



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207DRAFT

May 5, 1995

From: L. Wayne Ferguson
Office of the Actuary

Subject: Actuarial Evaluation of Expenditure Reduction Proposals
for HI Solvency

The solvency of the Medicare Hospital Insurance program (HI) has recently been the subject of considerable discussion. To facilitate this discussion, the Office of the Actuary has prepared the attached four tables which show a sensitivity analysis of several illustrative benefit reduction proposals of the general type described in recent press accounts. Under no circumstances should the analysis be treated as advocating a particular approach; neither should a negative inference be made from the absence of other analyses. The purpose is to help provide a framework for analysis by the program's policymakers.

Tables on sold

Before discussing the tables, some background information might prove useful. During calendar years 1996 through 2002, Medicare HI is projected to spend \$1,121 billion.¹ 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 \$267 billion for those years. If spending growth were constrained to population growth plus an allowance for general inflation (as measured by the Consumer Price Index), then the reduction in HI expenditures for 1996-2002 would be about \$139 billion.

Four general approaches to reducing HI expenditures are illustrated. The first is simply to reduce outlays by the same overall percentage in all years. To illustrate, if a 30 percent reduction in total outlays for the 75-year period were desired, then outlays would be reduced by 30 percent in each year. Table 1 shows the financial effect of such overall reductions in expenditures.

Another approach would be to reduce the rate of growth by a fixed percentage each year. For example, a fixed percentage reduction of 1 percent would reduce 8 percent growth to 7 percent. Over

¹This estimate and all others shown in this memorandum are based on the intermediate set of assumptions from the 1995 Trustees Report.

time, the effects of these lower growth rates would accumulate. Table 2 shows the financial effects of alternative fixed reductions in growth rates.

A variation of the above approach would be to cap ^{Fixed} 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, HI expenditure growth is projected to be 9 percent in 1996 and 7.9 percent in 2002. An 8 percent cap would reduce 1996 growth by 1 percent but would not affect growth in 2002. The aggregate cap approach is shown in Table 3 for alternative growth caps.

In practice, future Medicare population growth will not be constant. It is estimated to be under 2 percent annually for the next 16 years, 2-3 percent as the baby boomers retire between 2010 and 2030, and well under 1 percent afterwards. Capping aggregate growth at constant levels would thus result in arbitrary fluctuations in per capita growth. Accordingly, some have advocated a cap on per capita expenditure growth rather than a cap on aggregate growth rates. The effects of alternative per capita growth constraints are shown in Table 4.

For expediency, the tables were calculated on a calendar year, incurred basis² with all changes assumed to first occur in 1996 and continue thereafter. While some public discussion centers on a fiscal year, cash basis, any differences in using either basis should be negligible.

Each table provides the following information for each scenario:

- 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 for various years. (Estimates are shown only for the next 10 years since inflation causes such amounts to lose their meaning over long periods.)

²However, the current law numbers are from the Trustees Report and are thus shown on a calendar year, cash basis except for the actuarial balances which were already calculated on an incurred basis in the Trustee Report.

- 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.
- D. The year the trust fund is depleted.

The tables can also be used to evaluate the effects of proposals to reduce expenditures by specific dollar savings amounts. It is important to note, however, that there would be more than one way that such reductions might occur. For example, if a savings of about \$100 billion is proposed, Table 1 indicates that a flat reduction of 10 percent would reduce expenditures by \$112 billion in 7 years; alternatively, Table 3 indicates that \$115 billion could be achieved in 10 years with a 7 percent aggregate cap. In practice, many other approaches could result in the same total dollar effect.

To further illustrate the use of the tables, Table 2 indicates that a fixed 2 percent reduction in future growth rates would reduce the 75-year actuarial deficit from 3.52 percent of taxable payroll to 0.22 percent. Table 4 shows that a 5 percent per capita cap would result in a 71 percent trust fund ratio in the year 2000 and fund depletion in 2005, 3 years later than under present law.

Once again, these estimates are illustrative and do not represent an expression of desired policy by any specific organization or policymaker. Moreover, the implications of any effort to reduce HI costs deserve careful consideration and analysis extending well beyond these illustrations. Questions on these estimates should be addressed to Richard S. Foster, Solomon M. Mussey, John A. Wandishin, or myself.

L. Wayne Ferguson, A.S.A.
Actuary

Same % Reduction

Table 1 -- 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	Flat percentage reduction				
		10%	20%	30%	40%	50%
A. Actuarial Balance (percentage of taxable payroll)						
Valuation Period						
1995-2019.....	-1.33%	-0.89%	-0.45%	-0.01%	0.44%	0.88%
1995-2044.....	-2.68	-2.09	-1.51	-0.93	-0.35	0.23
1995-2069.....	-3.52	-2.85	-2.18	-1.51	-0.84	-0.17
B. Reduction in HI expenditures (in billions)						
1996.....	-	\$13	\$25	\$38	\$50	\$63
1997.....	-	14	27	41	54	68
1998.....	-	15	29	44	59	73
1999.....	-	16	32	47	63	79
2000.....	-	17	34	51	68	85
2001.....	-	18	37	55	74	92
2002.....	-	20	40	60	80	100
2003.....	-	21	43	64	86	107
2004.....	-	23	46	69	93	116
2005.....	-	25	50	75	100	125
1996-2000.....	-	74	147	221	295	368
1996-2002.....	-	112	224	336	448	560
1996-2005.....	-	162	363	545	727	908
C. Trust Fund Ratio (assets at beginning of year as percentage of annual expenditures)						
1996.....	109%	119%	133%	153%	178%	214%
1997.....	100%	117%	144%	178%	223%	287%
1998.....	88%	113%	151%	200%	265%	356%
1999.....	74%	106%	155%	218%	303%	420%
2000.....	58%	97%	157%	233%	336%	479%
2001.....	39%	85%	155%	245%	365%	532%
2002.....	19%	72%	152%	254%	391%	582%
2003.....	(*)	57%	146%	261%	413%	627%
2004.....	(*)	40%	139%	265%	433%	669%
2005.....	(*)	23%	130%	267%	451%	707%
2010.....	(*)	(*)	63%	250%	500%	849%
2015.....	(*)	(*)	(*)	191%	490%	989%
2020.....	(*)	(*)	(*)	91%	429%	902%
2025.....	(*)	(*)	(*)	(*)	325%	839%
2030.....	(*)	(*)	(*)	(*)	189%	741%
2035.....	(*)	(*)	(*)	(*)	57%	637%
2040.....	(*)	(*)	(*)	(*)	(*)	530%
2045.....	(*)	(*)	(*)	(*)	(*)	420%
2050.....	(*)	(*)	(*)	(*)	(*)	303%
2055.....	(*)	(*)	(*)	(*)	(*)	177%
2060.....	(*)	(*)	(*)	(*)	(*)	37%
2065.....	(*)	(*)	(*)	(*)	(*)	(*)
2069.....	(*)	(*)	(*)	(*)	(*)	(*)
D. Year of trust fund depletion.....						
	2002	2006	2013	2023	2036	2061

exactly what I'd like to see this is

* Fund is depleted.

Note: The above estimates are based on the intermediate set of assumptions from the 1995 Trustees Report.

Table 2 -- Estimated financial effects of alternative proposals to reduce HI aggregate expenditure's growth rates by a fixed annual percentage. (fixed reduction)

	Present law	Fixed Reduction		
		1%	2%	3%
A. Actuarial Balance				
(percentage of taxable payroll)				
Valuation Period				
1995-2019.....	-1.33%	-0.81%	-0.36%	0.02%
1995-2044.....	-2.68	-1.38	-0.43	0.27
1995-2069.....	-3.52	-1.51	-0.22	0.64
B. Reduction in HI expenditures				
(in billions)				
1996.....	-	\$1	\$2	\$3
1997.....	-	2	5	7
1998.....	-	4	8	12
1999.....	-	6	11	17
2000.....	-	8	15	22
2001.....	-	10	20	29
2002.....	-	13	24	36
2003.....	-	15	30	43
2004.....	-	19	36	52
2005.....	-	22	42	61
1996-2000.....	-	21	42	62
1996-2002.....	-	44	86	126
1996-2005.....	-	100	194	282
C. Trust Fund Ratio (assets at beginning of year as percentage of annual expenditures)				
1996.....	109%	108%	109%	110%
1997.....	100%	96%	101%	104%
1998.....	88%	88%	93%	96%
1999.....	74%	75%	83%	92%
2000.....	58%	61%	73%	86%
2001.....	39%	45%	62%	80%
2002.....	19%	28%	50%	74%
2003.....	(*)	10%	38%	69%
2004.....	(*)	(*)	26%	64%
2005.....	(*)	(*)	13%	60%
2010.....	(*)	(*)	(*)	56%
2015.....	(*)	(*)	(*)	77%
2020.....	(*)	(*)	(*)	113%
2025.....	(*)	(*)	(*)	164%
2030.....	(*)	(*)	(*)	236%
2035.....	(*)	(*)	(*)	356%
2040.....	(*)	(*)	(*)	558%
2045.....	(*)	(*)	(*)	885%
2050.....	(*)	(*)	(*)	1383%
2055.....	(*)	(*)	(*)	2094%
2060.....	(*)	(*)	(*)	3046%
2065.....	(*)	(*)	(*)	4288%
2069.....	(*)	(*)	(*)	5520%
D. Year of trust fund depletion.....				
	2002	2001	2006	Never

OFF OF baseline

* Fund is depleted.

