cross / Blue Shield Association Letter to Senator Roth, 4/24/00] <i>In addition, HIAA says that coverage anticipated by the Republican proposal is "virtually impossible for insurers to offer to seniors at an affordable premium."</i> [HIAA Release, 6/13/00] <i>"HR 4680 ... provides no assurance to a Medicare beneficiary that her prescription drug needs will be met."</i> [Consortium for Citizens with Disabilities, 6/27/00] <i>"This legislation would not guarantee universal and affordable access to seniors (and is) at odds with the... principles of any meaningful prescription drug bill."</i> [Leadership Council of Aging Organizations 6/21/00]
What Do You Get	No deductible, 50 percent coinsurance up to \$5,000 in costs when phased in. Out-of-pocket spending limited to \$4,000	Benefits would vary from plan to plan. "Standard" option has a deductible of \$250, a 50 percent copayment up to \$2,100 in costs. Out-of-pocket spending limited to \$6,000
How Much Does it Cost	\$26 per month in 2003 for <u>all</u> participants	Premiums would vary from plan to plan. Average of \$39 in 2003 – 50 percent higher than the President's plan.
What is the Value of Coverage	Value of coverage in 2003: \$835	Value of coverage in 2003: \$670 Seniors would pay more 50 percent more for a benefit that is 20 percent less valuable.
Do Seniors Have Choice	Plans: <u>Yes</u> . In fee-for-service, managed care, or retiree plans if eligible Drugs: <u>Yes</u> . Doctor-prescribed drugs are guaranteed without going through insurer or managed care plan Pharmacies: <u>Yes</u> . All local, qualified pharmacies would be accessible	Plans: <u>Yes</u> , but only if private insurers participate Drugs: <u>No</u> . Beneficiaries would only be able to access certain drugs through an appeals process Pharmacies: <u>No</u> . Insurers could restrict participating pharmacies
Start-Date	2002	2003
Takes Medicare Off-Budget, Improves Efficiency & Effectiveness	Yes.	No.
Who Supports	Virtually all major representatives of seniors and people with disabilities	Drug companies and their allies



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

To: *Born & Tracy / Jack Jones*
From: *Jeann*
Fy1

Dan L. Crippen
Director

June 28, 2000

Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20510

Admin's Risk
OTHER ADMIN
Profit } *12%*

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the House Committee on Ways and Means on June 21, 2000, with a Manager's Amendment provided on June 28, 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

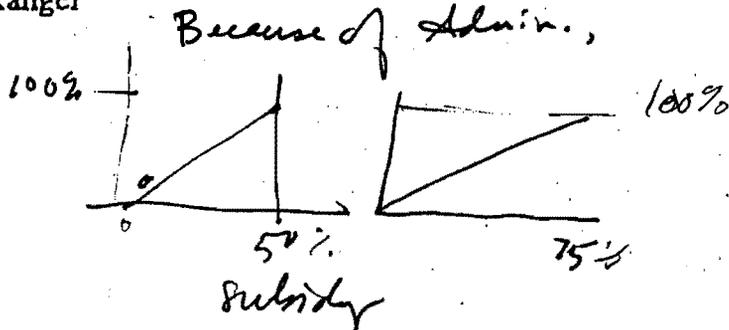
Sincerely,

Dan L. Crippen
per Dan L. Crippen

Enclosure

cc: Honorable Charles B. Rangel
Ranking Democrat

6000 + 2%
4000 + 20%





CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 28, 2000

H.R. 4680
Medicare Rx 2000 Act

*As ordered reported by the House Committee on Ways and Means on June 21, 2000, with
a Manager's Amendment provided on June 28, 2000*

SUMMARY

The Medicare Rx 2000 Act would:

- Establish a prescription drug benefit for Medicare enrollees and a subsidy program for certain low-income participants;
- Establish a new Medicare Benefits Administration (MBA) to oversee the prescription drug benefit and the Medicare+Choice program, and to administer the low-income subsidy program;
- Establish a disease management demonstration project;
- Modify Medicare's coverage and appeals process;
- Adjust payment rates for Medicare+Choice plans; and
- Expand coverage of certain injectable and infusable drugs under Medicare Part B.

The Manager's Amendment would permit the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, cap participation in the disease management project at 30,000, and extend the deadline for Medicare+Choice plans to announce whether they will participate in the program in 2001. The amendment also contains several technical corrections.

H.R. 4680 would affect both direct spending and revenues; therefore, pay-as-you go procedures would apply. CBO estimates that enacting the bill would increase direct spending by \$0.4 billion in 2001, by \$40 billion over the 2001-2005 period, and by \$159 billion over the 2001-2010 period. The prescription drug benefit and the changes in

coverage and payment rates for medical benefits for Medicare enrollees account for nearly all of those increases in direct spending. We estimate that on-budget revenues and off-budget revenues would each decline by less than \$50 million a year from 2003 through 2010. The bill also would lead to an increase in the market price of prescription drugs, which would result in:

- Slight increases in direct spending for Medicaid and health benefits for retired federal employees,
- Slight increases in discretionary spending for health programs of several federal agencies, and
- A small decrease in federal tax revenues.

Each of those effects would be less than \$50 million in most years.

Subject to appropriation of the necessary amounts, CBO estimates that administering the prescription drug benefit and modifying the coverage and appeals process would cost \$0.2 billion in 2001 and \$6.5 billion over the 2001-2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments. Other provisions in the bill would result in net savings to state and local governments of approximately \$3 billion over the 2001-2005 period and \$19 billion over the 2001-2010 period.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA (\$109 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4680 is shown in Table 1. The bill would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all federal agencies for employee health benefits. It also would reduce federal revenues by a small amount. The bill would have no effect on outlays or revenues in 2000.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By Fiscal Year, in Billions of Dollars									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare Outlays										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	a	a	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid Outlays										
Change to current-law drug spending	0	0	-2.6	-3.7	-4.1	-4.6	-5.1	-5.7	-6.3	-7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	-0.6	-1.3	-1.2	-0.8	-0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	-2.7	-4.1	-3.9	-3.8	-3.7	-3.9	-4.4	-4.9
Effect of higher drug prices on outlays by federal programs										
Medicaid	0	0	a	a	a	a	a	a	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	a	a	a	a	a	a	a	a
Subtotal, on-budget	0	0	a	a	a	a	a	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	a	a	a	a	a	a	a	a
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	a	a	a	a	a	a	a	a
Social Security payroll taxes (off-budget)	0	0	a	a	a	a	a	a	a	a
Total	0	0	a	a	a	a	a	a	a	-0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	0	0	a	a	a	a	a	a	a	a
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

SOURCE: Congressional Budget Office

NOTES: SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits

a: Costs or savings of less than \$50 million.

BASIS OF ESTIMATE

Prescription Drug Benefits

H.R. 4680 would create a voluntary outpatient prescription drug benefit under a new Part D of the Medicare program. CBO estimates that the Part D provisions would increase direct spending by \$35 billion over the 2001-2005 period and by \$142 billion from 2001 through 2010. Of that 10-year total, \$81 billion represents outlays for federal reinsurance payments to plans offering qualified prescription drug coverage and \$92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by \$31 billion in net federal Medicaid savings associated with the new drug program, because part D would replace Medicaid coverage for some individuals. (States would also accrue additional net Medicaid savings totaling \$3 billion through 2005 and about \$19 billion over the 2001-2010 period.)

CBO estimates that the cost associated with administering the new Part D benefit and other related activities, subject to the appropriation of the necessary amounts, would total \$2 billion over the 2001-2005 period and more than \$5 billion over the 2001-2010 period.

Two other provisions, which would modify Part B coverage of certain drugs and biologicals and create a disease management demonstration project, would add almost \$2 billion over the 10-year period.

Coverage of the Part D Program. H.R. 4680 would provide federal reinsurance payments to entities offering qualified prescription drug coverage to Medicare beneficiaries. Eligible entities would include sponsors of prescription drug plans (PDPs), Medicare+Choice organizations, and qualified retiree prescription drug plans—all of which would have to offer qualified drug coverage and comply with other requirements under Part D. Either the specified standard coverage or a benefit design that is at least actuarially equivalent to standard coverage would meet the bill's requirements. Such qualified coverage also would have to include access to negotiated prescription drug prices for all of a beneficiary's purchases of covered drugs.

The bill defines standard coverage for 2003 as a \$250 deductible; 50 percent coinsurance—or an actuarially equivalent cost-sharing rate—on the next \$2,100 in total drug spending to reach an "initial coverage limit" of \$1,050, and an annual limit on out-of-pocket spending of \$6,000 (see Table 2). Qualified standard coverage would make the beneficiary responsible for paying 100 percent of drug costs for all drug spending above the \$1,050 benefit maximum but below the \$6,000 out-of-pocket limit. In other words, in 2003 a beneficiary would begin to pay 100 percent of drug costs after annual drug spending exceeded \$2,350 until a total of \$7,050 was spent in that year. After annual drug spending exceeded \$7,050,

the beneficiary would pay no more for drugs and the plan would pay 100 percent of any additional drug spending in that year. The dollar amounts for the deductible, initial coverage limit, and out-of-pocket limit would be updated annually by the percentage increase in average per capita expenditures for covered outpatient drugs for Medicare beneficiaries.

TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary*	
		Spending in the Interval	Cumulative Spending
\$ 0 to 250	100 percent	\$ 250	\$ 250
\$ 250.01 to 2,350	50 percent	1,050	1,300
\$ 2,350.01 to 7,050	100 percent	4,700	6,000
Above \$ 7,050	0 percent	0	6,000

*Assumes beneficiary spends the full amount in the interval.

Alternative coverage designs would qualify under Part D as long as:

- The actuarial value of total coverage is at least equal to the actuarial value of standard coverage,
- The unsubsidized value of coverage (after receiving federal reinsurance payments) is at least actuarially equivalent to the unsubsidized value of standard coverage,
- The benefit design provides for payments by the plan under the initial coverage limit to be at least actuarially equivalent to the amount paid under standard coverage, and
- The limit on out-of-pocket spending is the same as the limit required for the standard package for beneficiaries whose drug spending equals at least \$2,350 (in 2003).

H.R. 4680 also would allow third parties (such as Medicaid or employer-sponsored health insurance) to pay a beneficiary's cost-sharing obligation below the out-of-pocket limit and would require that the plan count those third-party contributions toward the beneficiary's out-of-pocket contributions.

The bill would require sponsors of qualifying plans to cover prescription drugs, insulin, and biologicals but would prohibit coverage for a specific list of drugs, such as hair growth products. Drugs currently covered under Medicare Parts A and B would continue to be

products. Drugs currently covered under Medicare Parts A and B would continue to be covered under current law rules.

Qualifying PDPs would assume full financial risk for costs not subject to federal reinsurance subsidies but would be permitted to obtain insurance to cover that risk. The bill would permit insurers to coordinate with other entities to manage the pharmacy benefit. CBO assumes that most insurers would administer the benefit through pharmacy benefit management (PBM) companies.

Administration and Oversight. The bill would create a new agency in the Department of Health and Human Services called the Medicare Benefits Administration (MBA) to administer the new Part D drug benefit, the low-income subsidy program, and the Medicare+Choice program. The plan oversight function currently within the Health Care Financing Administration (HCFA) would be consolidated within the new agency. Premiums set by plans would be subject to rate review and negotiation with the Administrator of the MBA.

H.R. 4680 would require that each Part B beneficiary have access to at least two qualifying plans, at least one of which is a PDP. The MBA could provide financial incentives to existing sponsors to ensure the availability of two plans. If two plans are not available in an area, the MBA would be required to offer a qualifying prescription drug plan. The MBA could establish such a plan on a regional or nationwide basis. CBO assumes that the MBA would offer coverage through its own plan only to beneficiaries who do not have a choice of two qualifying private plans.

Federal Payments for Reinsurance. Sponsors of PDPs, Medicare + Choice organizations, and qualified retiree prescription drug plans who offer qualified drug coverage would be eligible for federal reinsurance payments. Those federal payments would be based on the lesser of the drug costs per enrollee paid by the plan or the amount that would have been paid by the plan if the coverage offered was standard coverage. Such payments by the plans would be considered "allowable drug costs" for the federal reinsurance subsidy. In 2003, the reinsurance schedule for each enrollee would be:

- 30% of allowable drug costs for total drug spending between \$1,251 and \$1,350;
- 50% of allowable drug costs for total drug spending between \$1,351 and \$1,450;
- 70% of allowable drug costs for total drug spending between \$1,451 and \$1,550;
- 90% of allowable drug costs for total drug spending between \$1,551 and \$2,350;

- 90% of allowable drug costs for total drug spending exceeding \$7,050.

The bill also would require the MBA to adjust the subsidy payments so that the total of such subsidy payments for each year is equal to 35 percent of covered outpatient drug payments made by plans based on standard coverage. CBO assumes it would take at least one year to calculate the amount of the adjustment, so those adjustments would be made with a two-year lag.

Plans would charge beneficiaries a premium to cover drug spending that is not subsidized by the federal government plus the plan's cost of administering the benefit and the plan's profit. CBO estimates that plans would charge beneficiaries an annual premium that would average \$470 in 2003 and would grow to \$809 in 2010.

\$39/yr

Enrollment. All Medicare beneficiaries would have a one-time chance to purchase qualified drug coverage from the sponsor of a qualifying plan when they first become eligible for Medicare and during a six-month open enrollment period starting in 2003. During that time, insurers would not be allowed to underwrite their premiums or exclude beneficiaries from coverage based on pre-existing conditions. Rather, the plan would have to charge the same premium to all enrollees in a service area who maintain continuous prescription drug coverage. (Service area is not defined.) Continuous prescription drug coverage refers to prescription drug coverage offered under a PDP, a Medicare+Choice plan, Medicaid, a group health plan, certain Medigap policies, a state pharmaceutical assistance program, or a program of the Department of Veterans Affairs. Beneficiaries would be allowed to change plans each year.

\$62/yr

Plans could charge a higher premium to enrollees who did not enroll at the first opportunity or who let coverage lapse for 63 days or longer, except in a few limited circumstances.

Medicare+Choice Drug Benefits. H R. 4680 would require that all Medicare+Choice plans offering drug benefits meet the qualified prescription drug coverage standards under Part D. However, a Medicare+Choice plan could elect not to offer prescription drug coverage. Medicare+Choice plans that offer qualifying coverage under Part D would be able to charge a separate prescription drug premium and receive federal reinsurance payments.

CBO's Estimating Assumptions for Prescription Drug Benefits

Participation. CBO assumes that Medicare enrollees who have drug coverage under current law that is not federally subsidized would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes that beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit. Of those

who purchase Part B but do not have drug coverage, CBO assumes that 46 percent would purchase a qualified drug plan. In total, CBO estimates that 80 percent of beneficiaries in Part B (equal to 74 percent of all Medicare enrollees) would participate in the drug benefit provided by H.R. 4680.

10 M
PEOPLE

CBO also expects states to pay the premiums charged by sponsors of qualified drug plans and the cost-sharing obligations of Medicaid beneficiaries who are dually eligible for Medicare and Medicaid benefits, because that would shift some of the costs for drug coverage for those dual-eligibles from the states to Medicare.

Effectiveness of PBMs. Under H.R. 4680, PBMs would compete against one another for the business of managing the benefit for sponsors of qualifying prescription drug plans. The bill would allow PBMs to use a broad range of current market tools to manage the pharmacy benefits for PDPs, though it would impose certain restrictions on the PBMs' activities.

PBMs would be allowed to negotiate discounts with pharmacies that agree to participate in their networks but would need to guarantee access that is convenient to beneficiaries. PBMs would also be allowed to design restrictive formularies and negotiate rebates from manufacturers of brand-name drugs in exchange for preferred status on the health plan's formulary. However, the bill specifies that the formularies would need to cover all therapeutic classes, which could dilute some of their negotiating power with manufacturers. As long as cost-sharing requirements under a plan are actuarially equivalent to the standard plan for spending under the benefit maximum, the bill would allow PBMs to establish differential copayment requirements that encourage beneficiaries to select lower-priced options, such as generic, preferred formulary, or mail-order drugs.

The appeals process specified under the bill would allow access to off-formulary drugs at a physician's request when the on-formulary drug is considered not as effective as the off-formulary version for the patient or has significant adverse effects for the enrollee. CBO assumes this process would interfere with a PBM's ability to negotiate rebates from manufacturers in certain circumstances. Considering all these factors, CBO estimates that PBMs would be able to reduce spending by an average of about 25 percent from what an uninsured retail purchaser would pay under current law.

Drug Pricing Assumptions and Effects on Other Federal Purchasers. Enrollees whose drug expenses exceed the stop-loss amount would no longer be price-conscious. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 2 percent higher if H.R. 4680 is enacted.

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Higher drug prices would also affect spending by other federal programs for prescription drugs. Medicaid, the Federal Employees Health Benefits (FEHB) program, the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the U.S. Coast Guard would all be affected.

CBO estimates that higher drug prices would increase direct spending for Medicaid and for annuitants covered by the FEHB program by less than \$50 million over the 2001-2005 period and by \$0.3 billion over the 2001-2010 period. Subject to the appropriation of necessary amounts, discretionary spending by federal agencies for active workers covered by the FEHB program, DOD, VA, PHS, and the U.S. Coast Guard would increase by \$0.1 billion over the 2001-2010 period. The net impact over the same period for active and retired postal employees would be negligible.

Revenue Impact. As a result of higher drug prices, H.R. 4680 would also lead to a loss of federal income and payroll tax revenues by raising the costs of employer-sponsored health insurance and correspondingly reducing the amount of taxable compensation. CBO estimates that the bill would reduce revenues by less than \$50 million over the 2001-2005 period and by \$0.2 billion from 2001 through 2010. Social Security payroll taxes, which are off-budget, account for \$0.1 billion of that 10-year total.

Low-Income Subsidies

A central feature of the bill is the provision of assistance to low-income beneficiaries who participate in Medicare Part D. CBO expects the low-income subsidies, including payments from the SMI trust fund to state Medicaid programs for administrative costs, would increase Medicare spending by \$23 billion over the 2001-2005 period and by \$92 billion over the 2001-2010 period, amounts that slightly exceed the federal reinsurance payments. Because Medicaid currently pays for a share of prescription drug costs for about 13 percent of Medicare beneficiaries who are dually-eligible for both programs, about a quarter of the bill's Medicare Part D spending (the federal reinsurance payment and the low-income subsidies) would be offset by a decline in the federal share of Medicaid spending. The bill also would increase Medicaid spending for prescription drugs for some new enrollees and the U.S. territories, withhold some funds from states, increase other Medicaid benefits for new enrollees, and provide additional Medicaid payments for administration. CBO estimates those provisions would lead to a decrease in net federal Medicaid spending of \$11 billion over the 2001-2005 period and a decrease of \$31 billion over the 2001-2010 period.

Medicare spending on low-income subsidies. Under the bill, Medicare would subsidize spending for premiums and cost sharing under Part D for certain low-income Medicare beneficiaries (except those residing in the U.S. territories). Subsidies would be 100 percent

federally financed. Beneficiaries with incomes below 135 percent of the poverty level and with limited assets would receive a premium subsidy equal to the premium for standard coverage (or its actuarial equivalent). They would also receive a subsidy for cost sharing up to 95 percent of the maximum amount permitted under the initial coverage limit (in 2003, that would be 95 percent of \$1,300, or \$1,235). Individuals with incomes between 135 and 150 percent of the poverty level would receive smaller premium subsidies determined using a sliding scale, but would not be eligible for subsidies for cost sharing.

Participation in the subsidy program would grow over time as beneficiaries become aware of and apply for those subsidies, though some low-income Medicare beneficiaries who would participate in Part D and who would be eligible for subsidy assistance would choose not to participate in the subsidy program. CBO expects that about 8 million Medicare beneficiaries, or one quarter of the enrollees in Part D, would receive subsidy assistance by 2007. Most of those subsidy recipients currently receive full or partial medical assistance under Medicaid. We estimate that Medicare payments for low-income subsidies would total \$23 billion over the 2001-2005 period and \$90 billion over the 2001-2010 period.

The bill would require that state Medicaid programs perform eligibility determinations for the subsidies (see below for more detail) and would offer states a higher federal match rate than the average rate of 50 percent to perform those services. Although the Medicaid program would initially incur the costs of administration, Medicare's Supplementary Medical Insurance (SMI) Trust Fund would ultimately transfer funds to Medicaid to cover some of Medicaid's new administrative costs. CBO estimates that Medicare spending for those administrative costs would total \$0.2 billion over the 2001-2005 period and \$1.4 billion over the 2001-2010 period.

Changes in Medicaid drug spending. In 2007, about 5.5 million low-income Medicare beneficiaries are expected to be eligible for full benefits under Medicaid, which covers prescription drugs for most beneficiaries. Under the bill, the Medicare Part D benefit would become the primary payor for prescription drugs for those beneficiaries. Cost-sharing assistance provided by Medicare to full dual-eligibles under 135 percent of poverty also would replace Medicaid assistance. Thus, savings would accrue to the Medicaid program, and would be shared with the states at the regular federal match rate (57 percent, on average). Medicaid would continue to pay for prescription drug spending not covered by the new Part D benefit and for some cost-sharing subsidies, including spending in the gap between the initial coverage limit and the annual out-of-pocket limit.

CBO anticipates that state Medicaid programs would pay premiums and cost-sharing amounts for full dual-eligibles who are not eligible for subsidy assistance to enroll them in the new drug benefit program. The bill would not allow full dual-eligibles over 135 percent of poverty access to Part D subsidy assistance (except for some dual-eligibles under 150

percent of poverty who might be eligible for premium subsidies). Those beneficiaries would be worse off under the new drug benefit than under current law if Medicaid did not pay for prescription drug spending beyond the scope of the Part D benefit. Although the bill is silent on the question of whether states would be permitted to enroll and subsidize dual-eligibles above the subsidy thresholds, CBO assumes that they would be allowed to do so and would be reimbursed at the regular federal match rate for Medicaid.

Medicaid's savings would be partially offset by new drug spending. Because CBO expects that the new drug program would increase participation of full dual-eligibles in the Medicaid program, Medicaid would be required to pay for their prescription drug spending not covered by the Part D benefit or Medicare subsidies. Finally, federal Medicaid spending in the U.S. territories would increase by additional amounts provided in the bill for prescription drug assistance to low-income Medicare beneficiaries. CBO estimates that net federal Medicaid spending for prescription drugs would decline by \$10 billion over the 2001-2005 period and by \$39 billion over the 2001-2010 period.

Reduction in federal payments to states. The bill would reduce federal Medicaid payments to states on a quarterly basis in each fiscal year through 2006. The amount of the reduction would be based on the amount of low-income subsidies that Part D of Medicare would pay for dually-eligible beneficiaries in each state. It would equal the product of that amount, the state's Medicaid matching rate, and a percentage that would decline from 80 percent in 2003 to 20 percent in 2006.

CBO anticipates that the reduction would be difficult to administer because it is likely that states would demand that the federal government document its spending on subsidy payments before withholding funds. CBO's estimate therefore assumes a six-month lag between the time that low-income subsidies are paid and the time that any reductions in federal Medicaid payments are made. CBO also anticipates that potential conflicts between states and the federal government over the amount of the withholding could result in HCFA making less than the full amount of the reduction specified in the bill. Overall, CBO estimates that those reductions would lower federal Medicaid outlays by \$3 billion over the 2001-2005 period and by \$4 billion over the 2001-2010 period.

Impact on other Medicaid benefits. In addition to its regular benefits, Medicaid pays for some or all of the premiums and out-of-pocket expenses incurred by certain Medicare beneficiaries with low incomes and limited resources. Medicaid covers Medicare premiums and cost sharing for beneficiaries with incomes below the poverty level, and the Part B premium for beneficiaries with incomes between 100 and 120 percent of the poverty level. However, many of the Medicare beneficiaries who are eligible for this Medicaid assistance are not enrolled in Medicaid; some may not be aware of their eligibility, while others may prefer to avoid the hassle of Medicaid's enrollment process and pay Medicare cost sharing

program and may choose not to participate.

CBO believes that the attractiveness of assistance for a prescription drug benefit would boost the number of low-income Medicare beneficiaries enrolled in Medicaid by about 1.5 million by 2006 (a 20 percent increase). The bill would require state Medicaid programs to determine the eligibility of Medicare beneficiaries for the low-income subsidies under Part D of Medicare. Some beneficiaries, while applying for those subsidies in a local Medicaid office, would learn that they are eligible for additional assistance under Medicaid and would enroll. CBO estimates that provision would increase federal Medicaid spending by \$2 billion over the 2001-2005 period and by \$10 billion over the 2001-2010 period.

Administrative Costs for Medicaid. The bill would affect Medicaid spending for administrative costs in a number of ways. As noted above, state Medicaid programs would be required to determine the eligibility of Medicare beneficiaries for low-income subsidies under Part D. The federal Medicaid matching rate for costs related to those determinations would rise from 60 percent in 2003 to 100 percent after 2006. (The current match rate for most administrative costs is 50 percent.) CBO assumes that states would reclassify some of their regular administrative expenses as Part D administrative costs to take advantage of the higher match rate. As noted above, Medicare (SMI) would transfer funds to Medicaid to cover the portion of Medicaid's administrative costs reimbursed above the regular federal match rate.

The bill would also necessitate increased spending on administration as more low-income Medicare beneficiaries enroll in Medicaid, but would yield savings as states would have reduced responsibility for handling prescription drug claims for full-dual eligibles. CBO estimates that net federal Medicaid outlays for administration would increase by \$0.7 billion over the 2001-2005 period and \$1.6 billion over the 2001-2010 period.

Disease Management Project

H.R. 4680 would direct the Administrator of the MBA to conduct a three-year demonstration project to evaluate the impact of disease management services on the costs and health outcomes of Medicare Part B beneficiaries with certain illnesses. Eligible beneficiaries would have to have advanced-stage congestive heart failure, diabetes, or coronary heart disease and would be required to secure the approval of their physicians in order to participate.