Note: The above estimates are based on the intermediate set of assumptions from the 1995 Trustees Report.

Table 3 -- Estimated financial effects of alternative proposals to limit aggregate HI expenditures' growth rates to a specified maximum percentage (aggregate cap)

	Present law	Aggregate cap			Fixed
		5%	6%	7%	
A. Actuarial Balance					
(percentage of taxable payroll)					
Valuation Period					
1995-2019.....	-1.33%	0.02%	-0.36%	-0.81%	
1995-2044.....	-2.68	0.19	-0.56	-1.53	
1995-2069.....	-3.52	0.29	-0.77	-2.05	
B. Reduction in HI expenditures					
(in billions)					
1996.....	-	\$5	\$3	\$2	
1997.....	-	9	6	4	
1998.....	-	13	10	6	
1999.....	-	18	13	7	
2000.....	-	24	17	10	
2001.....	-	30	21	12	
2002.....	-	37	26	14	
2003.....	-	45	31	17	
2004.....	-	53	37	20	
2005.....	-	62	43	23	
1996-2000.....	-	69	49	29	
1996-2002.....	-	137	97	55	
1996-2005.....	-	296	208	115	
C. Trust Fund Ratio (assets at beginning of year as percentage of annual expenditures)					
1996.....	109%	111%	110%	109%	
1997.....	100%	106%	103%	100%	
1998.....	88%	101%	96%	90%	
1999.....	74%	97%	87%	79%	
2000.....	58%	92%	78%	65%	
2001.....	39%	86%	68%	51%	
2002.....	19%	82%	57%	35%	
2003.....	(*)	77%	46%	18%	
2004.....	(*)	73%	34%	(*)	
2005.....	(*)	70%	23%	(*)	
2010.....	(*)	65%	(*)	(*)	
2015.....	(*)	80%	(*)	(*)	
2020.....	(*)	113%	(*)	(*)	
2025.....	(*)	162%	(*)	(*)	
2030.....	(*)	225%	(*)	(*)	
2035.....	(*)	306%	(*)	(*)	
2040.....	(*)	402%	(*)	(*)	
2045.....	(*)	513%	(*)	(*)	
2050.....	(*)	635%	(*)	(*)	
2055.....	(*)	770%	(*)	(*)	
2060.....	(*)	918%	(*)	(*)	
2065.....	(*)	1081%	(*)	(*)	
2069.....	(*)	1222%	(*)	(*)	
D. Year of trust fund depletion.....					
	2002	Never	2006	2003	

* Fund is depleted.

Note: The above estimates are based on the intermediate set of assumptions from the 1995 Trustees Report.

Table 4 -- Estimated financial effects of alternative proposals to limit per capita HI expenditures' growth rates to a specified maximum percentage (per capita cap)

	Present law	Per capita cap			
		3%	4%	5%	6%
A. Actuarial Balance					
(percentage of taxable payroll)					
Valuation Period					
1995-2019.....	-1.33%	0.12%	-0.26%	-0.70%	-1.13%
1995-2044.....	-2.68	0.23	-0.53	-1.54	-2.39
1995-2069.....	-3.52	0.50	-0.48	-1.96	-3.19
B. Reduction in HI expenditures					
(in billions)					
1996.....	-	\$5	\$4	\$3	\$1
1997.....	-	10	7	5	2
1998.....	-	15	11	7	3
1999.....	-	21	16	10	4
2000.....	-	28	21	13	6
2001.....	-	35	26	17	7
2002.....	-	43	32	21	9
2003.....	-	52	39	25	10
2004.....	-	62	46	30	12
2005.....	-	72	54	34	13
1996-2000.....	-	78	58	34	17
1996-2002.....	-	157	117	75	32
1996-2005.....	-	342	256	164	67
C. Trust Fund Ratio (assets at beginning of year as percentage of annual expenditures)					
1996.....	109%	112%	110%	109%	108%
1997.....	100%	107%	104%	101%	98%
1998.....	88%	104%	98%	92%	87%
1999.....	74%	101%	91%	82%	74%
2000.....	58%	98%	84%	71%	58%
2001.....	39%	96%	76%	58%	41%
2002.....	19%	95%	69%	45%	23%
2003.....	(*)	95%	61%	31%	4%
2004.....	(*)	96%	54%	16%	(*)
2005.....	(*)	98%	46%	(*)	(*)
2010.....	(*)	125%	11%	(*)	(*)
2015.....	(*)	165%	(*)	(*)	(*)
2020.....	(*)	204%	(*)	(*)	(*)
2025.....	(*)	229%	(*)	(*)	(*)
2030.....	(*)	257%	(*)	(*)	(*)
2035.....	(*)	323%	(*)	(*)	(*)
2040.....	(*)	455%	(*)	(*)	(*)
2045.....	(*)	679%	(*)	(*)	(*)
2050.....	(*)	992%	(*)	(*)	(*)
2055.....	(*)	1402%	(*)	(*)	(*)
2060.....	(*)	1911%	(*)	(*)	(*)
2065.....	(*)	2573%	(*)	(*)	(*)
2069.....	(*)	3242%	(*)	(*)	(*)
D. Year of trust fund depletion.....					
	2002	Never	2011	2005	2003

* Fund is depleted.

Note: The above estimates are based on the intermediate set of assumptions from the 1995 Trustees Report.

Office of the Actuary
Health Care Financing Administration
May 5, 1995

CHAPTER FOUR

ENTITLEMENTS AND OTHER MANDATORY SPENDING 269

ENT-30 REDUCE MATCHING RATES FOR ADMINISTRATIVE COSTS IN THE
MEDICAID, FOSTER CARE, AND ADOPTION ASSISTANCE PROGRAMS

Savings from Current- Law Spending	Annual Savings (Millions of dollars)					Cumulative Five-Year Savings
	1996	1997	1998	1999	2000	
Reduce Matching Rates to 50 Percent						
Budget Authority	605	685	760	835	920	3,805
Outlays	605	685	760	835	920	3,805
Reduce Matching Rates to 45 Percent						
Budget Authority	1,180	1,340	1,470	1,620	1,770	7,380
Outlays	1,180	1,340	1,470	1,620	1,770	7,380

The Medicaid program provides medical assistance to low-income people who are recipients of Supplemental Security Income and to current or recent recipients of Aid to Families with Dependent Children, as well as certain other low-income individuals. The Foster Care and Adoption Assistance programs provide benefits and services to children in need.

In all of these programs, the federal government pays half of most administrative costs; state and local governments pay the remaining share. Higher matching rates have been set for some types of expenses as an inducement for local administrators to undertake more of a particular administrative activity than they would if such expenses were matched at 50 percent. For example, in Medicaid, enhanced matching rates are applied to the costs of automating claims processing, reviewing medical and health care use, and establishing and operating fraud control units. In Foster Care and Adoption Assistance, training costs are matched at 75 percent.

Reducing the higher matching rates to 50 percent would decrease federal outlays by \$0.6 billion in 1996 and by \$3.8 billion over the 1996-2000 period. Medicaid would account for virtually all of the reduction; outlays would decline by only \$0.4 billion over the period for Foster Care and Adoption Assistance. Considerably greater savings would be gener-

ated if all the matching rates for administrative costs were reduced to 45 percent, because an additional 5 percent of the total administrative expenses would be shifted to the states. Federal outlays would fall by \$1.2 billion in 1996 and by \$7.4 billion over the 1996-2000 period. Medicaid would account for \$6 billion of the total over the five years.

Reducing the higher matching rates to 50 percent would be appropriate if the need to provide special incentives for these activities no longer exists. For example, all state Medicaid programs have already established computer systems and are currently operating units to control fraud and abuse. Reducing all matching rates to 45 percent would provide states with stronger incentives to reduce administrative inefficiencies, because the states would be liable for a greater share of the cost of such inefficiencies.

States might respond to either option by reducing their administrative efforts, however, and might thereby raise program costs and offset some of the federal savings. Specifically, states might make less effort to eliminate waste and abuse in payments to providers. In addition, this proposal might harm recipients by encouraging states to lower benefits or to limit services provided under these programs in order to constrain total costs.

Medicare Part B

By fiscal year, in billions of dollars.

Under Illustrative Growth Rates	1995	1990	1997	1998	1999	2000	2001	2002	2003	2004	2005	7 Year 2002/1998	10 Year 2005/1998
Benefit Outlays	65.9	74.9	83.9	83.5	104.6	117.1	131.3	147.9	166.8	188.4	212.9	12.0%	12.3%
		13.9%	11.9%	11.5%	11.9%	12.0%	12.2%	12.6%	12.8%	12.9%	13.0%		
Premium Receipts	-20.1	-20.3	-21.9	-24.4	-26.0	-27.2	-28.0	-30.0	-31.5	-33.1	-34.3	6.8%	6.0%
		0.8%	0.0%	11.6%	6.4%	4.9%	4.9%	4.9%	5.0%	5.0%	3.8%		
Net Benefit Outlays	45.7	54.7	62.0	69.1	78.6	89.0	102.8	117.9	135.3	155.3	178.5	13.7%	14.1%
		19.7%	13.4%	11.4%	13.8%	14.3%	14.4%	14.7%	14.8%	14.7%	15.0%		
Limit Part B Growth Rate to Half of Baseline Average												7 Yr	10 Yr
Seven Year Average													
Outlays		69.7	73.9	78.3	83.0	88.0	93.3	98.9	104.8	111.1	117.6	-168.0	-402.4
Savings		-5.2	-10.0	-15.2	-21.6	-28.1	-34.1	-40.0	-46.0	-52.0	-58.1		
Growth Rate		6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%		
Ten Year Average													
Outlays		69.8	74.1	78.7	83.5	88.6	94.1	99.9	106.0	112.5	119.5	-164.5	-384.5
Savings		-5.1	-9.0	-14.8	-21.1	-28.5	-37.3	-46.0	-54.8	-63.8	-73.4		
Growth Rate		0.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%		
Limit Part B Growth Rate to Two-Thirds of Baseline Average													
Seven Year Average													
Outlays		71.0	78.7	82.8	88.5	96.0	104.4	112.7	121.7	131.4	142.0	-119.4	-292.4
Savings		-3.9	-7.2	-10.6	-15.1	-20.5	-27.0	-35.2	-45.1	-56.9	-70.9		
Growth Rate		8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%		
Ten Year Average													
Outlays		71.2	77.0	83.3	90.1	97.5	105.5	114.2	123.8	133.7	144.0	-114.3	-280.5
Savings		-3.8	-6.9	-10.2	-14.4	-19.6	-25.8	-33.7	-43.3	-54.7	-68.2		
Growth Rate		8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%		
Limit Part B Growth Rate to Three-Fourths of Baseline Average													
Seven Year Average													
Outlays		71.7	78.1	85.2	92.8	101.2	110.3	120.2	131.0	142.8	155.7	-93.7	-232.2
Savings		-3.2	-5.7	-8.3	-11.8	-15.9	-21.1	-27.7	-35.8	-45.6	-57.2		
Growth Rate		9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%		
Ten Year Average													
Outlays		71.8	76.5	85.7	93.6	102.2	111.7	122.0	133.2	145.5	158.9	-87.7	-219.0
Savings		-3.1	-5.4	-7.8	-11.0	-14.8	-19.7	-25.9	-33.8	-42.8	-53.9		
Growth Rate		9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%	9.2%		

To	Sue Nelson	From	Lori Housman
CA	SBC	CA	CBO
Dept		From	
Part	33848	Part	

DRAFT

cal year, in billions of dollars)

	1988	1987	1986	1985	1980	2001	2002	2003	2004	2005
CBO HI March Baseline										
Part A Outlay Growth	10.4%	9.2%	8.4%	8.1%	7.7%	7.5%	7.3%	7.4%	7.5%	7.8%
End of Year Balance	128.3	119.9	104.7	82.5	53.2	16.1	-28.7	-85.3	-152.4	-232.8
Surplus (Income-outlays)	-2.4	-9.4	-15.3	-22.2	-29.3	-37.1	-45.8	-55.8	-67.1	-80.4
Trust Fund Ratio	1.051	0.846	0.809	0.653	0.478	0.287	0.081	-0.139	-0.371	-0.818

The average annual rate of growth must be reduced by over 3 percentage points to 4.9 % in order to achieve a ratio of at least 100% throughout the period. This represents almost \$340 billion in outlay reductions over the 10 year period, and \$165 billion over the period 1986-2002.

	1988	1987	1986	1985	2000	2001	2002	2003	2004	2005
Part A Outlay Growth	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
End of Year Balance	135.9	139.4	143.7	148.4	153.7	160.1	167.4	176.0	185.0	197.4
Surplus (Income-outlays)	4.1	3.8	4.2	4.7	5.4	6.4	7.3	8.5	9.9	11.5
Trust Fund Ratio	1.107	1.089	1.067	1.049	1.034	1.022	1.015	1.013	1.016	1.024
Outlay reductions	-8,342	-12,111	-17,578	-23,253	-28,938	-35,024	-41,399	-48,536	-56,740	-65,918
5 yr	-88,221									
7 yr	-164,643									
10 yr	-335,838									

→ Even at this massive cut
 all while the LTC solving
 → Cut more the necessary?
 → AKA

05/04/95 18:21 09 202 6220073 TREAS EXEC SEC 002

Medicare Part B Under Illustrative Growth Rates	By fiscal year, in billions of dollars.										7 Year	10 Year	
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2002/1998	2005/1998
Benefit Outlays	65.8	74.9	83.9	93.5	104.6	117.1	131.3	147.9	166.8	188.4	212.9		
		13.9%	11.9%	11.5%	11.9%	12.0%	12.2%	12.6%	12.8%	12.9%	13.0%	12.0%	12.3%
Premium Receipts	-20.1	-20.3	-21.0	-24.4	-26.0	-27.2	-29.0	-30.0	-31.5	-33.1	-34.3		
		0.8%	0.0%	11.6%	6.4%	4.9%	4.9%	4.9%	5.0%	5.0%	3.8%	6.8%	6.0%
Net Benefit Outlays	45.7	54.7	62.9	69.1	78.6	89.9	102.8	117.9	135.3	155.3	178.5		
		19.7%	13.4%	11.4%	13.8%	14.3%	14.4%	14.7%	14.8%	14.7%	15.0%	13.7%	14.1%
Limit Part B Growth Rate to Half of Baseline Average												7 Yr	10 Yr
<u>Seven Year Average</u>													
Outlays		69.7	73.9	78.3	83.0	88.0	93.3	98.9	104.8	111.1	117.6		
Savings		-5.2	-10.0	-15.2	-21.6	-29.1	-38.1	-49.0	-62.0	-77.0	-95.1	-168.0	-402.4
Growth Rate		6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%		
<u>Ten Year Average</u>													
Outlays		69.8	74.1	78.7	83.5	88.6	94.1	99.9	106.0	112.5	118.5		
Savings		-5.1	-9.8	-14.8	-21.1	-28.5	-37.3	-48.0	-60.8	-75.8	-93.4	-164.5	-384.5
Growth Rate		0.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%		
Limit Part B Growth Rate to Two-Thirds of Baseline Average													
<u>Seven Year Average</u>													
Outlays		71.0	76.7	82.8	89.5	96.6	104.4	112.7	121.7	131.4	142.0		
Savings		-3.9	-7.2	-10.6	-15.1	-20.5	-27.0	-35.2	-45.1	-56.9	-70.9	-119.4	-292.4
Growth Rate		8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%		
<u>Ten Year Average</u>													
Outlays		71.2	77.0	83.3	90.1	97.5	105.5	114.2	123.8	133.7	144.0		
Savings		-3.6	-6.9	-10.2	-14.4	-19.6	-25.8	-33.7	-43.3	-54.7	-68.2	-114.3	-280.5
Growth Rate		8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%		
Limit Part B Growth Rate to Three-Fourths of Baseline Average													
<u>Seven Year Average</u>													
Outlays		71.7	76.1	81.2	87.8	95.2	103.3	112.2	121.9	132.8	145.7		
Savings		-3.2	-5.7	-8.3	-11.8	-15.9	-21.1	-27.7	-35.8	-45.6	-57.2	-93.7	-232.2
Growth Rate		8.0%	8.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%		
<u>Ten Year Average</u>													
Outlays		71.8	76.5	81.7	88.6	96.2	104.5	113.6	123.4	134.5	147.9		
Savings		-3.1	-5.4	-7.8	-11.0	-14.8	-19.7	-25.9	-33.8	-42.8	-53.9	-87.7	-218.0
Growth Rate		8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%	8.2%		

To: Sue Nelson
 From: Lori Housman
 CC: SBC
 Dept: CBP
 Fax # 33898
 Fax #

DRAFT

MAY-04-95 12:58 PM FROM: ...

cal year, in billions of dollars)

	1988	1987	1986	1985	2000	2001	2002	2003	2004	2005
CBO HI March Baseline										
Part A Outlay Growth	10.4%	9.2%	8.4%	8.1%	7.7%	7.5%	7.3%	7.4%	7.5%	7.6%
End of Year Balance	120.3	110.0	104.7	82.5	53.2	16.1	-20.7	-85.3	-152.4	-232.0
Surplus (Income-outlays)	-2.4	-0.4	-15.3	-22.2	-29.3	-37.1	-45.8	-55.0	-67.1	-80.4
Trust Fund Ratio	1.051	0.846	0.809	0.653	0.470	0.267	0.081	-0.130	-0.371	-0.810

The average annual rate of growth must be reduced by over 3 percentage points to 4.8 % in order to achieve a ratio of at least 100% throughout the period. This represents almost \$340 billion in outlay reductions over the 10 year period, and \$165 billion over the period 1988-2002.