Participants would be entitled to additional prescription drug benefits paid through the enrolling disease management organization (DMO). More specifically, the organization would pay for a beneficiary's premium, deductible, and cost-sharing under Part D plus any

amounts not covered by the plan because of the initial coverage limit. The organization would pay for all prescription drug costs for participants who are not enrolled under Part D. CBO expects that offering such highly desirable drug benefits would create strong demand for disease management services among chronically ill beneficiaries.

Given the nature of the contractual agreements outlined in the bill, however, whether disease management organizations would enter into contracts under those conditions is uncertain. Much of that uncertainty involves the interpretation of how the fee would be negotiated between DMOs and the Administrator. The bill would require that the fee paid to DMOs be negotiated in a manner that would guarantee a "net reduction in expenditures under the Medicare program" for participating beneficiaries. However, accurately estimating the benchmark spending against which the savings or costs would be measured would be extremely difficult, particularly because the bill would delay the implementation of improved risk adjustment factors. As a result, CBO believes that there is no assurance that the demonstration project could be implemented so as to reduce Medicare expenditures and that, on the contrary, it would increase costs to the Medicare program overall.

Moreover, the extent to which DMOs would be willing to participate in the project is unclear. CBO assumes that it is unlikely that DMOs would assume full risk for any additional costs associated with the expanded drug benefit unless those costs are reflected in the negotiated fee. Under the bill, DMOs are not directly provided any gatekeeper authority to control access to or reimbursement for benefits under Parts A, B, or D. If DMOs must guarantee a "net reduction in expenditures under the Medicare program," with those expenditures defined to include additional premium and cost-sharing assistance paid under the project, CBO assumes that all DMOs would decline to participate. However, if those drug benefit payments are included in the negotiated fee, CBO assumes DMOs would enter into those agreements.

Without any legislative restrictions on the number of qualifying beneficiaries allowed to join the demonstration project, CBO would assume that up to 300,000 of them would enroll, if DMOs decided to participate and offer those benefits. Assuming an equal probability that regulations implementing the project would include or exclude payments for drug benefits from the negotiated fee, CBO estimates that such enrollment in the demonstration project would increase federal spending by about \$1.1 billion over the 2001-2005 period. However, because the Manager's Amendment to the bill would limit participation to 30,000 enrollees, CBO estimates that the demonstration project would increase net federal spending by \$0.3 billion over 2001-2005 period and by \$0.4 billion over the 2001-2010 period.

Medicare Coverage and Appeals Process

H.R. 4680 would modify the current appeals process for the Medicare fee-for-service program to make it similar to the appeals process under the Medicare+Choice program. The bill would allow Medicare beneficiaries the right to an initial determination of coverage before services are provided. The bill would provide for external contractors to independently handle reconsiderations for denied services, impose time limits for the appeals processes, provide rules for the review of local and national coverage decisions, authorize continuing education for reviewers and adjudicators, limit beneficiaries' liability, and eliminate the Secretary's ability to overturn or modify the decisions of the Provider Reimbursement Review Board with regard to appeals by Part A providers. CBO estimates those provisions would increase direct spending by about \$50 million in 2001, \$0.7 billion between 2001 and 2005, and \$3 billion from 2001 through 2010. Assuming appropriation of the necessary amounts, CBO assumes that the appeals and coverage provisions would increase discretionary spending by \$44 million in 2001 and by \$1.1 billion over the 2001-2010 period.

Medicare+Choice Reforms

Under current law, payment rates for Medicare+Choice plans are defined according to plan members' county of residence, and are then adjusted for each beneficiary's demographic and risk characteristics. The geographic payment rates are the highest of three different rates: a minimum floor rate; a blend of the county-specific rates existing before the Balanced Budget Act of 1997 and the national average rate, adjusted for local costs; or the previous year's rate increased by 2 percent. The floor and county-specific rates are updated each calendar year by the expected rate of increase in per-capita Medicare costs, minus specified percentage reductions from that rate of increase over the 1998-2002 period. The updated county rates are used to calculate a new national average and hence the new blended rates. The share of the national average rate in the blend will increase until reaching 50 percent local and 50 percent national rates some time after 2002. Finally, a "budget neutrality adjustment" is applied to the blended rates to ensure that the expected Medicare+Choice payments are the same as if all payments were completely based on local rates. That adjustment may either increase or lower the counties' rates depending upon interactions with other factors in the payment system.

The bill would eliminate the reductions from the national per capita growth rate for 2001 and 2002. In 2002, the bill would increase the floor payment rate from an estimated \$432 to \$450 and would allow plans to choose to be paid a 50:50 blend of local and national rates beginning in 2002. Between 2002 and 2005, the bill would establish a minimum update of 2.5 percent instead of 2 percent for counties served by one or fewer plans. The bill would

eliminate the budget neutrality adjustment beginning in 2003, and in 2004, would allow plans to negotiate a rate of payment with HCFA regardless of the county-specific rate, as long as the negotiated rate does not exceed the national average per-capita cost and does not increase more than the expected rate of increase for private insurance, minus the cost of prescription drugs. Finally, the bill would phase in implementation of improved methods of adjusting payments to reflect differences in health status, with full implementation delayed until 2013. CBO estimates that those provisions would increase Medicare outlays by \$4 billion over the 2001-2005 period and by \$13 billion over the 2001-2010 period.

Coverage of Drugs and Biologicals under Part B

The bill would expand the Part B outpatient drug benefit to include coverage of certain drug products that are not usually self-administered by the patient but are administered incident to a physician's service. CBO estimates that this provision would increase federal spending by \$0.7 billion over the 2001-2005 period and by \$1.3 billion over the 2001-2010 period.

SPENDING SUBJECT TO APPROPRIATION

The bill would establish the Medicare Benefits Administration to oversee the prescription drug benefit and to assume certain responsibilities of the Health Care Financing Administration. Subject to appropriation of the necessary amounts, CBO estimates those activities would increase federal spending by \$0.2 billion in 2001 and by \$5.4 billion over the 2001-2005 period. With the administrative costs of the coverage and appeals provision and the effect on federal purchasers of higher prices for prescription drugs (both described above), CBO estimates that enacting H.R. 4680 would increase discretionary spending by a total of \$6.6 billion over the 10-year period, assuming appropriation of the necessary amounts.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	390	1,550	9,180	12,800	15,960	18,360	21,080	23,780	26,450	29,440
Changes in receipts	0	0	0	-2	-5	-10	-10	-15	-20	-25	-35

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs). This prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs could result in a shift of premium payments away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues to states. CBO cannot estimate the magnitude of those losses because we have no basis for predicting the size of such shifts or the degree to which such plans would have been taxable in the absence of the preemption.

The bill includes a number of preemptions that would be intergovernmental mandates as defined by UMRA, but those preemptions would impose no costs on state, local, or tribal governments. Among the preemptions are protections from civil or criminal liability for certain federal contractors, waivers of state licensing requirements, and preemption of laws establishing minimum coverage requirements.

Other Impacts

CBO estimates that the bill would reduce state Medicaid spending by about \$3 billion over the 2001-2005 period and by \$19 billion over the 2001-2010 period. A number of factors would contribute to that reduction. State Medicaid programs would benefit as coverage responsibility for dual-eligibles shifts from Medicaid to PDPs for prescription drug coverage and to Medicare for cost-sharing subsidies. However, some savings would be offset by prescription drug spending for new enrollees who are fully eligible for both Medicare and Medicaid. As a result CBO estimates that net state spending for prescription drug coverage would decline by \$8 billion over the 2001-2005 period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state revenues by \$3 billion over the same period. Additionally, increased Medicaid enrollment and other changes are expected to increase state spending by

\$1.6 billion over the 2001-2005 period.

As a condition of approval for their Medicaid plans, states would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare and would be required to transmit that information to the MBA. However, states have the ability to alter their programmatic and financial responsibilities for Medicaid to accommodate this additional determination requirement; consequently, this requirement would not be an intergovernmental mandate as defined in UMRA. Additional costs would total approximately \$0.3 billion over the 2001-2005 period. Costs would decrease over time because the matching rate from the federal government would increase annually until 2007 when it would reach 100 percent.

State and local governments that provide health insurance to their employees or retired employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in the costs of their health plans. Because CBO cannot predict how states would restructure the prescription drug component of their health plans, we cannot estimate the amount of such savings.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA (\$109 million in 2000, adjusted annually for inflation).

PREVIOUS CBO ESTIMATE

On June 21, 2000, CBO produced a preliminary analysis of H.R. 4680, as modified in discussions with staff. That analysis concluded the bill would increase direct spending by \$38.6 billion over the 2001-2005 period and by \$155 billion over the 2001-2010 period. The current estimate is \$1.4 billion higher over the first five years and \$4 billion higher over the 10-year period. Two revisions in the committee-approved bill—the addition of the disease management project, and an increase in the updates to rates paid to Medicare+Choice plans in 2001 and 2002—increased the estimate by \$1.5 billion for the 2001-2005 period and by \$3.4 billion for the 2001-2010 period. The remaining differences are due to numerous refinements of estimating assumptions and to differences between specifications discussed with staff and the legislative language in the reported bill and subsequently modified by the

Manager's Amendment dated June 28, 2000.

This estimate includes one significant change in the display of the estimated cost of administering the low-income subsidy. The previous estimate combined the transfer from SMI to Medicaid for administering the low-income subsidy and the administrative spending that is funded through Medicaid. The current estimate displays those components separately.

The estimated impact on revenues is unchanged. The estimate of spending subject to appropriation was incomplete in the previous analysis.

ESTIMATE PREPARED BY:

Federal Costs: Charles Betley, Tom Bradley, Julia Christensen, Jeanne De Sa, Eric Rollins, and Christopher Topoleski (226-9010); and Sandra Christensen, Karuna Patel, and Judith Wagner (226-2666).

Impact on State, Local, and Tribal Governments: Leo Lex (225-3220)

Impact on the Private Sector: Bruce Vavrichek (226-2676)

ESTIMATE APPROVED BY:

Robert A. Sunshine
Assistant Director for Budget Analysis

FINAL VOTE RESULTS FOR ROLL CALL 349

(Republicans in roman; Democrats in *italic*; Independents underlined)

H RES 539 RECORDED VOTE 28-JUN-2000 2:00 PM

QUESTION: On Agreeing to the Resolution

BILL TITLE: Providing for consideration of H.R.4680; Medicare Rx 2000 Act

	AYES	NOES	PRES	NV
REPUBLICAN	212	7		3
DEMOCRATIC	3	205		3
INDEPENDENT	1	1		
TOTALS	216	213		6

--- AYES 216 ---

Aderholt	Goodlatte	<i>Peterson (MN)</i>
Archer	Goodling	Peterson (PA)
Armey	Goss	Petri
Bachus	Graham	Pickering
Baker	Granger	Pitts
Ballenger	Green (WI)	Pombo
Barr	Greenwood	Porter
Barrett (NE)	Gutknecht	Portman
Bartlett	Hansen	Pryce (OH)
Barton	Hastert	Quinn
Bass	Hastings (WA)	Radanovich
Bateman	Hayes	Ramstad
Bereuter	Hayworth	Regula
Biggert	Hefley	Reynolds
Bilbray	Herger	Riley
Bilirakis	Hill (MT)	Rogan
Bliley	Hilleary	Rogers
Blunt	Hobson	Rohrabacher
Boehlert	Hoekstra	Ros-Lehtinen
Boehner	Horn	Roukema
Bonilla	Houghton	Royce
Bono	Hulshof	Ryan (WI)
Brady (TX)	Hunter	Ryun (KS)
Bryant	Hutchinson	Salmon
Burr	Hyde	Sanford
Burton	Isakson	Saxton
Buyer	Istook	Scarborough
Callahan	Jenkins	Schaffer

Calvert	Johnson (CT)	Sensenbrenner
Camp	Johnson, Sam	Sessions
Campbell	Kasich	Shaw
Canady	Kelly	Shays
Cannon	King (NY)	Sherwood
Castle	Kingston	Shimkus
Chabot	Knollenberg	Shuster
Chambliss	Kolbe	Simpson
Coble	Kuykendall	Skeen
Collins	LaHood	Smith (MI)
Combest	Largent	Smith (NJ)
Cooksey	Latham	Smith (TX)
Cox	LaTourette	Spence
Crane	Lazio	Stearns
Cubin	Leach	Stump
Cunningham	Lewis (CA)	Sununu
Davis (VA)	Lewis (KY)	Sweeney
Deal	Linder	Talent
DeLay	LoBiondo	Tancredo
DeMint	Lucas (OK)	Tauzin
Diaz-Balart	Manzullo	Taylor (NC)
Dickey	Martinez	Terry
Doolittle	McCollum	Thomas
Dreier	McCrary	Thornberry
Duncan	McHugh	Thune
Dunn	McInnis	Tiahrt
Ehlers	McIntosh	Toomey
Ehrlich	McKeon	Trafican
English	Metcalf	Upton
Everett	Mica	Vitter
Ewing	Miller (FL)	Walden
Fletcher	Miller, Gary	Walsh
Foley	Moran (KS)	Wamp
Fossella	Myrick	Watkins
Fowler	Nethercutt	Watts (OK)
Franks (NJ)	Ney	Weldon (FL)
Frelinghuysen	Northup	Weldon (PA)
Gallegly	Norwood	Weller
Gekas	Nussle	Whitfield
Gibbons	Ose	Wicker
Gilchrest	Oxley	Wilson
Gillmor	Packard	Wolf