	1988	1987	1986	1985	2000	2001	2002	2003	2004	2005
Part A Outlay Growth	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
End of Year Balance	135.0	139.4	143.7	148.4	153.7	160.1	167.4	176.0	185.0	197.4
Surplus (Income-outlays)	4.1	3.8	4.2	4.7	5.4	6.4	7.3	8.5	9.9	11.5
Trust Fund Ratio	1.107	1.080	1.067	1.049	1.034	1.022	1.015	1.013	1.016	1.024
Outlay reductions	-0,342	-12,111	-17,570	-23,253	-28,938	-35,024	-41,300	-48,536	-56,740	-65,918
5 yr	-88,221									
7 yr	-164,843									
10 yr	-335,838									

→ But at this massive cut L
 → what the LTT solution
 → cut more than necessary?
 → AHA

RESTRUCTURING MEDICARE AS A VOUCHER PROGRAM: ISSUES

Background

A number of organizations and individuals have proposed restructuring the Medicare program in a manner commonly described as a "voucher" program. While the specifics may vary, voucher programs have the following general components:

- o Medicare beneficiaries would choose among alternative private plans (presumably primarily or exclusively managed care plans such as HMOs and PPOs) from which they would obtain their Medicare benefits. Some proposals also retain traditional (fee-for-service) Medicare; others would allow private plans to offer a fee-for-service option but would not retain Medicare in its current form.
- o Medicare would make a "federal contribution" (the voucher amount, also referred to as a "defined contribution") toward the premium of a beneficiary's health plan. In many voucher proposals, this federal contribution would be derived from the competitive bids the plans would submit for their Medicare premiums. There may also be a "bid" for traditional Medicare, most likely derived from the method now used to set Medicare's HMO payment rates. Some proposals using this method set the federal contribution at the lowest bid; some use the weighted average of all plan bids. The federal contribution for all plans could also be set using other methods, for example, a method based on Medicare's current HMO payment rates.
- o If a plan's premium exceeded the federal contribution, the beneficiary would pay the difference between the federal contribution and the premium of the plan they selected. If a plan's premium was less than the federal contribution, the difference would be rebated to the beneficiary. As far as beneficiary payments or rebates, traditional Medicare would be treated like any other plan: beneficiaries would either pay the difference between the Medicare "bid" and the federal contribution or receive a rebate of the difference.

Issues

Restructuring Medicare as a voucher program represents a radical departure from the current program. Such a change raises a number of issues, some of them articulated by proponents of a voucher program.

1. Lack of risk adjusters that project medical costs at the individual level. Individual medical costs vary widely: the healthiest 50% of Medicare beneficiaries account for only 4% of Medicare spending, but the sickest 2% account for

nearly 30% of Medicare spending. Also, when individuals choose among alternative plans, persons with different medical needs typically prefer some plans over others, perhaps because of the physicians in the plan's network or the benefit package. Because some plans may enroll a higher proportion of sicker beneficiaries, it is important to adjust voucher amounts for individual enrollees based on their relative risk of needing medical services. However, development of reliable risk adjustment methods is in its early stages.

2. Possibility of a two-tiered system. Some plans may focus only on enrolling low-income beneficiaries while others may target those with higher incomes. In 1992 about 83% of Medicare spending was for beneficiaries with incomes below \$25,000, and over 60% was for beneficiaries with incomes below \$15,000. It is reasonable to assume that in a voucher program, the lower income elderly and disabled would enroll disproportionately in plans that charged premiums at or below the federal contribution rate. Middle and upper class beneficiaries who could afford to supplement the federal contribution may be more inclined to choose a more expensive plan with more amenities. On average, individuals with lower incomes have lower health status and, therefore, higher medical costs than individuals with higher incomes. However, in the absence of a reliable risk adjustment method, plans enrolling lower income beneficiaries may not be adequately compensated and, hence, may not be able to cope with the greater health care needs of lower income enrollees.
3. Some Medicare beneficiaries are not able to make informed choices. About 5% of the elderly, or about 1.7 million beneficiaries, live in nursing homes; an estimated one million beneficiaries are disabled on the basis of mental impairments and have no representative payee; and the Alzheimer's Association estimates that 10% of the elderly, or about 3.4 million beneficiaries, suffer from Alzheimer's. Many of these beneficiaries, as well as other frail beneficiaries, would not be able to make informed choices among alternative plans that are offered. In addition, some of the roughly 30 million beneficiaries who live in the community may be vulnerable to aggressive sales techniques, unless marketing were carefully regulated.
4. Geographic variation in voucher amounts. Currently, per person Medicare expenditures vary a great deal between regions because costs, practice patterns, and the availability of providers varies tremendously. The Medicare statute requires Medicare payments to HMOs to be based on Medicare's local (county) fee-for-service costs and, therefore, HMO payment rates reflect these wide geographic variations. Currently, these differences are spelled out in the Medicare HMO ratebook, but they are not visible to

DRAFT

beneficiaries. However, if voucher amounts were based on Medicare's current spending in local geographic areas, these differences would become starkly apparent.

If voucher amounts were based on Medicare's current spending in local geographic areas, beneficiaries in Minneapolis, Portland (OR), or Rochester might question why, when they paid the same HI tax during their working years, their federal contribution is in the range of about \$350-400 per month while beneficiaries in Miami, New York City, and Philadelphia have a federal contribution of over \$600. However, basing payment on another method that results in lower payments to some local areas would also result in dislocations for both beneficiaries and providers in those areas.

5. There may not be enough private plan participation. For a voucher system to work properly, there should be a wide range of plans available to Medicare beneficiaries, and beneficiaries should not be subject to health screening or pre-existing condition requirements. However, Medicare's experience to date raises questions about whether large numbers of private plans would participate in this type of program. Outside of the one-time 6-month open enrollment period, insurers offering Medigap coverage may refuse to offer a policy to people with certain medical histories, i.e., they can health screen and impose pre-existing condition requirements. For example, in one state, only 9 out of 66 plans are "guaranteed issue", i.e., issuance of a policy is not contingent on health status. Of these 9 policies, 7 impose pre-existing condition limitations for up to 6 months. (Limitations in excess of 6 months are prohibited under Federal statute.) In another state, only 2 out of 33 Medigap insurers offer guaranteed issue policies. Beneficiaries seeking coverage from the other 31 insurers face questions about their health status and may be required to have a medical exam to qualify for coverage. Furthermore, it can be very difficult for Medicare beneficiaries to purchase Medigap policies that include drug coverage because insurers do not offer policies with drug coverage on a guaranteed issue basis.

Medicare's experience with managed care entities to date indicates that, because the Medicare population has more chronic conditions, and is considered a high-risk population, plans must make an institutional commitment to caring for an enrolled group with different health care needs than younger enrollees. Indeed, in the early years of the Medicare HMO program, some plans dropped out or decided not to contract with Medicare because of the different requirements of caring for Medicare beneficiaries. In addition, HMOs have only exhibited interest in payment alternatives that pay more than Medicare's current payment rates. Currently only about 30% of HMOs have chosen to

DRAFT

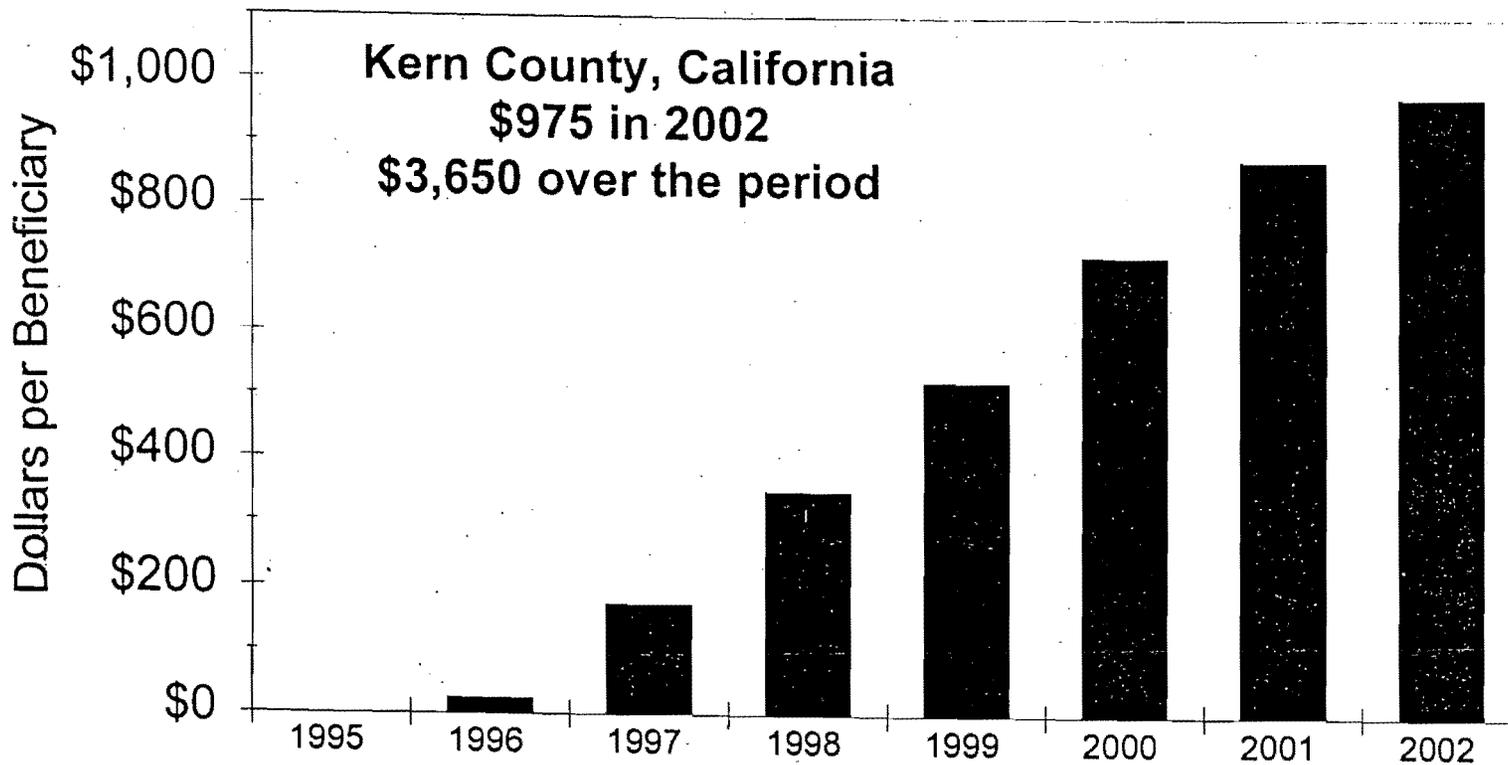
contract with Medicare on a risk payment basis; an additional 12% contract on a cost reimbursement basis. It is not clear that a voucher program would provide a payment that would encourage more plan participation. (The Medicare statute does not allow most managed care plans to health screen; none can impose pre-existing condition requirements.)