Gilman	Paul	Young (AK)
Goode	Pease	Young (FL)

--- NOES 213 ---

Abercrombie	Gejdenson	Murtha
Ackerman	Gephardt	Nadler
Allen	Gonzalez	Napolitano
Andrews	Gordon	Neal
Baca	Green (TX)	Oberstar
Baird	Gutierrez	Obey
Baldacci	Hall (OH)	Olver
Baldwin	Hall (TX)	Ortiz
Barcia	Hastings (FL)	Owens
Barrett (WI)	Hill (IN)	Pallone
Becerra	Hilliard	Pascrell
Bentsen	Hinchey	Pastor
Berkley	Hinojosa	Payne
Berman	Hoeffel	Pelosi
Berry	Holden	Phelps
Bishop	Holt	Pickett
Blagojevich	Hooley	Pomeroy
Blumenauer	Hostettler	Price (NC)
Bonior	Hoyer	Rahall
Borski	Inslee	Rangel
Boswell	Jackson (IL)	Reyes
Boucher	Jackson-Lee (TX)	Rivers
Boyd	Jefferson	Rodriguez
Brady (PA)	John	Roemer
Brown (FL)	Johnson, E. B.	Rothman
Brown (OH)	Jones (OH)	Roybal-Allard
Capps	Kanjorski	Rush
Capuano	Kaptur	Sabo
Cardin	Kennedy	Sanchez
Carson	Kildee	Sanders
Chenoweth-Hage	Kilpatrick	Sandlin
Clay	Kind (WI)	Sawyer
Clayton	Kleczka	Schakowsky
Clement	Klink	Scott
Clyburn	Kucinich	Serrano
Coburn	LaFalce	Shadegg
Condit	Lampson	Sherman



June 27, 2000

Dear Representative:

The need for prescription drug coverage in Medicare is no longer a question of debate. Prescription drugs are as much a part of modern medicine as doctor and hospital services. It only stands to reason that Medicare should provide such coverage for older and disabled Americans, just as employer-sponsored insurance does for many younger Americans.

In the bills coming before the House this week, each party has taken a different path to providing prescription drug coverage in Medicare. While we recognize that there can be different approaches to addressing this issue, we also know that a solution that can stand the test of time will require true bipartisanship. We therefore urge both sides to begin a discussion that will promote the strengths of each proposal while minimizing their respective weaknesses.

We are pleased that both the House Republican and Democratic bills include a voluntary prescription drug benefit in Medicare – a benefit to which every Medicare beneficiary is entitled. Further, both bills provide for a benefit that would be available in either fee-for-service or managed care settings. And while there are differences, both bills describe the core prescription drug benefit in statute. These are important steps and represent real progress over the past year.

AARP will continue to measure Medicare prescription drug benefit proposals against our principles, including: the need for a benefit that is available to all; provides affordable, meaningful and dependable coverage; is workable; and fosters high quality health care now and in the future.

The legislation being debated and voted this week raises many questions that must be addressed. Key among these is whether the proposed 5-year (2001-2005) \$40 billion federal subsidy that was included in the Budget Resolution is adequate both to assure an affordable benefit and to create a broad insurance risk pool and stable program. Beginning with the President's proposal last year to provide a prescription drug benefit that would cost approximately \$40 billion over 5 years, and then again this year in the Congressional Budget Resolution, policy makers in both parties have grappled with this challenge.

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AARP has consistently called for a more adequate federal subsidy for two interrelated reasons:

1. Affordability. Under each proposal beneficiaries generally would be liable for a 50 percent coinsurance on prescription drugs (in addition to any deductible such as that included in the Ways and Means reported bill). Beneficiaries would also be responsible for costs above the benefit limit, until reaching a "catastrophic limit" in both bills. In addition, they would be subject to a monthly premium. In the Democratic proposal, the monthly premium is set at \$25.00 per month for the first year. In the Ways and Means proposal, plans' premiums are estimated to average \$37.00 per month in the first year.

Both bills protect those with incomes below 135 percent of poverty (\$11,300 per individual, \$15,200 per couple) and partially protect those with incomes between 135 percent and 150 percent of poverty (\$12,500 per individual, \$16,900 per couple). But for millions of older persons – middle income singles and couples – the monthly premiums, coupled with the 50 percent coinsurance, may prove too high a cost. As a result, many beneficiaries may elect not to participate in the benefit.

For example, in the case of both proposals, Mrs. Jones, a single woman living alone on a \$15,000 annual income, would pay a 50 percent coinsurance on all of her medicines, the monthly prescription-drug premium (in addition to the basic Medicare Part B premium), the deductible if there is one, and the negotiated price for all prescriptions between the benefit limit and the out-of-pocket cap. If Mrs. Jones has very high drug costs she would clearly come out ahead. However, if she anticipates that her drug costs would continue where they are now – around \$50.00 per month (\$600 per year), and compared this to the cost of a Medicare benefit – the premium, coinsurance, and any deductible – she might conclude that the benefit is not worthwhile for her. Without enrollees like Mrs. Jones – i.e., beneficiaries with modest drug costs – in the risk pool, the benefit could become very expensive for other enrollees.

2. The need for a healthy risk pool. Both Congress and the President agreed early in this debate that any plan must be voluntary. The two alternatives are structured so as to minimize the tendency toward risk selection, i.e., "cherry picking." Yet the success of these proposals, as with virtually any proposal, rests on whether the program is attractive enough to beneficiaries to draw a broad risk pool; i.e., to attract not only those who are sick, but also those who are healthy. To accomplish this, the vast majority of beneficiaries must view the benefit package and the amount they will pay (in deductibles, coinsurance and premiums) as a "good buy." Without a broad risk

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pool the cost for individuals who do sign up will eventually prove unaffordable, leading either to a cutback in the benefit, or to an even higher federal contribution.

While preliminary estimates of the percent of beneficiaries who will participate in each of these plans have been high, we are concerned that when beneficiaries sit at their kitchen tables and assess whether this coverage is a good buy for them, they will add up their premium, 50 percent coinsurance, any deductible, and their likely exposure to the "doughnut" between the benefit limit and the out-of-pocket cap. Without a higher federal subsidy to reduce the premium and strengthen the benefit it is unclear whether beneficiaries with average to low costs will opt to take this coverage.

We are mindful of the importance of fiscal discipline, which helped get us to the point where the federal budget is running surpluses. This fortunate development makes it far more possible to adopt a prescription drug benefit in Medicare. But as our healthy economy and budget surplus make additional funds available, the inadequacy of the \$40 billion five-year federal subsidy must be addressed.

Ways and Means Bill

Beyond the question of the level of subsidy, the Ways and Means-reported bill raises some important questions that must be resolved before we believe our members would support it. Key among these are:

- The language of the bill provides an assurance that "The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B...has available a...prescription drug plan." If there is no private entity offering, then the bill calls on the Administrator to structure a plan so that Medicare bears a greater share of the risk – in effect making Medicare the insurer of last resort. Given the dependence on private sector entities (e.g., Pharmacy Benefit Managers [PBMs] and insurance companies) to offer coverage, will these entities agree to share risk with Medicare to provide prescription drug coverage? And, will the dependence on private entities result in much higher costs to beneficiaries for the same or similar benefits?
- The bill creates a standard benefit package, but also allows for actuarially equivalent plans to be offered. Will the benefits be meaningful and dependable – from year-to-year and plan-to-plan, and not be subject to the volatility that has developed in the Medicare managed care market?

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- The bill authorizes the Administrator to review compliance with the benefit coverage, subsidy, and actuarial equivalence requirements established in the bill. **Will the Medicare Benefits Administration be given the resources to carry out the authority to scrutinize drug plans to assure that beneficiaries receive the reinsurance subsidy and prescription drug discounts outlined in the bill?**
- The bill calls for the creation of a companion agency within HHS to administer the prescription drug benefit and the Medicare+Choice program. **How will the creation of two separate agencies to administer Medicare make the operation of the program more efficient?** By keeping Medicare within the Department of Health and Human Services, the Ways and Means proposal assures that the Administrators, as well as the Secretary would continue to be accountable to Congress for the operation of the program. **How will the Ways and Means proposal ensure seamless administration of both traditional fee-for-service and private health insurance options?**

Democratic Alternative

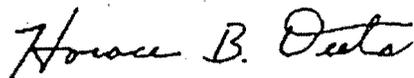
The Democratic alternative also raises some important questions:

- Beneficiaries will have a monthly premium of \$25.00 in 2003 and a 50 percent coinsurance until they reach the benefit cap. As under the Ways and Means bill, they must also pay the full negotiated price of their prescriptions between the benefit cap and the stop-loss level (\$4000 in the Democratic alternative). **While the value of the federal subsidy to beneficiaries is higher than in the Ways and Means bill, will beneficiaries find the monthly premium to be affordable enough to enroll in Part D?**
- The bill provides a broad zone of "non-interference by the Secretary" of HHS not to interfere in negotiations between benefit administrators and manufacturers or wholesalers. **Will this compromise the Secretary's ability to hold down overall program costs, which will, in turn, drive beneficiary premiums?**
- **What level of discount will benefit administrators be able to negotiate given that all prescription drugs are covered regardless of whether the medicine is included in a formulary?**
- **Given the current constraints on HCFA resources, will the Administrator of HCFA have the necessary resources and flexibility to effectively oversee Medicare fee-for-service, Medicare+Choice and the new prescription drug plans?**

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Our members – and your constituents – have sent us a clear message: we need prescription drug coverage in Medicare now. AARP is determined to work with Members of Congress on both sides of the aisle to bring about bipartisan legislation that is consistent with our principles. It is on that basis – bipartisanship and consistency with our principles – that AARP will decide which legislation that it will support or oppose. AARP urges Members of Congress to work together with the President toward meaningful bipartisan legislation that creates dependable and affordable prescription drug coverage for all beneficiaries and strengthens Medicare for the future.

Sincerely,



Horace B. Deets



The Voice for Health Care Consumers

FOR IMMEDIATE RELEASE
JUNE 13, 2000

CONTACT: JOHN FAIRBANKS
KATHRYN SCHROEDER
202-628-3030

FamiliesUSA Director Ron Pollack calls Republican Prescription Drug Proposal a 'Mirage'

Statement by Ron Pollack, Executive Director of FamiliesUSA, on the prescription drug proposal announced today by House Republicans:

"This proposal has all the attributes of a mirage – it looks inviting from a distance, but once you get up close, you realize there's nothing there.

"The Republicans' 'new' plan does not offer any concrete benefit. Like previous versions of this proposal, it relies on private insurance companies to offer prescription drug-only coverage, something the insurers have already emphatically stated they will not do. In fact, the president of the Health Insurance Association of America has called this idea 'an empty promise to America's seniors.' "

"Under this proposal, most seniors would have to pay 100 percent of the cost of the benefit. A widow or widower living on as little as \$12,525 a year would not get any help with the cost of insurance premiums, even if the insurance companies can be persuaded to offer it.

"What's more, consumers do not know what they'll actually get out of this. The Republican proposal leaves the actual benefit undefined. It could be some paltry amount that offers no real help to seniors. Any prescription drug insurance policy with real coverage will be priced far out of reach for most of our senior citizens.

"What seniors really need is a guaranteed drug benefit in Medicare that covers basic and catastrophic drug needs, not a hazy promise of private insurance that evaporates once you get close enough to look at it."

FamiliesUSA is the national organization for health care consumers. It is non-profit and non-partisan and advocates for high-quality, affordable health care for all Americans.

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GRAHAM PRESCRIPTION DRUG PLAN

Introduced as "Medicare Outpatient Drug Act of 2000" (S. 2758) on June 20th. Sponsors include: Senators Graham, Baucus, Bryan, Conrad, Robb, and Rockefeller, Chafee and Lincoln.

Offered as amendment to the Labor/HHS appropriations bill on June 23rd. Rejected 44-53, with two Republicans, Chafee and Fitzgerald, voting for and one Democrat, Breaux, voting against.

Provision	Graham Bill	President's Plan
Start Date	2003	2002
Deductible	\$250	None
Beneficiary Cost-Sharing	50% from \$250 up to \$3,500 in beneficiary costs 25% from \$3,500 up to \$4,000 in beneficiary costs	50% from \$0 up to \$5,000 in total costs when fully phased in
Stop-Loss	\$4,000 in beneficiary costs	\$4,000 in beneficiary costs
Premium Assistance	50% premium subsidy; with subsidy phased down to 25% for higher income	50% premium subsidy
Monthly Premium	\$38 (2003)*	\$25 (2002)
Administration	Medicare contracts with multiple PBMs per geographic region to administer Rx benefit. Part D administered by HCFA.	Medicare contracts with single PBMs per geographic region to administer Rx benefit. Part D administered by HCFA.
Low-Income Subsidies	Through Medicaid program, full premium and cost-sharing assistance for beneficiaries up to 135% of poverty (\$11,300). Partial premium assistance for those between 135% and 150% (\$12,500). Federal government will pay for subsidies below 100% of poverty at current federal matching percentage. From 100% to 150%, federal government will pay for subsidies at 100%.	Through Medicaid program, full premium and cost-sharing assistance for beneficiaries up to 135% of poverty (\$11,300). Partial premium assistance for those between 135% and 150% (\$12,500). Federal government will pay for subsidies below 100% of poverty at current federal matching percentage. From 100% to 150%, federal government will pay for subsidies at 100%.
Cost	\$53 b / 5 yrs, \$241 b / 10 yrs*	\$79 b / 5 yrs; \$253 b / 10 yrs

* Informal CBO scoring

(P.F.F. year start)

Key differences between Graham's and the President's bill include:

- The Graham bill includes a deductible, bases cost-sharing on beneficiary out-of-pocket costs (rather than total costs), and has no gap between the benefit cap and stop-loss.
- Multiple PBMs would administer the benefit in each geographic region. The President's plan uses one PBM per region to maximize purchasing power (multiple PBMs dilute leverage in negotiating with manufacturers and pharmacies), similar to private sector practice.
- Premium assistance is income-related. The Graham bill includes a provision that reduces premium assistance to beneficiaries from 50% to 25% based on their income. This provision was dropped when the Graham bill was offered as an amendment to Labor/HHS.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

June 28, 2000
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 4680 - Medicare Rx 2000 Act
(Thomas (R) CA and seven cosponsors)

The Administration strongly opposes House passage of H.R. 4680 because its private insurance benefit does not meet the President's test of being a meaningful Medicare prescription drug benefit that is affordable and accessible for all beneficiaries. H.R. 4680 builds on an unstable and unreliable Medigap market, an approach which the insurance industry itself has concluded is unworkable. If H.R. 4680 were presented to the President, he would veto it.

The President has made passing a voluntary Medicare prescription drug benefit one of his highest priorities. His principles for a drug benefit are that it be voluntary; be accessible to all beneficiaries; be meaningful; give eligible seniors and people with disabilities bargaining power to reduce drug prices; assure access to medically necessary drugs; and be affordable to beneficiaries and the Medicare program.

The President's plan would ensure that Medicare pays half of all participants' prescription drug costs up to \$5,000 when fully phased in and that no eligible senior or person with a disability pays more than \$4,000 out-of-pocket. In addition, seniors would benefit from price discounts negotiated by private pharmacy benefit managers. Beneficiaries would have a choice of getting coverage through traditional Medicare, managed care, or retiree plans. Those who voluntarily opted for the new benefit would pay a monthly premium of \$25 in the first year, and low-income seniors would pay no or lower premiums and cost sharing. This coverage would start in 2002 and is part of the President's overall plan to strengthen and modernize Medicare.

The Democratic substitute, which the President strongly supports, also provides an affordable, meaningful Medicare drug benefit. It, too, covers half of costs up to \$5,000 when fully phased in, includes a stop-loss of \$4,000, and ensures that seniors have a choice of coverage through Medicare fee-for-service, managed care or retiree coverage. The President is dismayed that the Republican leadership refused to allow a vote on a true Medicare benefit that provides the resources necessary to ensure that premiums are affordable.

H.R. 4680 does not meet the President's principles for a meaningful prescription drug benefit. Specifically:

- **Private insurance model does not ensure access to a dependable benefit.** H.R. 4680 relies on private insurers to offer Medicare beneficiaries a prescription drug benefit. The private insurance industry itself has repeatedly stated that they would not participate in this flawed plan. Even if they do participate, insurers could not be relied on to provide

continuous coverage in all areas -- the same problem that we have in Medicare managed care today. Under the President's plan and the Democratic substitute, all beneficiaries -- including those in rural or otherwise underserved areas -- would be guaranteed a defined, accessible, reliable Medicare benefit for the same premium.

-- **Private insurance model would not be affordable to all beneficiaries.** Under H.R. 4680, Medicare would not provide a single dollar of direct premium assistance for middle-class beneficiaries (any senior with income above \$12,600). Instead, the plan relies on subsidies to insurers, not seniors. Insurers would set premiums. Thus, seniors would pay different premiums from plan to plan and place to place. A rural senior would be at particular risk of facing excessive premiums since insurers would likely face little competition and less incentive to offer affordable coverage. The premium cited by the Republican leadership for H.R. 4680 has not been confirmed by the Congressional Budget Office or any other independent entity, unlike the President's plan. Even accepting the Republicans' claim that the premium would average \$37 per month, this premium would be over 40 percent higher than the President's plan premium of \$25 per month.

-- **Seniors would pay more for less valuable and meaningful coverage.** Under H.R. 4680, seniors and people with disabilities would pay a higher premium for less generous coverage. According to an analysis by the Department of Health and Human Services, the President's benefit would be 25 percent more valuable in 2003 and 50 percent more valuable when fully phased in than that of H.R. 4680. Moreover, private insurers may vary their benefits by setting their own deductibles, copays, and benefit limits within an actuarial value. This allows insurers to discourage enrollment by the oldest seniors and most disabled beneficiaries by offering no deductible and low copays, but also a low benefit cap that leaves a large gap in coverage before the stop-loss kicks in. In addition, private plans could limit access to community pharmacists and needed medications. Under the President's plan, seniors and people with disabilities would have a real choice: choice of using their community pharmacist and access to prescriptions that their doctor -- not their insurance company -- determines are necessary.

The Administration also objects to creating a new bureaucracy to administer the new drug benefit and Medicare+Choice. This is inconsistent with the President's principles of efficient administration of the drug benefit. The Administration believes that the prescription drug benefit should be integrated into the Medicare program like all other Medicare benefits. In addition, provisions in H.R. 4680 related to the Medicare Advisory Board and its reporting requirements raise constitutional concerns.

Pay-As-You-Go Scoring

H.R. 4680 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's estimate of the pay-as-you-go cost of this legislation is under development. The Congressional Budget Office estimates that H.R. 4680 will increase direct spending by a total of \$39.7 billion over five years.

* * * * *

Sent to Gene -
Take home
in case he calls you

September 7, 1999

MEMORANDUM FOR GENE SPERLING

**FROM: CHRIS JENNINGS
JASON FURMAN
JEANNE LAMBREW**

SUBJECT: CORRECTED MEDICARE ESTIMATES

In scoring the Administration's proposals the HCFA Actuaries incorrectly overlooked the effects of the additional HI savings after 2014. In 2014 savings are about \$23 billion and they continue to grow by 6 to 7 percent per year over the following years. Taking these savings into account extends the projected life of the Medicare trust fund to 2031. The HI reforms alone extend solvency to 2022. The following table shows several alternative Medicare scenarios and their consequences for Medicare solvency and paying down the debt.

In replicating the HCFA Actuaries estimates we uncovered several other technical issues in their methodology, some of which appear to be either mistakes or potentially unnecessary shortcuts. Revising their methodology would show further extensions of the HI trust fund under the President's policy and would also have a tiny effect on the baseline insolvency date (moving it by a few days). We plan to have a Medicare Deputies meeting soon which would discuss these technical trust-fund estimation issues.

MEDICARE AND SURPLUS DEDICATION: EFFECTS OF CHANGES

		OMB			CBO <1>		
		00-04	00-09	00-15	00-04	00-09	00-15
ORIGINAL PROPOSAL	Insolvency Date	2030			2027		
	Eliminate Debt <2>	2014			2015		
	Total Surplus	50	374	794	50	374	794
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	29	328	715	17	263	535
	-- <i>Surplus transfer</i>	21	259	546	11	208	402
-- <i>Savings</i>	8	69	168	6	54	133	
	Change in Surplus	--	--	--	--	--	--
ORIGINAL W/ \$20 BILLION BBA GIVE-BACKS <3>	Insolvency Date	2030			2027		
	Eliminate Debt <2>	2015			2015		
	Total Surplus	50	374	794	50	374	794
	- Net Costs (Drugs)	27	59	101	39	124	280
	- Solvency	23	315	693	11	250	514
	-- <i>Surplus transfer</i>	18	253	535	8	202	391
-- <i>Savings</i>	5	63	158	3	48	122	
	Change in Surplus	--	--	--	--	--	--
2027 <4>	Insolvency Date	2027			2027		
	Eliminate Debt <2>	2015			2015		
	Total Surplus	41	261	556	50	364	776
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	20	215	477	16	253	517
	-- <i>Surplus transfer</i>	12	146	308	10	199	384
-- <i>Savings</i>	8	69	168	6	54	133	
	Change in Surplus	-9	-113	-238	-0	-9	-18
2025 <4>	Insolvency Date	2025			2025		
	Eliminate Debt <2>	2016			2016		
	Total Surplus	36	204	435	47	299	649
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	15	158	356	13	188	391
	-- <i>Surplus transfer</i>	7	89	187	7	133	257
-- <i>Savings</i>	8	69	168	6	54	133	
	Change in Surplus	-14	-170	-359	-4	-75	-144
NO SURPLUS TRANSFERS <5>	Insolvency Date	2021			2020		
	Eliminate Debt <2>	2016			2016		
	Total Surplus	29	115	248	40	166	392
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	8	69	168	6	54	133
	-- <i>Surplus transfer</i>	0	0	0	0	0	0
-- <i>Savings</i>	8	69	168	6	54	133	
	Change in Surplus	-21	-259	-546	-11	-208	-402

MEDICARE AND SURPLUS DEDICATION: EFFECTS OF CHANGES

		OMB			CBO <1>		
		00-04	00-09	00-15	00-04	00-09	00-15
\$328 BILLION OVER 10 <4>	Insolvency Date	2030			2029		
	Eliminate Debt <2>	2014			2015		
	Total Surplus	50	374	794	53	439	917
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	29	328	715	19	328	659
	-- <i>Surplus transfer</i>	21	259	546	13	273	525
	-- <i>Savings</i>	8	69	168	6	54	133
Change in Surplus	--	--	--	+2	+65	+123	
\$300 BILLION OVER 10 <4>	Insolvency Date	2030			2028		
	Eliminate Debt <2>	2015			2015		
	Total Surplus	48	346	736	51	412	864
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	27	300	656	18	300	606
	-- <i>Surplus transfer</i>	19	231	488	12	246	472
	-- <i>Savings</i>	8	69	168	6	54	133
Change in Surplus	-2	-28	-58	+1	+38	+71	
\$200 BILLION OVER 10 <4>	Insolvency Date	2027			2025		
	Eliminate Debt <2>	2015			2015		
	Total Surplus	40	246	525	46	311	670
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	19	200	445	13	200	412
	-- <i>Surplus transfer</i>	11	131	277	7	146	278
	-- <i>Savings</i>	8	69	168	6	54	133
Change in Surplus	-10	-128	-269	-4	-62	-124	
\$100 BILLION OVER 10 <4>	Insolvency Date	2023			2022		
	Eliminate Debt <2>	2016			2016		
	Total Surplus	32	146	314	41	211	476
	- Net Costs (Drugs)	21	46	79	34	111	259
	- Solvency	10	100	234	7	100	217
	-- <i>Surplus transfer</i>	3	31	66	1	45	84
	-- <i>Savings</i>	8	69	168	6	54	133
Change in Surplus	-19	-228	-480	-9	-163	-318	

<1> The CBO estimates only use CBO scoring for HI savings and net prescription drug costs; baseline and surplus amount from OMB scoring.

<2> The debt numbers are the calendar year that the debt is eliminated. Alternative scenarios assume that all of the remaining on-budget surplus is spent on discretionary spending or tax cuts.

<3> This assumes that the givebacks come out of the proposed transfers and leave the overall allocation of surplus to Medicare unchanged.

<4> The OMB solvency numbers pro-rate the solvency transfers either to hit a target solvency year or to hit a target 10 year number. The CBO solvency numbers follow the same procedure, pro-rating the solvency transfers implied by the original proposal under CBO scoring.

<5> The no surplus transfers scenario assumes the same accounting rules as the other scenarios, that is that the HI savings are not used to boost the on-budget surplus and thus for greater spending or tax cuts.

MEMORANDUM

April 26, 1999

From: Richard S. Foster
Solomon M. Mussey
Elliott A. Weinstein
Office of the Actuary
Health Care Financing Admin.

Subject: Actuarial Evaluation of Illustrative Approaches for Improving HI Solvency Through Expenditure Reductions or Payroll Tax Increases—Update Based on 1999 Trustees Report

The long-range solvency of the Medicare Hospital Insurance (HI) program remains the subject of considerable discussion. Most of the discussion has focused on the reductions in HI expenditures that would be required to meet certain financing or budgetary goals. This memorandum provides an analysis of the effects on the HI trust fund of various illustrative approaches for reducing future HI expenditures or raising payroll tax rates.

The analysis presented here should not be interpreted as advocating a particular approach to addressing the projected financial imbalance for the HI trust fund; nor should a negative inference be made from the absence of other analyses. Our purpose is to help provide a framework for analysis by the program's policymakers. Also, in the case of the illustrative proposals to reduce expenditures, this memorandum provides no information as to how such reductions might be accomplished. In other words, these estimates illustrate the financial impact of various theoretical changes in expenditure levels or growth rates—development of legislative provisions that would result in such changes is rather more challenging.