While these are rational economic behaviors for Medigap insurers and managed care plans, they raise questions about a robust managed care market competing for Medicare enrollees.

A related question is that of the enrollment capacity of participating plans, i.e., how would a situation where a plan has the capacity to enroll 5,000 enrollees, but 15,000 beneficiaries want to enroll be addressed?

6. Quality measurement is still in its early stages. In order for beneficiaries to compare competing alternative plans, they will need comparative information on price, quality, network composition, benefits, cost-sharing, and other factors. While comparative information on most of these elements can be obtained, the quality of care provided by competing plans is difficult to measure--but of vital importance to potential enrollees, particularly if they can only change plans on a yearly basis (as proposed in many voucher proposals). The need for reliable quality of care assessment is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages.

Growing Cost of Retaining Your Medicare Coverage under Republican Voucher Proposal



The 1995 AAPCC was multiplied by the private sector growth rate per person (CBO) and the Republican Conference Agreement's per beneficiary spending to get the difference. This amount was reduced by a premium offset due to the slower Part B growth. Numbers rounded to the nearest \$25.

**Cost of Retaining Your Medicare Coverage Under
Republican Voucher Proposal**

Member	County	State	Cost of Remaining in Current Medicare	
			2002	1996-2002
US			\$800	\$2,975
Thomas	Kern	CA	\$975	\$3,650
Johnson N	Fairfield	CT	\$925	\$3,450
McCrery	Bossier	LA	\$750	\$2,850
Ensign	Clark	NV	\$1,025	\$3,850
Christensen	Douglas	NE	\$800	\$3,025
Crane	Cook	IL	\$1,075	\$4,050
Houghton	Cayuga	NY	\$750	\$2,850
Johnson S	Dallas	TX	\$950	\$3,550
Stark	Santa Clara	CA	\$900	\$3,375
Cardin	Howard	MD	\$1,125	\$4,225
McDermott	King	WA	\$800	\$3,000
Kleczka	Milwaukee	WI	\$850	\$3,225
Lewis	Clayton	GA	\$1,100	\$4,175
Archer	Washington	TX	\$500	\$1,825
Gibbons	Hillsborough	FL	\$900	\$3,375

These estimates represent the difference between the AAPCC for these counties in 1995, projected to 2002 using CBO data on current private spending per person, minus the same AAPCC in 1995 multiplied by the Republican Conference Agreement spending per beneficiary growth rate. These numbers are net of a premium offset resulting from the slower Part B growth under the Republican proposal. Numbers are rounded to the nearest \$25.

DATE OF TRUST FUND INSOLVENCY UNDER
VARIOUS LEGISLATIVE PROPOSALS

Question:

If the President's program were implemented, what affect would this have on the expected date of insolvency for the Medicare Hospital Insurance Trust Fund? How does this compare to the House/Senate/Conference Budget Resolution?

Answer:

- o It is difficult to pin down exhaustion dates for the dates for the different plans because they are based on different baselines. Our Office of the Actuary is currently working on revising the baselines so that we can have standardize the measure of trust fund solvency.
- o However, our best estimates show that the life of the trust fund will be extended to at least FY 2005 under the President's plan and at least FY 2010 under the Conference Budget Resolution.

Prepared by OLIGA, 7/19/95.

**SAVINGS NEEDED TO MEET SHORT TERM
INSOLVENCY**

Question:

How much Part A savings are needed to meet the Trustees Test of short-term solvency for the HI Trust Fund?

Answer:

- o First, let me define the Trustee's Test of short-term solvency. Short-term solvency means that the HI Trust Fund would have at least one year of reserves for at least 10 consecutive years.
- o In order for the trust fund to have at least one year of reserves for the next 10 years, Medicare Part A spending would need to be reduced by \$302 billion cumulatively from FY96 through FY2005. However, the savings would have to be distributed in a particular way over the next 10 years in order to meet the test.
- o The only information we have thus far is that the Republican proposal will cut \$270 billion from Medicare over 7 years. We have no confirmed information on how much of this savings will go into the HI trust fund, nor how the savings will be distributed over time. Consequently, we cannot say whether the Republican plan will meet the test of short-term solvency.

Prepared by OLIGA, 7/19/95.

CAUSES OF LONG RANGE FINANCING PROBLEMS

Q: What are the primary causes of the long-range financing imbalance for the HI program? Is it due to demographic factors, price increases, expected growth in utilization of services, or other factors.

A:

- In the long run, the major factor is the ratio of tax-paying workers to Medicare beneficiaries
 - When the baby boomers reach retirement age in about 2010, the growth in the number of tax paying workers will decrease while the number of Medicare beneficiaries will begin to increase. Right now, about four workers support every Medicare beneficiary. By the middle of the next century, this ratio will drop to about two workers for each beneficiary.
 - It is anticipated that the increase in beneficiaries will be accompanied by increases in hospital admissions and in the complexity of services provided.
- Other factors dominate in the short run.

Notwithstanding these long range financing issues, the Trust Fund is projected by the Trustees to become exhausted even before this major demographic shift begins to occur. This is result of increasing utilization due to many factors including -

- Technological advances;
- Increasing age of the beneficiary population;
- Expanded supply of services;
- Increase in the number of alternative services.

WHEN TRUST FUND RUNS OUT

Q: Could you explain what actually happens when the Trust Fund runs out of money? Can the trustees borrow? What happens to beneficiaries?

A:

- ▶ We all agree that permitting the Trust Fund to run out of money would be a disaster that we must prevent.
 - Beneficiaries likely will suffer if hospitals respond by refusing to accept Medicare patients.
 - The confidence of all Americans in the promises of the Federal government would certainly be shaken.
- ▶ The Trustees cannot borrow from other Trust Funds or from the General Fund. There is no other source, in current law, for payment of Part A benefits.
- ▶ Thus, if the Fund runs out of money, it would appear necessary to delay payment of claims until new income flows into the Trust Fund or Congress appropriates additional funds.
 - If we hold claims more than 30 days, they will incur interest charges, an additional cost to the government.

REPEALING TAX ON SOCIAL SECURITY BENEFITS

Q: Could you give estimates of the effects on the Trust Fund of repealing the OBRA-93 provision relating to taxation of Social Security benefits?

A:

- o We estimate that if the proposal became effective January 1996, the Trust Fund would lose \$31.2 billion over the next seven calendar years, and it would be depleted about eight months sooner.

BACKGROUND:

- o This proposal, a component of the Republican Contract with America, would lower the maximum proportion of OASDI benefits subject to Federal income taxes to 50 percent. OBRA 93 increased the percentage from 50 to 85 percent and dedicated the revenue to the HI Trust Fund.

Q: Since this tax increase fell exclusively on the elderly, isn't that unfair? Why should we not repeal it?

A:

- o While this tax increase was on a specific group, we think it is important to see it in context.
 - The increase did not fall on all of the elderly, but only on the 13 percent with the highest incomes.
 - The amount of the increase was modest, particularly considering the return that current beneficiaries have received in both Social Security and Medicare for their contributions and premiums.
- o Since these revenues from higher income beneficiaries are deposited directly into the HI Trust Fund, repeal would further undermine the Trust Fund.
 - To repeal this tax and in the same year increase premiums on high income beneficiaries, as some in Congress have suggested, would not appear to be much of an advance.

IMPACT OF OBRA 93 ON TRUST FUND

Q: OBRA-93 included about \$50 billion in Medicare savings -- more than Congress had ever done before. How much did OBRA-93 help the Trust Funds?

A:

- o OBRA-93 postponed the date when the Trust Fund would be exhausted by about three years.

BACKGROUND:

OBRA-93 Medicare provisions included:

- Depositing tax revenues from the increased income taxation of Social Security benefits into the Medicare HI Trust Fund.
- Repealing the wage cap for Medicare HI payroll tax.
- Imposing constraints on the growth of Medicare payments to providers.

PART B PREMIUM

Q: Why shouldn't beneficiaries be asked to bear some of the problem? Should we raise the premiums and deductibles? After all, because of a quirk in the law, the Part B premium will actually drop in 1996. Why not keep it the same as in 1995?

A:

- o In 1995, beneficiaries pay a premium equal to 31.5 percent of program costs.
- o Since the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress has intended the premium be set at 25 percent of the program costs of aged beneficiaries.
- o The fact that the percentage is now above 25 percent is not the result of an explicit policy decision. It is partly a result of forecast error and partly stems from interaction effects produced by subsequent legislation.
- o We believe that is reasonable and appropriate for beneficiaries to continue to pay a Part B premium that covers at least 25 percent of program costs.
 - Congress reaffirmed the 25 percent figure in OBRA-93.
 - The Administration has proposed, and the House has passed, a proposal to permanently extend the SMI premium at 25 percent of the program costs.

BACKGROUND:

TEFRA and subsequent legislation mandated the premium be set at 25 percent for 1984-90. In OBRA-90, Congress wrote the dollar values of the premiums for 1991-95 in statute, using figures that were then estimated to yield 25 percent. Program growth has been slower than expected, partly as a result of changes in OBRA-93, so the actual percentage rose above 25 percent.

For 1996-98, Congress specified that the premium should be 25 percent of program costs as determined each year by the Actuary. After 1998, current law would generally cause the premium to grow at the rate of the Social Security cost-of-living adjustment, regardless of relation to Part B program costs.

Low-income beneficiaries are protected from higher premiums by several provisions: (a) a hold-harmless provision prevents Social Security checks from falling even when an increase in the Part B premium would otherwise lead to that result and (b) the Qualified Medicare Beneficiary (QMB) provision requires Medicaid programs to pay Part B premiums for low-income Medicare beneficiaries.

Classified by OMB 7/14/95
(Chart 7)

Explanation of "Estimated Present Values of Medicare Part A (HI) Benefits and Contributions on July 1, 1995 for Retirement on That Date at Age 65

The three tables present the estimated present value of Medicare contributions and benefits for three different cohorts of individuals working during three time periods (currently 65 years old, attaining 65 in 2015, and attaining 65 in 2035).

The first column indicates the earnings level at which taxes were paid- low, average, and high. The second column indicates the present value of accumulated contributions with interest. The third column indicates the present value of expected benefits. Note that benefits are different for males, females, and couples. The last column provides the ratio of expected benefits to contributions.

The tables were prepared by the Office of the Actuary, HCFA, and are based on the 1995 Trustees Report. The assumptions underlying the tables are included on each table.

The ratio of expected benefits to contributions varies depending on the wage history of the individual. For Part A, a beneficiary with an average wage history turning 65 today will receive benefits worth about 2-1/2 times the accumulated value (with interest) of the HI taxes they and their employer contributed. A low-wage earner will receive benefits almost 6 times as great as contributions. On the other hand, individuals who have always earned at the social security maximum will receive benefits roughly equal to contributions.¹

OBRA 93 eliminated the cap on wages subject to HI taxes. Thus, by 2035, for persons with very high wages, the ratio of expected benefits to contributions for future beneficiaries will be less than 1.

Although not true for all cells of the tables, it is clear that female beneficiaries have a higher ratio of benefits to contributions because of their lower working wage levels and couples are similarly affected.

These findings are not unexpected given the design of the Medicare program. Beneficiaries who paid taxes adequate for a 1970s program are receiving the benefits of a 1995 program. Because medical cost inflation has been substantially higher than the increase in wages, the value of the benefits received by 1995 retirees are greater than the tax contributions paid throughout a beneficiary's working career.

¹While the text discusses the ratio of expected benefits to contributions based on the entire HI contribution (i.e., the employee, employer and self-employed shares) for an individual, the accompanying tables show the ratio of expected benefits to the employee's HI contributions only.

Lower ratios for future retirees are due, in part, to the age of the Medicare program. If one assumes that the average person works for 45 years, than current beneficiaries have not paid into the program as long as future beneficiaries will.

The tables are for hypothetical retirees with steady career earnings who survive to age 65 and have average life expectancy thereafter. In practice, Medicare is social insurance that provides medical services to those who need them. Some participants will die before becoming eligible for benefits, thus receiving a zero return on their HI taxes. Others may have more severe medical problems, or live longer, and receive care worth far more than the value of their taxes.

Estimated Present Values of Medicare Part A (HI) Benefits and Contributions on July 1, 1995,
for Retirement on that Date at Age 65 1/

Earnings on Which HI Taxes Were Paid 2/	Present Value of Accumulated HI Contributions with Interest, 1966-1995 3/ 4/	Present Value of Expected HI Benefits to be Paid for Person Attaining Age 65 in 1995 5/			Ratio of Present Value of Expected HI Benefits to Present Value of Accumulated HI Taxes 6/		
		Male	Female	Couple	Male	Female	Couple 7/
Low	5,770	50,070	55,780	105,850	9:1	10:1	18:1
Average	12,520	50,070	55,780	105,850	4:1	4:1	8:1
High (SS)	25,790	50,070	55,780	105,850	2:1	2:1	4:1
High (HI)	33,030	50,070	55,780	105,850	2:1	2:1	3:1

1/ For hypothetical retirees, due to the caveats described in 2/, 5/, and 6/, below.
As calculated based on the 1995 Trustees Report intermediate assumptions.

2/ "Low" indicates 43% of average earnings; "High (SS)" indicates earnings each year at the OASDI maximum taxable amount; and "High (HI)" indicates earnings at the HI maximum taxable amount each year through 1993, at \$200,000 for 1994, and at an amount indexed from the 1994 amount (based on the increase in average earnings) for 1995. (The HI and OASDI maximum taxable amounts are the same through 1990; for 1991-1993, the HI amount is larger than that for OASDI; and there is no HI maximum taxable amount for 1994 and later.)

3/ For those not self-employed, and including employee contributions only; if contributions made by the employer on behalf of the employee were included, contributions would be twice that shown here.

4/ June interest rates for the HI trust fund were used for each year, to accumulate the contributions to July 1, 1995. (The interest rate used for 1995 is as specified in the 1995 Trustees Report intermediate assumptions.)

5/ Present value at July 1, 1995, of expected future benefits, discounted for both interest and mortality effects. Mortality is based on life tables for appropriate cohort group. June interest rates from the 1995 Trustees Report intermediate assumptions were used, including the assumed ultimate interest rate of 6.25%.

6/ As discussed in 2/, these ratios include the employee contribution only. These ratios also assume no HI contributions are made after age 65, from either employment or taxation of Social Security benefits.

7/ Assumes one spouse had no covered earnings at all. For couples where both spouses have covered earnings (assuming, as is assumed throughout, that at least one of them has earned enough quarters of coverage to entitle them to HI), the ratio would be somewhere between the single person ratio and the couple ratio for the spouse with higher covered earnings.

Health Care Financing Administration
Office of the Actuary
Office of Medicare & Medicaid Cost Estimates
Division of Hospital Insurance
May 16, 1995

**Estimated Present Values of Medicare Part A (HI) Benefits and Contributions on July 1, 2015,
for Retirement on that Date at Age 65 1/**

Earnings on Which HI Taxes Were Paid 2/	Present Value of Accumulated HI Contributions with Interest, 1970-2015 3/ 4/	Present Value of Expected HI Benefits to be Paid for Person Attaining Age 65 in 2015 5/			Ratio of Present Value of Expected HI Benefits to Present Value of Accumulated HI Taxes 6/		
		Male	Female	Couple	Male	Female	Couple 7/
Low	29,100	170,870	185,640	356,510	6:1	6:1	12:1
Average	64,670	170,870	185,640	356,510	3:1	4:1	6:1
High (\$\$)	142,590	170,870	185,640	356,510	1:1	1:1	3:1
High (HI)	285,900	170,870	185,640	356,510	1:1	1:1	1:1

1/ For hypothetical retirees, due to the events described in 2/, 3/, and 6/, below.
As calculated based on the 1995 Trustees Report intermediate assumptions.

2/ "Low" indicates 43% of average earnings; "High (\$\$)" indicates earnings each year at the OASDI maximum taxable amount; and "High (HI)" indicates earnings at the HI maximum taxable amount each year through 1993, at \$200,000 for 1994, and at amounts indexed from the 1994 amount (based on the increase in average earnings) for 1995 and later. (The HI and OASDI maximum taxable amounts are the same through 1990; for 1991-1993, the HI amount is larger than that for OASDI; and there is no HI maximum taxable amount for 1994 and later.)

3/ For those not self-employed, and including employee contributions only; if contributions made by the employer on behalf of the employee were included, contributions would be twice that shown here.

4/ June interest rates for the HI trust fund were used for each year, to accumulate the contributions to July 1, 2015. (The interest rates used for 1995 and later are as specified in the 1995 Trustees Report intermediate assumptions.)