The illustrations presented in this memorandum are based on the intermediate financial projections from the 1999 HI Trustees Report. Under different economic and demographic conditions, such as the Trustees' "low cost" or "high cost" assumptions, the steps required to reach financial balance can differ significantly from those based on the intermediate assumptions. Equivalently, a legislative package designed to restore balance under the intermediate assumptions could ultimately result in too much or too little savings, depending on actual future economic and other conditions.

I. Background

Under section 1817(b) of the Social Security Act, the Board of Trustees for the HI program is required to report to Congress annually on the financial status of the HI trust fund. In keeping with the program's long-term financial obligations, the law requires both a short-range and a long-range evaluation of the trust fund's actuarial status. The latest Trustees Report was issued to Congress on March 30, 1999.

Based on the intermediate assumptions in the 1999 Trustees Report, the HI trust fund is estimated to be depleted in 2015 and to have a 75-year actuarial deficit of 1.46 percent.

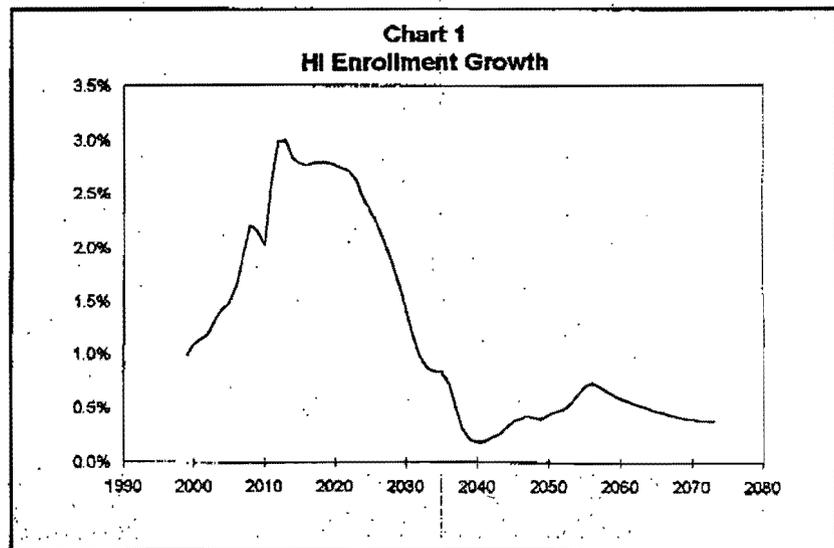
The 1999 Trustees Report projections show that the program continues to face a serious imbalance between projected income and expenditures in the long range, in part due to the demographic changes that will occur with the retirement of the post-World War II "baby boom" generation. To bring HI into actuarial balance for the next 25 years under the intermediate assumptions would require that expenditures be reduced by 11 percent or revenues increased by 12 percent or some combination thereof. Alternative combinations of such measures are shown in the table below. Over the full 75 years of the Trustees' projection, substantially greater changes would be required.

Alternative combinations of revenue increases or
expenditure reductions for actuarial balance during
1999-2023 (1999 intermediate assumptions)

<u>Revenue Increase</u>	<u>Expenditure Reduction</u>
0%	11%
5%	7%
10%	2%
12%	0%

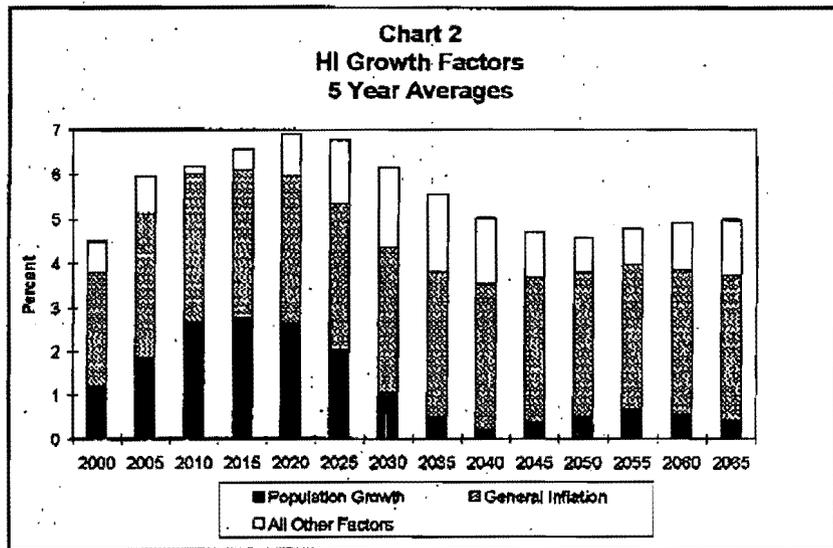
The analysis shown in the annual Trustees Report is significantly different in scope and purpose from the financial projections for the HI trust fund shown in the President's Budget or the projections of the Congressional Budget Office (CBO). Budget estimates are generally prepared for at most the next 10 years and are based on somewhat different assumptions concerning future economic growth, inflation rates, medical care utilization, etc. For purposes of evaluating the financial status of the Social Security and Medicare programs, Congress normally relies on the Trustees' projections. Specific proposals to address the current financial imbalance would normally be evaluated using the Trustees' assumptions. Their effects would also be "scored" for budget purposes using Administration and/or CBO budget assumptions.

HI expenditures for benefits and administrative expenses are projected to increase in the future for several reasons. One factor is growth in the number of eligible beneficiaries. Chart 1



shows the projected annual rate of increase in the number of beneficiaries over the next 75 years. Enrollment is estimated to grow around 2 percent or less annually until 2010, around 2-3 percent between 2010 and 2030, when the baby boom generation retires, and well under 1 percent afterwards. While the baby boom represents a serious long-term issue for HI solvency, they are not the primary cause of the short-range financial problem. In particular, the trust fund is projected to be depleted in 2015 under the intermediate assumptions—shortly after the first baby boomers reach age 65.

Chart 2 shows projected enrollment growth, general inflation (as measured by the Consumer Price Index), and other cost factors which contribute to HI expenditure growth. Each bar represents the average annual growth rate over the 5-year period beginning with the year shown. During 2005-2009, for example, HI expenditures are expected to increase by about 6 percent annually. Beneficiary growth accounts for 1.9 percent of the total and general inflation represents another 3.2 percent. The residual, 0.8 percent, is attributable to all other factors, including assumed additional inflation in the health care sector, increasing utilization and intensity of medical services, and so forth.



As noted above, future growth in the number of beneficiaries will vary considerably. General inflation is assumed to be fairly stable in the range of about 3.3 percent annually throughout the projection period. The residual factors vary significantly over time (see section II.F of the HI Trustees Report for the specific assumptions). Part of this variation is attributable to demographic effects: average per-beneficiary utilization of health services will initially decrease, with the influx of 65-year-old baby boomers. Subsequently, as these individuals age, average utilization and intensity will accelerate. Table 1, attached, lists the components of HI expenditure growth rates.

During calendar years 1999 through 2008, the HI program is projected to spend a total of \$1,600 billion under the intermediate assumptions. If growth in program spending were limited to increases attributable to population growth alone, then the resulting reduction in HI expenditures compared to present law would be about \$204 billion for those years. If spending growth were constrained to population growth plus an allowance for general inflation, then the reduction in HI expenditures for 2000-2008 would be about \$77 billion.

II. Measures used to evaluate financial effect of proposals

In the budget context, most attention is focused on the dollar amount of expenditure reductions over a given period of time. To evaluate trust fund solvency, however, several key factors are considered. For each of the illustrative proposals to reduce HI expenditures or increase taxes, we show the following results:

- A. The "actuarial balance" for the next 25, 50, and 75 years. This amount is expressed as a percentage of the total wages, salaries, and self-employment earnings subject to the HI payroll tax. It represents the net difference between future HI income and expenditures over the period in question. Positive figures are surpluses and negative figures are deficits.
- B. The dollar reduction in HI expenditures or increase in tax revenues for various years. (Estimates are shown only for the next 10 years since such amounts are difficult to interpret for long periods of time, due to the changing value of the dollar.)
- C. The "trust fund ratio," which is the ratio of HI trust fund assets at the beginning of the year to HI expenditures for that year. The Board of Trustees has recommended that HI assets be maintained at the level of one year's expenditures, to serve as an adequate contingency reserve against temporary economic downturns or other adverse circumstances.
- D. The year the trust fund is depleted.
- E. The results of the Trustees' tests for short-range financial adequacy and long-range close actuarial balance.¹

It is important to note the extreme sensitivity of measures based on trust fund assets (i.e., the trust fund ratio and the year of trust fund depletion described in C and D above). As can be seen in the attached tables, seemingly minor differences in expenditure growth rates can result in major changes in the projected level of assets. For this reason, evaluation of the long-range financial status of the HI program (and Social Security) has generally focused more on the actuarial balance, which is a more stable measure of the program's financial status. Conversely, short-range analysis is generally based on the trust fund ratio.

III. Reducing future expenditures by an overall percentage (Table 2)

Four general approaches to reducing HI expenditures are illustrated in this memorandum. The first would reduce outlays by the same overall percentage in all years, compared to current law projections. For example, under present law HI expenditures are projected to increase from \$136 billion in calendar year 1998 to \$221 in 2008 (see chart 3). If policymakers wished to address the actuarial deficit in the first 25 years by uniformly reducing HI expenditures in all years, then as noted

¹These tests are complex. See the Glossary in the 1999 HI Trustees Report for complete definitions.

previously expenditures would have to be reduced by about 11 percent in each year. Such a reduction is illustrated in chart 3. (Mathematically, this approach is equivalent to reducing outlays in the first year by the desired percentage and then allowing subsequent expenditures to increase at the same rates as projected under current law.)

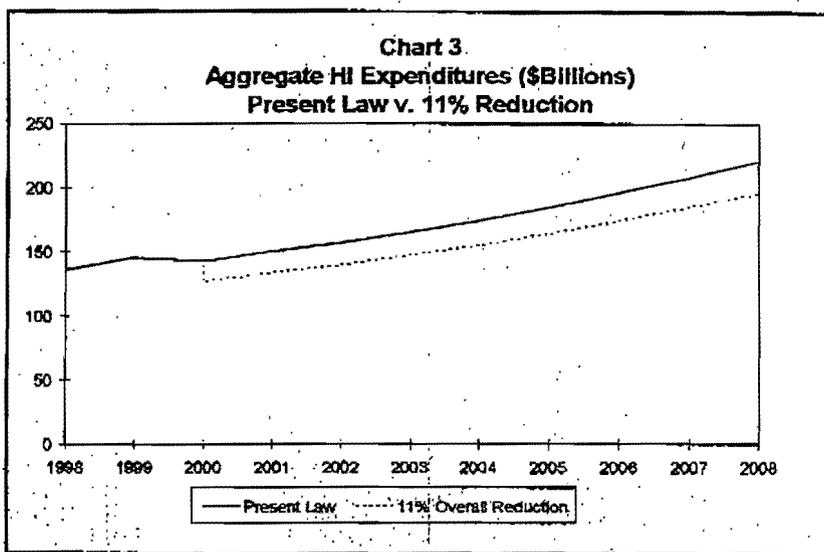
Table 2 shows the effects on the financial status of the HI trust fund of alternative proposals to reduce outlays in all future years

by 10, 20, 30, or 40 percent relative to the levels projected under present law. These results indicate that a 10-percent reduction would delay trust fund depletion by 12 years; a 20-percent reduction by 25 years. A 10-percent reduction would result in an actuarial balance of -0.05 percent for 1999-2023 (i.e., almost an exact balance between future income and expenditures for the period), but an overall reduction of over 30 percent would be required to achieve a zero balance over the full 75-year projection period.

As noted previously, these examples are intended to illustrate the nature of the financial imbalance facing the HI program and the impact of theoretical general approaches to closing the imbalance. In practice, developing legislative packages that would result in overall expenditure reductions of the magnitude illustrated here would be very challenging.

IV. Reducing annual growth in expenditures by a specified percentage (Table 3)

Another approach would be to reduce the rate of growth by a fixed percentage each year. Under present law, for example, HI expenditures are projected to increase on average at about 4.6 percent annually during 2000-2004. Under this category of proposals, an attempt would be made to reduce annual growth rates by a specified amount, such as 1 percentage point each year (i.e., to about 3.6 percent during 2000-2004). Similarly, growth rates in subsequent years would also be reduced by 1 percentage point. Over time, the effects of these lower growth rates would accumulate.



The effects of alternative reductions in growth rates are shown in table 3. To achieve solvency over the full 75-year projection period, growth rates would have to be reduced by about 1.3 percentage points in every year, relative to the intermediate projections. The effects of such a reduction are illustrated in chart 4. As can be seen by comparing charts 3 and 4, a reduction in growth rates would produce a different pattern of savings than would an overall percentage reduction.