5/ Present value at July 1, 2015, of expected future benefits, discounted for both interest and mortality effects. Mortality is based on life tables for appropriate cohort group. June interest rates from the 1995 Trustees Report intermediate assumptions were used, including the assumed ultimate interest rate of 6.25%.

6/ As discussed in 2/, these ratios include the employee contribution only. These ratios also assume no HI contributions are made after age 65, from either employment or taxation of Social Security benefits.

7/ Assumes one spouse had no covered earnings at all. For couples where both spouses have covered earnings (assuming, as is assumed throughout, that at least one of them has earned enough quarters of coverage to entitle them to HI), the ratio would be somewhere between the single person ratio and the couple ratio for the spouse with higher covered earnings.

Health Care Financing Administration
Office of the Actuary
Office of Medicare & Medicaid Cost Estimates
Division of Hospital Insurance
May 16, 1995

Private solutions eyed for Medicare

House GOP plans to avoid turf fights

By Major Garrett
THE WASHINGTON TIMES

House Republicans have agreed on the broad outlines of the Medicare-reform package, and key committee chairmen have agreed to produce identical legislation in a move designed to minimize intraparty turf battles.

Republicans have agreed to offer seniors more choices in the private health care market as an alternative to Medicare. They hope this approach, which is to be released publicly in September, will reduce Medicare costs without drastically limiting the quality or availability of health care.

According to senior House GOP sources, Speaker Newt Gingrich of Georgia, Ways and Means Committee Chairman Bill Archer of Texas and Commerce Committee Chairman Thomas J. Bliley Jr. of Virginia have agreed to draft virtually identical bills.

This strategy, GOP sources said, was devised after observing the turf battles that bedeviled the Democrats' health reform efforts last year.

"One of the problems with the previous Congress was that things broke down because of turf battles," said Ari Fleischer, spokesman for the Ways and Means Committee. "Republicans have seen the results of the failure to work together and do not intend to make those mistakes. We're a unified majority."

According to several senior Republican sources, the House Medicare-reform bill will include these provisions:

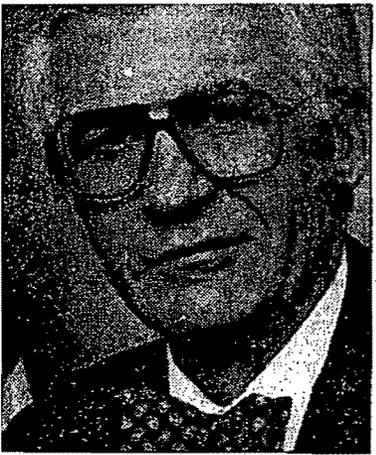
- Medicare recipients could choose to stay with the current program but would have to pay higher monthly premiums.

Recipients now pay \$46.10 per month for Medicare Part B, which provides physician, laboratory and outpatient services. These premiums are scheduled to rise to \$110 per month by 2004. Under the Republican plan, the premiums would rise even higher.

- Recipients would receive a yearly lump-sum payment of up to \$6,700 to purchase health insurance from health maintenance organizations (HMOs) or other group health organizations.

- Workers about to become eligible for Medicare could choose to receive a government payment of up to \$6,700 to enroll in the insurance system operated by their em-

PHOTOCOPY
PRESERVATION



**House Commerce
Committee Chairman
Thomas J. Bliley Jr.
has agreed to avoid
interpanel squabbles.**

employers or unions.

• Recipients also could choose to open medical savings accounts.

Under the GOP plan, recipients would receive \$2,000 to place in an interest-bearing account each year. The government would cover the first \$2,000 of medical care per year, and costs above that would be drawn out of the medical savings account. Recipients would still have to pay monthly Medicare premiums.

House Republican leaders last week emerged from extensive meetings with an agreement on the outlines of their program to reduce the growth of Medicare by \$270 billion through 2002.

Even with these savings, Medicare spending would rise 5.5 percent per year.

Hearings will begin after Congress returns from the Fourth of July recess.

Rep. Bill Thomas, California Republican and chairman of the Ways and Means subcommittee on health, and Rep. Michael Bilirakis, Florida Republican and chairman

The GOP effort is the largest ever to restrain Medicare's exploding costs and the first to introduce market-based solutions to entice seniors into other forms of health insurance.

Congress in the past has raised Medicare premiums or reduced reimbursement allotments for doctors and hospitals. The Republicans intend to increase premiums for wealthier seniors, but these changes are not expected to produce significant savings.

One of the problems for Republicans will be proving that their proposed changes will produce the necessary savings to meet the deficit-reduction targets in the budget-balancing plan.

Because many of the reforms are experimental, the Congressional Budget Office is unlikely to agree they will produce the targeted \$270 billion in savings.

Senior GOP sources said Mr. Thomas intends to create a "look-back" provision that would require Congress to raise premiums or reduce reimbursements if the

billion in 1997; \$27 billion in 1998 and \$38 billion in 1999. The lion's share of the savings, \$184 billion, would come in the final three years of the plan.

The GOP proposals largely have been endorsed by the American Medical Association, the nation's largest physicians lobby, and doctors generally support encouraging patients to participate in other health-insurance programs rather than seeing Medicare reimbursements reduced.

Hospitals, especially rural and urban ones, are fearful GOP reforms will reduce the number of patients in facilities that are operating well below capacity.

So far, the American Hospital Association and the Federation of American Hospital Systems have not opposed the Republican plan. Mr. Gingrich has met regularly with the groups in an attempt to keep them on board.

Republicans will devote the next few weeks leading up to the plan's release building the case to reform Medicare to keep it solvent.



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
OFFICE OF HEALTH LEGISLATION**

**HHH Bldg, Room 405H
200 Independence Avenue, SW
Washington, D.C. 20201**

PHONE: 690-7450

FAX: 690-8425

FROM: SEE BELOW

TO: SEE BELOW

HOLLY BODE

NAME: Chris Jennings

SHARON CLARKIN

OFFICE: _____

SEAN DONOHUE

ROOM #: _____

SUSAN EMMER

PHONE #: _____

NICKY LAWRENCE

FAX #: 456-7431

ANDREA LEVARIO

DATE: _____

JUDY LEWIS

PAGES: _____

(INCLUDING COVER)

ROGER MCCLUNG

DEBRA SPEIGHT

MARC SMOLONSKY

CARL TAYLOR

REMARKS: These are the Medicare examples

MEDICARE EXAMPLES

- An elderly woman in rural Kansas would face the prospect of entering an institution because she lacks the additional \$1,000 in the year 2002 that would be necessary to purchase home health services under Medicare. Today, this cost saving benefit helps keep her at home and in the community.
- Under the Republican voucher plan, an elderly, chronically ill man who has been seeing the same doctor for decades could be forced to join an HMO and find a new physician or, to stay with the doctor he trusts, he would have to pay higher out-of-pocket costs that could lead to impoverishment within a few short years.
- A younger, healthy beneficiary may enroll in a Medical Savings Account (MSA) or high deductible, catastrophic insurance plan as proposed by the Republicans. She would utilize her savings for her high deductible when her health care needs increase. However, as she ages, she would be locked into a system that could fast deplete the reserves she has accumulated. When those reserves are depleted, who will pay for her health care?
- An elderly widow, living on a meager income, who has a chronic health care condition could be turned away by a hospital or doctor because she can't pay the co-payments and deductible under the Republican plan. Her only choice is to wait until she is sick enough to get care in a hospital emergency room -- which means that the taxpayers or the privately insured would have to pay for her expensive treatment.
- A middle aged couple who is trying to juggle the expenses of putting their children through college and saving for their own retirement could be put at grave financial risk if their aging parents become sick and can no longer afford the care they need. For the elderly parents who have worked hard all of their lives, their pride and independence is diminished when they have to shift this burden to their children.
- The vast majority of beneficiaries would see their choices erode because the amount the Republicans would give them to pay for their health care needs would force them into a managed care plan. For the three-fourths of our elderly citizens, who have incomes below \$25,000, the Medicare fee-for-service option as they know it today may not be affordable.
- Republicans want to force all Medicare beneficiaries into managed care plans by changing the current system where they are guaranteed a package of benefits into a voucher program

where they are guaranteed nothing. There are many drawbacks to this proposal.

For instance, in Wyoming where managed care plans don't exist, older Americans would have no choice but to pay more than they do now under the current program for fee-for-service benefits.

- Even though senior citizens currently are paying more than 21 percent of their annual income for Medicare cost-sharing, the Republicans would require them to find an additional \$400 a year to cover an increase in their premiums. For many, this may mean a choice between adequate food and health care services.
- Under the Republican voucher plan, skilled nursing facility services may be out of reach for most elderly beneficiaries. This is because they would have to pay an additional \$1,000 more in out of pocket costs in 2002 than they do today. Because of the extra costs, they may forgo care and risk being returned to their homes prematurely leading to a re-hospitalization with serious complications.

Previous Republican Statements on Cutting Medicare

"The reimbursement levels of Medicare have reached potentially disastrous levels..."

From the "Minority Views" included with the Ways and Means Committee Report on the Health Security Act (H.R. 3600) signed by every Republican Member of the Committee, July 14, 1994:

"For more than a decade Congress has cut back on payments to doctors and hospitals until they no longer cover the cost of care for Medicare... patients -- and the additional massive cuts in reimbursement to providers proposed in this bill [H.R. 3600] will reduce the quality of care for the nation's elderly. There will be no place else to shift."