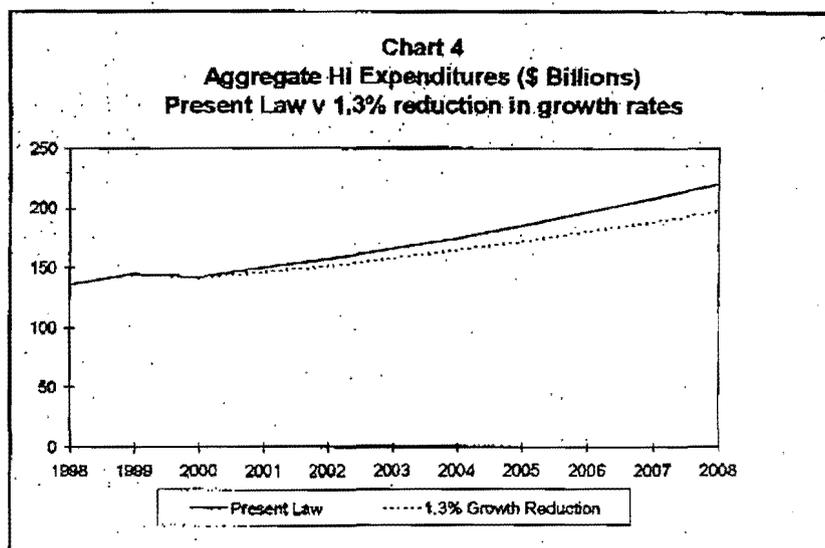
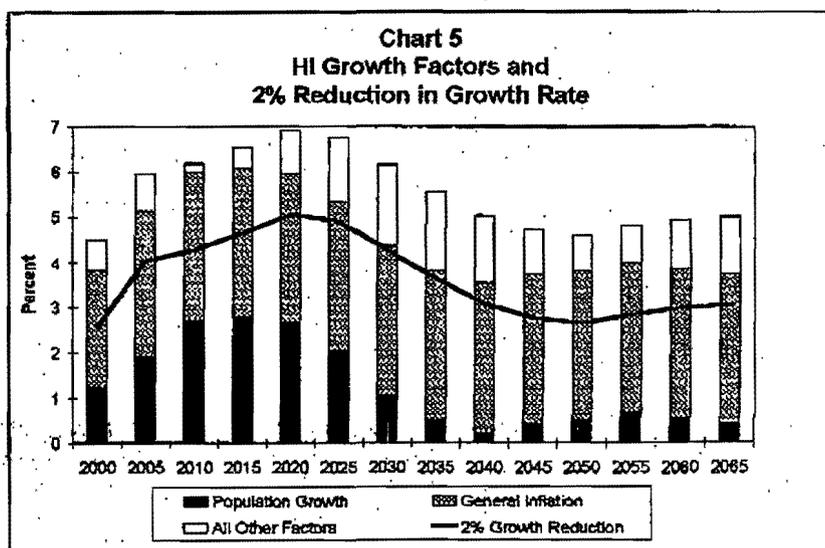


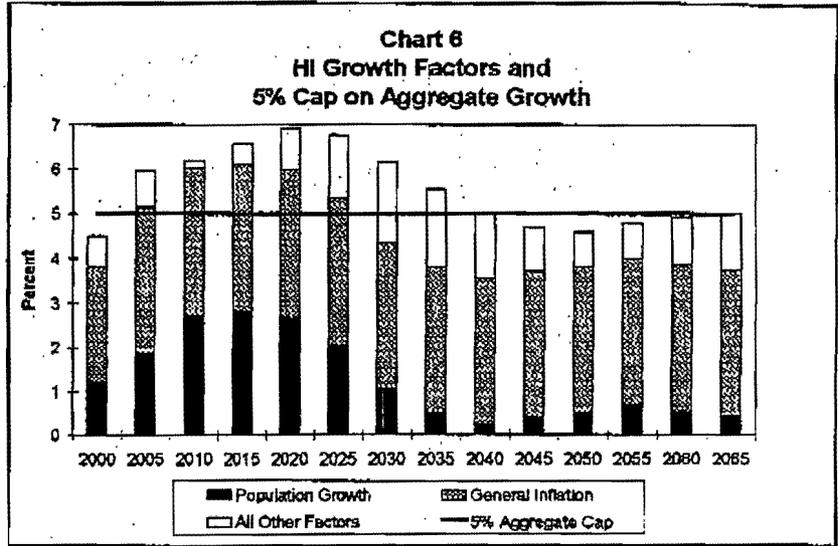
Chart 5 illustrates the nature of proposals to reduce expenditure growth rates. Growth rates under present law would be reduced by the same amount in each period (in this illustration, 2 percentage points). It is also apparent from chart 5 that achieving a 2-percentage-point reduction would necessitate growth rates below the level associated with population growth plus general inflation.



V. Limiting annual growth in aggregate expenditures to a specified maximum percentage (Table 4)

A variation of the approach described in the previous section would be to cap aggregate expenditure increases at a targeted level. If annual program growth fell below the target, the cap would have no effect; however, if expenditures grew faster than the target, then growth would be limited to the target level. For example, under the 1999 Trustees Report assumptions HI expenditure growth is projected to be 5.7 percent in 2001 and 6.1 percent in 2008. A 6-percent cap would not affect growth in 2001 but would reduce 2008 growth by 0.1 percentage points.

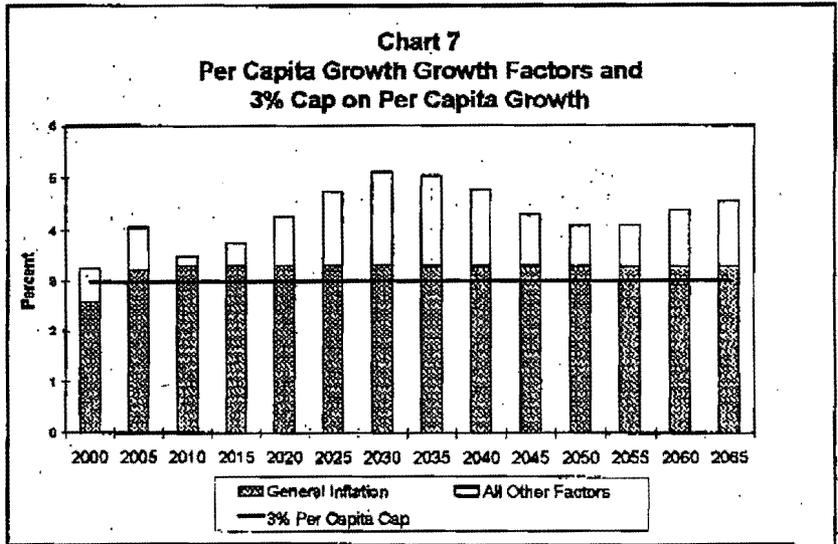
The financial effects of alternative caps on aggregate spending growth are shown in table 4. A 5-percent cap would fall a little short of bringing the program into exact actuarial balance throughout the long-range projection period.² Chart 6 compares a 5-percent cap with the projected expenditure growth rates under present law. As indicated, most of the reduction in growth rates under such a proposal would occur in the first half of the projection period.



VI. Limiting annual growth in per capita expenditures to a specified maximum percentage (Table 5)

Since Medicare population growth will not be constant (as indicated in the introduction), capping aggregate growth at constant levels would result in arbitrary fluctuations in per capita growth. Accordingly, some analysts have considered a cap on per capita expenditure growth rather than a cap on aggregate growth rates.

Table 5 presents the estimated financial effects of alternative caps on per capita HI expenditure growth. The results indicate that a 3-percent per capita cap would nearly bring the program into balance throughout the long-range period. Chart 7 illustrates the 3-percent per capita growth



²Under the intermediate assumptions, HI tax revenue is projected to increase at around 5 percent per year. Most of this increase is due to assumed increases in average earnings subject to the HI payroll tax; a small portion is attributable to growth in the number of covered workers. Thus, if annual expenditure growth could be reduced to below 5 percent, then income and outgo would remain in approximate balance indefinitely.

limitation in comparison to the projected per capita growth rates. As indicated, such a cap would generally require restricting growth to less than the levels required to keep pace with projected general inflation.

VII. Increasing the employer/employee tax rate by a specified percentage (Table 6)

Section I of this report illustrated the combinations of expenditure reductions and/or revenue increases necessary to achieve actuarial balance over the first 25-year projection period. The scenarios in this report have so far considered the effects of reductions in HI expenditures. Alternatively, the effects of increasing the HI employer/employee tax rate by a specified percentage can be considered. Currently, the HI payroll tax rate is 1.45% for employers and employees, each, for a total of 2.9%, and this tax rate will remain in effect in all future years unless legislation is enacted to modify the rate. Table 6 illustrates the financial effects of alternative proposals to increase the employer/employee tax rate by a specified percentage. For example, a 0.25% increase in the tax rate for employers and employees, each, yielding a combined 0.5% increase and hence a new total payroll tax rate of 3.4%, would result in an exhaustion date of 2031 (into the second 25-year projection period). A 0.75% employer/employee tax increase, increasing the combined tax rate from 2.9% to 4.4%, would maintain solvency over the full 75-year projection period and would meet the Trustees' test of long-range close actuarial balance.

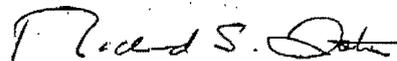
In each of these tax illustrations, an increase in the tax rate would initially result in an accumulation of trust fund assets while tax income exceeded expenditures. Subsequently, as expenditures increased as a percentage of taxable payroll to a level in excess of the combined tax rate, income would be inadequate to cover costs and trust fund assets would be drawn down to cover the shortfall. This financing pattern is very similar to the projected financial operations for the Social Security program and has generated considerable debate over the advantages and disadvantages of accumulating large trust fund reserves invested in Treasury securities. A discussion of these issues exceeds the scope of this memorandum.

VIII. Conclusion

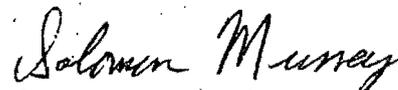
The results here indicate that substantial reductions in future HI expenditures or expenditure growth rates and/or increases in payroll tax rates would be required to address projected deficits. The illustrations also show that the year-by-year patterns of savings can vary substantially among the different approaches.

As a final illustration, table 7 shows the year-by-year expenditure reductions or payroll tax revenue increases that would be required to exactly balance income and outlays and to maintain trust fund assets at the level of one year's expenditures. The results indicate that a reduction in expenditures of about \$65 billion or about 4 percent of present-law expenditures would be required during 2000-2008, with steadily larger reductions necessary in later years. The corresponding increases in HI tax revenues are a bit larger in the short range, and considerably larger in the long run.

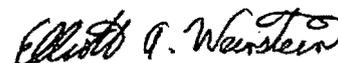
Once again, these estimates are illustrative and do not represent an expression of desired policy by the Office of the Actuary or the Health Care Financing Administration. Moreover, the implications of any effort to reduce HI costs or increase HI taxes deserve careful consideration and analysis extending well beyond these illustrations.



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Attachments: 7

Table 1--Projected growth of factors affecting future HI expenditures,
based on the intermediate set of assumptions from the 1999
Trustees Report.

Average annual percentage increase in...

Period	No. of HI beneficiaries	General inflation 1/	All other factors 2/	HI expenditures	
				Aggregate	Per Capita
1999	0.99%	1.90%	-1.12%	1.76%	0.76%
2000-2004	1.23	2.58	0.68	4.55	3.28
2005-2009	1.89	3.24	0.82	6.05	4.08
2010-2014	2.70	3.30	0.18	6.28	3.49
2015-2019	2.79	3.30	0.45	6.66	3.76
2020-2024	2.66	3.30	0.95	7.06	4.29
2025-2029	2.03	3.30	1.43	6.90	4.77
2030-2034	1.05	3.30	1.81	6.27	5.17
2035-2039	0.51	3.30	1.74	5.63	5.09
2040-2044	0.23	3.30	1.48	5.07	4.83
2045-2049	0.40	3.30	1.00	4.75	4.33
2050-2054	0.51	3.30	0.78	4.64	4.11
2055-2059	0.68	3.30	0.81	4.84	4.13
2060-2064	0.54	3.30	1.08	4.98	4.42
2065-2069	0.43	3.30	1.26	5.05	4.60
1999-2019	2.09	3.05	0.46	5.69	3.52
2020-2044	1.30	3.30	1.48	6.19	4.83
2045-2069	0.51	3.30	0.99	4.85	4.32

1/ As measured by the Consumer Price Index.

2/ All other factors include "excess" wage and price increases in the health sector, relative to the CPI, and increases in the average volume and intensity of services per beneficiary. After 2010, much of the variation shown in the all-other category is related to change in the utilization of services as the baby boom generation moves into and through the beneficiary population.