From the "Minority Views" included with the Ways and Means Committee Report on the Health Security Act (H.R. 3600) signed by every Republican Member of the Committee, July 14, 1994:

"Medicare Part A, I hope, will not be on the table [to fund tax cuts] because I would like to see that reserved for when we reform the health care later on next year."

Congressman Bill Archer, December 18, 1994, on "Meet the Press"

"We have here in this bill the seeds of the destruction of Medicare... let's not destroy a health care program in this country that we know works and that our seniors are depending on."

- Congressman Clay Shaw, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"Make no mistake about it for the elderly in this country, [these cuts are] going to devastate their program under Medicare."

- Congressman Bill Archer, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"The Medicare cuts proposed by the President would devastate the Medicare program... The committee must not approve these destructive Medicare cuts."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

"I just don't believe that quality of care and availability of care can survive these additional cuts. And that is the price that is going to have to be paid to pay for these cuts."

- Congressman Bill Archer, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"I would love to believe that we could achieve the level of cuts you have in this bill... But history tells us that this isn't possible. And I think we are just playing games here, we are just making the numbers match. That's all Democrats have done in your bill to make it revenue neutral. You have just estimated the number needed from Medicare to make the numbers match, and I think the public understands that."

- Congressman Jim McCrery, June 25, 1994, speaking against proposed Medicare expenditure reductions during Ways and Means Committee consideration of H.R. 3600

"The Republicans are attempting to secure the program which would be almost absolutely destroyed and trashed if the cuts that have been brought into the bill are established."

- Congressman Clay Shaw, June 25, 1994, speaking against proposed Medicare expenditure reductions during the Ways and Means Committee consideration of H.R. 3600

"Mr. Chairman, I recognize and agree with your call for bipartisan support on this issue, but there are some proposals that many of us in good conscience will never support because we know that they are bad for the American people."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

"I think those of us on this committee especially well remember the lessons of Medicare catastrophic coverage legislation, and recognize that making changes without broad public support is a potential disaster."

- Congressman Clay Shaw, May 18, 1994, press release referring to the health care reform proposal (H.R. 3600) presented by President Clinton.

NOTE: The 1994 Ways and Means Committee health reform bill would have achieved \$168 billion in Medicare savings over seven years, all of which would have been re-directed to expand health care coverage, as compared to 1995 Republican proposals to reduce Medicare spending by nearly \$300 billion over seven years.

"Forget the budget pressure, let's find out what number saves Medicare. We'll plug that into the budget. We're not going to find out what number the budget needs and try to reshape Medicare to that effect."

- Speaker Newt Gingrich, May 7, 1995, on "Meet the Press"

May 12, 1995

IS ARMEY ACCUSING FELLOW REPUBLICANS OF LYING?

Dear Colleague:

"In a blistering attack delivered to an American Enterprise Institute forum on the politics of Medicare," the *National Journal* reported this week, "[Majority Leader Dick] Armeley insisted 'anyone claiming we are cutting Medicare is simply lying,' since the program will continue to grow, only at a slower rate."

Is Mr. Armeley saying that Republicans on the Ways and Means Committee lied last year during consideration of health care reform? It seems a reasonable conclusion to reach.

After all, Republicans in 1994 called a proposed \$168 billion reduction in Medicare spending a "cut." Why less than a year later a \$283 billion "cut" in Medicare should not be considered one would be a mystery.

[See the reverse side for Republicans' 1994 portrayal of reductions in Medicare expenditures.]

Remember, the level of cuts (or reductions in growth, or whatever one prefers to call it) proposed last year is one half the level passed by Budget Committee Republicans this year.

You decide what's a cut.

If federal policy is changed so that services now fully covered by Medicare are only partially covered, and charges currently paid by Medicare are pushed on to beneficiaries, wouldn't you call this a cut? (See page 10 of the "House Republican Budget Committee Recommendations" for three such examples.)

And if the funds not spent on Medicare beneficiaries create room in the budget to cut taxes for wealthy Americans, isn't it accurate to describe the Medicare cuts as financing tax cuts for well-to-do Americans?

I've never had difficulty accepting that reductions in projected expenditures can be considered cuts. And *this year*, because of the drastic nature of the Republican Medicare proposals -- and the Republican desire to shove

Every Republican on the Ways and Means Committee last year, eleven of which are on the panel this year as well, were signatories to the following statement --

"...the additional massive CUTS in reimbursement to providers proposed in this bill will reduce the quality of care for the nation's elderly."

The current Ways and Means Chairman made the following charge last year --

"I just don't believe that quality of care and availability of care can survive these additional CUTS. And that is the price that is going to have to be paid to pay for these CUTS."

Current Subcommittee Chairman Clay made the following indictment --

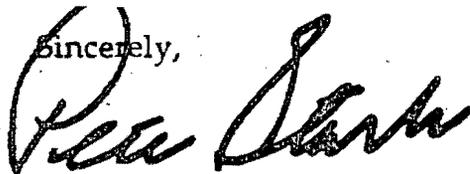
"The Medicare CUTS proposed by the President would devastate the Medicare program... The committee must not approve these destructive Medicare CUTS."

A Republican Member of the Health Subcommittee this year and last year commented --

"I would love to believe that we could achieve the level of CUTS you have in this bill... But history tells us that isn't possible."

NOTE: The 1994 Ways and Means Committee health reform bill would have achieved \$168 billion in Medicare savings over seven years, all of which would have been re-directed to expand health care coverage, as compared to 1995 Republican proposals to reduce Medicare spending by \$283 billion over seven years, none of which would be reinvested to cover uninsured Americans.

Sincerely,

A handwritten signature in black ink, appearing to read "Pete Stark". The signature is written in a cursive, flowing style with a large initial "P".

Pete Stark
Member of Congress

239 Cannon House Office Building, Washington, DC 20515 202-225-5065

Numbers Cited by the Administration on Medicare

Increase in average out-of-pocket costs:

Single Beneficiary: \$625 in 2002; \$2,825 over seven-year period
Medicare Couple: \$1,250 in 2002; \$5,650 over seven-year period

The Republican Conference Agreement estimates of saving were released on June 30, 1995. That document contained:

- \$270 billion in Medicare cuts over seven years;
- \$71 billion in Medicare cuts in 2002 alone.

The estimate is based on the assumption that 50% of the total cuts would be borne by beneficiaries. This is consistent with the recent Republican Ways and Means document outlining Medicare cuts. These estimates assume that the current policy of setting the Part B premium at 25% will be extended when it expires in 1998.

For couples, this increase in premiums and out of pocket costs is multiplied by two. For the seven year period, the increases in each year are added together to get a cumulative total.

Premium increase of \$1,650 over seven years

In the Republicans' Ways and Means document outlining potential premium increases, they listed increasing the premium to 31.5%, 33%, or 35%. The Congressional Budget Office has estimated the change in premiums for several different levels. These estimates suggest that the monthly premium would be \$109 under the mid-range option of 33% in 2002, relative to \$61 under current law, and \$83 if the current policy of 25% is extended beyond its expiration in 1998. When the 33% premium is subtracted from the 25% premium, multiplied by 12 to get the annual savings, this means a \$320 increase in 2002, and approximately \$1,650 increase over the seven years. Note: this estimate does not include a premium offset, which would result if the premium increase were accompanied by a set of Part B spending reductions.

Increase of \$1,700 for the average home health user; \$1,400 for the average SNF user

The Congressional Budget Office, in its "Reducing the Deficit: Spending and Revenue Options", estimated the cost of a 20% coinsurance for all home health care for Medicare beneficiaries. Their 2000 estimate, extended to 2002, was divided by the projected number of users of home health to get an average of \$1,400 in 2002. This is consistent with the AARP's analysis of the same policy, which showed the increase cost of \$1,200 in the year 2000. This estimate of \$1,700 includes the increased premium (from 25% to 33%) in 2002 (about \$300) plus the average

increase in coinsurance for home health users (\$1,400). The same methodology was used to estimate the \$1,400 increase in payments for the average beneficiary in a nursing home in 2002 (assuming 20% coinsurance for skilled nursing facilities).

Private health care costs growth is over 40% more than the per-beneficiary growth rate in the Republican Conference Agreement

Data from the Congressional Budget Office (CBO) suggest that the projected private sector spending per insured person will grow at 7.1% between 1996 and 2002. The Republican Conference Agreement estimates of spending after their cuts show Medicare spending per beneficiary growing at 4.9%. The private rate of 7.1% is about 44% higher than the Republican Medicare growth rate per beneficiary of 4.9%.

Elderly currently pay 21% of their income on health care.

The Urban Institute estimated that in 1994, the elderly paid on average \$2,519 in out-of-pocket costs for health care, which translates into 21% of their income. This is more dramatic for the poor elderly, who pay 34% of their income for out-of-pocket costs, and for the oldest elderly, who pay on average \$3,782 in out-of-pocket costs. (See: "Out-of-Pocket Health Care Costs for Older Americans in 1994", The Urban Institute, May 1995).

543-6911

CLINTON LIBRARY PHOTOCOPY