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Table 2 - Estimated financial effects of alternative proposals to reduce future HI expenditures by an overall percentage in all years, relative to present law ("overall reduction")

	Present law	Reduce present-law expenditures in each year by...			
		10%	20%	30%	40%
A. Actuarial Balance (percentage of taxable payroll)					
1999-2023.....	-0.40%	-0.05%	0.30%	0.64%	0.99%
1999-2048.....	-1.08%	-0.66%	-0.23%	0.19%	0.61%
1999-2073.....	-1.46%	-0.99%	-0.53%	-0.06%	0.40%
B. Reduction in HI expenditures (in billions)					
2000.....	-	\$11	\$21	\$32	\$43
2001.....	-	15	30	45	60
2002.....	-	16	31	47	62
2003.....	-	16	33	49	65
2004.....	-	17	35	52	69
2005.....	-	18	37	55	73
2006.....	-	19	39	58	78
2007.....	-	21	41	62	82
2008.....	-	22	44	66	88
2000-2004.....	-	75	150	225	299
2000-2008.....	-	155	311	466	620
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
2000.....	85%	94%	106%	121%	140%
2001.....	86%	107%	133%	165%	208%
2002.....	86%	118%	157%	207%	274%
2003.....	86%	128%	180%	248%	338%
2004.....	85%	136%	202%	287%	401%
2005.....	82%	144%	224%	326%	462%
2006.....	79%	151%	244%	363%	521%
2007.....	74%	157%	263%	398%	579%
2008.....	69%	163%	281%	433%	637%
2010.....	56%	171%	316%	502%	750%
2015.....	6%	170%	375%	638%	990%
2020.....	(*)	130%	386%	715%	1154%
2025.....	(*)	46%	342%	724%	1232%
2030.....	(*)	(*)	258%	687%	1260%
2035.....	(*)	(*)	147%	632%	1280%
2040.....	(*)	(*)	15%	571%	1312%
2045.....	(*)	(*)	(*)	505%	1360%
2050.....	(*)	(*)	(*)	435%	1422%
2055.....	(*)	(*)	(*)	355%	1486%
2060.....	(*)	(*)	(*)	261%	1534%
2065.....	(*)	(*)	(*)	149%	1563%
2070.....	(*)	(*)	(*)	20%	1578%
D. Year of trust fund depletion.....					
	2016	2027	2040	2070	Never
E. Board of Trustees tests:					
Short range test.....	No	Yes	Yes	Yes	Yes
Long-range test.....	No	No	No	Yes	Yes

* Fund is depleted.

- Notes:
1. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 2000.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1999 HI Trustees Report.

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Table 3 -- Estimated financial effects of alternative proposals to reduce annual growth in HI expenditures ("growth rate reduction")

	Present law	Reduce expenditure growth rate in each year by...		
		0.5%	1%	1.5%
A. Actuarial Balance (percentage of taxable payroll)				
1999-2023.....	-0.40%	-0.19%	0.00%	0.18%
1999-2048.....	-1.08%	-0.60%	-0.20%	0.15%
1999-2073.....	-1.46%	-0.75%	-0.18%	0.28%
B. Reduction in HI expenditures (in billions)				
2000.....	-	\$1	\$1	\$2
2001.....	-	1	3	4
2002.....	-	2	4	7
2003.....	-	3	6	9
2004.....	-	4	8	12
2005.....	-	5	10	15
2006.....	-	6	13	19
2007.....	-	8	15	22
2008.....	-	9	18	27
2000-2004.....	-	11	22	34
2000-2008.....	-	39	78	117
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)				
2000.....	85%	86%	86%	87%
2001.....	86%	88%	90%	91%
2002.....	86%	89%	92%	95%
2003.....	86%	90%	94%	99%
2004.....	85%	90%	97%	104%
2005.....	82%	90%	100%	110%
2006.....	79%	90%	103%	117%
2007.....	74%	89%	106%	124%
2008.....	69%	88%	109%	132%
2010.....	56%	85%	117%	151%
2015.....	6%	65%	131%	203%
2020.....	(*)	19%	127%	251%
2025.....	(*)	(*)	96%	281%
2030.....	(*)	(*)	38%	296%
2035.....	(*)	(*)	(*)	312%
2040.....	(*)	(*)	(*)	347%
2045.....	(*)	(*)	(*)	415%
2050.....	(*)	(*)	(*)	529%
2055.....	(*)	(*)	(*)	700%
2060.....	(*)	(*)	(*)	925%
2065.....	(*)	(*)	(*)	1209%
2070.....	(*)	(*)	(*)	1560%
D. Year of trust fund depletion.....				
	2015	2021	2032	Never
E. Board of Trustees tests:				
Short range test.....	No	No	No	Yes
Long-range test.....	No	No	No	Yes

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 2000.
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Table 4 – Estimated financial effects of alternative proposals to limit annual growth in aggregate HI expenditures to a specified maximum percentage ("aggregate cap")

	Cap annual growth in aggregate expenditures at...			
	Present law	4%	5%	6%
A. Actuarial Balance (percentage of taxable payroll)				
1999-2023.....	-0.40%	0.23%	-0.05%	-0.31%
1999-2048.....	-1.08%	0.45%	-0.11%	-0.73%
1999-2073.....	-1.46%	0.58%	-0.20%	-1.00%
B. Reduction in HI expenditures (in billions)				
2000.....	-	\$0	\$0	\$0
2001.....	-	0	0	0
2002.....	-	1	0	0
2003.....	-	3	0	0
2004.....	-	6	1	0
2005.....	-	9	3	0
2006.....	-	13	5	0
2007.....	-	18	8	1
2008.....	-	23	10	1
2000-2004.....	-	10	1	0
2000-2008.....	-	73	27	2
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)				
2000.....	85%	85%	85%	85%
2001.....	86%	86%	86%	86%
2002.....	86%	87%	86%	86%
2003.....	86%	87%	86%	86%
2004.....	85%	88%	84%	85%
2005.....	82%	90%	83%	82%
2006.....	78%	93%	81%	79%
2007.....	74%	98%	80%	74%
2008.....	69%	103%	80%	69%
2010.....	56%	119%	79%	57%
2015.....	6%	179%	76%	12%
2020.....	(*)	270%	69%	(*)
2025.....	(*)	394%	57%	(*)
2030.....	(*)	554%	38%	(*)
2035.....	(*)	753%	10%	(*)
2040.....	(*)	996%	(*)	(*)
2045.....	(*)	1284%	(*)	(*)
2050.....	(*)	1621%	(*)	(*)
2055.....	(*)	2011%	(*)	(*)
2060.....	(*)	2461%	(*)	(*)
2065.....	(*)	2977%	(*)	(*)
2070.....	(*)	3566%	(*)	(*)
D. Year of trust fund depletion.....				
	2015	Never	2035	2015
E. Board of Trustees tests:				
Short range test.....	No	No	No	No
Long-range test.....	No	Yes	No	No

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 2000.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1999 HI Trustees Report.

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Table 5 -- Estimated financial effects of alternative proposals to limit annual growth in per capita HI expenditures to a specified maximum percentage ("per capita cap")

	Cap annual growth in per capita expenditures at...			
	Present law	2%	3%	4%
A. Actuarial Balance (percentage of taxable payroll)				
1999-2023.....	-0.40%	0.23%	-0.10%	-0.36%
1999-2048.....	-1.08%	0.45%	-0.16%	-0.78%
1999-2073.....	-1.46%	0.72%	-0.03%	-0.93%
B. Reduction in HI expenditures (in billions)				
2000.....	-	\$0	\$0	\$0
2001.....	-	2	0	0
2002.....	-	4	1	0
2003.....	-	6	2	0
2004.....	-	10	4	0
2005.....	-	15	6	1
2006.....	-	20	9	2
2007.....	-	25	12	2
2008.....	-	30	14	2
2000-2004.....	-	22	7	0
2000-2008.....	-	112	48	7
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)				
2000.....	85%	85%	85%	85%
2001.....	86%	88%	86%	86%
2002.....	86%	90%	87%	86%
2003.....	86%	93%	87%	86%
2004.....	85%	97%	87%	85%
2005.....	82%	102%	87%	82%
2006.....	79%	109%	88%	79%
2007.....	74%	118%	89%	75%
2008.....	69%	128%	91%	71%
2010.....	56%	152%	93%	61%
2015.....	6%	217%	88%	16%
2020.....	(*)	286%	58%	(*)
2025.....	(*)	363%	5%	(*)
2030.....	(*)	471%	(*)	(*)
2035.....	(*)	654%	(*)	(*)
2040.....	(*)	955%	(*)	(*)
2045.....	(*)	1406%	(*)	(*)
2050.....	(*)	2027%	(*)	(*)
2055.....	(*)	2842%	(*)	(*)
2060.....	(*)	3885%	(*)	(*)
2065.....	(*)	5255%	(*)	(*)
2070.....	(*)	7040%	(*)	(*)
D. Year of trust fund depletion.....				
	2015	Never	2025	2016
E. Board of Trustees tests:				
Short range test.....	No	No	No	No
Long-range test.....	No	Yes	No	No

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 2000.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1999 HI Trustees Report.

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Table 6 – Estimated financial effects of alternative proposals to increase the HI tax rate for employers and employees, each, by a specified percentage

	Increase the employer/employee payroll tax rate by ...				
	Present law	0.25%	0.50%	0.75%	1.00%
A. Actuarial Balance (percentage of taxable payroll)					
1999-2023.....	-0.40%	0.08%	0.56%	1.04%	1.51%
1999-2048.....	-1.08%	-0.59%	-0.10%	0.38%	0.87%
1999-2073.....	-1.46%	-0.97%	-0.48%	0.01%	0.50%
B. Increase in payroll tax revenues (in billions)					
2000.....	-	\$17	\$35	\$52	\$69
2001.....	-	24	48	72	96
2002.....	-	25	50	75	101
2003.....	-	26	53	79	105
2004.....	-	28	55	83	110
2005.....	-	29	58	87	115
2006.....	-	30	61	91	121
2007.....	-	32	64	96	127
2008.....	-	33	67	100	134
2000-2004.....	-	120	241	361	481
2000-2008.....	-	244	491	735	978
C. Trust Fund Ratio (assets at beginning year as a % of annual expenditures)					
2000.....	85%	85%	85%	85%	85%
2001.....	86%	103%	119%	136%	152%
2002.....	86%	119%	151%	183%	216%
2003.....	86%	134%	182%	231%	279%
2004.....	85%	148%	212%	276%	340%
2005.....	82%	161%	241%	320%	400%
2006.....	79%	172%	268%	363%	458%
2007.....	74%	183%	294%	404%	515%
2008.....	69%	194%	319%	445%	571%
2010.....	56%	212%	368%	525%	681%
2015.....	6%	233%	460%	687%	914%
2020.....	(*)	211%	497%	783%	1070%
2025.....	(*)	141%	473%	806%	1138%
2030.....	(*)	31%	405%	780%	1154%
2035.....	(*)	(*)	312%	735%	1158%
2040.....	(*)	(*)	202%	685%	1168%
2045.....	(*)	(*)	79%	634%	1190%
2050.....	(*)	(*)	(*)	581%	1222%
2055.....	(*)	(*)	(*)	519%	1252%
2060.....	(*)	(*)	(*)	441%	1265%
2065.....	(*)	(*)	(*)	345%	1258%
2070.....	(*)	(*)	(*)	230%	1236%
D. Year of trust fund depletion.....					
	2015	2031	2047	Never	Never
E. Board of Trustees tests:					
Short range test.....	No	Yes	Yes	Yes	Yes
Long-range test.....	No	No	No	Yes	Yes

* Fund is depleted.

- Note 1. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.
 2. Illustrative proposals are assumed to take effect starting in 2000.
 3. All years shown are calendar years.
 4. The Board of Trustees tests are complex. Complete definitions of these tests are available in the Glossary of the 1999 HI Trustees Report.

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Table 7--Estimated reductions in HI expenditures or increases in payroll tax revenues required to maintain HI trust fund assets at 100% of annual expenditures ("actuarial balance")

CY	Reduction in HI expenditures...		Increase in payroll tax revenues...	
	In billions of dollars	As a % of present law expenditures	In billions of dollars	As a % of present law payroll taxes
2000	\$8	5%	\$9	7%
2001	17	11%	17	12%
2002	2	1%	2	1%
2003	2	1%	4	3%
2004	3	2%	4	3%
2005	5	3%	6	4%
2006	7	4%	9	5%
2007	9	4%	11	6%
2008	12	5%	13	7%
2010	(*)	7%	(*)	8%
2015	(*)	13%	(*)	17%
2020	(*)	20%	(*)	31%
2025	(*)	29%	(*)	48%
2030	(*)	35%	(*)	63%
2035	(*)	40%	(*)	76%
2040	(*)	42%	(*)	85%
2045	(*)	43%	(*)	89%
2050	(*)	44%	(*)	91%
2055	(*)	45%	(*)	96%
2060	(*)	46%	(*)	101%
2065	(*)	47%	(*)	106%
2070	(*)	49%	(*)	114%
2000-2008	65	4%	75	5%
2000-2070	(*)	43%	(*)	88%

* Estimates of the dollar expenditure reductions and payroll tax increases, and their totals, are shown only through 2008, since inflation causes such amounts to lose their meaning over long periods.

Notes: 1. Currently, the trust fund ratio is slightly under 100%. Under these scenarios, the ratio would reach 100% in the year 2002, after which the necessary reductions or increases would maintain the ratio at 100% every year thereafter. This would result in a slightly negative actuarial balance over the entire period beginning from 2000, and a zero actuarial balance beginning from 2002. Both the short-range and long-range tests of the Trustees would be satisfied over the entire period.

2. The above estimates are based on the intermediate set of assumptions from the 1999 Trustees Report.

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Surplus